

**SELF-FUNDED
PLAN DOCUMENT
FOR**

Clafin University

**GROUP MEDICAL, DENTAL
& SHORT-TERM DISABILITY PLAN**

**Restated
Effective Date: February 1, 2019**

TABLE OF CONTENTS

ABOUT YOUR PLAN	1
PREAUTHORIZATION.....	4
CLAIMS FILING AND APPEAL PROCEDURES	6
CASE MANAGEMENT.....	11
MEDICAL SCHEDULE OF BENEFITS	13
PRESCRIPTION DRUG BENEFITS	18
DENTAL SCHEDULE OF BENEFITS	19
MEDICAL BENEFITS	20
HUMAN ORGAN OR TISSUE TRANSPLANT BENEFITS	26
SHORT TERM DISABILITY BENEFITS.....	28
FAMILY MEDICAL LEAVE ACT AND LEAVE OF ABSENCE.....	31
DENTAL BENEFITS	32
COVERED DENTAL EXPENSES	33
MEDICAL EXCLUSIONS AND LIMITATIONS.....	35
DENTAL EXCLUSIONS AND LIMITATIONS.....	40
ELIGIBILITY FOR COVERAGE.....	41
TERMINATION OF THIS PLAN OF BENEFITS	44
WOMEN’S HEALTH AND CANCER RIGHTS ACT OF 1998.....	48
FAMILY AND MEDICAL LEAVE ACT (“FMLA”).....	48
CONSOLIDATED OMNIBUS BUDGET RECONCILIATION ACT OF 1985	49
SUBROGATION / RIGHT OF REIMBURSEMENT	52
WORKERS’ COMPENSATION PROVISION.....	53
COORDINATION OF BENEFITS.....	54
ERISA RIGHTS.....	57
DISCLOSURE OF PROTECTED HEALTH INFORMATION TO PLAN SPONSOR.....	59
GENERAL INFORMATION	62
PLAN SPECIFIC INFORMATION	65
DEFINITIONS.....	66
INDEX	80

Capitalized terms are defined in the Definitions section of this Plan Document.

ABOUT YOUR PLAN

Because of the dramatic increase in the cost of medical care, group health Plans encourage and reward those covered individuals who are selective in their purchase of medical services.

Please review this booklet, which describes your health Plan. Be a selective medical consumer and assume the major role in keeping the cost of medical services at a minimum.

Your Plan Sponsor has established a comprehensive Group Health Plan (“Plan”) for its Employees. In connection with the Plan, your Plan Sponsor has retained the services of *Planned Administrators, Inc.* (“PAI”) (a third-party administrator) to process and pay health claims and to provide administrative services in connection with the operation of this Plan of Benefits. PAI has contracted with **BlueCross BlueShield of South Carolina Preferred Blue and First Health** as the Preferred Provider Organizations (“PPOs”).

You will receive maximum Benefits when you use Providers who participate in the PPO Program (the term “PPO Providers” is explained further below) and when you obtain authorization (when required) for services. You will pay more if you do not use PPO Providers or if you do not obtain prior authorization (unless it is an emergency). This information explains how to obtain authorization for services or supplies covered under this Plan.

It is your responsibility to ensure that your Provider is a PPO Provider. You should verify your Provider’s status before services are rendered. To verify whether your Provider is a PPO Provider, you may:

- Ask the Provider if they participate in the PPO program referenced above.
- See the appropriate website for Provider information. Link available on www.paisc.com.
- Call PAI.*

* The methods of verifying PPO participation may have timing differences between when a Provider is participating in the PPO or terminating from the PPO. The preferable method of obtaining the most correct information is to ask your Provider.

The PPOs for this Group Health Plan are:

South Carolina Employees:	BlueCross BlueShield of South Carolina Preferred Blue Network
Georgia/Maryland/North Carolina/ Arkansas/Florida Employees:	First Health
Traveling outside network area:	First Health

PPO Providers include Hospitals, Skilled Nursing Facilities, Home Health Agencies, hospices, doctors and other Providers of medical services and supplies (as listed in the Definitions section) that have a written agreement with the PPO. Under their agreement with the PPO, PPO Providers will:

- File all claims for Benefits or supplies with PAI;
- Ask you to pay only the Deductible, per occurrence Copays and Coinsurance amounts, if any, for Benefits;
- Accept the preferred allowance as payment in full for Covered Expenses;
- Make sure that all necessary approvals are obtained from the Medical Services Department.

Non-PPO Providers include Hospitals, Skilled Nursing Facilities, Home Health Agencies, hospices, doctors and other Providers of medical services and supplies that are not under contract with the PPO. Non-PPO Providers can bill you their total charge. They may ask you to pay the total amount of their charges at the time you receive services or supplies, or to file your own claims, and you will need to obtain any necessary approvals for benefits to be paid. In

addition to Deductibles and Coinsurance, you are responsible for the difference between the Non-PPO Provider's charge and the Allowed Amount for Covered Expenses.

Although Benefits typically are reduced when you use a Non-PPO Provider, Benefits provided by a Non-PPO Provider will be covered at the PPO Provider level under these circumstances:

- In the event treatment is for an Emergency Medical Condition as defined in this Plan of Benefits and PPO Provider care is not available;
- For Dependents living out of state;
- For treatment by a Specialist when a PPO Provider Specialist is not available;
- For Non-PPO Provider ancillary services rendered in a PPO Provider Hospital, and/or
- The Participant requires a Transplant and the Transplant is performed at a Centers of Excellence (COE) facility.

Out-of-area Emergency Provision—If a Participant receives care for an Emergency Medical Condition from a Non-Participating Provider, the Plan will pay for Benefits at a PPO Provider level of Benefits if all of these conditions are met:

- You were traveling for reasons other than seeking medical care when the Emergency Medical Condition occurred.
- You were treated for an accidental injury or new Emergency Medical Condition.

Benefits under this provision are subject to the Deductibles or Copays, Coinsurance and all Plan of Benefits maximums, limits and exclusions.

If you have claims that meet all of these conditions, write or call PAI. PAI will review your claims to determine if additional Benefits can be provided.

Customer Service

PAI is committed to helping you understand your coverage and obtain maximum Benefits on your claims. If you have questions about your coverage, you may call or write PAI at:

Planned Administrators, Inc.
Attn: Claims
P.O. Box 6927
Columbia, SC 29260
800-768-4375
www.paisc.com

Once a claim has been processed, you will have access to an Explanation of Benefits (EOB) at www.paisc.com or by contacting customer service. An EOB also will be mailed to you. The EOB explains who provided the care, the kind of service or supply received, the amount billed, the Allowed Amount, the Coinsurance rate and the amount paid. It also shows Benefit Year Deductible information and the reasons for denying or reducing a claim.

Time Limits to File a Claim

Claims must be filed no later than 12 months from the incurred dates of service in which you or your Dependents receive the medical services or supplies. Exceptions may be made where you show that you were not legally competent to file the claim.

Authorized Representatives and Representatives designated under Health Insurance Portability and Accountability Act of 1996 (HIPAA)

Unless expressly permitted by law, you and your Dependent's PHI generally cannot be released to any other person without your or your Dependent's consent. Nevertheless, there are instances when you may want someone to discuss your PHI with PAI or receive an Explanation of Benefits etc. to manage your care. In order to comply with applicable laws and also to comply with your request, you must sign a written authorization form. To obtain a copy of the form, please log in to your Member page at www.paisc.com and click on the Forms tab where you will find the PAI HIPAA Forms option. You can print this form and mail to the PAI address, or you can call 800-768-4375 for a copy of the form.

A Provider may be considered a Participant's authorized representative without a specific designation by the Participant when the claim request is for an Urgent Care Claim. A Provider may be a Participant's authorized representative with regard to non-Urgent Care Claims for Benefits or an appeal of an Adverse Benefit Determination only when the Participant gives the Plan supervisor a specific written designation in a format that is reasonably acceptable to PAI to act as an authorized representative. All information and notifications will continue to be directed to the Participant unless the Participant gives contrary directions.

PREAUTHORIZATION

To receive the maximum Benefits, certain types of services and equipment and all Admissions require Preauthorization in order to be covered under the Plan. Depending on the type of service, either the BlueCross BlueShield of South Carolina Medical Review Department or Companion Benefit Alternatives, Inc. (“CBA”) must give advance authorization for the services and equipment that require Preauthorization and for all Admissions.

All Admissions and some Benefits (as indicated herein or on the Schedule of Benefits) require Preauthorization to determine the Medical Necessity of such Admission or Benefit. The Group Health Plan reserves the right to add or remove Benefits that are subject to Preauthorization. Each Participant is responsible for obtaining Preauthorization and the appropriate review. If Preauthorization is not obtained for an Admission or outpatient services and the Participant is still admitted, Benefits may be reduced (up to and including denial of all or a portion of the room and board charges associated with the Admission) as listed on the Schedule of Benefits. If a PPO fails to obtain Preauthorization, they are required to write off this reduced amount and cannot bill the Participant for this amount. The Participant is responsible for obtaining Preauthorization for Admission to a Non-PPO Provider facility, and the Participant will be responsible for any penalty or reduction in payable charges as stated in the Schedule of Benefits if approval is not obtained. Preauthorization is obtained through these procedures:

1. For all Admissions that are not the result of an Emergency Medical Condition, Preauthorization is granted or denied in the course of the Preadmission Review.
2. For all Admissions that result from an Emergency Medical Condition, Preauthorization is granted or denied in the course of the Emergency Admission Review.
3. For Admissions that are anticipated to require more days than approved through the initial review process, Preauthorization is granted or denied for additional days in the course of the Continued Stay Review.
4. For specific Benefits that require Preauthorization, Preauthorization is granted or denied in the course of the Preauthorization process.
5. For items requiring Preauthorization, the Medical Review Department or CBA must be called at the numbers listed below or on the Identification Card.

Items requiring Preauthorization are listed on the Schedule of Benefits.

Who to Call for Preauthorization

For Preauthorization for medical care, call the BlueCross BlueShield of South Carolina Medical Review Department at 800-652-3076.

For Preauthorization for Inpatient and Outpatient Mental Health Services, Mental Health Conditions or Substance Abuse Services, call CBA at 800-868-1032. CBA is a Mental Health and Substance Abuse subsidiary of BlueCross BlueShield of South Carolina.

If you are unsure if Preauthorization is required, call PAI customer service. Nevertheless, customer service representatives cannot give approval for services.

These numbers also are on your Identification Card. Be sure to keep your Identification Card with you at all times, since you never know when you may need to reach us.

When you call for Preauthorization, you will be asked for:

- Your name and ID number
- Participant’s Employer
- The patient’s name and relationship to you
- The Provider’s name, address and phone number
- If applicable, the Hospital or Skilled Nursing Facility’s name, address and phone number

- The reason the requested service, supply or Admission is necessary

After careful review, your Physician and Hospital will be notified whether the service, supply or Admission is approved as Medically Necessary and how long the approval is valid.

If you are or a Dependent is undergoing a human organ and/or tissue Transplant, written approval must be obtained in advance [and the procedure must be done at a facility that PAI designates]. **If PAI does not pre-approve these services in writing** [or they are not done by a Provider PAI designates], then this Plan will not pay any Benefits.

If your Physician recommends services and supplies for you or your Dependent for any reason, make sure you tell your Physician that your health insurance Plan requires Preauthorization. Participating Providers will be familiar with this requirement and will get the necessary approvals.

Please note that if your claim for services or Benefits is denied, you may request further review under the guidelines set out in the Claims Filing and Appeal Procedures section of this booklet. Remember that a denial of a Preauthorization is a denied claim for purposes of an appeal.

CLAIMS FILING AND APPEAL PROCEDURES

A. CLAIMS FILING PROCEDURES

1. Where a Participating Provider renders services, generally the Participating Provider should either file the claim on a Participant's behalf or provide an electronic means for the Participant to file a claim while the Participant is in the Participating Provider's office. Nevertheless, the Participant is responsible for ensuring that the claim is filed.
2. Written notice of receipt of services on which a claim is based must be furnished to PAI, at its address listed in this booklet, within twenty (20) days of the beginning of services, or as soon thereafter as is reasonably possible. Failure to give notice within the time does not invalidate nor reduce any claim if the Participant can show that it was not reasonably possible to give the notice within the required time frame and if notice was given as soon as reasonably possible. Upon receipt of the notice, PAI will furnish or cause a claim form to be furnished to the Participant. If the claim form is not furnished within fifteen (15) days after PAI receives the notice, the Participant will be deemed to have complied with the requirements of this Plan of Benefits as to proof of loss. The Participant must submit written proof covering the character and extent of the services within this Plan of Benefits' time fixed for filing proof of loss.
3. For Benefits not provided by a Participating Provider, the Participant is responsible for filing claims with PAI. When filing the claims, the Participant will need:
 - a. A claim form for each Participant. Participants can get claim forms from PAI at the telephone number indicated on the Identification Card or via the website, www.paisc.com.
 - b. Itemized bills from the Provider(s). These bills should contain the:
 - i. Provider's name and address;
 - ii. Participant's name and date of birth;
 - iii. Participant's Identification Card number;
 - iv. Description and cost of each service;
 - v. Date that each service took place;
 - vi. Description of the illness or injury and diagnosis.
 - c. Participants must complete each claim form and attach the itemized bill(s) to it. If a Participant has other insurance that already paid on the claim(s), the Participant also should attach a copy of the other Plan's Explanation of Benefits notice.
 - d. Participants should make copies of all claim forms and itemized bills for the Participant's records, since they will not be returned. Claims should be mailed to PAI's address listed on the claim form.
4. PAI must receive the claim within ninety (90) days after the beginning of services. Failure to file the claim within the ninety (90) day period, nevertheless, will not prevent payment of Covered Expenses if the Participant shows it was not reasonably possible to file the claim timely, provided the claim is filed as soon as is reasonably possible. Except in the absence of legal capacity, claims must be filed no later than twelve (12) months following the date services were received.
5. Receipt of a claim by PAI will be deemed written proof of loss and will serve as written authorization from the Participant to PAI to obtain any medical or financial records and documents useful to the Plan of Benefits. The Plan of Benefits, however, is not required to obtain any additional records or documents to support payment of a claim and is responsible to pay claims only on the basis of the information supplied at the time the claim was processed. Any party who submits medical or financial reports and documents to PAI in support of a Participant's claim will be deemed to be acting as the agent of the Participant. If the Participant desires to appoint an Authorized Representative in connection with such Participant's claims, the Participant should contact PAI for an Authorized Representative form.

6. There are four (4) types of claims: Pre-Service Claims, Urgent Care Claims, Post-Service Claims, and Concurrent Care Claims. The Group Health Plan will make a determination for each type of claim within these time periods:
 - a. Pre-Service Claim
 - i. A determination will be provided in writing or in electronic form within a reasonable period of time, appropriate to the medical circumstances, but no later than fifteen (15) days from receipt of the claim.
 - ii. If a Pre-Service Claim is improperly filed, or otherwise does not follow applicable procedures, the Participant will be sent notification within five (5) days of receipt of the claim.
 - iii. An extension of fifteen (15) days is permitted if PAI (on behalf of the Group Health Plan) determines, for reasons beyond the control of PAI, an extension is necessary. If an extension is necessary, PAI will notify the Participant within the initial fifteen (15) day time period that an extension is necessary, the circumstances requiring the extension, and the date PAI expects to render a determination. If the extension is necessary to request additional information, the extension notice will describe the required information. The Participant will have at least forty-five (45) days to provide the required information. If PAI does not receive the required information within the forty-five (45) day time period, the claim will be denied. PAI will make its determination within fifteen (15) days of receipt of the requested information, or, if earlier, the deadline to submit the information. If PAI receives the requested information after the forty-five (45) days, but within two hundred twenty-five (225) days, the claim will be reviewed as a first-level appeal. Reference the Claims Filing and Appeal Procedures section, B. Appeal Procedures for an Adverse Benefit Determination, for details regarding the appeals process.
 - b. Urgent Care Claim
 - i. A determination will be sent to the Participant in writing or in electronic form as soon as possible, taking into account the medical exigencies, but no later than seventy-two (72) hours from receipt of the claim.
 - ii. If the Participant's Urgent Care Claim is determined to be incomplete, the Participant will be sent a notice to this effect within twenty-four (24) hours of receipt of the claim. The Participant then will have forty-eight (48) hours to provide the additional information. Failure to provide the additional information within forty-eight (48) hours may result in the denial of the claim.
 - iii. If the Participant requests an extension of Urgent Care Benefits beyond an initially determined period and makes the request at least twenty-four (24) hours prior to the expiration of the original determination period, the Participant will be notified within twenty-four (24) hours of receipt of the request for an extension.
 - c. Post-Service Claim
 - i. A determination will be sent within a reasonable time period, but no later than thirty (30) days from receipt of the claim.
 - ii. An extension of fifteen (15) days may be necessary if PAI (on behalf of the Group Health Plan) determines, for reasons beyond the control of PAI, an extension is necessary. If an extension is necessary, PAI will notify the Participant within the initial thirty (30) day time period that an extension is necessary, the circumstances requiring the extension, and the date PAI expects to render a determination. If the extension is necessary to request additional information, the extension notice will describe the required information. The Participant will have at least forty-five (45) days to provide the required information. If PAI does not receive the required information within the forty-five (45) day time period, the claim will be denied. PAI will make its determination within fifteen (15) days of receipt of the requested information, or, if earlier, the deadline to submit the information. If PAI receives the requested information after the forty-five (45) days, but within two hundred twenty-five (225) days, the claim will be reviewed as a first-level appeal. Reference the Claims Filing and Appeal Procedures section, B. Appeal Procedures for an Adverse Benefit Determination, for details regarding the appeals process.

d. Concurrent Care Claim

The Participant will be notified if there is to be any reduction or termination in coverage for ongoing care sufficiently in advance of such reduction or termination to allow the Participant time to appeal the decision before the Benefits are reduced or terminated.

7. Notice of Determination

- a. If the Participant's claim is filed properly, and the claim is in part or wholly denied, the Participant will receive notice of an Adverse Benefit Determination. This notice will:
 - i. State the specific reason(s) for the Adverse Benefit Determination;
 - ii. Reference the specific Plan of Benefits provisions on which the determination is based;
 - iii. Describe additional material or information, if any, needed to complete the claim and the reasons such material or information is necessary;
 - iv. Describe the claims review procedures and the Plan of Benefits and the time limits applicable to such procedures, including a statement of the Participant's right to bring a civil action under section 502(a) of ERISA following an Adverse Benefit Determination on review;
 - v. Disclose any internal rule, guideline, or protocol relied on in making the Adverse Benefit Determination (or state that such information is available free of charge upon request);
 - vi. If the reason for denial is based on a lack of Medical Necessity, or Experimental or Investigational services exclusion or similar limitation, explain the scientific or clinical judgment for the determination (or state that such information will be provided free of charge upon request).
- b. The Participant will also receive a notice if the claim is approved.

B. APPEAL PROCEDURES FOR AN ADVERSE BENEFIT DETERMINATION

1. The Participant has one hundred eighty (180) days from receipt of an Adverse Benefit Determination to file an appeal. An appeal must meet these requirements:
 - a. An appeal must be in writing;
 - b. An appeal must be sent (via U.S. mail or FAX) at the address or FAX number below:

Planned Administrators, Inc.
Attention: Appeals
P.O. Box 6927
Columbia, SC 29260
FAX 803-870-8012
 - c. The appeal request must state that a formal appeal is being requested and include all pertinent information regarding the claim in question;
 - d. An appeal must include the Participant's name, address, identification number and any other information, documentation or materials that support the Participant's appeal.
2. The Participant may submit written comments, documents, or other information in support of the appeal, and will (upon request) have access to all documents relevant to the claim. A person other than the person who made the initial decision will conduct the appeal. No deference will be afforded to the initial determination.
3. If the appealed claim involves an exercise of medical judgment, the Plan Sponsor will consult with an appropriately qualified health care practitioner with training and experience in the relevant field of medicine. If a health care professional was consulted for the initial determination, a different health care professional will be consulted on the appeal.
4. The final decision on the appeal will be made within the time periods specified below:
 - a. Pre-Service Claim

PAI (on behalf of the Group Health Plan) will decide the appeal within a reasonable period of time, taking into account the medical circumstances, but no later than thirty (30) days after receipt of the appeal.

b. Urgent Care Claim

The Participant may request an expedited appeal of an Urgent Care Claim. This expedited appeal request may be made orally, and the Plan Sponsor will communicate with the Participant by telephone or facsimile. The Plan Sponsor will decide the appeal within a reasonable period of time, taking into account the medical circumstances, but no later than seventy-two (72) hours after receipt of the request for an expedited appeal.

c. Post-Service Claim

PAI (on behalf of the Group Health Plan) will decide the appeal within a reasonable period of time, but no later than sixty (60) days after receipt of the appeal.

d. Concurrent Care Claim

The Plan Sponsor will decide the appeal of Concurrent Care Claims within the time frames set forth in the Claims Filing and Appeal Procedures section, B. Appeal Procedures for an Adverse Benefit Determination, item 4 a.-c., depending on whether such claim also is a Pre-Service Claim, an Urgent Care Claim or a Post-Service Claim.

5. Notice of Final Internal Appeals Determination

a. If a Participant's appeal is denied in whole or in part, the Participant will receive notice of an Adverse Benefit Determination.

- i. State specific reason(s) for the Adverse Benefit Determination;
- ii. Reference specific provision(s) of the Plan of Benefits on which the Benefit determination is based;
- iii. State that the Participant is entitled to receive, upon request and free of charge, reasonable access to and copies of all documents, records, and other information relevant to the claim for Benefits;
- iv. Disclose and provide any internal rule, guideline, or protocol relied on in making the Adverse Benefit Determination;
- v. If the reason for an Adverse Benefit Determination on appeal is based on a lack of Medical Necessity, or Experimental or Investigational services or other limitation or exclusion, explain the scientific or clinical judgment for the determination (or state that such information will be provided free of charge upon request);
- vi. Include a statement regarding the Participant's right to request an external review;
- vii. Include a statement regarding the Participant's right to bring an action under section 502(a) of ERISA.

b. The Participant will also receive a notice if the claim on appeal is approved.

6. The Plan Sponsor may retain PAI to assist the Plan Sponsor in making the determination on appeal. Regardless of its assistance, PAI is acting only in an advisory capacity and is not acting in a fiduciary capacity. The Plan Sponsor at all times retains the right to make the final determination.

C. EXTERNAL REVIEW PROCEDURES

1. After a Participant has completed the appeal process, a Participant may be entitled to an additional, external review of the Participant's claim at no cost to the Participant. An external review may be used to reconsider the Participant's claim if PAI has denied, either in whole or in part, the Participant's claim. In order to qualify for external review, the claim must have been denied, reduced, or terminated.

2. After a Participant has completed the appeal process (and an Adverse Benefit Determination has been made), such Participant will be notified in writing of such Participant's right to request an external review. The Participant should file a request for external review within four (4) months of receiving the notice of PAI's decision on the Participant's appeal. In order to receive an external review, the Participant will be required to authorize the release of such Participant's medical records (if needed in the review for the purpose of reaching a decision on Participant's claim).
3. Within six (6) business days of the date of receipt of a Participant's request for an external review, PAI will respond by either:
 - a. Assigning the Participant's request for an external review to an Independent Review Organization and forwarding the Participant's records to such organization;
 - b. Notifying the Participant in writing that the Participant's request does not meet the requirements for an external review and the reasons for PAI's decision.
4. The external review organization will take action on the Participant's request for an external review within forty-five (45) days after it receives the request for external review from PAI.
5. Expedited external reviews are available if the Participant's Physician certifies that the Participant has a serious medical condition. A serious medical condition, as used in the Claims Filing and Appeal Procedures section, C. External Review Procedures, item 5, means one requires immediate medical attention to avoid serious impairment to body functions, serious harm to an organ or body part, or would place the Participant's health in serious jeopardy. If the Participant may be held financially responsible for the treatment, a Participant may request an expedited review of PAI's decision if PAI's denial of Benefits involves Emergency Medical Care and the Participant has not been discharged from the treating Hospital.

CASE MANAGEMENT

Case management is provided through a contract between PAI and BlueCross BlueShield of South Carolina.

COMPREHENSIVE CASE MANAGEMENT

In the event of a serious or catastrophic illness or injury, this Plan of Benefits provides for a comprehensive case management program. The comprehensive case management program is a patient-centered approach to developing a comprehensive plan of cost-effective health care. The services provided under the case management program include:

- A. Evaluation and assistance for the Participant to help develop a plan of services to meet specific needs;
- B. Assistance with obtaining unusual equipment or supply needs;
- C. Assistance in home care planning and implementation;
- D. Arrangements for needed nursing/caregiver services;
- E. Providing help with assessment of rehabilitation needs and Provider arrangements;
- F. Offering appropriate and effective alternative care/therapy suggestions for Mental Health Services and/or Substance Abuse Services as determined by medical care review;
- G. Monitoring and assuring treatment programs and interventions for Mental Health Services and/or Substance Abuse Services;
- H. Functioning as an effective resource for information on treatment facilities and available care for Mental Health Services and/or Substance Abuse Services.

The case management program is voluntary and will not provide Benefits in excess of those ordinarily available under the Plan.

ALTERNATIVE TREATMENT PLAN UNDER CASE MANAGEMENT

In the course of the case management program, the Plan Administrator shall have the right to alter or waive the normal provisions of this Plan of Benefits when it is reasonable to expect a cost-effective result without a sacrifice to the quality of patient care.

Benefits provided under this section are subject to all other Plan of Benefits provisions. Alternative care will be determined on the merits of each individual case, and any care or treatment provided will not be considered as setting any precedent or creating any future liability with respect to that Participant or any other Participant. Nothing contained in this Plan of Benefits shall obligate the Plan Administrator to approve an alternative treatment plan.

Health Management Program

Your Employer will provide you with access to *Health Management*, a disease management program. *Health Management* gives participants with any of these diseases the opportunity to learn more about their conditions and how they can better care for themselves:

- **Asthma (Adult and Pediatric)**
- **Chronic Obstructive Pulmonary Disease (COPD)**
- **Diabetes (Adult and Pediatric)**
- **Heart Disease**
 - **Congestive Heart Failure (CHF)**
 - **Coronary Artery Disease (CAD)**
 - **Hyperlipidemia (High Cholesterol)**
 - **Hypertension (High Blood Pressure)**
- **Metabolic Health**
- **Migraine**

Covered Participants identified as having any of the conditions above will automatically be enrolled in Health Management. For Covered Participants who do not want to participate, call 855-838-5897.

Maternity Care is a maternity outcome management program which includes monitoring of all pre-natal care to ensure healthy babies and alternative treatment when Medically Necessary. Access to *Maternity Care* is as:

- *Maternity Care* should be notified of the expectant mother's delivery date as soon as she finds out she is pregnant, or when a woman is planning to become pregnant.
- In order to identify Participants who may be high risk during their pregnancies, all expectant mothers and their Physicians will be asked to complete a risk assessment form for *Maternity Care* at the beginning of their pregnancies and again during the second trimester.
- The *Maternity Care* nurse reviews the assessment form, and determines whether or not the expectant mother is at risk for preterm delivery or pregnancy complications.
- *Maternity Care* will contact the expectant mother's Physician to assure appropriate prenatal care.
- The expectant mother will be encouraged to visit her Physician on a regular basis and keep her scheduled appointments.
- High-risk pregnancies will be monitored by the *Maternity Care* nurse who will assist in arranging and monitoring any required special care.

For more information call 855-838-5897.

MEDICAL SCHEDULE OF BENEFITS

This Schedule of Benefits and the Benefits described herein are subject to all terms and conditions of the Plan of Benefits. In the event of a conflict between the Plan of Benefits and this Schedule of Benefits, the Schedule of Benefits shall control. Capitalized terms used in this Schedule of Benefits have the meaning given to such terms in the Plan of Benefits. Percentages stated are those paid by the Group Health Plan. Covered Expenses will be paid only for Benefits that are Medically Necessary.

Benefit Year is from January 1st – December 31st.

Deductibles:

Benefit Year Deductible: Benefits with an “*” indicate that the Benefit Year Deductible is waived.	\$3,400 per Participant per Benefit Year at a Participating Provider, limited to \$6,800 per family \$6,800 per Participant per Benefit Year at a Non-Participating Provider, limited to \$13,600 per family
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Benefit Year Deductible and any Copays must be met before any Covered Expenses are paid.

Covered Expenses that are applied to the Benefit Year Deductible shall contribute to both the Participating and Non-Participating Provider Benefit Year Deductible.

Maximums:

Annual Out-of-Pocket Maximum: Includes Benefit Year Deductible, Medical and Prescription Drug Copays, and Medical and Prescription Drug Coinsurance	\$7,150 per Participant and \$14,300 per family at a Participating Provider \$15,000 per Participant and \$30,000 per family at a Non-Participating Provider Covered Expenses that are applied to the Out-of-Pocket Maximum shall contribute to both the Participating and Non-Participating Provider Out-of-Pocket Maximums. Allowed Amounts are paid at 100% after the Out-of-Pocket Maximum is met. Penalties do not contribute to the Out-of-Pocket Maximum determination, nor does the percentage of reimbursement change from the amount indicated on the Schedule of Benefits.
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Preauthorization Requirements:

- ◆ **All Admissions require Preauthorization**—If Preauthorization is not obtained for services at a Participating Provider, room and board charges will be denied. Preauthorization for services at a Non-Participating Provider is your responsibility, and you will be responsible for the first \$500 if it is not obtained.
- ◆ **These services require Preauthorization.** If Preauthorization is not obtained, Benefits may be denied.
 - * Home Health Care
 - * Hospice Care
 - * Admissions for physical rehabilitation
 - * Air ambulance
 - * Human organ and/or tissue Transplants
 - * Durable Medical Equipment when the purchase price or rental cost of the equipment is \$250 or more
 - * Sclerotherapy
 - * Septoplasty
 - * Any surgical procedure that may be potentially cosmetic: e.g., blepharoplasty, reduction mammoplasty
 - * Hysterectomy
 - * Inpatient and Outpatient for Mental Health
 - * Inpatient and Outpatient for Substance Abuse

INPATIENT HOSPITAL SERVICES:	PPO:	Non-PPO:
Preauthorization required		
Room and Board: If a facility has only private rooms, the Plan will consider the average private room rate	70%	50%
Skilled Nursing Facility: Limited to 100 days per Calendar Year	70%	50%
Residential Treatment Facility:	70%	50%
Physical Rehabilitation Facility:	70%	50%
Intensive Care Unit, Cardiac Care Unit, Burn Unit:	70%	50%
Newborn Nursery:	70%	50%
Physician Expenses:	70%	50%
Radiology/Pathology Charges:	70%	50%
Mental Health or Substance Abuse:	70%	50%
Anesthesia:	70%	50%

OUTPATIENT SERVICES:	PPO:	Non-PPO:
Hospital Charges:	70%	50%
Physician Charges:	\$30 Copay, then *100%	50%
Hospital Charges for Surgery:	70%	50%
Hospital Physician Charges for Surgery:	70%	50%
Outpatient Clinic Visits:	\$30 Copay, then *100%	50%
Emergency Room Facility Charges: Copay waived if admitted	\$150 Copay, then 70%	\$150 Copay, then 70%
Emergency Room Physician Charges:	70%	70%
Preadmission Testing:	*70%	Not Covered
Anesthesia:	70%	50%
Cardiac Rehabilitation:	70%	50%
Mental Health or Substance Abuse: Preauthorization required	70%	50%
Diagnostic Colonoscopies: Includes Facility, Anesthesia, Lab, Pathology	70%	50%
Diagnostic X-ray, Laboratory, Pathology, and Radiology:	*100%	*100%

PHYSICIAN OFFICE SERVICES:	PPO:	Non-PPO:
Physician Office Visit: Including Mental Health, Substance Abuse, Surgery and Accident Generalist: Specialist:	\$30 Copay, then *100% \$40 Copay, then *100%	50%
Urgent Care:	\$50 Copay, then *100%	\$50 Copay, then *100%
Retail Clinics:	\$20 Copay, then *100%	50%
Injections:	*100%	50%
Birth Control Device Surgery: IUD, Implanon and Norplant	*100%	50%
Lab, X-ray, Pathology and Radiology:	*100%	*100%
Supplies:	\$30 Copay, then *100%	50%
Allergy Serum and Injections:	70%	50%
MRIs and CT Scans (includes reading of scans): Billed by the office	\$30 Copay, then *100%	50%
MRIs and CT Scans (includes reading of scans): Associated with an office visit but billed separately	70%	50%
PET Scans (includes reading of scans):	70%	50%

Generalists include General Practice, Internal Medicine, Pediatricians, OB/GYNs, Nurse Practitioners and Mixed Specialty.

NOTE: Licensed Marriage/Family Therapists are Providers under this Plan of Benefits.

OTHER SERVICES:	PPO:	Non-PPO:
Chiropractic Care: Limited to 20 visits per Calendar Year	\$30 Copay, then *100%	50%
Hospice Care: Preauthorization required—Includes Bereavement Counseling	70%	50%
Home Health Care: Limited to 100 visits per Calendar Year—Preauthorization required	70%	50%
Durable Medical Equipment: Preauthorization is required if \$250 or more	70%	50%
Second Surgical Opinion (not mandatory):	70%	50%
Human Organ/Tissue Transplants: Preauthorization required—Covered only at a facility approved by PAI in writing.	70%	50%
Ambulance:	70%	70%
Prosthetic Bras after a Mastectomy: Limited to 4 per Calendar Year	70%	70%
Prosthetics:	70%	50%
Physical Therapy:	70%	50%
Occupational Therapy:	70%	50%
Speech Therapy:	70%	50%
Radiation Therapy and Chemotherapy:	70%	50%
Wig/Toupee after Chemotherapy, Radiation Therapy, Infusion Therapy or Burns: Limited to 1 wig/toupee per lifetime	70%	70%
Temporomandibular Joint Disorder (TMJ): Limited to \$5,000 per lifetime	70%	50%
Orthotics: See MEDICAL BENEFITS section for specific Benefit information	70%	50%
Infertility: Limited to care, supplies and services to diagnose infertility only	70%	50%
Dialysis:	70%	70%
Diabetic Self-Management Education Programs:	70%	50%
Diabetic Supplies:	70%	50%
Maternity Care: Initial visit to determine pregnancy: Subsequent prenatal/postnatal visits and delivery	\$30 Copay, then *100% 70%	50%
Morbid Obesity Treatment: Limited to \$10,000 per lifetime for non-surgical treatment only	70%	50%
Colorectal Screenings:	70%	Not Covered
Bone Density Scans:	70%	Not Covered
Private Duty Nursing:	70%	50%
All Other Covered Benefits:	70%	50%

WELLNESS SERVICES	PPO:	Non-PPO:
Annual Physical Exam: Flu Shots and Gardasil immunizations included. Shingles immunizations covered for age 60 and over.	*100%	Not Covered
Annual Gynecological Exam or Prostate Exam:	*100%	Not Covered
Well-Child Care: Includes Office Visit charges, routine Exams, Labs/blood testing, X-rays, Hearing, Vision screening and Immunizations.	*100%	Not Covered
Annual Routine Mammograms: Limited to age 40 and over	*100%	Not Covered
Routine Colonoscopy for age 50 and above: Subject to ACA age Guidelines	*100%	Not Covered

Preventive services according to guidelines under ACA are covered with no cost sharing PPO including Women's Services as required by Health Care Reform.

PRESCRIPTION DRUG BENEFITS

Prescription Drug Benefits are subject to all of the Prescription Drug Exclusions listed in this document.

Prescription Drugs are provided through the Caremark Prescription Drug Program from the Advanced Choice Pharmacy Network (**Walgreens Pharmacy is excluded**). Caremark uses the Medispan defined drug/therapeutic classification for product coverage and exclusion. Prescription Drugs will be covered in this manner:

Participating Pharmacies:

Copay per prescription (34-day supply maximum per prescription):

Non-Preferred Brand Name Drug	\$60 Copay, then 0%
Preferred Brand Name Drug	\$40 Copay, then 0%
Generic Drug	\$10 Copay, then 0%
Specialty Drug	25% Coinsurance with a \$60 minimum and \$150 maximum

Mail Service Pharmacy:

Copay per Prescription (90-day supply maximum per prescription):

Non-Preferred Brand Name Drug	\$120 Copay, then 0%
Preferred Brand Name Drug	\$80 Copay, then 0%
Generic Drug	\$20 Copay, then 0%
Specialty Drug	25% Coinsurance with a \$120 minimum and \$300 maximum

Prescription Drug Copays track to the Annual Out-of-Pocket Maximum.

Note: All Seasonal (Flu) vaccines and Non-Seasonal vaccines as outlined by the CDC are covered at zero cost to Participants at the Pharmacy.

Smoking Cessation Drugs are covered at zero cost to Participants with no limits.

Contraceptives are covered per ACA guidelines with no cost to the Participant.

Mandatory Generic Drug Policy:

If a Generic Drug is available and the Participant chooses to get a Brand Name Drug instead, the Participant will be required to pay the Brand Name Drug Copay plus the difference in the cost of the Brand Name Drug and the Generic Drug. If the Physician prescribes the drug as "Dispense as Written," the Participant will be required to pay only the Brand Name Drug cost. **For a list of Preferred/Non-Preferred Brand Name Drugs, participants can go to <https://www.caremark.com/wps/portal>.**

Step Therapy Program:

Through the Step Therapy Program Participants are required to try cost-effective "First Choice" medications before trying (or "stepping up to") more expensive "Second Choice" medications.

Prior Authorization Program

A quality and safety program that promotes the proper use of certain medications by requiring prior approval before the Plan will cover them.

Quantity Management Program:

The Quantity Management Program is a quality and safety program that promotes the safe use of medications. The program limits the amount of some medications that are covered.

DENTAL SCHEDULE OF BENEFITS

All Benefits are subject to the fee schedule and Benefit Year Deductible (unless indicated otherwise). Please refer to the Covered Dental Expenses section for a complete listing of Benefits and any additional conditions/limitations that may apply.

<u>CLASSES OF EXPENSES</u>	<u>% TO PAY</u>	<u>DEDUCTIBLE</u> <u>Yes or No</u>
CLASS I – Diagnostic and Preventive Dental Benefits	100%	No
CLASS II - Basic Dental, Oral Surgery and Periodontic Services	80%	Yes
CLASS III - Prosthodontic Services	50%	Yes
CLASS IV up to age 19- Orthodontic Benefits	50%	Yes
Lifetime Maximum per Participant for Orthodontic Benefits:		\$1,000
Maximum per Participant per Benefit Year for Classes I-III:		\$1,000
Per Benefit Year Dental Deductible -		
Per Participant:		\$50
Per Family:		\$150

Note: Dental coverage applies only if you elected this benefit during open enrollment, or upon your initial eligibility period as a new hire, or upon applicable and approved qualified life events.

MEDICAL BENEFITS

A. Payment

The payment of Covered Expenses for Benefits is subject to all terms and conditions of the Plan of Benefits and the Schedule of Benefits. In the event of a conflict between the Plan of Benefits and the Schedule of Benefits, the Schedule of Benefits controls. Covered Expenses will be paid only for Benefits:

1. Performed or provided on or after the Participant Effective Date;
2. Performed or provided prior to termination of coverage;
3. Provided by a Provider, within the scope of his or her license;
4. For which the required Preadmission Review, Emergency Admission Review, Preauthorization and/or Continued Stay Review has been requested and Preauthorization was received from PAI (the Participant should refer to the Schedule of Benefits for services that require Preauthorization);
5. That are Medically Necessary;
6. That are not subject to an exclusion of this Plan of Benefits;
7. After the payment of all required Benefit Year Deductibles, Coinsurance and Copays.

B. Specific Covered Benefits

If all of these requirements are met, the Group Health Plan will provide the Benefits described in this section:

1. All of the requirements of this Benefits Section must be met;
2. The Benefit must be listed in this section;
3. The Benefit (separately or collectively) must not exceed the dollar amount or other limitations contained on the Schedule of Benefits;
4. The Benefit must not be subject to one or more of the exclusions set forth in the Exclusions and Limitations Section.

The Group Health Plan will provide these Benefits:

1. Covered Expenses for **ambulance transportation** (including air ambulance when necessary) when used:
 - A. Locally to or from a Hospital providing Medically Necessary services in connection with an accidental injury or that is the result of an Emergency Medical Condition;
 - B. To or from a Hospital in connection with an Admission.

In some cases, emergency transportation by an air ambulance may qualify as ambulance service. Air ambulance service must be Medically Necessary. Medical Necessity is established when the patient's condition is such that the use of any other method of transportation is contraindicated. All air ambulance services will be individually considered for Medical Necessity and prior authorization should be obtained if possible.

2. Covered Expenses made by an **Ambulatory Surgical Center** or minor emergency medical clinic.
3. Covered Expenses for the cost and administration of an **anesthetic**; however, anesthesia rendered by the attending surgeon or his/her assistant is excluded.
4. Covered Expenses for **artificial limbs or breast prosthesis**, to replace body parts when the replacement is necessary because of physiological changes.

5. When an **assistant surgeon** is required to render technical assistance at an operation, the eligible expense for such services shall be limited to 20% of the Allowed Amount of the surgical procedure.
6. Covered Expenses incurred for the treatment of **autism**.
7. Services, supplies, care and treatment in connection with **birth control**.
8. **Blood transfusions**, including cost of blood, blood plasma, blood plasma expanders and other blood products not donated or replaced by a blood bank.
9. Covered Expenses for **bone density scans**.
10. Phase II **cardiac rehabilitation** (to improve a patient's tolerance for physical activity or exercise) will be covered under a medically supervised and controlled reconditioning program.
11. Covered Expenses for **chiropractic care**.
12. Charges incurred for Routine Participant Costs for items and services related to **clinical trials** are covered when:
 - A. The Participant has cancer or other life-threatening disease or condition;
 - B. The referring Provider is a Participating Provider that has concluded the Participant's involvement in such a trial would be appropriate;
 - C. The Participant provides medical and scientific information establishing the Participant's involvement in such a trial would be appropriate;
 - D. The services are furnished in connection with an Approved Clinical Trial.

Group Health Plans may not:

- A. Deny a Qualified Individual participation in an Approved Clinical Trial with respect to the treatment of cancer or another life-threatening disease or condition;
- B. Deny (or limit or impose additional conditions on) a Qualified Individual the coverage of Routine Participant Costs for items and services furnished in connection with participation in the trial;
- C. Discriminate against an individual on the basis of the individual's participation in the trial.

USE OF IN-NETWORK PROVIDERS: If one or more Participating Providers participate in an Approved Clinical Trial, then the Plan requires the Qualified Individual participate in the trial through a Participating Provider accepting patients for the trial.

USE OF OUT-OF-NETWORK PROVIDERS: Qualified Individuals participating in Approved Clinical Trials conducted outside the State in which the Qualified Individual resides will receive out-of-network Benefits for Routine Participant Costs.

13. Covered Expenses for diagnostic **colonoscopies**.
14. Covered Expenses for **colorectal screenings**.
15. Initial **contact lenses** or one pair of **eyeglasses** required following cataract surgery;
16. Covered Expenses for **cosmetic surgery**, only for these situations:
 - A. When the malappearance or deformity is due to a congenital anomaly;
 - B. When due solely to surgical removal of all or part of the breast tissue because of an injury or illness to the breast;
 - C. When required for the medical care and treatment of a cleft lip and palate.

Coverage for the proposed cosmetic surgery or treatment must be Preauthorized by the Medical Review Department prior to the date of that surgery or treatment.

17. Charge for **dental services** rendered by a Physician for treatment of an accidental injury to Natural Teeth if all treatment is rendered within twelve (12) months of the accidental injury.
18. **Diabetic self-management education programs** meant to enable a diabetic and his/her family to understand the disease and to manage its daily therapy. Such a program must be prescribed by a Physician or a health care

professional designated by the Physician, and may be taught by a Physician, registered nurse, licensed Pharmacist or other health care professional who knows the disease and its treatment. Benefits will be payable on the same basis as any other illness under this Plan of Benefits.

19. Covered Expenses for **diabetic supplies** and **self-injectables**.
20. Charges for **dialysis**.
21. Covered Expenses for Prescription **Drugs** requiring a written prescription of a licensed Physician; such drugs must be necessary for the treatment of an illness or injury.
22. Covered Expenses for **Durable Medical Equipment** (such as renal dialysis machines, resuscitators or Hospital-type beds), required for temporary therapeutic use in the Participant's home by an individual patient for a specific condition when such equipment ordinarily is not used without the direction of a Physician. If such equipment is not available for rent, the monthly payments toward the purchase of the equipment may be approved by the Plan supervisor. Benefits will be reduced to standard equipment allowances when deluxe equipment is used. The rental or purchase Benefits cannot exceed the purchase price of the equipment. Oxygen concentrators are covered when Medically Necessary, limited to rental only. **Preauthorization required for expenses \$250 or more.**
23. Covered Expenses for **electrocardiograms**, electroencephalograms, pneumoencephalograms, basal metabolism tests or similar well-established diagnostic tests generally approved by Physicians throughout the United States.
24. Covered Expenses for Preauthorized **Home Health Care** when rendered to a homebound Participant in the Participant's current place of residence.
25. Covered Expenses for Preauthorized **Hospice Care** provided in an inpatient or outpatient setting.
26. **Hospital Covered Expenses** for:
 - A. Daily room and board charges in a Hospital, not to exceed the daily semiprivate room rate (charges when a Hospital private room has been used will be reimbursed at the average semiprivate room rate in the facility). Hospitals with all private rooms will be allowed at the prevailing private room rate;
 - B. The day on which a Participant leaves a Hospital or Skilled Nursing Facility, with or without permission, is treated as the discharge day and will not be counted as an inpatient care day, unless he returns to the Hospital by midnight of the same day. The day the Participant returns to the Hospital or Skilled Nursing Facility is treated as the Admission day and is counted as an inpatient care day. The days during which the Participant is not physically present for inpatient care are not counted as inpatient days;
 - C. Confinement in an intensive care unit, cardiac care unit or burn unit;
 - D. Miscellaneous Hospital services and supplies during Hospital confinement if such charges should not have been included in the underlying Hospital charge (as determined by the Plan);
 - E. Inpatient charges for well newborn care for nursery room and board and for professional service. Eligible expenses will be subject to the fee schedule rates for pediatric services and circumcision;
 - F. Outpatient Hospital services and supplies and emergency room treatment.
27. Charges otherwise covered under the Plan that are incurred for the care and treatment due to a **human organ or tissue Transplant** are subject to these limits:
 - A. The Transplant must be performed to replace an organ or tissue
 - B. These donor charges are eligible expenses under the Plan:
 - i. evaluating the organ or tissue (does not include charges for locating a suitable donor, a suitable organ or suitable tissues) ;
 - ii. removing the organ or tissue from the donor.

Charges for transportation of the organ or tissue from within the United States and Canada to the place where the Transplant is to take place. When the donor is covered under another plan and the recipient is a covered person under this Plan, this Plan will pay as secondary for the donor's eligible expenses. Eligible expenses will be charged to the recipient. When both the donor and the recipient are covered under this Plan, eligible expenses

incurred by each covered person will be treated separately for each covered person. When the donor is not covered by any plan and the recipient is a covered person under this Plan, the donor's eligible expenses will be charged to the recipient and paid by this Plan

28. Care, supplies and services to diagnose **infertility**.
29. Covered Expenses for **maternity care**.
30. Any expenses incurred in obtaining **medical records** in order to substantiate Medical Necessity.
31. Covered Expenses for dressings, sutures, casts, splints, trusses, crutches, pacemakers, braces (not dental braces) or other **Medical Supplies** determined by the Plan to be appropriate for treatment of an illness or injury.
32. Covered Expenses for **Mental Health Services** if rendered by a licensed medical Physician (M.D.), licensed psychologist (Ph.D.), clinical psychologist, licensed masters social worker, licensed marriage/family therapist or licensed professional counselor. Expenses for psychological testing are also covered.
33. Non-surgical treatment for **morbid obesity** to include nutritional counseling, weight loss programs through a Physician, or medications. Limited to \$10,000 per lifetime for non-surgical treatment only.
34. Covered Expenses for **MRIs, CT and PET scans**, including reading of the scans.
35. Covered Expenses for **newborn care**. The Plan of Benefits will comply with the terms of the Newborns' and Mothers' Health Protection Act of 1996. The Plan of Benefits will not restrict Benefits for any length of Hospital stay in connection with childbirth for the mother or newborn child to less than forty-eight (48) hours following a vaginal delivery (not including the day of delivery), or less than ninety-six (96) hours following a cesarean section (not including the day of surgery). Nothing in this paragraph prohibits the mother's or newborn's attending Provider, after consulting with the mother, from discharging the mother or her newborn earlier than the specified time frames or from requesting additional time for hospitalization. In any case, PAI may not require that a Provider obtain authorization from PAI for prescribing a length of stay not in excess of forty-eight (48) or ninety-six (96) hours as applicable. Nevertheless, Preauthorization is required to use certain Providers or facilities, or to reduce out-of-pocket costs.
36. Covered Expenses rendered by a **Nurse Practitioner**.
37. Covered Expenses for the treatment and services rendered by an **occupational therapist** in a home setting, at a facility or institution whose primary purpose is to provide medical care for an illness or injury, or at a free-standing outpatient facility.
38. Covered Expenses for these **oral surgical procedures**:
 - A. Excision of wholly or partly unerupted impacted teeth;
 - B. Open or closed reduction of a fracture or dislocation of the jaw;
 - C. Excision of tumors and cysts of the jaws, cheeks, lips, tongue, roof and floor of the mouth when a lab exam is required; excision of benign bony growths of the jaw and hard palate; external incision and drainage of cellulitis and incision of sensory sinuses, salivary glands or ducts.
39. Initial purchase, fitting and repair of custom made or prefabricated **orthotics** that are fitted and adjusted such as braces, splints or other appliances which are required for support for an injured or deformed part of the body as a result of a disabling congenital condition or an injury or sickness. Orthopedic shoes are not covered unless attached to a brace.
40. Covered Expenses for **oxygen** and other gases and their administration.
41. Covered Expenses incurred for Admission in a **physical rehabilitation facility or Skilled Nursing Facility** for participation in a multidisciplinary team-structured rehabilitation program following severe neurologic or physical impairment. The Participant must be under the continuous care of a Physician, and the attending Physician must certify that the individual requires nursing care 24 hours a day. Nursing care must be rendered by a registered nurse or a licensed vocational or practical nurse. The confinement cannot be primarily for domiciliary, custodial, personal-type care, care due to senility, alcoholism, drug abuse, blindness, deafness, mental deficiency, tuberculosis or mental disorders.

42. Covered Expenses for the treatment or services rendered by a **physical therapist** in a home setting, a facility or institution whose primary purpose is to provide medical care for an illness or injury, or at a free-standing duly licensed outpatient therapy facility.
43. Covered Expenses for the services of a **Physician** for medical care and/or surgical treatments including office, home visits, Hospital inpatient care, Hospital outpatient visits/exams, clinic care, and surgical opinion consultations, subject to:
- In-Hospital medical service consists of a Physician's visit or visits to a Participant who is a registered bed-patient in a Hospital or Skilled Nursing Facility for treatment of a condition other than that for which surgical service or obstetrical service is required, as:
- A. In-Hospital medical Benefits will be provided, limited to one visit per specialty per day;
 - B. In-Hospital medical Benefits in a Skilled Nursing Facility;
 - C. When two or more Physicians, within the same study, render in-Hospital medical services at the same time, payment for such service will be made only to one Physician;
 - D. Concurrent medical/surgical care Benefits for in-Hospital medical service in addition to Benefits for surgical service will be provided only:
 - i. When the condition for which in-Hospital medical service requires medical care not related to Surgical or obstetrical service and does not constitute a part of the usual, necessary and related pre-operative and postoperative care but requires supplemental skills not possessed by the attending surgeon or his assistant;
 - ii. When a Physician other than a surgeon admits a Participant to the Hospital for medical treatment and it later develops that surgery becomes necessary, such Benefits cease on the date of surgery for the admitting Physician and become payable under the surgeon only;
 - iii. When the surgical procedure performed is designated by the Plan supervisor as a "warranted diagnostic procedure" or as a "minor surgical procedure."
44. **Preadmission testing** for a scheduled Admission when performed on an outpatient basis prior to such Admission. The tests must be in connection with the scheduled Admission and:
- A. The tests must be made within seven (7) days prior to Admission;
 - B. The tests must be ordered by the same Physician who ordered the Admission and must be Medically Necessary for the illness or injury for which the Participant is subsequently admitted to the Hospital.
45. **Preventive services** (non-GF plans only) are covered according to:
- A. United States Preventive Services Task Force (USPSTF recommendations Grade A or B);
 - B. Centers for Disease Control and Prevention (CDC) recommendations for immunizations;
 - C. Health Resources and Services Administration (HRSA) recommendations for children and women preventive care and screening;
 - D. Women's preventive services as provided under the ACA.
- These Benefits are provided without any cost-sharing by the Participant when the services are provided by a Participating Provider. Any other covered preventive screenings will be provided as shown in the Schedule of Benefits.
46. **Private Duty Nursing Care** by an actively practicing licensed nurse (R.N., L.P.N., or L.V.N.) that are deemed Medically Necessary. Coverage is not available for private duty nursing in a Hospital if the services are ordinarily provided by the hospital nursing staff or if the private duty nurse is a close relative or sitter.
47. Covered Expenses for **prosthetics**.
48. **Prosthetic bras** after a mastectomy, limited as stated in the Schedule of Benefits.
49. Covered Expenses for **radiation therapy** or treatment, and **chemotherapy**.
50. Covered Expenses at a **Residential Treatment Center**.

51. Expenses for a **Second Opinion** (Not Mandatory). The Second Opinion must be rendered by a board-certified surgeon who is not professionally or financially associated with the Physician or the surgeon who rendered the first surgical opinion. The surgeon who gives the second surgical opinion may not perform the surgery. If the Second Opinion is different from the first, a third opinion also will be payable, provided the opinion is obtained before the procedure is performed. The conditions that apply to a Second Opinion also apply to any third surgical opinion.
52. Fees of a licensed **speech therapist** for restorative speech therapy for speech loss or impairment due to:
 - A. Surgery for correction of a congenital condition of the oral cavity, throat or nasal complex (other than a frenulectomy);
 - B. An injury or illness.
53. Covered Expenses for **Substance Abuse** treatment will be payable if rendered by a licensed medical Physician (M.D.), licensed psychologist (Ph.D.), clinical psychologist, licensed masters social worker, licensed marriage/family therapist or licensed professional counselor. Services or charges for Detoxification are also covered.
54. Covered Expenses for **surgical procedures**, subject to:
 - A. If two or more operations or procedures are performed at the same surgical approach, the total amount covered for the operations or procedures will be payable for the major procedure only, or Benefits will be payable according to the recommendations of the Medical Review Department;
 - B. If two or more operations or procedures are performed at the same time, through different surgical openings or by different surgical approaches, the total amount covered will be paid according to the Allowed Amount for the operation or procedure bearing the highest allowance, plus one half of the Allowed Amount for all other operations or procedures performed;
 - C. If an operation consists of the excision of multiple skin lesions, the total amount covered will be paid according to the Allowed Amount for the procedure bearing the highest allowance, 50 percent (50%) for procedures bearing the second- and third-highest allowance, 25 percent (25%) for procedures bearing the fourth- through the eighth-highest allowance, and 10 percent (10%) for all other procedures;
 - D. If an operation or procedure is performed in two or more steps or stages, coverage for the entire operation or procedure will be limited to the allowance for such operation or procedure;
 - E. If two or more Physicians perform operations or procedures in conjunction with one another, other than as an assistant at surgery or anesthesiologist, the allowance, subject to the above paragraphs, will be prorated between them by the Plan supervisor when so required by the Physician in charge of the case;
 - F. Certain surgical procedures, which are normally exploratory in nature, are designated as “independent procedures” by the Plan supervisor, and the Allowed Amount is covered when such a procedure is performed as a separate and single entity. Nevertheless, when an independent procedure is performed as an integral part of another surgical service, the total amount covered will be paid according to the Fee Schedule for the major procedure only.
55. Medically Necessary services for care and treatment of jaw joint conditions, including **Temporomandibular Joint syndrome**.
56. Covered Expenses for services for **voluntary sterilization** for Participants.
57. Covered Expenses for **wellness services**.
58. Charges associated with the initial purchase of a **wig/toupee after chemotherapy, radiation therapy, infusion therapy or burns**, limited as stated in the Schedule of Benefits.
59. Covered Expenses for **x-rays**, microscopic tests, and **laboratory tests**.

HUMAN ORGAN OR TISSUE TRANSPLANT BENEFITS

When Preauthorized by PAI (and performed by a Provider PAI designates), Benefits are payable for all expenses for medical and surgical services and supplies incurred while covered under this Plan of Benefits for human organ/tissue Transplants as indicated in these paragraphs. The Benefits are subject to the Benefit Year Deductible amount, Coinsurance percentage and/or money maximum specified in the Medical Schedule of Benefits.

1. Benefits are available for human organ, tissue and bone marrow transplantation, subject to determination made on an individual, case-by-case basis in order to establish Medical Necessity. Preauthorization must be obtained in writing from the Medical Review Department.
2. Benefits will be provided only when the Hospital and Physician customarily charge a Transplant recipient for such care and services.
3. When only the Transplant recipient is a covered Participant, the Benefits of the Plan will be provided for the recipient. Benefits will also be provided for the donor under this Plan of Benefits to the extent that such Benefits are not provided under any other form of coverage. In no such case under the Plan of Benefits will any payment of a "personal service" fee be made to any donor. Only the necessary Hospital and Physicians' medical care and services expenses with respect to the donation will be considered for Benefits.
4. When only the donor is a Participant, the donor will receive Benefits for care and services necessary to the extent that such Benefits are not provided under any recipient who is not a Participant under this Plan of Benefits. The recipient will not be eligible for Benefits when only the donor is a Participant.
5. When both the recipient and the donor are Participants, Benefits will be provided for both in accordance with the respective Group Health Plan Covered Expenses.

Health care Benefits for Transplants include Covered Expenses such as patient workup, travel (as specified below), pre-Transplant care, the Transplant, post-Transplant care, and immunosuppressive drugs (while inpatient).

***Transplant Travel Expense Services**

Benefits for transportation, lodging and food are available to you only if you or your covered Dependent is the recipient of a Preauthorized organ/tissue Transplant from a Preauthorized, in-network Transplant facility.

Health care Benefits for Transplant travel services are subject to the Transplant travel Benefit maximum of \$5,000 and include coverage for travel expenses incurred by you or your covered Dependent as well as for charges resulting from transportation, lodging (up to \$150 a day) and food (up to \$75 a day) associated with a Preauthorized organ/tissue Transplant.

These Benefits are not subject to any individual or family deductible shown in the Medical Schedule of Benefits referenced within this document. These Benefits are only available if you or your Dependent is the recipient of an organ/tissue Transplant. No Benefits are available if you or your Dependent is a donor.

The term "recipient" is defined to include you or your covered Dependent regarding Preauthorized Transplant-related services during the:

- a) evaluation;
- b) candidacy;
- c) Transplant event;
- d) post-Transplant care.

Travel expenses for the person receiving the Transplant will include charges for:

- a) transportation to and from the Transplant site (including charges for a rental car used during a period of care at the Transplant facility);
- b) lodging while at or traveling to and from the Transplant site;
- c) food while at or traveling to and from the Transplant site.

The charges associated with the items a), b) and c) above also will be considered covered travel expenses for one companion to accompany you. The term companion includes a spouse, family member, legal guardian of you or your Dependent, or any person not related to you but actively involved as your caregiver.

By way of example, but not of limitation, travel expenses will not include any charges for:

- a) Transplant travel Benefit costs incurred due to travel within 60 miles of your home;
- b) laundry bills;
- c) telephone bills;
- d) alcohol or tobacco products;
- e) transportation charges that exceed coach class rates.

SHORT TERM DISABILITY BENEFITS

Employees who receive paid personal days must use them as part of the disability period. Benefits will still begin as stated below.

COVERED SERVICES	PERCENTAGE AND/OR DOLLAR AMOUNT
<p>Employees with continuous service of less than five years.</p> <p>Weekly Benefit Limit:</p> <p>Elimination Period:</p> <p>Benefits are payable for:</p> <p>Injury:</p> <p>Illness:</p> <p>Maximum period payable:</p>	<p>60% of covered weekly earnings to a maximum of \$1,153.85</p> <p>31 continuous days</p> <p>Beginning on the 31st day of Total Disability</p> <p>Beginning on the 31st day of Total Disability</p> <p>22 weeks</p>

EXECUTIVE BENEFIT FOR PRESIDENT

Employees who receive paid personal days must use them as part of the disability period. Benefits will still begin as stated below.

COVERED SERVICES	PERCENTAGE AND/OR DOLLAR AMOUNT
<p>Employees with continuous service of less than five years.</p> <p>Weekly Benefit Limit:</p> <p>Elimination Period:</p> <p>Benefits are payable for:</p> <p>Injury:</p> <p>Illness:</p> <p>Maximum period payable:</p>	<p>60% of covered weekly earnings</p> <p>31 continuous days</p> <p>Beginning on the 31st day of Total Disability</p> <p>Beginning on the 31st day of Total Disability</p> <p>22 weeks</p>

This Benefit applies when an Employee has a Total Disability that meets all of these tests:

1. Total Disability starts while the Employee is covered for this Benefit.
2. Total Disability is being continuously treated by a Physician.
3. Total Disability (Totally Disabled) means the complete inability to perform any and every duty of the Employer's occupation or of a similar occupation for which the person is reasonably capable due to education and training, as a result of injury or illness.

The Employer shall reserve the option of requesting periodic physical examinations from either the current Physician on the case or a Physician of the Employer's choice. Failure to provide requested Physicians' statements will result in termination of Benefits. Employees are responsible for providing this information in a clearly understandable format:

- ❖ History regarding when symptoms first appeared or accident happened;
- ❖ Diagnosis;
- ❖ Dates of treatment;
- ❖ Nature of treatment;
- ❖ Progress;
- ❖ Prognosis;
- ❖ Suitability for rehabilitation;
- ❖ Physician's signature and tax I.D. number.

Additional information may be required based upon the individual illness or injury.

BENEFIT PAYMENT

Benefits will be paid for a Total Disability up to a Weekly Benefit Limit as described in the Schedule of Benefits. Benefits are payable as described in the Schedule of Benefits.

PERIOD OF TOTAL DISABILITY

Period of Total Disability is the period of time that an Employee is Totally Disabled. New periods due to the same or related causes must be separated by return to Active Work for at least two weeks in a row. New periods due to different causes must be separated by return to Active Work for at least one day.

SHORT TERM DISABILITY CLAIMS PROCEDURE

Following is a description of how the Plan processes Claims for Benefits. A Claim is defined as any request for a Plan Benefit, made by a claimant or by a representative of a claimant that complies with the Plan's reasonable procedure for making Benefit Claims. The times listed are maximum times only. A period of time begins at the time the Claim is filed. Decisions will be made within a reasonable period of time appropriate to the circumstances. "Days" means calendar days.

Initial Claims

A Claim must be resolved, at the initial level, within 45 days of receipt. A Plan may, nevertheless, extend this decisions making period for an additional 30 days for reasons beyond the control of the Plan.

If, after extending the time period for a first period of 30 days, the Plan Administrator determines that it will still be unable, for reasons beyond the control of the Plan, to make a decision within the extension period, the Plan may extend decision making for a second 30-day period.

Appropriate notice must be provided to the claimant before the end of the first 45 days and again before the end of each succeeding 30-day period. This notice will explain the circumstances requiring the extension and the date the Plan Administrator expects to render a decision to the claimant. It will explain the standards on which entitlement to the Benefits is based, the unresolved issues that prevent a decision, the additional issues that prevent a decision, and the additional information needed to resolve the issues.

The claimant will have 45 days to provide the information required.

Adverse Benefit Determinations

The Plan Administrator shall provide written or electronic notification of any Adverse Benefit Determination. The notice will state:

- ❖ The specific reason or reasons for the adverse determination.

- ❖ Reference to the specific Plan provisions on which the determination was based.
- ❖ A description of any additional material or information necessary for the claimant to perfect the Claim and an explanation of why such material or information is necessary.
- ❖ A description of the Plan's review procedures and the time limits applicable to such procedures. This will include a statement of the claimant's right to bring civil action under section 502 of ERISA following an Adverse Benefit Determination on review.
- ❖ A statement that the claimant is entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the Claim.
- ❖ If the Adverse Benefit Determination was based on an internal rule, guideline, protocol, or other similar criterion, the specific rule, guideline, protocol, or criterion will be provided free of charge. If this is not practical, a statement will be included that such a rule, guideline, protocol, or criterion was relied upon in making the Adverse Benefit Determination and a copy will be provided free of charge.
- ❖ If the Adverse Benefit Determination is based on the Medical Necessity or Experimental and/or Investigational treatment or similar exclusion or limit, and explanation of the scientific or clinical judgment for the determination, applying the terms of the Plan to the claimant's medical circumstances will be provided. If this is not practical, a statement will be included that such explanation will be provided free of charge, upon request.

Appeals

When a claimant receives an Adverse Benefit Determination, the claimant has 180 days following receipt of the notification in which to appeal the decision. A claimant may submit written comments, documents, records, and other information relating to the Claim. If the claimant so requests, he or she will be provided, free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the Claim.

The claimant will be notified of the determination on review of the Adverse Benefit Determination no later than 45 days after receipt of the request for review, unless special circumstances require an extension of time for processing. In such a case, the claimant will be notified, before the end of the initial review period, of the special circumstances requiring the extension and the date a decision is expected. If an extension is provided, the Plan Administrator must notify the claimant of the determination on review no later than 90 days after receipt of the request for review.

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

- ❖ was relied upon in making the benefit determination;
- ❖ was submitted, considered, or generated in the course of making the benefit determination, without regard to whether it was relied upon in making the Benefit determination;
- ❖ demonstrated compliance with the administrative processes and safeguards designed to ensure and to verify that benefit determinations are made in accordance with Plan documents and Plan provisions have been applied consistently with respect to all claimants;
- ❖ constituted a statement of policy or guidance with respect to the Plan concerning the denied treatment option or Benefit.

The review shall take into account all comments, documents, records, and other information submitted by the claimant relating to the Claim, without regard to whether such information was submitted or considered in the initial Benefit determination. The review will not afford deference to the initial adverse determination and will be considered by a fiduciary of the Plan who is neither the individual who made the adverse determination nor a subordinate of that individual.

COVERED WEEKLY EARNINGS

Covered weekly earnings is the Employee's rate of weekly earnings from the Employer in effect on the later of:

1. the Employee's effective date of coverage under the Plan;
2. the start of the Total Disability.

FAMILY MEDICAL LEAVE ACT AND LEAVE OF ABSENCE

Eligible Employees who are unable to perform the essential functions of their positions because of a serious health condition or disability shall be granted Family and Medical Leave. Employees may use accumulated sick and vacation leave for FMLA personal sick leave of absence.

Eligible Employees shall be granted Family and Medical Leave to care for a family member with a serious health condition that qualifies under the Family and Medical Leave Act. To be compensated for family sick leave under FMLA, Employees are required to use any vacation leave first and then any available sick leave.

There are options available to the University if an Employee becomes mentally or physically incapable of performing his or her job and has been determined to be permanently disabled by the treating Physician. The University should determine if there is any reasonable accommodation, including transfer or demotion to another position that will enable the Employee to perform the job. If not, the University may recommend that the Employee apply for disability or early retirement. If an Employee declines disability or early retirement, the University may apply the Policy on Termination to address unsatisfactory performance.

Employees who wish to use sick leave must make their request as far in advance as possible and complete the Request for Leave Application. Employees who anticipate being disabled from work due to a medical condition, including, but not limited to such things as elective surgery, pregnancy, and management in planning for the Employee's childbirth, should submit a Physician's certification of disability as far in advance as possible to assist management in planning for the Employees absence. For leave under the Family and Medical Leave Act (FMLA), 30 days notice is required for events that are foreseeable, such as birth, adoption, or planned medical treatment.

The use of sick leave shall be subject to verification. The University may, before approving the use of sick leave, require the certification of a Physician or other acceptable documentation providing inclusive dates.

An Employee's use of paid sick leave may be denied if the Employee fails to comply with the University's request for verification of the need for sick leave or if the verification provided is inadequate or incomplete, and failure to adhere to other requirements under the Family and Medical Leave Act.

Employees who meet the length of service and hours worked requirements have rights under the Family and Medical Leave Act. As a general rule, Employees must request leave of absence under this law and policy through the "Request for Leave Application" process, but in appropriate situations, the University reserves the right to place Employees on Family and Medical Leave status without the leave application.

This is applicable to all administrators, faculty, staff, and hourly Employees with 12 months of service or 1,250 hours in the preceding twelve months.

Eligible Employees who are unable to perform the essential functions of their positions because of a serious health condition or disability shall be granted Family and Medical Leave. Employees may use accumulated sick and vacation leave for FMLA personal sick leave of absence.

Eligible Employees shall be granted Family and Medical Leave to care for a family member with a serious health condition that qualifies under the Family and Medical Leave Act. To be compensated for family sick leave under FMLA, Employees are required to use any vacation leave first and then any available sick leave.

An Employee's use of paid sick leave may be denied if the Employee fails to comply with the University's request for verification of the need for sick leave or if the verification provided is inadequate or incomplete, and failure to adhere to other requirements under the Family and Medical Leave Act.

Employees taking leave must continue to pay their portion of the health Benefit plan premiums on or before the same date that such portion of premium would be deducted from the Employee's wages. An Employee's failure to pay his or her portion of the health Benefit plan premium may result in a loss of health insurance coverage.

Employees who do not return to work after the expiration of leave under this law and policy will be required to reimburse the University for the portion of the health insurance paid by the University to continue coverage during the leave period. Nevertheless, an Employee who does not return to work because of the presence of a serious health condition which prevents the Employee from performing his/her duties or circumstances beyond the Employee's control will not be required to reimburse the University.

DENTAL BENEFITS

This Benefit applies when covered dental charges are incurred by a person while covered under this Plan of Benefits.

DEDUCTIBLE

A. Individual Deductible

This is an amount of dental charges (for an individual with single coverage) for which no Covered Expenses will be paid. Before Covered Expenses will be paid for Benefits in a Benefit Year, a Participant must meet the Deductible shown in the Dental Schedule of Benefits.

B. Family Deductible

This is an amount of dental charges (for individuals with family coverage) for which no Covered Expenses will be paid. When the amount shown in the Dental Schedule of Benefits has been paid by members of a family unit toward their Benefit Year Deductible, the Deductible for the family unit will be considered as being satisfied for that year.

BENEFIT PAYMENT

Each Benefit Year, Benefits will be paid for a Participant for the dental charges in excess of his Deductible, up to the Maximum Dental Benefit amount. No Benefits will be paid in excess of the Maximum Dental Benefit amount. Payment will be made at the rate shown under Dental Percentage payable in the Dental Schedule of Benefits.

DENTAL CHARGES

Dental charges are paid based upon the Maximum Payment for necessary care, appliance or other dental material listed as a covered dental service.

A dental charge is incurred on the date the service or supply for which it is made is performed or furnished. However, there are times when one overall charge is made for all or part of a course of treatment. In this case, the Plan supervisor will apportion that overall charge to each of the separate visits or treatments. The prorated charge will be considered to be incurred as each visit or treatment is completed.

Predetermination of Benefits

Except in an emergency, you should discuss dental charges with your dentist before treatment begins. If you or a Dependent needs dental treatment that the dentist estimates will cost **\$300** or more, you should ask your dentist to file for predetermination of Benefits with PAI. By doing this, both you and the dentist will know in advance how much your dental Plan will pay for the course of treatment your dentist recommends.

Here's How Predetermination Works

Your dentist should list, on a claim form, the treatment he plans to perform and his charges for that treatment. The dentist then should send the form to PAI. PAI will let you and your dentist know the amount of money that can be paid under your coverage for the recommended treatment.

COVERED DENTAL EXPENSES

Class I - Diagnostic and Preventive Dental Services

1. Dental examinations, cleaning, scaling, polishing and diagnosis limited to 2 per Calendar Year;
2. Full mouth x-rays every thirty-six (36) months;
3. Supplementary bitewing x-rays twice per Calendar Year, if your dentist feels they are necessary;
4. Fluoride treatment, for Participants under age nineteen (19), twice per Calendar Year;
5. Emergency palliative treatment for the relief of pain;
6. Sealants on the occlusal surface of a permanent posterior tooth for Dependent Children under age sixteen (16).

Class II - Basic Dental, Oral Surgery and Periodontic Services

1. Dental X-rays not included in Class I;
2. Fillings, other than gold;
3. Simple extractions including local anesthesia and routine post-operative care;
4. General anesthesia, upon demonstration of Medical Necessity;
5. Oral surgery limited to removal of impacted teeth and boney impacted teeth, preparation of the mouth for dentures and removal of tooth-generated cysts of less than ¼ inch.

NOTE: If a person has active medical and dental coverage, Benefits for the removal of impacted teeth and boney impacted teeth will be considered under the medical Plan.

6. Endodontics (root canals);
7. Recementing bridges, crowns or inlays;
8. Antibiotic drugs,
9. Space maintainers.

Class III - Prosthodontics

1. Gold restorations, including inlays, onlays and foil fillings;

NOTE: Cost of gold restoration in excess of the cost of amalgam, porcelain or plastic materials will be included only when the teeth must be restored with gold.

2. Installation of crowns;
3. Installing precision attachments for removable dentures to replace one or more Natural Teeth. This service also includes all adjustments made during six (6) months following the installation;
4. Addition of clasp or rest to existing partial removable dentures;
5. Initial installation of fixed bridgework to replace one or more natural teeth;
6. Repair of crowns, bridgework and removable dentures;
7. Rebasement or relining of removable dentures;
8. Replacing an existing removable partial or full denture or fixed bridgework; adding teeth to an existing removable partial denture; or adding teeth to existing bridgework to replace newly extracted Natural Teeth. Nevertheless, this item will apply only if one of these tests is met:
 - a. the existing denture or bridgework was installed at least five (5) years prior to its replacement and cannot currently be made serviceable;
 - b. the existing denture is of an immediate temporary nature. Further, the replacement by permanent dentures is required and must take place within twelve (12) months from the date the temporary denture was installed.

Class IV – Orthodontics up to age 19

This means the prevention and correction of irregularities in the alignment of the teeth and the prevention or correction of malocclusion. Benefits for Orthodontics are only available as:

1. Evaluation.

Cephalometric x-rays or diagnostic casts. This Benefit is only for orthodontic evaluation prior to and in connection with Active Orthodontic Treatment.

2. Exposure or Extraction of Teeth.

Surgical exposure of impacted unerupted teeth or simple surgical extraction of teeth. This Benefit is provided only in connection with (and prior to) Active Orthodontic Treatment. The Allowed Amount for this Benefit includes local anesthesia and routine postoperative care. Local anesthesia and routine postoperative care are not payable separately, even if billed separately.

3. Active Orthodontic Treatment.

Fixed or removable orthodontic appliances. This Benefit is only for movement or guidance of the Natural Teeth during Active Orthodontic Treatment. The Allowed Amount for this Benefit includes periodic follow-up examinations and adjustments during the whole course of Active Orthodontic Treatment. Periodic follow-up examinations and adjustments during the whole course of Active Orthodontic Treatment are not payable separately, even if billed separately.

Orthodontic Definitions

Active Orthodontic Treatment: The corrective movement of Natural Teeth through the bone by means of one or more active appliances to correct a Handicapping Malocclusion. Active Orthodontic Treatment does not include treatment intended to retain or maintain occlusion or the positioning or relationship of the Natural Teeth.

Handicapping Malocclusion: A malocclusion (deviation from normal occlusion, or abnormalities in the positioning or relationship of the Natural Teeth) that severely interferes with the ability of a person to chew food, as determined by the Plan Administrator.

MEDICAL EXCLUSIONS AND LIMITATIONS

Notwithstanding any provision of the Plan to the contrary, if the Plan generally provides Benefits for a type of injury, then in no event shall a limitation or exclusion of Benefits be applied to deny coverage for such injury if the injury results from an act of domestic violence or a medical condition (including both physical and mental health conditions), even if the medical condition is not diagnosed before the injury.

1. Any service or supply that is not **Medically Necessary**.
2. Charges incurred as a **result of declared or undeclared war or any act of war** or caused during service in the armed forces of any country.
3. **Professional services** billed by a Physician or nurse who is an employee of a Hospital or Skilled Nursing Facility and paid by the Hospital or facility for the service.
4. **Travel expenses**, whether or not recommended by a Physician.
5. Any medical **social services, recreational or Milieu Therapy, education testing or training**, except as part of Preauthorized Home Health Care or Hospice Care program.
6. **Nutritional counseling except as covered under ACA guidelines or vitamins, food supplements, and other dietary supplies** even if the supplements are ordered or prescribed by a Physician. Exceptions to this exclusion are noted under the Medical Schedule of Benefits and the Prescription Drug Benefits section.
7. Services, supplies or charges for **pre-marital and pre-employment physical examinations**.
8. Any service or supply for which a Participant is entitled to receive payment or Benefits (whether such payment or Benefits have been applied for or paid) under any law (now existing or that may be amended) of the United States or any state or political subdivision thereof, except for Medicaid. These include, but may not be limited to, Benefits provided by or payable under **workers' compensation laws**, the Veteran's Administration for care rendered for service-related disability, or any state or federal Hospital services for which the Participant is not legally obligated to pay. This exclusion applies if the Participant receives such Benefits or payments in whole or in part, and is applied to any settlement or other agreement regardless of how it is characterized and even if payment for medical expenses is specifically excluded.
9. Services to the extent the Participant is entitled to payment or Benefits under any **state or federal** program that provides health care Benefits, including Medicare, but only to the extent Benefits are paid or are payable under such programs.
10. Charges incurred for which the Participant is not in the absence of this coverage **legally obligated** to pay or for which a charge would not ordinarily be made in the absence of this coverage.
11. Any illness or injury received while committing or attempting to commit a **felony or while engaging in an illegal occupation**.
12. Any service (other than Substance Abuse Services), medical supplies, charges or losses resulting from a Participant being **Legally Intoxicated or under the influence of any drug or other substance**, or taking some action the purpose of which is to create a euphoric state or alter consciousness. The Participant, or Participant's representative, must provide any available test results showing blood alcohol and/or drug/substance levels upon request. If the Participant refuses to provide these test results, no Benefits will be provided.

Legal Intoxication or Legally Intoxicated means the Participant's blood alcohol level was at or in excess of the amount established under applicable state law to create a presumption and/or inference that the Participant was under the influence of alcohol, when measured by law enforcement or medical personnel.
13. Services and supplies received as the result of any intentionally **self-inflicted injury**.
14. All charges in connection with treatments or medications where the patient either is in **non-compliance with or is discharged from a Hospital or Skilled Nursing Facility** against medical advice.
15. Care and treatment billed by a Hospital for non-Medical Emergency Admissions on a **Friday or a Saturday**. This does not apply if surgery is performed within 24 hours of Admission.

16. Charges incurred for services or supplies that constitute **personal comfort or beautification items**, such as television or telephone use.
17. All **cosmetic procedures** and any related **medical supplies**, in which the purpose is improvement of appearance or correction of deformity without restoration of bodily function. Examples of services that are cosmetic and are not covered are: rhinoplasty (nose); mentoplasty (chin), rhytidoplasty (face lift); surgical planing (dermabrasion); and blepharoplasty (eyelid).
18. Charges for **custodial care**, including sitters and companions.
19. Care, treatment, services or supplies **not recommended and approved by a Physician**; or treatment, services or supplies when the covered person is not under the regular care of a Physician. Regular care means ongoing medical supervision or treatment which is appropriate care for the injury or illness.
20. Charges for **services, supplies or treatment** not commonly and customarily recognized throughout the Physician's profession or by the American Medical Association as generally accepted and Medically Necessary for the Participant's diagnosis and/or treatment of the Participant's illness or injury; or charges for procedures, surgical or otherwise, which are specifically listed by the American Medical Association as having no medical value.
21. Any Medical Supplies or services rendered by a Participant to himself or herself or by a Participant's **immediate family** (parent, Child, spouse, brother, sister, grandparent or in-law).
22. Charges for inpatient confinement, primarily for x-rays, laboratory, diagnostic study, physiotherapy, hydrotherapy, medical observation, convalescent, custodial or rest care, or any medical examination or test **not connected with an active illness or injury**, unless otherwise provided under any preventable care covered under this Plan of Benefits.
23. Charges incurred in connection with **routine vision care, eye refractions, the purchase or fitting of eyeglasses, contact lenses, non-prescription lenses or hardware, hearing aids, or such similar aid devices**. This exclusion shall not apply to aphakic patients and soft lenses, or sclera shells intended for use as corneal bandages, or the initial purchase of eyeglasses or contact lenses following cataract surgery. This exclusion includes any surgical procedure for the correction of a **visual refractive problem**, including radial keratotomy.
24. Charges incurred for treatment on or to the **teeth, the nerves or roots of the teeth, gingival tissue or alveolar processes**.
25. Treatment of **infertility** (including the reversal of voluntary sterilization).
26. **Experimental or Investigational** services, including surgery, medical procedures, devices or drugs. The Group Health Plan reserves the right to approve, upon medical review, non-labeled use of chemotherapy agents that have been approved by the Food and Drug Administration (FDA) for cancer.
27. Charges incurred for treatment or supplies of weak, strained, or **flat feet**, instability or imbalance of the feet, treatment of any tarsalgia, metatarsalgia or bunion (other than operations involving the exposure of bones, tendons or ligaments), cutting or removal by any method of toenails or superficial lesions of the feet, including treatment of corns, calluses and hyperkeratoses, unless needed in treatment of a metabolic or peripheral-vascular disease.
28. Charges for **maintenance care**. Unless specifically mentioned otherwise, the Plan of Benefits does not provide Benefits for services and supplies intended primarily to maintain a level of physical or mental function.
29. Any service or supply rendered to a Participant for the treatment of **obesity** or for the purpose of weight reduction. This includes all procedures designed to restrict the Participant's ability to assimilate food; for example, gastric bypass, the insertion of gastric bubbles, the wiring shut of the mouth, and any other procedure the purpose of which is to restrict the ability of the Participant to take in food, digest food or assimilate nutrients. Also excluded are services, supplies or charges for the correction of complications arising from weight control procedures, services, supplies or charges, such as procedures to reverse any restrictive or diversionary procedures and such reconstructive procedures as may be necessitated by the weight loss produced by these non-covered restrictive or diversionary procedures, except as specified on the Schedule of Benefits. Examples of such reconstructive procedures include, but are not limited to, abdominal panniculectomy and removal of excessive skin from arms, legs or other areas of the body. Membership fees to weight control programs are also excluded.

30. Surgical treatment for **morbid obesity**.
31. Any service or treatment for complications resulting from any **non-covered procedures**.
32. Any charges for **elective abortions**, except for abortion performed in accordance with federal Medicaid guidelines.
33. Charges for a **Dependent Child's pregnancy**, including abortions, except for pregnancy as the result of a criminal act or as provided under Women's Preventive Care and in accordance with ACA guidelines.
34. Charges not included as part of a Hospital bill for autologous **blood donation** that involves collection and storage of a patient's own blood prior to elective surgery.
35. Charges incurred for **take-home drugs** upon discharge from the Hospital.
36. **Exercise programs** for treatment of any condition.
37. **Spare items** of the nature of braces of the leg, arm, back and neck, artificial arms, legs or eyes, lenses for the eye, or hearing aids, unless needed due to physiological changes.
38. Care and treatment of **hair loss**, except for a wig or toupee after chemotherapy, radiation therapy, infusion therapy or burns, as stated in the Schedule of Benefits.
39. Charges incurred for **holistic or homeopathic medicine** including services or accommodations provided in connection with holistic or homeopathic treatment or supplies.
40. Air conditioners, air-purification units, humidifiers, allergy-free pillows, blanket or mattress covers, electric heating units, swimming pools, orthopedic mattresses, exercising equipment, vibratory equipment, elevators or stair lifts, blood pressure instruments, stethoscopes, clinical thermometers, scales, elastic bandages or stockings, wigs, non-Prescription Drugs and medicines, first aid supplies and non-Hospital adjustable beds.
41. **Acupuncture or hypnosis**, except when performed by a Physician in lieu of anesthesia.
42. Care and treatment for **sleep apnea**, unless Medically Necessary.
43. Care, treatment, and services related to the treatment of the **surrogate parent** and the Child born of a surrogate parent. Surrogacy usually refers to a woman's pregnancy who, usually by way of a pre-arranged legal contract, agrees to be artificially inseminated with the semen of another woman's husband/partner, conceive a Child, carry it to term, and after its birth surrender it to the natural father and his wife/partner, regardless whether payment is part of the agreement.
44. Care, treatment or supplies for which a charge was incurred **before a person was covered under this Plan or after coverage ceased** under this Plan.
45. Charges that exceed any **Benefit limitations** stated in the Medical Schedule of Benefits of this PlanDocument.
46. Care, treatment or supplies **outside of the U.S.** if travel is for the sole purpose of obtaining medical services.
47. Admissions or portions thereof for **custodial care or long-term care** including:
 - A. Rest cares;
 - B. Long-term acute or chronic psychiatric care;
 - C. Care to assist a Participant in the performance of activities of daily living (including, but not limited to: walking, movement, bathing, dressing, feeding, toileting, continence, eating, food preparation and taking medication);
 - D. Care in a sanitarium;
 - E. Custodial or long-term care;
 - F. Psychiatric or Substance Abuse residential treatment when provided at therapeutic schools; wilderness/boot camps; therapeutic boarding homes; halfway houses; and therapeutic group homes.

48. **Counseling and psychotherapy services** for these conditions are not covered:
- A. Feeding and eating disorders in early childhood and infancy;
 - B. Tic disorders, except when related to Tourette's disorder;
 - C. Elimination disorders;
 - D. Mental disorders due to a general medical condition;
 - E. Sexual function disorders;
 - F. Sleep disorders;
 - G. Medication-induced movement disorders;
 - H. Nicotine dependence, unless specifically listed as a covered Benefit in the Plan of Benefits or on the Medical Schedule of Benefits.
49. Medical supplies, services or charges for the diagnosis or treatment of learning disorders, dissociative disorders, developmental speech delay, communication disorders, developmental coordination disorders, mental retardation or vocational rehabilitation.
50. **Behavioral, Educational, or Alternate Therapy Programs:**
- Any behavioral, educational or alternative therapy techniques to target cognition, behavior language and social skills modification, including:
- A. Applied Behavioral Analysis (ABA) therapy unless Medically Necessary for the treatment of Autism Spectrum Disorder;
 - B. Teaching, Expanding, Appreciating, Collaborating and Holistic (TEACCH) programs;
 - C. Higashi schools/daily life;
 - D. Facilitated communication;
 - E. Floor time;
 - F. Developmental Individual—Difference Relationship-based model (DIR);
 - G. Relationship Development Intervention (RDI);
 - H. Holding therapy;
 - I. Movement therapies;
 - J. Music therapy;
 - K. Animal assisted therapy.
51. **Prescription Drug Exclusions** under this Plan of Benefits:
- A. Therapeutic devices or appliances, including hypodermic needles, syringes, support garments, ostomy supplies and non-medical substances regardless of intended use;
 - B. Blood products, blood serum;
 - C. Prescription Drugs that have not been prescribed by a Physician;
 - D. Prescription Drugs not approved by the Food and Drug Administration;
 - E. Prescription Drug refills in excess of the number specified on the Physician's prescription order or Prescription Drug refills dispensed more than one (1) year after the original prescription date;
 - F. Unless different time frames are specifically listed on the Schedule of Benefits more than a thirty-one (31) day supply for Prescription Drugs (ninety (90) day supply for Prescription Drugs obtained through a Mail Service Pharmacy) or unless the quantity is limited by a Quantity Management Program;

- G. Any type of service or handling fee (with the exception of the dispensing fee charged by the pharmacist for filling a prescription) for Prescription Drugs, including fees for the administration or injection of a Prescription Drug;
- H. Dosages that exceed the recommended daily dosage of any Prescription Drug as described in the current Physician's Desk Reference or as recommended under the guidelines of the Pharmacy Benefit Manager, whichever is lower;
- I. Prescription Drugs used for or related to cosmetic purposes, including hair growth, unless otherwise specified on the Schedule of Benefits;
- J. Prescription Drugs related to any treatment for infertility;
- K. A charge for impotence medication (except when Medically Necessary due to a physiological condition or to organic disease).
- L. Prescription Drugs administered or dispensed in a Physician's office, Skilled Nursing Facility, Hospital or any other place that is not a Pharmacy licensed to dispense Prescription Drugs in the state where it is operated;
- M. Prescription Drugs for which there is an over-the-counter equivalent and over-the-counter supplies or supplements;
- N. Prescription Drugs that are being prescribed for a specific medical condition that are not approved by the Food and Drug Administration for treatment of that condition (except for Prescription Drugs for the treatment of a specific type of cancer, provided the drug is recognized for treatment of that specific cancer in at least one standard, universally accepted reference compendia or is found to be safe and effective in formal clinical studies, the results of which have been published in peer-reviewed professional medical journals);
- O. Prescription Drugs or services that require Preauthorization by PAI and Preauthorization is not obtained;
- P. Prescription Drugs for injury or disease that are paid by workers' compensation benefits (if a workers' compensation claim is settled, it will be considered paid by workers' compensation benefits);
- Q. Prescription Drugs that are not Medically Necessary;
- R. Prescription Drugs that are not authorized when part of a Step Therapy program;
- S. Experimental drugs and medicines, even though a charge is made to the covered person;
- T. A drug or medicine labeled: "Caution-limited by federal law to investigation use;"
- U. A charge for Prescription Drugs which may be properly received without charge under local, state or federal programs.

52. Home Health Care Exclusions under the Home Health Care Benefit:

- A. Services and supplies not included in the Medical Schedule of Benefits, but not limited to, general housekeeping services and services for custodial care;
- B. Services of a person who ordinarily resides in the home of the Participant, or is a Participant's immediate family member (parent, Child, spouse, brother, sister, grandparent or in-law);
- C. Transportation services.

Notwithstanding the above exclusions, in the event that, after review of the medical records, other documentation, and case notes, the health care management medical director (or similarly titled position) of Planned Administrators, Inc. (PAI) deems a plan of treatment and procedures are appropriate care for a Participant, the Plan shall deem the cost of the plan of treatment and procedures a Covered Expense.

DENTAL EXCLUSIONS AND LIMITATIONS

1. **Dental Exclusions** under the dental coverage:
 - A. **Services and supplies** for which the dentist does not charge.
 - B. Services and supplies primarily for **cosmetic or aesthetic purposes**, including personalization or characterization of dentures.
 - C. **Oral hygiene, plaque control** programs or dietary instructions;
 - D. **Implants**, including any appliances and/or crowns and the surgical insertion or removal of implants;
 - E. Services that, to any extent, are **payable under any medical expense benefit** of the Plan;
 - F. **Orthognathic surgery**—Surgery to correct malpositions in the bones of the jaw;
 - G. Charges for **missed appointments** or for completion of claim forms;
 - H. Services or supplies that do not meet **accepted standard of dental practice**;
 - I. Services rendered by a dentist **beyond the scope** of his license.
 - J. Charges for **visits at home or in the Hospital**, except in connection with emergency care;
 - K. Services or supplies covered by **workers' compensation**;
 - L. **Treatment after a person is no longer covered** by this Plan of Benefits, even though treatment began before coverage ended, except that if dentures were ordered and fitted while coverage was still in force, payment will be made if the dentures are delivered within 31 days after coverage ended. Further, a person may have extended coverage for the completion of dental services under a treatment plan approved by PAI prior to termination of coverage, provided the dental services are completed within 30 days from the date of approval of the treatment plan.
 - M. Replacement of a **denture** that could have been repaired or extended.
 - N. Replacement of **lost or stolen appliances**.
 - O. Dental services done by **more than one dentist** - if a person transfers from the care of one dentist to the care of another dentist during the same course of treatment or if more than one dentist renders services for the same procedure, Benefits are provided only for the amount payable if only one dentist had performed the service.
 - P. **More expensive treatment than is necessary** - if a dentist and Participant select a more expensive course of treatment than is usually provided by other dentists, consistent with sound professional standards of dental practice, Benefits are payable for the less costly procedure.
 - Q. Services or supplies that are **not Medically Necessary**.
 - R. Crowns for teeth that are restorable by other means.
 - S. **Crowns, fillings or appliances** that are used to connect (splint) teeth, or change or alter the way the teeth meet, including altering the vertical dimension, restoring the bite (occlusion) or are cosmetic.
 - T. Services for accidental injury (except as covered under Medical Benefits).
 - U. Charges for services rendered by a Physician, nurse or licensed therapist who is a Participant's immediate family member (parent, Child, spouse, brother, sister, grandparent or in-law), or resides in the same household as the Participant.

Orthodontic Exclusions and Limitations

- A. The entire course of Active Orthodontic Treatment and any preliminary Orthodontic evaluation or exposure or extraction of teeth are excluded from being Covered Dental Services (and no Benefits are payable) if the Date Started for the Active Orthodontic Treatment is prior to the Enrollment Date of coverage.
- B. Orthodontic Benefits are provided only for or in connection with Active Orthodontic Treatment to correct a Handicapping Malocclusion.
- C. Covered Dental Expenses for Orthodontics do not include orthodontic evaluation or exposure or extraction of teeth, which is not an essential preliminary to Active Orthodontic Treatment, which is actually performed.

ELIGIBILITY FOR COVERAGE

Eligibility:

Waiting Period:	Coverage for new Employees hired following the Effective Date of the Plan of Benefits will commence on the first day of the month following date of hire.
Annual Enrollment:	Months of December and January for a February 1 st effective date
Actively at Work: Minimum hours per week:	At least 30 full-time hours per week
Dependent Child, in addition to meeting the requirements contained in the Plan of Benefits; the maximum age limitation to qualify as a Dependent Child is:	An Employee may cover a Dependent Child up to the end of the calendar month during which the Dependent Child reaches age 26 for medical and dental Benefits
The column to the right identifies other group classifications, as defined by the Plan Sponsor, that also may participate in the Plan of Benefits:	Retirees, age 65 and older, with 30 years of service Retired President at age 65 Spouse of Retired Employee provided the spouse was covered when the Retiree retired from active employment
The column to the right identifies other group classifications, as defined by the Plan Sponsor, that may not participate in the Plan of Benefits;	A spouse of an Employee who has access to healthcare coverage through their Employer
Coverage for Participants will terminate the last day of the month in which employment is terminated.	

A. ELIGIBILITY

1. Every Employee who is Actively at Work and who has completed the Waiting Period on or after the Plan Sponsor Effective Date is eligible to enroll (and to enroll his or her Dependents) for coverage under this Plan of Benefits.
2. If an Employee is not Actively at Work or has not completed the Waiting Period such Employee is eligible to enroll (and to enroll his or her Dependents) beginning on the next day that the Employee is:
 - a. Actively at Work;
 - b. Has completed the Waiting Period.
3. Dependents are not eligible to enroll for coverage under Plan of Benefits without the sponsorship of an Employee who is enrolled under this Plan of Benefits.
4. Probationary periods and/or contribution levels will not be based on any factor that discriminates in favor of higher-wage Employees as required under the Affordable Care Act (“ACA”).

B. ELECTION OF COVERAGE

Any Employee may enroll for coverage under the Group Health Plan for such Employee and such Employee’s Dependents by completing and filing a Membership Application with the Plan Sponsor. Dependents must be enrolled within thirty-one (31) days of the date on which they first become Dependents. Employees and Dependents also may enroll if eligible under the terms of any late enrollment or Special Enrollment procedure.

NOTE: Employees with Qualifying Events or life events may add, terminate or change their coverage within thirty (30) days of the event.

C. COMMENCEMENT OF COVERAGE

Coverage under the Group Health Plan will commence as:

1. Employees and Dependents eligible on the Plan Sponsor Effective Date

For Employees who are Actively at Work prior to and on the Plan Sponsor Effective Date, coverage will generally commence on the Plan of Benefits Effective Date.

2. Employees and Dependents Eligible After the Plan of Benefits Effective Date

Employees and Dependents who become eligible for coverage after the Plan of Benefits Effective Date and have elected coverage will have coverage after they have completed the Waiting Period.

3. Dependents Resulting from Marriage

Dependent(s) resulting from the marriage of an Employee will have coverage effective the date of marriage provided they have enrolled for coverage within thirty-one (31) days after marriage and the coverage has been paid for under this Plan of Benefits.

4. Newborn Children

A newborn Child will have coverage from the date of birth provided he or she has been enrolled for coverage within thirty-one (31) days after the Child's birth and the coverage has been paid for under this Plan of Benefits.

5. Adopted Children

For an adopted Child of an Employee:

- a. Coverage shall be retroactive to the Child's date of birth when a decree of adoption is entered within thirty-one (31) days after the date of the Child's birth.
- b. Coverage shall be retroactive to the Child's date of birth when adoption proceedings have been instituted by the Employee within thirty-one (31) days after the date of the Child's birth, and if the Employee has obtained temporary custody of the Child.
- c. For an adopted Child other than a newborn, coverage shall begin when temporary custody of the Child begins. Nevertheless, such coverage shall only continue for one (1) year unless a decree of adoption is entered, in which case coverage shall be extended so long as such Child is otherwise eligible for coverage under the terms of this Plan of Benefits.

6. Special Enrollment

In addition to enrollment under Eligibility for Coverage Section (C) (2-5) above, the Group Health Plan shall permit an Employee or Dependent who is not enrolled to enroll if each of these is met:

- a. The Employee or Dependent was covered under a group health Plan or had Creditable Coverage at the time coverage was previously offered to the Employee or Dependent;
- b. The Employee stated in writing at the time of enrollment that the reason for declining enrollment was because the Employee or Dependent was covered under a group health Plan or had Creditable Coverage at that time. This requirement shall apply only if the Plan Sponsor required such a statement at the time the Employee declined coverage and provided the Employee with notice of the requirement and the consequences of the requirement at the time;
- c. The Employee or Dependent's coverage described above:
 - i. Was under a COBRA continuation provision and the coverage under the provision was exhausted;
 - ii. Was not under a COBRA continuation provision described in section 6(c)(i), above, and either the coverage was terminated as a result of loss of eligibility for the coverage (including as a result of legal separation, divorce, death, termination of employment) or reduction in the number of hours of employment), or if the Plan Sponsor's contributions toward the coverage were terminated;

- iii. Was one of multiple Plans offered by a Plan Sponsor and the Employee elected a different Plan during an open enrollment period or when a Plan Sponsor terminates all similarly situated individuals;
- iv. Was under a HMO that no longer serves the area in which the Employee lives, works or resides;
- v. Was under a Plan where the Participant incurred a claim that met or exceeded a lifetime limit on all benefits. The Special Enrollment period is continued until at least thirty (30) days after a claim is denied due to the operation of the lifetime limit on all benefits;
- vi. Under the terms of the Plan, the Employee requests the enrollment not later than thirty-one (31) days after date of exhaustion described in 6(c) (i) above, or termination of coverage or Plan Sponsor contribution described in 6(c) (ii) above.

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

Medicaid or State Children’s Health Insurance Program Coverage

- A. The Employee or Dependent was covered under a Medicaid or State Children’s Health Insurance Program Plan and coverage was terminated due to loss of eligibility;
- B. The Employee or Dependent becomes eligible for assistance under a Medicaid or State Children’s Health Insurance Program Plan;
- C. The Employee or Dependent requests such enrollment not more than sixty (60) days after either:
 - i. the date of termination of Medicaid or State Children’s Health Insurance Program coverage;
 - ii. determination that the Employee or Dependent is eligible for such assistance.

D. DEPENDENT CHILD’S ENROLLMENT

- 1. A Dependent’s eligibility for or receipt of Medicaid assistance will not be considered in enrolling that Dependent for coverage under this Plan of Benefits.
- 2. Absent the sponsorship of an Employee, Dependents are not eligible to enroll for coverage under this Plan of Benefits.

E. PARTICIPANT CONTRIBUTIONS

The Participant is solely responsible for making all payments for any Premium.

F. DISCLOSURE OF MEDICAL INFORMATION

By accepting Benefits or payment of Covered Expenses, the Participant agrees that the Group Health Plan (and including BlueCross on behalf of the Group Health Plan) may obtain claims information, medical records, and other information necessary for the Group Health Plan to consider a request for Preauthorization, a Continued Stay Review, an Emergency Admission Review, a Preadmission Review or to process a claim for Benefits.

TERMINATION OF THIS PLAN OF BENEFITS

A. TERMINATION OF THIS PLAN OF BENEFITS

Termination of an Employee's coverage and all of such Employee's Dependents' coverage will occur on the earliest of these dates:

1. The date the Group Health Plan is terminated pursuant to Sections (B)-(E) below.
2. The date an Employee retires unless the Group Health Plan covers such individual as a retiree.
3. The date an Employee ceases to be eligible for coverage as set forth in the Eligibility Section.
4. The last day of the month in which employment is terminated, except that a qualified Employee (as qualified under the Family and Medical Leave Act of 1993) may be considered Actively at Work during any leave taken pursuant to the Family and Medical Leave Act of 1993.
5. The date the Employee fails to return to work at the conclusion of an approved leave of absence.
6. In addition to terminating when an Employee's coverage terminates, a Dependent spouse's coverage terminates on the date of entry of a court order ending the marriage between the Dependent spouse and the Employee regardless of whether such order is subject to appeal.
7. In addition to terminating when an Employee's coverage terminates, a Dependent Child's coverage terminates when that individual no longer meets the definition of a Dependent under the Group Health Plan.
8. In addition to terminating when an Employee's coverage terminates, an Incapacitated Dependent's coverage terminates when that individual no longer meets the definition of an Incapacitated Dependent.
9. Death of the Employee.
10. The last day of the calendar month in which the covered Employee ceases to be in one of the Eligible Classes. In addition to death or termination of Active Employment of the covered Employee, this also includes an Employee on disability leave of absence or other leave of absence, unless the Plan specifically provides for continuation during these periods.
11. A Dependent's coverage will terminate on the earliest of these dates: the last day of the calendar month in which the Plan or Dependent coverage under the Plan is terminated; or the date that the Employee's or Retiree's coverage under the Plan terminates for any reason, except for death. In the case of death, the termination date will be the last day of the calendar month.

B. TERMINATION FOR FAILURE TO PAY PREMIUMS

1. If a Participant fails to pay the Premium during the Grace Period, such Participant shall automatically be terminated from participation in the Group Health Plan, without prior notice to such Participant.
2. In the event of termination for failure to pay Premiums, Premiums received after termination will not automatically reinstate the Employee in participation under the Group Health Plan absent written agreement by the Plan Sponsor. If the Employee's participation in the Group Health Plan is not reinstated, the late Premium will be refunded to the Employee.

C. TERMINATION WHILE ON LEAVE

During an Employee's leave of absence that is taken pursuant to the Family and Medical Leave Act, the Plan Sponsor must maintain the same health Benefits as provided to Employees not on leave. The Employee must continue to pay his or her portion of the Premium. If Premiums are not paid by an Employee, coverage ends as of the due date of that Premium contribution.

D. CONTINUATION DURING PERIODS OF PLAN SPONSOR-CERTIFIED DISABILITY OR LEAVE OF ABSENCE

An Employee may remain eligible for a limited time if Active, full-time work ceases due to a Plan Sponsor-certified disability or leave of absence. While continued, coverage will be that which was in force on the last day worked as an Active Employee. Nevertheless, if benefits reduce for others in the class, they will also reduce for the continued person.

Employees who meet the length of service and hours worked requirements have rights under the Family and Medical Leave Act. As a general rule, Employees must request leave of absence under this law and policy through the “Request for Leave Application” process, but in appropriate situations, the University reserves the right to place Employees on Family and Medical Leave status without the leave application.

Eligible Employees who are unable to perform the essential functions of their positions because of a serious health condition or disability shall be granted Family and Medical Leave. Employees may use accumulated sick and vacation leave for FMLA personal sick leave of absence.

Eligible Employees shall be granted Family and Medical Leave to care for a family member with a serious health condition that qualifies under the Family and Medical Leave Act. To be compensated for family sick under FMLA, Employees are required to use any vacation leave first and then any available sick leave.

An eligible Employee is entitled to up to twelve (12) weeks of unpaid leave during a twelve (12)-month period. Leave to care for a newly born or newly received Child must be taken consecutively. Leave required because of the Employee's own serious health condition or that of a spouse, Child, or parent, may be taken intermittently or by means of a modified work schedule when necessary.

When both spouses are employed by Claflin University, they are each entitled to separate leave for serious (personal) health conditions for themselves, each other, their Children, or their parents. Nevertheless, they are jointly entitled to a **combined** total of twelve (12) work weeks of family leave for the birth and care of the newborn Child, and for placement of a Child for adoption or foster care.

Employees who must be absent due to their **own** serious health condition will be paid for time lost from work by first using their accrued sick leave and then vacation leave, if the condition persists. Employees who must be absent due to **family** related medical reasons will be paid for time lost from work by using their accrued vacation leave first. Employees who exhaust their sick and/or vacation leave while on Family and Medical Leave will automatically be placed on leave without pay.

Employees who wish to use sick leave must make their request as far in advance as possible and complete the Request for Leave Application. Employees who anticipate being disabled from work due to a medical condition, including, but not limited to such things as elective surgery, pregnancy, and childbirth, should submit a Physician's certification of disability as far in advance as possible to assist management in planning for the Employee's absence. For leave under the Family and Medical Leave Act (FMLA), thirty (30) days notice is required for events that are foreseeable, such as birth, adoption, or planned medical treatment.

The use of sick leave shall be subject to verification. The University may, before approving the use of sick leave, require the certification of a Physician or other acceptable documentation providing inclusive dates.

An Employee's use of paid sick leave may be denied if the Employee fails to comply with the University's request for verification of the need for sick leave or if the verification provided is inadequate or incomplete, and failure to adhere to other requirements under the Family and Medical Leave Act.

Employees taking leave must continue to pay their portion of the health benefit Plan Premiums on or before the same date that such portion of Premium would be deducted from the Employee's wages. An Employee's failure to pay his or her portion of the health benefit Plan Premium may result in a loss of health insurance coverage.

Employees who do not return to work after the expiration of leave under this law and policy will be required to reimburse the University for the portion of the health insurance paid by the University to continue coverage during the leave period. Nevertheless, an Employee who does not return to work because of the presence of a serious health condition which prevents the Employee from performing his/her duties or circumstances beyond the Employee's control will not be required to reimburse the University. For additional assistance regarding the University's leave policies, please refer to the Human Resources Department.

E. TERMINATION DUE TO A RESCISSION OF COVERAGE

In the event that a Participant:

1. Performs an act, practice, or omission that constitutes fraud;
2. Makes an intentional misrepresentation of material fact,

The Participant's coverage under this Plan of Benefits will terminate retroactively at one of these times:

1. If event occurs upon application for participation in the Plan, the Participant's coverage will be void from the time of his/her effective date;
2. If event occurs at any other time, the Participant's coverage will terminate retroactively to the date of the event occurrence, as outlined above.

In the event your coverage is rescinded, you will be given 30 days' advance written notice of the Rescission as well as the retroactive effective date. Any Premiums paid will be returned once the Plan Administrator deducts the amount for any claims paid.

A Participant has an internal appeal right following written notice of a Rescission of coverage as outlined within the Claims Filing and Appeal Procedures section of this document.

F. NOTICE OF TERMINATION TO PARTICIPANTS

Other than as expressly required by law, if the Group Health Plan is terminated for any reason, the Plan Sponsor is solely responsible for notifying all Participants of such termination and that coverage will not continue beyond the termination date.

G. REINSTATEMENT

The Group Health Plan in its sole discretion (and upon such terms and conditions as any stop-loss carrier or the Plan Sponsor may determine) may reinstate coverage under the Group Health Plan that has been terminated for any reason. If a Participant's coverage (and including coverage for the Participant's Dependents) for Covered Expenses under the Group Health Plan terminates while the Participant is on leave pursuant to the Family and Medical Leave Act because the Participant fails to pay such Participant's Premium, the Participant's coverage will be reinstated without new probationary periods if the Participant returns to work immediately after the leave period, re-enrolls and, within thirty-one (31) days following such return, pays all such Employee's portion of the past due amount and then current Premium.

H. PLAN SPONSOR IS AGENT OF PARTICIPANTS

By accepting Benefits, a Participant agrees that the Plan Sponsor is the Participant's agent for all purposes of any notice under the Group Health Plan. The Participant further agrees that notifications received from, or given to, the Plan Sponsor by PAI are notification to the Employees except for any notice required by law to be given to the Participants by PAI.

I. PERSONNEL POLICIES

Except as required under the Family and Medical Leave Act or the Uniformed Services Employment and Reemployment Rights Act, the Plan Sponsor's current personnel policies regarding Waiting Periods, continuation of coverage or reinstatement of coverage shall apply during these situations: Plan Sponsor-certified disability, leave of absence, layoff, reinstatement, hire or rehire.

J. RETURN TO WORK

An Employee who returns to work **within six (6) months** of a layoff or an approved leave of absence will retain the same insurance status as prior to the said date, provided any required contributions have been paid in full. No new eligibility Waiting Period will apply unless these conditions were still to be met at the time of layoff or leave of absence.

An Employee who returns to work **after six (6) months** of an approved leave of absence or layoff will be considered a new Employee and will be subject to all eligibility requirements, including all requirements relating to the Effective Date of coverage.

K. STATUS CHANGE

If an Employee or Dependent has a status change while covered under this Plan of Benefits (i.e. Employee to Dependent, COBRA to active) and no interruption in coverage has occurred, the Plan of Benefits will allow continuity of coverage with respect to any Waiting Period.

WOMEN'S HEALTH AND CANCER RIGHTS ACT OF 1998

In the case of a Participant who is receiving Covered Expenses in connection with a mastectomy the Group Health Plan will pay Covered Expenses for each of these (if requested by such Participant):

- A. Reconstruction of the breast on which the mastectomy has been performed;
- B. Surgery and reconstruction of the other breast to produce a symmetrical appearance;
- C. Prosthesis and physical complications at all stages of mastectomy, including lymphedemas.

The Plan of Benefits' Benefit Year Deductible and Copay will apply to these Benefits.

FAMILY AND MEDICAL LEAVE ACT ("FMLA")

The Group Health Plan must comply with FMLA as outlined in the regulations issued by the U.S. Department of Labor. During any leave taken under the FMLA, the Plan Sponsor will maintain coverage under this Plan of Benefits on the same basis as coverage would have been provided if the Employee had been continuously employed during the entire leave period.

In general, eligible Employees may be entitled to:

Twelve workweeks of leave in a 12-month period for:

- the birth of a Child and to care for the newborn Child within one year of birth;
- the placement with the Employee of a Child for adoption or foster care and to care for the newly placed Child within one year of placement;
- to care for the Employee's spouse, Child, or parent who has a serious health condition;
- a serious health condition that makes the Employee unable to perform the essential functions of his or her job;
- any qualifying exigency arising out of the fact that the Employee's spouse, son, daughter, or parent is a covered military member on "covered active duty;" or

Twenty-six workweeks of leave in a single 12-month period to care for a covered service member with a serious injury or illness of a service member spouse, son, daughter, parent, or next of kin to the Employee (military caregiver leave).

CONSOLIDATED OMNIBUS BUDGET RECONCILIATION ACT OF 1985

The Consolidated Omnibus Budget Reconciliation Act of 1985 (“COBRA”) requires that Plan Sponsors allow these categories of eligible people continue coverage under the Group Health Plan after such individuals would ordinarily not be eligible.

You also may have other options available when you lose this coverage. For example, you may be eligible to enroll into an individual plan through the Health Insurance Marketplace. By enrolling in coverage through the Marketplace, you may qualify for lower costs on your monthly premiums and lower out-of-pocket costs. (For more information about the Marketplace, visit www.HealthCare.gov). Additionally, you may qualify for a 30-day special enrollment period for another group health plan for which you are eligible (such as a spouse's plan), even if that plan generally does not accept late enrollees.

If you decide to continue this coverage, it is available for a period of up to 18, 29 or 36 months, depending on the circumstances:

- A. 18 months for Employees whose working hours are reduced – during a non-FMLA leave of absence or when an Employee changes from full-time to part-time – and any family members who also lose coverage for this reason;
- B. 18 months for Employees who voluntarily quit work and any family members who also lose coverage for this reason;
- C. 18 months for Employees who are part of a layoff and any family members who also lose coverage for this reason;
- D. 18 months for Employees who are fired, unless the firing is due to gross misconduct of the Employee, and any family members who also lose coverage for this reason;
- E. 29 months for Employees and all covered Dependents who are determined to be disabled under the Social Security Act before or during the first sixty (60) days after termination of employment or reduction of hours of employment. Notice of the Social Security Disability determination must be given to the Plan Sponsor within 60 days of the determination of disability and before the end of the first 18 months of continuation of coverage. Nevertheless, if the determination was prior to termination, the Notice can be provided with COBRA election form in order to secure the extension;
- F. 36 months for Employees’ widows or widowers and their Dependent Children;
- G. 36 months for separated (in states where legal separation is recognized) or divorced husbands or wives of the Employee and their Dependent Children;
- H. 36 months for Dependent Children who lose coverage under the Plan of Benefits because they no longer meet the Plan’s definition of a Dependent Child;
- I. 36 months for Dependents who are not eligible for Medicare when the Employee is eligible for Medicare and no longer has coverage with the Plan Sponsor;
- J. For Plans providing coverage for retired Employees and their Dependents, a special rule applies for such persons who would lose coverage due to the Plan Sponsor filing for Title 11 Bankruptcy. (Loss of coverage includes a substantial reduction of coverage within a year before or after the bankruptcy filing.) Upon occurrence of such an event, retired Employees and their eligible Dependents may continue their coverage under the Plan of Benefits until the date of death of the retiree. If a retiree dies while on this special continued coverage, surviving Dependents may elect to continue coverage for up to 36 additional months.

Except for items E, G, and H, above, the Plan Administrator is responsible for getting the proper form(s) to the Participant so continuation of coverage can be applied for.

For items E, G, and H, the Participant is responsible for notifying the Plan Administrator within sixty (60) days that the qualifying event has occurred. The notice must be given in writing to the Plan Administrator and should contain the: (1) name of benefit Plan, (2) Covered Employee’s name, (3) your name and address, and (4) type of qualifying event and date it occurred. Upon receipt of notice, the Plan Sponsor will then forward the COBRA application form to the Participant or the appropriate Dependent.

The Participant or the appropriate Dependent must complete a COBRA application form and return it to the Plan Administrator no later than 60 days (called the election period) from the later of: (1) the date the Participants coverage ends, or (2) the date the Participant receives notice of the right to apply for continuation coverage.

An application by the Participant or their spouse for continuation of coverage also applies to any other family members who also lose coverage for the same reason. Nevertheless, each family member losing coverage for the same reason is entitled to make a separate application for continuation of coverage. If there is a choice among types of coverage under the Plan of Benefits, each family member can make a separate selection from the available types of coverage.

During an 18-month continuation of coverage period, some persons may have another situation occur to them from among items B, C, D, and F through I. They will be entitled to continuation of coverage for an overall total of up to **36** months. For items G and H, the Participant must notify the Plan Administrator within **60** days that the situation has occurred.

Premiums for continuation of coverage should be paid to the Plan Administrator or their designated party. The Plan Administrator has the right to require you to pay the entire Premium, even if active employees pay only part of the Premium. The Plan Administrator also has the right to charge and keep an extra two percent administration fee each month. For disabled employees who have applied for the 29-month COBRA continuation period, the Plan Administrator has the right to charge 150% of the applicable Premium each month for the 19th month through the 29th month of coverage.

For those Participants electing COBRA continuation of coverage, the first Premium payment must be postmarked and mailed to the Plan Administrator by the 45th day after the Participant elects continuation coverage. Thereafter, Premium payments are due on the first of each month. There is a 31-day grace period for payment of the monthly Premiums.

COBRA Continuation of Coverage ends earlier than the maximum continuation period under these circumstances:

- A. When Premiums are not paid on time.
- B. When the Participant who has continuation of coverage becomes covered under another group health Plan or Medicare, after the date of the COBRA election, through employment or otherwise.
- C. When a disabled person covered under the extended 29-month COBRA continuation period has been determined by the Social Security Administration to be no longer disabled, coverage ends for the disabled person and any covered family members on the later of 30 days after the determination or 18 months. (Notification must be given to the Company within 30 days of final determination.)
- D. The termination of the Group Health Plan.

Uniformed Services Employment and Re-employment Rights Act (USERRA)

- A. In any case in which an Employee or any of such Employee's Dependents has coverage under the Plan of Benefits, and such Employee is not Actively at Work by reason of active duty service in the uniformed services, the Employee may elect to continue coverage under the Plan of Benefits as provided in this section. The maximum period of coverage of the Employee and such Employee's Dependents under such an election shall be the lesser of:
- i. The twenty-four (24) month period beginning on the date on which the Employee's absence from being Actively at Work by reason of active duty service in the uniformed services begins;
 - ii. The day after the date on which the Employee fails to apply for or return to a position of employment, as determined under USERRA.

The continuation of coverage period under USERRA will be counted toward any continuation of coverage period available under COBRA.

- B. An Employee who elects to continue coverage under this section of the Group Health Plan must pay one hundred and two percent (102%) such Employee's normal Premium. Except that, in the case of an Employee who performs service in the uniformed services for less than thirty-one (31) days, such Employee will pay the normal contribution for the thirty-one (31) days.
- C. An Employee who is qualified for re-employment under the provisions of USERRA will be eligible for reinstatement of coverage under the Group Health Plan upon re-employment. Except as otherwise provided in this Article upon re-employment and reinstatement of coverage no new exclusion or Probationary Period will be imposed in connection with the reinstatement of such coverage if an exclusion or Waiting Period normally would have been imposed. This Article applies to the Employee who is re-employed and to a Dependent who is eligible for coverage under the Group Health Plan by reason of the reinstatement of the coverage of such Employee.
- D. This Section shall not apply to the coverage of any illness or injury determined by the Secretary of Veterans Affairs to have been incurred in, or aggravated during, performance of service in the uniformed services.

SUBROGATION / RIGHT OF REIMBURSEMENT

In the event Benefits are provided to or on behalf of a Participant under the terms of this Plan of Benefits, the Participant agrees, as a condition of receiving Benefits under the Plan of Benefits, to transfer to the Group Health Plan all rights to recover damages in full for such Benefits when the injury or illness occurs through the act or omission of another person, firm, corporation, or organization. The Group Health Plan shall be subrogated, at its expense, to the rights of recovery of such Participant against any such liable third party.

If, however, the Participant receives a settlement, judgment, or other payment relating to an injury or illness from another person, firm, corporation, organization or business entity for the injury or illness, the Participant agrees to reimburse the Group Health Plan in full, and in first priority, for Benefits paid by the Group Health Plan relating to the injury or illness. The Group Health Plan's right of recovery applies regardless of whether the recovery, or a portion thereof, is specifically designated as payment for, but not limited to, medical Benefits, pain and suffering, lost wages, other specified damages, or whether the Participant has been made whole or fully compensated for his/her injuries.

The Group Health Plan's right of full recovery may be from the third party, any liability or other insurance covering the third party, the insured's own uninsured motorist insurance, underinsured motorist insurance, any medical payments (Med-Pay), no fault, personal injury protection (PIP), malpractice, or any other insurance coverage that are paid or payable.

The Group Health Plan will not pay attorney's fees, costs, or other expenses associated with a claim or lawsuit without the expressed written authorization of the Group Health Plan.

The Participant shall not do anything to hinder the Group Health Plan's right of subrogation and/or reimbursement. The Participant shall cooperate with the Group Health Plan and execute all instruments and do all things necessary to protect and secure the Group Health Plan's right of subrogation and/or reimbursement, including assert a claim or lawsuit against the third party or any insurance coverage to which the Participant may be entitled. Failure to cooperate with the Group Health Plan will entitle the Group Health Plan to withhold Benefits due the Participant under the Plan of Benefits document. Failure to reimburse the Group Health Plan as required will entitle the Group Health Plan to deny future Benefit payments for all Participants under this policy until the subrogation/reimbursement amount has been paid in full.

It is further agreed that the Participant will sign a written agreement to repay the Group Health Plan in full out of any money that the Participant receives from a negligent person or organization. If the Participant fails to sign such an agreement, the Group Health Plan reserves the right to withhold payment of the Participant's claims, which relate to the negligence of another person or organization, until such time as the Participant signs the agreement to repay.

WORKERS' COMPENSATION PROVISION

This policy does not provide benefits for diagnosis, treatment or other service for any injury or illness that is sustained by a Participant that arises out of, in connection with, or as the result of any work for wage or profit when coverage under any Workers' Compensation Act or similar law is required or is otherwise available for the Participant. Benefits will not be provided under this Plan if coverage under the Workers' Compensation Act or similar law would have been available to the Participant but the Participant elects exemption from available Workers' Compensation coverage; waives entitlement to Workers' Compensation benefits for which he/she is eligible; fails to timely file a claim for Workers' Compensation benefits; seeks treatment for the injury or illness from a provider that is not authorized by the Participant's Plan Sponsor.

If the Group Health Plan, or its designee, including PAI (hereinafter referred to as "the Plan") pays Benefits for an injury or illness and the Plan determines the Participant also received Workers' Compensation benefits by means of a settlement, judgment, or other payment for the same injury or illness, Participant shall reimburse the Plan in full all Benefits paid by the Plan relating to the injury or illness.

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

As a condition of receiving Benefits under this Plan of Benefits, the Participant agrees to notify the Plan of any Workers' Compensation claim he/she may make and agrees to reimburse the Plan as described herein. The Participant shall not do anything to hinder the Plan's right of recovery. The Participant shall cooperate with the Plan, execute all documents, and do all things necessary to protect and secure the Plan's right of recovery, including assert a claim or lawsuit against the Workers' Compensation carrier or any other insurance coverage to which the Participant may be entitled. Failure to cooperate with the Plan will entitle the Plan to withhold Benefits due the Participant under this Plan of Benefits. Failure to reimburse the Plan as required under this Section will entitle the Plan to invoke the Workers' Compensation Exclusion and deny payment for all claims relating to the injury or illness and/or deny future Benefit payments for any such Participant until the reimbursement amount has been paid in full.

COORDINATION OF BENEFITS

Coordination of benefits rules apply when a Participant is covered by this Plan of Benefits and also covered by any other Plan or Plans. When more than one coverage exists, one Plan normally pays its benefits in full and the other Plan pays a reduced benefit. This Plan of Benefits will always pay either its Benefits in full or a reduced amount that, when added to the benefits payable by the other Plan or Plans, will not exceed 100% of Allowed Amounts. Only the amount paid by the Plan of Benefits will be included for purposes of determining the maximums in the Schedule of Benefits. Through the coordination of benefits, a Participant or Dependent will not receive more than the Allowed Amounts for a loss.

The coordination of benefits provision applies whether or not a claim is filed under the other Plan or Plans. The Participant agrees to provide authorization to this Plan of Benefits to obtain information as to benefits or services available from any other Plan or Plans, or to recover overpayments. All Benefits contained in the Plan of Benefits are subject to this provision.

When this Plan of Benefits is primary, Benefits are determined before those of the other Plan. The benefits of the other Plan are not considered. When this Plan of Benefits is secondary, Benefits are determined after those of the other Plan. Benefits may be reduced because of the other Plan's benefits. When there are more than two Plans this Plan of Benefits may be primary as to one and may be secondary as to another.

ORDER OF DETERMINATION

If a Participant covered hereunder is also covered for comparable benefits or services under another Plan that is the Primary Plan, Benefits applicable under this Plan of Benefits will be reduced so that, for benefits incurred, benefits available under all Plans shall not exceed the Allowed Amounts of such benefits.

This Plan of Benefits determines its order of Benefits using the first of these that applies:

- A. **General** - A Plan that does not coordinate with other Plans is always the Primary Plan;
- B. **Non-Dependent/Dependent** – The Benefits of the Plan that covers the person as an Employee, (other than a Dependent) is the Primary Plan; the Plan that covers the person as a Dependent is the Secondary Plan;
- C. **Dependent Child/Parents Not Separated or Divorced** - Except as stated in (D) below, when this Plan of Benefits and another Plan cover the same Child as a Dependent of different parents:
 1. The Primary Plan is the Plan of the parent whose birthday (month and day) falls earlier in the year. The Secondary Plan is the Plan of the parent whose birthday falls later in the year; but
 2. If both parents have the same birthday, the benefits of the Plan that covered the parent the longer time is the Primary Plan; the Plan that covered the parent the shorter time is the Secondary Plan;
 3. If the other Plan does not have the birthday rule, but has the gender rule and if, as a result, the Plans do not agree on the order of benefits, the rule in the other Plan will determine the order of benefits.
- D. **Dependent Child/Separated or Divorced Parents** - If two or more Plans cover a person as a Dependent Child of divorced or separated parents, benefits for the Child are determined in this order:
 1. First, the Plan of the parent with custody of the Child;
 2. Then, the Plan of the spouse of the parent with custody;
 3. Finally, the Plan of the parent without custody of the Child.

Nevertheless, if the specific terms of a court decree state that one parent is responsible for the health care expenses of the Child, then that parent's Plan is the Primary Plan. If a court decree exists stating that the parents shall share joint custody, without stating that one of the parents is financially responsible for the health care of the Child, the order of liability will be determined according to the rules for Dependent Children whose parents are not separated or divorced. Anyone who legally adopts the Child will assume natural parent status.

- E. **Active/Inactive Employee** - The Primary Plan is the Plan that covers the person as an Employee who is neither laid off nor retired (or as that Employee's Dependent). The Secondary Plan is the Plan that covers that person as

a laid off or retired Employee (or as that Employee's Dependent). If the other Plan does not have this rule, and if, as result the Plans do not agree on the order of Benefits, this rule does not apply.

- F. **Longer/Shorter Length of Coverage** - If none of the above rules determines the order of benefits, the Primary Plan is the Plan that covered an Employee longer. The Secondary Plan is the Plan that covered that person the shorter time.
- G. In the case of a Plan that contains order of benefit determination rules that declare that Plan to be excess to or **always secondary to all other Plans**, this Plan of Benefits will coordinate Benefits as:
1. If this Plan of Benefits is Primary, it will pay or provide Benefits on a Primary basis;
 2. If this Plan of Benefits is secondary, it will pay or provide Benefits first, but the amount of Benefits payable will be determined as if this Plan of Benefits were the Secondary Plan. The liability of this Plan of Benefits will be limited to such payment;
 3. If the Plan does not furnish the information needed by this Plan of Benefits to determine Benefits within a reasonable time after such information is requested, this Plan of Benefits shall assume that the benefits of the other Plan are the same as those provided under this Plan of Benefits, and shall pay Benefits accordingly. When information becomes available as to the actual benefits of the other Plan, any Benefit payment made under this Plan of Benefits will be adjusted accordingly.

H. **Right To Coordination of Benefits Information**

The Plan Administrator and PAI have the right:

1. To obtain or share information with any insurance company or other organization regarding coordination of benefits without the claimant's consent;
2. To require that the claimant provide the Plan Administrator with information on such other Plans so that this provision may be implemented;
3. To pay more than the amount due under this Plan of Benefits to an insurer or other organization if this is necessary, in the Plan Administrator or PAI's opinion, to satisfy the terms of this provision.

I. **Facility of Payment**

Whenever payments that should have been made under this Plan of Benefits in accordance with this provision have been made under any other Plan or Plans, the Plan Administrator will have the right, exercisable alone and in its sole discretion, to pay to any insurance company or other organizations or person making such other payments any amount it will determine in order to satisfy the intent of this provision, and amount so paid will be deemed to be Benefits paid under this Plan of Benefits and to the extent of such payment, the Plan Administrator will be fully discharged from liability under this Plan of Benefits. The Benefits that are payable will be charged against any applicable Maximum Payment or Benefit of this Plan of Benefits rather than the amount payable in the absence of this provision.

J. **Medicare**

Individuals Age 65 or Older

If you are a Participant and are age 65 or older, this Plan is the primary payer. Medicare will be the secondary payer.

If you are a retiree and are age 65 or older and are eligible to participate in this Plan, Medicare will be the primary payer and this Plan will pay secondary.

If you are not a Participant and are age 65 or older, Medicare will be your only medical coverage.

Disabled Participants*

If you are a Participant who is disabled, this Plan is the primary payer and Medicare is the secondary payer.

*This applies for Plans with 100 or more employees. (If the Plan has less than 100 employees, Medicare is primary for disabled individuals).

End-Stage Renal Disease

If you have End-Stage Renal Disease and are a Participant, this Plan is the primary payer and Medicare is the secondary payer for the first 30 months of eligibility or entitlement to Medicare. After 30 months, Medicare will be the primary payer, and this Plan will be the secondary payer.

COBRA - Age 65 or Older or Disabled

If you are age 65 or older or disabled, and covered by Medicare and COBRA, Medicare will be the primary payer and the COBRA coverage will pay secondary.

Coordination:

When Medicare is primary and the Plan is secondary, Medicare (Parts A and B) will be considered a Plan for the purposes of coordination of benefits. The Plan will coordinate benefits with Medicare whether or not the Participant or their Dependents is/are actually receiving Medicare benefits.

ERISA RIGHTS

As a Participant in this Group Health Plan you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (“ERISA”) provided the Plan Sponsor is subject to ERISA regulations. ERISA provides that all Participants shall be entitled to:

Receive Information about Your Plan and Benefits

Examine, without charge, at the Plan Administrator’s office and at other specified locations, such as work sites and union halls, all documents governing the Group Health Plan, including insurance contracts and collective bargaining agreements, and a copy of the latest annual report (Form 5500 Series) filed by the Plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Employee Benefits Security Administration (“EBSA”).

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

Receive, upon request, a summary of the Group Health Plan’s annual financial report. The Plan Administrator is required by law to furnish each Participant with a copy of this summary annual report.

Continue Group Health Plan Coverage

Continue health care coverage for yourself and your Dependents if there is a loss of coverage under the Group Health Plan as a result of a Qualifying Event. You or your Dependents may have to pay for such continuation coverage. You should review the documents governing COBRA continuation coverage rights.

Prudent Actions by Plan Fiduciaries

In addition to creating rights for Participants, ERISA imposes duties upon the people who are responsible for the operation of an employee welfare benefit plan. The people who administer an employee welfare benefit plan are called “fiduciaries” and have a duty to do so prudently and in the interest of the Participants. The Plan Sponsor is the fiduciary of the Group Health Plan.

Enforce Your Rights

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

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

No one, including your Plan Sponsor, your union, or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a Benefit or exercising your rights under ERISA.

Assistance with Your Questions

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

DISCLOSURE OF PROTECTED HEALTH INFORMATION TO PLAN SPONSOR

The Group Health Plan will disclose (or require PAI to disclose) Participant's PHI to the Plan Sponsor only to permit the Plan Sponsor to carry out Plan administration functions for the Group Health Plan not inconsistent with the requirements of HIPAA. Any disclosure to and use by the Plan Sponsor will be subject to and consistent with the provisions of the sections below.

1. Disclosure of Protected Health Information to Plan Sponsor.
 - a. The Group Health Plan and any health insurance issuer or business associate servicing the Group Health Plan will disclose PHI to the Plan Sponsor only to permit the Plan Sponsor to carry out Plan administration functions for the Group Health Plan not inconsistent with the requirements of the HIPAA and its implementing regulations, as amended. Any disclosure to and use by the Plan Sponsor of PHI will be subject to and consistent with the provisions of paragraphs 2 and 3 of this section.
 - b. Neither the Group Health Plan nor any health insurance issuer or business associate servicing the Plan of Benefits will disclose Participant's PHI to the Plan Sponsor unless the disclosures are explained in the Notice of Privacy Practices distributed to the Participants.
 - c. Neither the Group Health Plan nor any health insurance issuer or business associate servicing the Plan of Benefits will disclose Participant's PHI to the Plan Sponsor for the purpose of employment-related actions or decisions or in connection with any other benefit or employee benefit plan of the Plan Sponsor.
2. Restrictions on Plan Sponsor's Use and Disclosure of Protected Health Information.
 - a. The Plan Sponsor will neither use nor further disclose Participant's PHI, except as permitted or required by the Plan documents, as amended, or required by law.
 - b. The Plan Sponsor will ensure that any agent, including any subcontractor, to whom it provides Participant's PHI, agrees to the restrictions and conditions of the Plan of Benefits, with respect to PHI.
 - c. The Plan Sponsor will not use or disclose Participant PHI for employment-related actions or decisions or in connection with any other benefit or employee benefit plan of the Plan Sponsor.
 - d. The Plan Sponsor will report to the Group Health Plan any use or disclosure of Participant PHI that is inconsistent with the uses and disclosures allowed under this section promptly upon learning of such inconsistent use or disclosure.
 - e. The Plan Sponsor will make PHI available to the Participant who is the subject of the information in accordance with HIPAA.
 - f. The Plan Sponsor will make PHI available for amendment, and will on notice amend Participant PHI, in accordance with HIPAA.
 - g. The Plan Sponsor will track disclosures it may make of Participant PHI so that it can make available the information required for the Group Health Plan to provide an accounting of disclosures in accordance with HIPAA.
 - h. The Plan Sponsor will make available its internal practices, books, and records, relating to its use and disclosure of Participants' PHI, to the Group Health Plan and to the U.S. Department of Health and Human Services to determine compliance with HIPAA.
 - i. The Plan Sponsor will, if feasible, return or destroy all Participant PHI, in whatever form or medium (including in any electronic medium under the Plan Sponsor's custody or control), received from the Group Health Plan, including all copies of and any data or compilations derived from and allowing identification of any Participant who is the subject of the PHI, when the Participants' PHI is no longer needed for the Plan administration functions for which the disclosure was made. If it is not feasible to return or destroy all Participant PHI, the Plan Sponsor will limit the use or disclosure of any Participant PHI it cannot feasibly return or destroy to those purposes that make the return or destruction of the information infeasible.

3. Adequate Separation Between the Plan Sponsor and the Group Health Plan.

- a. Certain classes of employees or other workforce members under the control of the Plan Sponsor may be given access to Participant PHI received from the Group Health Plan or business associate servicing the Group Health Plan:
- b. These employees will have access to PHI only to perform the Plan administration functions that the Plan Sponsor provides for the Group Health Plan.
- c. These employees will be subject to disciplinary action and sanctions, including termination of employment or affiliation with the Plan Sponsor, for any use or disclosure of Participant PHI in breach or violation of or noncompliance with the provisions of this section of the Plan of Benefits. The Plan Sponsor will promptly report such breach, violation or noncompliance to the Group Health Plan, and will cooperate with the Group Health Plan to correct the breach, violation or noncompliance, to impose appropriate disciplinary action or sanctions on each employee or other workforce member causing the breach, violation or noncompliance, and to mitigate any deleterious effect of the breach, violation or noncompliance on any Participant, the privacy of whose PHI may have been compromised by the breach, violation or noncompliance.
- d. Plan Sponsor shall ensure that the separation required by the above provisions will be supported by reasonable and appropriate security measures.

4. Plan Sponsor Obligations to the security of Electronic Protected Health Information (“ePHI”):

Where ePHI will be created, received, maintained or transmitted to or by the Plan Sponsor on behalf of the Group Health Plan, the Plan Sponsor shall reasonably safeguard the ePHI as:

- a. Plan Sponsor will implement administrative, physical and technical safeguards that reasonably and appropriately protect the confidentiality, integrity and availability of the ePHI that the Plan Sponsor creates, receives, maintains or transmits on behalf of the Group Health Plan. Plan Sponsor will ensure that any agent, including a subcontractor, to whom it provides ePHI, agrees to implement reasonable and appropriate security measures to protect this information;
- b. The Plan Sponsor shall report any security incident of which it becomes aware to the Group Health Plan as provided below.
 - i. In determining how and how often Plan Sponsor shall report security incidents to Group Health Plan, both Plan Sponsor and Group Health Plan agree that unsuccessful attempts at unauthorized access or system interference occur frequently and that there is no significant benefit for data security from requiring the documentation and reporting of such unsuccessful intrusion attempts. In addition, both parties agree that the cost of documenting and reporting such unsuccessful attempts as they occur outweigh any potential benefit gained from reporting them. Consequently, both Plan Sponsor and Group Health Plan agree that this Agreement shall constitute the documentation, notice and written report of any such unsuccessful attempts at unauthorized access or system interference as required above and by 45 C.F.R. Part 164, Subpart C, and that no further notice or report of such attempts will be required. By way of example (and not limitation in any way), the Parties consider these to be illustrative (but not exhaustive) of unsuccessful security incidents when they do not result in unauthorized access, use, disclosure, modification, or destruction of ePHI or interference with an information system:
 - Pings on a Party’s firewall,
 - Port scans,
 - Attempts to log on to a system or enter a database with an invalid password or username,
 - Denial-of-service attacks that do not result in a server being taken off-line, and
 - Malware (e.g., worms, viruses)

- ii. Plan Sponsor shall, nevertheless, separately report to Group Health Plan (i) any successful unauthorized access, use, disclosure, modification, or destruction of the Group Health Plan's ePHI of which Plan Sponsor becomes aware if such security incident either (a) results in a breach of confidentiality; (b) results in a breach of integrity but only if such breach results in a significant, unauthorized alteration or destruction of Group Health Plan's ePHI; (c) results in a breach of availability of Group Health Plan's ePHI, but only if said breach results in a significant interruption to normal business operations. Such reports will be provided in writing within ten (10) business days after Plan Sponsor becomes aware of the impact of such security incident upon Group Health Plan's ePHI.

GENERAL INFORMATION

Whereas Plan Sponsor establishes this Group Health Plan and the applicable Benefits, rights and privileges that shall pertain to participating employees, hereinafter referred to as “Employees” and the eligible Dependents of such Employees, as herein defined, for which Benefits are provided through a fund established by the Plan Sponsor and hereinafter referred to as the “Plan of Benefits”:

ADMINISTRATIVE SERVICES ONLY

PAI provides administrative claims payment services only and does not assume any financial risk or obligation with respect to claims. The Group Health Plan is a self-funded health Plan, and the Plan Sponsor assumes all financial risk and obligation with respect to claims.

CLERICAL ERRORS

Clerical errors by PAI or the Plan Sponsor will not cause a denial of Benefits that should otherwise have been granted, nor will clerical errors extend Benefits that should otherwise have ended.

GOVERNING LAW

The Group Health Plan may be governed by and subject to ERISA and any other applicable federal law. If ERISA or another federal law does not apply, the Group Health Plan is governed by and subject to the laws of the State of South Carolina. If federal law conflicts with any state law, then such federal law shall govern. If any provision of the Group Health Plan conflicts with such law, the Group Health Plan shall automatically be amended solely as required to comply with such state or federal law.

IDENTIFICATION CARD

A Participant must present their Identification Card prior to receiving Benefits.

Having an Identification Card creates no right to Benefits or other services. To be entitled to Benefits, the cardholder must be a Participant whose Premium has been paid. Any person receiving Covered Expenses to which the person is not entitled will be responsible for the charges.

INFORMATION AND RECORDS

PAI and the Plan Sponsor are entitled to obtain such medical and Hospital records as may reasonably be required from any Provider incident to the treatment, payment and health-care operations for the administration of the Benefits hereunder and the attending Physician’s certification as to the Medical Necessity for care or treatment.

LEGAL ACTIONS

No action at law or in equity can be brought under the Group Health Plan until such Participant has exhausted the administrative process (including the exhaustion of all appeals) as described in this booklet. No such action may be brought after the expiration of any applicable period prescribed by law.

MISSTATEMENT OF AGE

If age is a factor in determining eligibility or amount of coverage and there has been a misstatement of age, the coverage or amounts of Benefits, or both, for which the person is covered shall be adjusted in accordance with the covered individual’s true age. Any such misstatement of age shall neither continue coverage otherwise validly terminated, nor terminate coverage otherwise validly in force. Contributions and Benefits will be adjusted on the contribution due date next following the date of the discovery of such misstatement.

NEGLIGENCE OR MALPRACTICE

PAI and the Plan Sponsor do not practice medicine. Any medical treatment, service or Medical Supplies rendered to or supplied to any Participant by a Provider is rendered or supplied by such Provider and not by PAI or the Plan Sponsor. PAI and the Plan Sponsor are not liable for any improper or negligent act, inaction or act of malfeasance of any Provider in rendering such medical treatment, service, Medical Supplies or medication.

NOTICES

Except as otherwise provided in this Plan of Benefits, any notice under the Group Health Plan may be given by United States mail, postage paid and addressed:

1. To PAI:
Planned Administrators, Inc.
Post Office Box 6927
Columbia, South Carolina 29260
2. To a Participant: To the last known name and address listed for the Employee on the membership application. Participants are responsible for notifying PAI of any name or address changes within thirty-one (31) days of the change.
3. To the Plan Sponsor: To the name and address last given to PAI. The Plan Sponsor is responsible for notifying PAI and Participants of any name or address change within thirty-one (31) days of the change.

NO WAIVER OF RIGHTS

On occasion, PAI (on behalf of the Group Health Plan) or the Plan Sponsor may, at their discretion, choose not to enforce all of the terms and conditions of this Plan of Benefits. Such a decision does not mean the Group Health Plan or the Plan Sponsor waives or gives up any rights under this Plan of Benefits in the future.

OTHER INSURANCE

Each Participant must provide the Group Health Plan (and its designee, including PAI) and the Plan Sponsor with information regarding all other Health Insurance Coverage to which such Participant is entitled.

PAYMENT OF CLAIMS

Except for the Participant's Provider, a Participant is expressly prohibited from assigning any right to payment of Covered Expenses or any payment related to Benefits. The Group Health Plan may pay Covered Expenses directly to the Employee or to the Non-Participating Provider upon receipt of due proof of loss for services provided by a Non-Participating Provider. Where a Participant has received Benefits from a Participating Provider or Contracting Provider, the Group Health Plan will pay Covered Expenses directly to such Participating Provider or Contracting Provider.

PHYSICAL EXAMINATION

The Group Health Plan has the right to examine, at their own expense, a Participant whose injury or sickness is the basis of a claim (whether Pre-Service, Post-Service, Concurrent or Urgent Care). Such physical examination may be made as often as the Group Health Plan (through its designee, including PAI) may reasonably require while such claim for Benefits or request for Preauthorization is pending.

PLAN AMENDMENTS

Upon thirty (30) days prior written notice, the Plan Sponsor may unilaterally amend the Group Health Plan. Increases in the Benefits provided or decreases in the Premium are effective without such prior notice. Notice of an amendment will be effective when addressed to the Plan Sponsor. PAI has no responsibility to provide individual notices to each Participant when an amendment to the Group Health Plan has been made.

PLAN IS NOT A CONTRACT

This Plan of Benefits constitutes the entire Group Health Plan. The Plan of Benefits will not be deemed to constitute a contract of employment or give any Employee of the Plan Sponsor the right to be retained in the service of the Plan

Sponsor or to interfere with the right of the Plan Sponsor to discharge or otherwise terminate the employment of any employee.

PLAN INTERPRETATION

The Plan Administrator has full discretionary authority to interpret and apply all Plan of Benefits provisions, including, but not limited to, all issues concerning eligibility and determination of Benefits. The Plan Administrator may contract with an independent administrative firm to process claims, maintain Group Health Plan data, and perform other Group Health Plan connected services; nevertheless, final authority to construe and apply the provisions of the Plan of Benefits rests exclusively with the Plan Administrator. Decisions of the Plan Administrator, made in good faith, shall be final and binding.

REPLACEMENT COVERAGE

If the Group Health Plan replaced the Plan Sponsor's prior Plan, all eligible persons who were validly covered under that Plan on its termination date will be covered on the Plan of Benefits Effective Date of the Group Health Plan, provided such persons are enrolled for coverage as stated in the Eligibility for Coverage Section.

TERMINATION OF PLAN

The Plan Administrator reserves the right at any time to terminate the Group Health Plan by a written instrument to that effect. All previous contributions by the Plan Administrator shall continue to be issued for the purpose of paying Benefits under the provisions of this Plan of Benefits with respect to claims arising before such termination, or shall be used for the purpose of providing similar health Benefits to covered Employees, until all contributions are exhausted.

PLAN SPECIFIC INFORMATION

Plan Name:	Clafin University
Name and Address of the Employer establishing the Plan:	Clafin University 400 Magnolia Street Orangeburg, South Carolina 29115
Employer ID Number:	57-0314374
Plan Number:	789
Type of Welfare Plan:	Medical, Dental and Short-Term Disability
Plan Funding:	Paid by the Employer and/or the Employee
Plan Administration:	Contract Administration, payment of claims administration
Agent and Address for Service of Legal Process/Fiduciary:	Clafin University 400 Magnolia Street Orangeburg, South Carolina 29115 803-535-5268
Plan Termination:	The right is reserved in the Plan for the Plan Administrator, by action of its Board of Directors, to terminate, suspend, withdraw, amend or modify the Plan in whole or in part, with respect to any class or classes of Employees, at any time, with proper notification and subject to the terms of the Plan and any applicable laws.
Plan Document:	A full description of the medical Benefits appears in the official Plan document which is the final authority. The papers may be examined in the company office of the Employer within thirty (30) days after your written request is received by the Plan Administrator

DEFINITIONS

Capitalized terms that are used in this Plan of Benefits shall have these defined meanings:

Actively at Work: a permanent, full-time employee who works at least the minimum number of hours per week and the minimum number of weeks per year (each as set forth in the ELIGIBILITY section) and who is not absent from work during the initial enrollment period because of a leave of absence or temporary layoff. An absence during the initial enrollment period due to a Health Status Related Factor will not keep an employee from qualifying for Actively at Work status.

Admission: the period of time between a Participant's entry as a registered bed-patient into a Hospital or Skilled Nursing Facility and the time the Participant leaves or is discharged.

Adverse Benefit Determination: any denial, reduction or termination of, or failure to provide or make (in whole or in part) payment for a claim for Benefits, including any such denial, reduction, termination, or failure to provide or make payment that is based on a determination of a Participant's or beneficiary's eligibility to participate in a Plan, and including a denial, reduction or termination of, or failure to provide or make payment (in whole or in part) for a Benefit that results from the application of any utilization review as well as a failure to cover an item or service for which Benefits are otherwise provided because it is determined to be Experimental or Investigational or not Medically Necessary or appropriate. **A Rescission of coverage, whether or not the Rescission has an adverse effect on any particular Benefit, also is considered an Adverse Benefit Determination.**

Allowed Amount: the amount the Plan Sponsor agrees to pay a Participating Provider or Non-Participating Provider as payment in full for a service, procedure, supply or equipment. For a Non-Participating Provider, (i) the Allowed Amount shall not exceed the Maximum Payment and (ii) in addition to the Member's liability for deductibles, Copays and/or coinsurance, the Participant may be balance billed by the Non-Participating Provider for any difference between the Allowed Amount and the billed charges.

Ambulatory Surgical Center: a licensed facility that:

1. Has permanent facilities equipped and operated primarily for the purpose of performing surgical procedures on an outpatient basis;
2. Has continuous Physician services and registered professional nursing service whenever a patient is in the facility;
3. Does not provide accommodations for patients to stay overnight;
4. Is not, other than incidentally, a facility used as an office or clinic for the private practice of a Physician or oral surgeon.

Ambulatory Surgical Center includes an endoscopy center.

Approved Clinical Trial: means* a phase I, phase II, phase III, or phase IV clinical trial that is conducted in relation to the prevention, detection, or treatment of cancer or other life-threatening disease or condition and is:

1. A Federally Funded Trial—the study or investigation is approved or funded (which may include funding through in-kind contributions) by one or more of these:
 - a. The National Institutes of Health;
 - b. The Centers for Disease Control and Prevention;
 - c. The Agency for Health Care Research and Quality;
 - d. The Centers for Medicare & Medicaid Services;
 - e. Cooperative group or center of any of the entities described in clauses (i) through (iv) or the Department of Defense or the Department of Veterans Affairs;

- f. A qualified non-governmental research entity identified in the guidelines issued by the National Institutes of Health for center support grants;
- g. Any of these departments if the conditions described in paragraph (2) are met:
 - i. The Department of Veterans Affairs.
 - ii. The Department of Defense.
 - iii. The Department of Energy.
- 2. A Food and Drug Administration Trial—the study or investigation is conducted under an investigational new drug application reviewed by the Food and Drug Administration.
- 3. A Drug Trial for investigating new drug applications—the study or investigation is a drug trial that is exempt from having such an investigational new drug application.

*Conditions for Departments. The conditions for a study or investigation conducted by a Department referenced above are that the study or investigation has been reviewed and approved through a system of peer review that the Health and Human Services determines:

- 1. To be comparable to the system of peer review of studies and investigations used by the National Institutes of Health;
- 2. Assures unbiased review of the highest scientific standards by Qualified Individuals who have no interest in the outcome of the review.

Benefit Year: the period of time set forth on the Schedule of Benefits. The initial Benefit Year may be more or less than twelve (12) months.

Benefit Year Deductible: the amount, if any, listed on the Schedule of Benefits that must be paid by the Participant each Benefit Year before the Group Health Plan will pay Covered Expenses. The Benefit Year Deductible is subtracted from the Allowed Amount before Coinsurance is calculated. Participants must refer to the Schedule of Benefits to determine if the Benefit Year Deductible applies to the Out-of-Pocket Maximum.

Benefits: medical services or Medical Supplies that are:

- 1. Medically Necessary;
- 2. Preauthorized (when required under this Plan of Benefits or the Schedule of Benefits);
- 3. Included in this Plan of Benefits;
- 4. Not limited or excluded under the terms of this Plan of Benefits.

Brand Name Drug: a Prescription Drug that is manufactured under a registered trade name or trademark.

Child: An Employee’s Child, whether a natural Child, adopted Child, foster Child, stepchild, or Child for whom an Employee has custody or legal guardianship. The term “Child” also includes an Incapacitated Dependent, or a Child of a divorced or divorcing Employee who, under a Qualified Medical Child Support Order, has a right to enroll under the Group Health Plan. The term “Child” does not include the spouse of an eligible Child.

Coinsurance: the sharing of Covered Expenses between the Participant and the Group Health Plan. After the Participant’s Benefit Year Deductible requirement is met, the Group Health Plan will pay the percentage of Allowed Amounts as set forth on the Schedule of Benefits. The Participant is responsible for the remaining percentage of the Allowed Amount. Coinsurance is calculated after any applicable Benefit Year Deductible or Copay is subtracted from the Allowed Amount based upon the network charge or lesser charge of the Provider.

For Prescription Drug Benefits, Coinsurance means the amount payable by the Participant, calculated as:

- 1. The percentage listed on the Schedule of Benefits; multiplied by
- 2. The amount listed in the Participating Provider’s schedule of allowance for that item calculated at the time of sale;
- 3. Without regard to any Credit or allowance that may be received by PAI.

Concurrent Care Claim: an ongoing course of treatment to be provided over a period of time or number of treatments.

Continued Stay Review: the review that must be obtained by a Participant (or the Participant's representative) regarding an extension of an Admission to determine if an Admission for longer than the time that was originally Preauthorized is Medically Necessary (when required).

Copay: the amount specified on the Schedule of Benefits that the Participant must pay directly to the Provider each time the Participant receives Benefits.

Covered Expenses: the amount payable by the Group Health Plan for Benefits. The amount of Covered Expenses payable for Benefits is determined as set forth in this Plan of Benefits and at the percentages set forth in the Schedule of Benefits. Covered Expenses are subject to the limitations and requirements set forth in the Plan of Benefits and on the Schedule of Benefits. Covered Expenses will not exceed the Allowed Amount.

Credit: financial credits (including rebates and/or other amounts) to PAI directly from drug manufacturers or other Providers through a Pharmacy Benefit Manager (PBM). Credits are used to help stabilize overall rates and to offset expenses and may not be payable to Plan Sponsor or Participants.

Reimbursements to a Participating Pharmacy, or discounted prices charged at Pharmacies, are not affected by these credits. Any Coinsurance that a Participant must pay for Prescription Drugs is based on the Allowed Amount at the Pharmacy and does not change due to receipt of any Credit received by PAI. Copays are not affected by any Credit.

Dependent: an individual who is:

1. An Employee's spouse which is any individual who is legally married under any state law;
2. A Child under the age set forth in the Eligibility for Coverage section;
3. An Incapacitated Dependent.

Detoxification: a Hospital service providing treatment to diminish or remove from a Patient's body the toxic effects of chemical substances, such as alcohol or drugs, usually as an initial step in the treatment of a chemical-dependent person.

Discount Services: services (including discounts on services) that are not Benefits but may be offered to Participants from time to time as a result of being a Participant.

Durable Medical Equipment: equipment that:

1. Can stand repeated use;
2. Is Medically Necessary;
3. Is customarily used for the treatment of a Participant's illness, injury, disease or disorder;
4. Is appropriate for use in the home;
5. Is not useful to a Participant in the absence of illness or injury;
6. Does not include appliances that are provided solely for the Participant's comfort or convenience;
7. Is a standard, non-luxury item (as determined by the Group Health Plan);
8. Is ordered by a medical doctor, oral surgeon, podiatrist or osteopath.

Prosthetic Devices, Orthopedic Devices and Orthotic Devices are considered Durable Medical Equipment. Items such as air conditioners, dehumidifiers, whirlpool baths, and other equipment that have nontherapeutic uses are not considered Durable Medical Equipment.

Emergency Admission Review: the review that must be obtained by a Participant (or the Participant's representative) within twenty-four (24) hours of or by the end of the first working day after the commencement of an Admission to a Hospital to treat an Emergency Medical Condition.

Emergency Medical Condition: a medical condition manifesting itself by acute symptoms of sufficient severity, including severe pain, such that a prudent layperson who possesses an average knowledge of health and medicine could reasonably expect the absence of immediate medical attention to result in:

1. Placing the health of the Participant, or with respect to a pregnant Participant, the health of the Participant or her unborn child, in serious jeopardy;
2. Serious impairment to bodily functions;
3. Serious dysfunction of any bodily organ or part.

Employee: any employee of the Employer (also known as Plan Sponsor) who is eligible for coverage as provided in the eligibility section of this Plan of Benefits, and who is so designated to PAI by the Employer (also known as Plan Sponsor).

Employer: the entity providing this Plan of Benefits, also known as Plan Sponsor.

Employer Effective Date: the date PAI begins to provide services under this Plan of Benefits, also known as Plan Sponsor Effective Date.

Enrollment Date: the date of enrollment in the Group Health Plan or the first day of the Waiting Period for enrollment, whichever is earlier.

Experimental or Investigational: surgical procedures or medical procedures, supplies, devices or drugs that, at the time provided, or sought to be provided, are in the judgment of PAI not recognized as conforming to generally accepted medical practice, or the procedure, drug or device:

1. Has not received required final approval to market from appropriate government bodies;
2. Is one about which the peer-reviewed medical literature does not permit conclusions concerning its effect on health outcomes;
3. Is not demonstrated to be as beneficial as established alternatives;
4. Has not been demonstrated to improve net health outcomes;
5. Is one in which the improvement claimed is not demonstrated to be obtainable outside the experimental or investigational setting.

Excepted Benefits:

1. Coverage only for accident, or disability income insurance, or any combination thereof;
2. Coverage issued as a supplement to liability insurance;
3. Liability insurance, including general liability insurance and automobile liability insurance;
4. Workers' compensation or similar insurance;
5. Automobile medical payment insurance;
6. Credit-only insurance;
7. Coverage for on-site medical clinics;
8. Other similar insurance coverage specified in regulations, under which benefits for medical care are secondary or incidental to other insurance benefits.

If offered separately:

1. Limited scope dental or vision benefits;
2. Benefits for long-term care, nursing home care, Home Health Care, community-based care, or any combination thereof;
3. Such other similar, limited benefits as specified in regulations.

If offered as independent, non-coordinated benefits:

1. Coverage only for a specified disease or illness;
2. Hospital indemnity or other fixed indemnity insurance.

If offered as a separate insurance policy:

1. Medicare supplemental health insurance (as defined under Section 1882(g)(1) of the Social Security Act);
2. Coverage supplemental to the coverage provided under Chapter 55 of Title 10 of the United States Code;
3. Similar supplemental coverage under a group health Plan.

Generic Drug: a Prescription Drug that has a chemical structure that is identical to and has the same bioequivalence as a Brand Name Drug but is not manufactured under a registered brand name or trademark or sold under a brand name. The Pharmacy Benefit Manager has the discretion to determine if a Prescription Drug is a Generic Drug.

Genetic Information: information about genes, gene products (messenger RNA and transplanted protein) or genetic characteristics derived from a Participant or family member of the Participant. Genetic Information includes information regarding carrier status and information derived from laboratory tests that identify mutations in specific genes or chromosomes, physical medical examinations, family histories, and direct analysis of genes or chromosomes. Nevertheless, Genetic Information shall not include routine physical measurements, chemical, blood, and urine analyses unless conducted to diagnose a genetic characteristic; tests for abuse of drugs; and tests for the presence of human immunodeficiency virus.

Grace Period: a period of time as determined by the Plan Sponsor that allows for the Participant to pay any Premium due.

Group Health Plan: an employee welfare benefit plan adopted by the Plan Sponsor to the extent that such Plan provides health benefits to employees or their dependents, as defined under the terms of such Group Health Plan, directly or through insurance, reimbursement or otherwise. This Plan of Benefits is a Group Health Plan.

Health Insurance Coverage: benefits consisting of medical 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 health maintenance organization 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.

Health Status Related Factor: information about a Participant's health, including health status, medical conditions (including both physical and mental illnesses), claims experience, receipt of health care, medical history, Genetic Information, evidence of insurability (including conditions arising out of acts of domestic violence), or disability.

HIPAA: the Health Insurance Portability and Accountability Act of 1996, as amended.

Home Health Agency: an agency or organization licensed by the appropriate state regulatory agency to provide Home Health Care.

Home Health Care: part-time or intermittent nursing care, health aide services, or physical, occupational, or speech therapy provided or supervised by a Home Health Agency and provided to a homebound Participant in such Participant's private residence.

Hospice Care: care for terminally ill patients under the supervision of a Physician, and is provided by an agency that is licensed or certified as a hospice or hospice care agency by the appropriate state regulatory agency.

Hospital: a short-term, acute-care facility licensed as a hospital by the state in which it operates. A Hospital is engaged primarily in providing medical, surgical, or acute behavioral health diagnosis and treatment of injured or sick persons, by or under the supervision of a staff of licensed Physicians, and continuous twenty-four (24) hour-a-day services by licensed, registered, graduate nurses physically present and on duty. The term Hospital does not

include Long Term Acute Care Hospitals, chronic care institutions or facilities that principally provide custodial, rehabilitative or long-term care, whether or not such institutions or facilities are affiliated with or are part of a Hospital. A Hospital may participate in a teaching program. This means medical students, interns, or residents participating in a teaching program may treat Participants.

Identification Card: the card issued by PAI to a Participant that contains the Participant's identification number.

Incapacitated Child: A covered Dependent Child who reaches the limiting age and is Totally Disabled, incapable of self-sustaining employment by reason of mental or physical handicap, primarily dependent upon the covered Employee for support and maintenance and unmarried. The Plan Administrator may require, at reasonable intervals during the two years following the Dependent's reaching the limiting age, subsequent proof of the child's Total Disability and dependency.

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

Independent Review Organization: An external review organization approved by the South Carolina Department of Insurance and accredited by a nationally recognized private accrediting organization, and not affiliated with the health carrier.

Late Enrollee: an Employee who enrolls under this Group Health Plan other than during:

1. The first period in which the Employee or Dependent is eligible to enroll if such initial enrollment period is a period of at least thirty (30) days;
2. A Special Enrollment period (as set forth in the Eligibility for Coverage section).

Life-Threatening Condition: means any disease or condition from which the likelihood of death is probable unless the course of the disease or condition is interrupted.

Mail Service Pharmacy: a Pharmacy maintained by the Pharmacy Benefit Manager that fills prescriptions and sends Prescription Drugs by mail.

Maternity Management Program: the voluntary program offered by the Group Health Plan to Participants who are pregnant.

Maximum Payment: the maximum amount the Group Health Plan will pay for a particular Benefit. The Maximum Payment will not be affected by any Credit. The Maximum Payment will be either:

1. The actual charge submitted to the Plan Supervisor for the service, procedure, supply or equipment by a Provider;
2. An amount based upon the reimbursement rates established by the Plan Sponsor in its Benefits Checklist;
3. An amount that has been agreed upon in writing by a Provider and the network used by the Plan Sponsor based upon factors including but not limited to, (i) governmental reimbursement rates applicable to the service, procedure, supply or equipment, or (ii) reimbursement for a comparable or similar service, procedure, supply or equipment, taking into consideration the degree of skill, time and complexity involved, geographic location and the circumstances giving rise to the need for the service, procedure, supply or equipment;
4. The lowest amount of reimbursement allowed for the same or similar services, procedure, supply or equipment when provided by a Participating Provider.

Medical Child Support Order: any judgment, decree or order (including an approved settlement agreement) issued by a court of competent jurisdiction or a national medical support notice issued by the applicable state agency that:

1. Provides child support with respect to a child or provides for health benefit coverage to a child, is made pursuant to a state domestic relations law (including a community property law), and relates to the Plan of Benefits;
2. Enforces a law relating to medical child support described in Section 1908 of the Social Security Act (as added by section 13822 of the Omnibus Budget Reconciliation Act of 1993) with respect to a group health Plan.
3. A Medical Child Support Order must clearly specify:
 - a. The name and the last known mailing address (if any) of each participant employee and the name and mailing address of each alternate recipient covered by the order;
 - b. A reasonable description of the type of coverage to be provided by the group health Plan to each such alternate recipient or the manner in which such type of coverage is to be determined;
 - c. The period to which such order applies;
 - d. Each group health Plan to which such order applies.
4. If the Medical Child Support Order is a national medical support notice, the order must also include:
 - a. The name of the issuing agency;
 - b. The name and mailing address of an official or agency that has been substituted for the mailing address of any alternate recipient;
 - c. The identification of the underlying Medical Child Support Order.
5. A Medical Child Support Order meets the requirement of this definition only if such order does not require a group health Plan to provide any type or form of the requirements of a law relating to medical child support described in Section 1908 of the Social Security Act (as added by section of 13822 of the Omnibus Budget Reconciliation Act of 1993).

Medically Necessary/Medical Necessity: health care services that a Physician, exercising prudent clinical judgment, would provide to a patient for the purpose of preventing, evaluating, diagnosing or treating an illness, injury, disease or its symptoms, and that are:

1. in accordance with generally accepted standards of medical practice;
2. clinically appropriate, in terms of type, frequency, extent, site and duration, and considered effective for the patient's illness, injury or disease;
3. not primarily for the convenience of the patient, Physician or other health care provider, and not more costly than an alternative service or sequence of services at least as likely to produce equivalent therapeutic or diagnostic results as to the diagnosis or treatment of that patient's illness, injury or disease.

For the purposes of this definition, "generally accepted standards of medical practice" means standards that are based on credible scientific evidence published in peer-reviewed medical literature generally recognized by the relevant medical community, Physician Specialty Society recommendations and the views of Physicians practicing in relevant clinical areas and any other relevant factors.

Medical Supplies: supplies that are:

1. Medically Necessary;
2. Prescribed by a Physician acting within the scope of his or her license (or are provided to a Participant in a Physician's office);
3. Are not available on an over-the-counter basis (unless such supplies are provided to a Participant in a Physician's office and should not (in PAI's discretion) be included as part of the treatment received by the Participant);
4. Are not prescribed in connection with any treatment or benefit that is excluded under this Plan of Benefits.

Mental Health Services: treatment (except Substance Abuse Services) for a condition that is defined, described or classified as a psychiatric disorder or condition in the most current *Diagnostic and Statistical Manual of Mental Disorders* published by the American Psychiatric Association and is not otherwise excluded by the terms and conditions of this Plan of Benefits.

Midwife: a person who is certified or licensed to assist women in the act of childbirth.

Milieu Therapy: type of treatment in which the patient's social environment is manipulated for his/her benefit.

Natural Teeth: teeth that:

1. Are free of active or chronic clinical decay;
2. Have at least 50% bony support;
3. Are functional in the arch;
4. Have not been excessively weakened by multiple dental procedures;
5. Teeth that have been treated for one (1) or more of the conditions referenced in 1-4 above and, as a result of such treatment, have been restored to normal function.

Non-Participating Provider: any Provider who does not have a current, valid contract with one of the networks used by this Plan of Benefits.

Non-Preferred Brand Name Drug: a Prescription Drug that bears a recognized brand name of a particular manufacturer but does not appear on the list of Preferred Brand Name Drugs and has not been chosen by PAI or its designated Pharmacy Benefit Manager to be a Preferred Brand Name Drug including any Brand Name Drug with an "A" rated Generic Drug available.

Orthopedic Device: any rigid or semirigid leg, arm, back or neck brace and casting materials that are used directly for the purpose of supporting a weak or deformed body member or restricting or eliminating motion in a diseased or injured part of the body.

Orthotic Device: any device used to mechanically assist, restrict, or control function of a moving part of the Participant's body.

Out-of-Pocket Maximum: the maximum amount (if listed on the Schedule of Benefits) of otherwise Covered Expenses incurred during a Benefit Year that a Participant will be required to pay.

Over-the-Counter Drug: a drug that does not require a prescription.

Participant: an Employee or Dependent who has enrolled (and qualifies for coverage) under this Plan of Benefits. A Participant may also include individuals who meet the criteria under the "other eligible group classifications" as defined in the Eligibility section of this document.

Participant Effective Date: the date on which a Participant is covered for Benefits under the terms of this Plan of Benefits.

Participating Provider: a Physician, Hospital or other Provider who has a signed contract with one of the networks used by this Plan of Benefits and who has agreed to provide Benefits to a Participant and submit claims to PAI and to accept the Allowed Amount as payment in full for Benefits. The participating status of a Provider may change.

Pharmacy: a licensed establishment where Prescription Drugs are filled and dispensed by a pharmacist licensed under the laws of the state where the pharmacist practices.

Physician: a person who is:

1. Not an:
 - a. Intern;
 - b. Resident;
 - c. In-house physician;
2. Duly licensed by the appropriate state regulatory agency as a:
 - a. Medical doctor;
 - b. Oral surgeon;
 - c. Osteopath;
 - d. Podiatrist;
 - e. Chiropractor;
 - f. Optometrist;
 - g. Psychologist with a doctoral degree in psychology;
3. Legally entitled to practice within the scope of his or her license;
4. Customarily bills for his or her services.

Physician Services: these services, performed by a Physician within the scope of his or her license, training and specialty and within the scope of generally acceptable medical standards as determined by PAI:

1. Office visits, which are for the purpose of seeking or receiving care for an illness or injury;
2. Basic diagnostic services and machine tests;
3. Physician Services include these services when performed by a medical doctor, osteopath, podiatrist or oral surgeon, but specifically excluding such services when performed by a chiropractor, optometrist, or licensed psychologist with a doctoral degree:
 - a. Benefits rendered to a Participant in a Hospital or Skilled Nursing Facility;
 - b. Benefits rendered in a Participant's home;
 - c. Surgical Services;
 - d. Anesthesia services, including the administration of general or spinal block anesthesia;
 - e. Radiological examinations;
 - f. Laboratory tests;
 - g. Maternity services, including consultation, prenatal care, conditions directly related to pregnancy, delivery and postpartum care, and delivery of one or more infants. Physician Services also include maternity services performed by certified nurse midwives.

Plan: any program that provides benefits or services for medical or dental care or treatment including:

1. Individual or group coverage, whether insured or self-insured. This includes, but is not limited to, prepayment, group practice or individual practice coverage;
2. Coverage under a governmental Plan or coverage required or provided by law. This does not include a state Plan under Medicaid (Title XIX, Grants to States for Medical Assistance Programs, of the United States Social Security Act, as amended).

Each contract or other arrangement for coverage is a separate Plan for purposes of this Plan of Benefits. If a Plan has two (2) or more parts and the coordination of benefits rules apply only to one (1) of the parts, each part is considered a separate Plan.

Plan Administrator: the entity charged with the administration of the Plan of Benefits. The Plan Sponsor is the Plan Administrator of this Plan of Benefits.

Plan of Benefits: This Plan of Benefits including, the membership application, the Schedule of Benefits, and all endorsements, amendments, riders or addendums.

Plan of Benefits Effective Date: 12:01 AM on the date listed on the Schedule of Benefits.

Plan Sponsor: also known as the Employer.

Post-Service Claim: any claim that is not a Pre-Service Claim.

Preadmission Review: the review that must be obtained by a Participant (or the Participant's representative) prior to all Admissions that are not related to an Emergency Medical Condition.

Preauthorized/Preauthorization: the approval of Benefits based on Medical Necessity prior to the rendering of such Benefits to a Participant. Preauthorization means only that the Benefit is Medically Necessary. Preauthorization is not a guarantee of payment or a verification that Benefits will be paid or are available to the Participant. Notwithstanding Preauthorization, payment for Benefits is subject to a Participant's eligibility and all other limitations and exclusions contained in this Plan of Benefits. A Participant's entitlement to Benefits is not determined until the Participant's claim is processed.

Preferred Brand Drug: a Prescription Drug that bears a recognized brand name of a particular manufacturer and appears on the list of Preferred Brand Drugs.

Preferred Brand Name Drug: a Prescription Drug that has been reviewed for cost effectiveness, clinical efficacy and quality that is preferred by the Pharmacy Benefit Manager for dispensing to Participants. Preferred Brand Name Drugs are subject to periodic review and modification by PAI or its designated Pharmacy Benefit Manager, and include Brand Name Drugs and Generic Drugs.

Premium: the monthly amount paid to the Plan Sponsor by the Participant for coverage under this Plan of Benefits. Payment of Premiums by the Participant constitutes acceptance by the Participant of the terms of this Plan of Benefits.

Prescription Drugs: a drug or medicine that is:

1. Required to be labeled that it has been approved by the Food and Drug Administration;
2. Bears the legend "Caution: Federal Law prohibits dispensing without a prescription" or "Rx Only" prior to being dispensed or delivered, or labeled in a similar manner;
3. Insulin.

Additionally, to qualify as a Prescription Drug, the drug must:

1. Be ordered by a medical doctor or oral surgeon as a prescription;
2. Not be entirely consumed at the time and place where the prescription is dispensed;
3. Be purchased for use outside a Hospital.

Prescription Drugs which otherwise may not meet the definition of Prescription Drugs:

1. DESI drugs – These drugs are determined by the FDA (Food and Drug Administration) as lacking substantial evidence of effectiveness. The DESI drugs do not have studies to back up the medications' uses, but since they have been used and accepted for many years without any safety problems, they continue to be used in today's marketplace.
2. Controlled substance 5 (CV) OTC's are covered. (Examples: Robitussin AC syrup and Naldecon-CX) Federal law designates these medications as OTC. Nevertheless, depending on certain state Pharmacy laws, the medications may be considered prescription medications and are, therefore, all covered.

3. Single entity vitamins – These vitamins have indications in addition to their use as nutritional supplements. For this reason, Plan supervisor recommends covering these medications. Single entity vitamins are used for the treatment of specific vitamin deficiency diseases. Some examples include: vitamin B12 (cyanocobalamin) for the treatment of pernicious anemia and degeneration of the nervous system; vitamin K (phytonadione) for the treatment of hypoprothrombinemia or hemorrhage; and folic acid for the treatment of megaloblastic and macrocytic anemias.

Prescription Drug Copay: the amount payable, if any, set forth on the Schedule of Benefits, by the Participant for each Prescription Drug filled or refilled.

Pre-Service Claim: any claim or request for a Benefit where prior authorization or approval must be obtained from BlueCross Medical Review Department before receiving the medical care, service or supply.

Primary Plan: a Plan whose benefits must be determined without taking into consideration the existence of another Plan.

Protected Health Information (PHI): Protected Health Information as that term is defined under HIPAA.

Prosthetic Device: any device that replaces all or part of a missing body organ or body member, except a wig, hairpiece or any other artificial substitute for scalp hair.

Provider: any person or entity licensed by the appropriate state regulatory agency and legally engaged within the scope of such person or entity's license in the practice of:

- ◆ Medicine
- ◆ Dentistry
- ◆ Optometry
- ◆ Podiatry
- ◆ Chiropractic Services
- ◆ Physical Therapy
- ◆ Behavioral Health
- ◆ Oral Surgery
- ◆ Speech Therapy
- ◆ Occupational Therapy

Provider includes a long-term-care Hospital, a Hospital, a rehabilitation facility, Skilled Nursing Facility, and nurses practicing in expanded roles (such as pediatric nurse practitioners, family practice nurse practitioners and certified nurse midwives) when supervised by a medical doctor or oral surgeon. The term Provider does not include physical trainers, lay midwives or masseuses.

Qualified Individual: means an individual who is a Participant in a health Plan who meets these conditions:

1. The individual is eligible to participate in an Approved Clinical Trial according to the trial protocol with respect to treatment of cancer or other life-threatening disease or condition;
2. Is either:
 - a. Referred by a participating health care provider and has concluded that the individual's participation in such trial would be appropriate;
 - b. The Participant provides medical and scientific information establishing that their participation in the trial would be appropriate.

Qualified Medical Child Support Order (QMCSO): a Medical Child Support Order that:

3. Creates or recognizes the existence of an Alternate Recipient's right to enroll under this Plan of Benefits;
4. Assigns to an Alternate Recipient the right to enroll under this Plan of Benefits.

Qualifying Event: for continuation of coverage purposes, a Qualifying Event is any one of these:

1. Termination of the Employee's employment (other than for gross misconduct) or reduction of hours worked that renders the Employee no longer Actively at Work and therefore ineligible for coverage under the Plan of Benefits;
2. Death of the Employee;

3. Divorce or legal separation of the Employee from his or her spouse;
4. A Child ceasing to qualify as a Dependent under this Plan of Benefits.
5. Entitlement to Medicare by an Employee, or by a parent of a Child;
6. A proceeding in bankruptcy under Title 11 of the United States Code with respect to an Employer from whose employment an Employee retired at any time.

Quantity Management Program: limits that restrict the quantity of Prescription Drugs that are covered under a Participant's Plan within a certain time frame. The limits established for these drugs are based on FDA and manufacturer dosing guidelines, medical literature, safety, accepted medical practice, appropriate use and benefit design. The limits, which are designed to promote the safe use of medication, affect only the amount of medication your Plan covers.

Rescission: a cancellation or discontinuance of coverage that has retroactive effect. A cancellation or discontinuance of coverage is not a Rescission if the cancellation or discontinuance of coverage:

1. Has only a prospective effect;
2. Is effective retroactively to the extent it is attributable to a failure to timely pay required premiums or contributions toward the cost of coverage.

A Rescission retroactively canceling coverage is permitted if an individual performs an act, practice or omission that constitutes fraud or if the individual makes an intentional misrepresentation of material fact, as prohibited by the terms of the Plan or coverage.

Residential Treatment Center: a licensed institution, other than a Hospital, which meets all six of these requirements:

1. Maintains permanent and full-time Facilities for bed care of resident patients, and
2. Has the services of a Psychiatrist (Addictionologist, when applicable) or Physician extender available at all times and is responsible for the diagnostic evaluation, provides face-to-face evaluation services with documentation a minimum of once/week and PRN as indicated;
3. Has a Physician or registered nurse (RN) present onsite who is in charge of patient care along with one or more registered nurses (RNs) or licensed practical nurses (LPNs) onsite at all times (24/7);
4. Keeps a daily medical record for each patient;
5. Is primarily providing a continuous structured therapeutic program specifically designed to treat behavioral health disorders and is not a group or boarding home, boarding or therapeutic school, half-way house, sober living residence, wilderness camp or any other facility that provides Custodial Care;
6. Is operating lawfully as a residential treatment center in the area where it is located.

Routine Participant Costs: include all items and services consistent with what is typically covered by the Plan for a Qualified Individual who is not enrolled in a clinical trial. This DOES NOT include services that are considered:

1. The investigational item, device, or service, itself;
2. Items and services provided solely to satisfy data collection and analysis needs and that are not used in the direct clinical management of the Participant;
3. A service that is clearly inconsistent with widely accepted and established standards of care for a particular diagnosis.

Schedule of Benefits: the pages of this Plan of Benefits so titled that specify the coverage provided and the applicable Copays, Coinsurance, Benefit Year Deductibles and Benefit limitations.

Second Opinion: an opinion from a Physician regarding a service recommended by another Physician before the service is performed, to determine whether the proposed service is Medically Necessary and covered under the terms of this Plan of Benefits.

Secondary Plan: the Plan that has secondary responsibility for paying a Participant's claim as determined through the coordination of benefits provisions of this Plan of Benefits.

Skilled Nursing Facility: an institution other than a Hospital that is certified and licensed by the appropriate state regulatory agency as a skilled nursing facility.

Special Enrollment: the time period during which an Employee or eligible Dependent who is not enrolled for coverage under this Plan of Benefits may enroll for coverage due to the involuntary loss of other coverage or under circumstances described in the Eligibility For Coverage section of this Plan of Benefits.

Specialist: a Physician who specializes in a particular branch of medicine.

Specialty Drugs: Prescription Drugs that treat a complex clinical condition and/or require special handling such as refrigeration. They generally require complex clinical monitoring, training and expertise. Specialty Drugs include, but are not limited to, infusible Specialty Drugs for chronic diseases, injectable and self-injectable drugs for acute and chronic diseases, and specialty oral drugs. Specialty Drugs are used to treat acute and chronic disease states (e.g. growth deficiencies, hemophilia, multiple sclerosis, rheumatoid arthritis, Gaucher's Disease, hepatitis, cancer, organ transplantation, Alpha 1-antitrypsin disease and immune deficiencies).

Step Therapy: a program that requires a Participant to use lower cost medications that are used to treat the same condition before obtaining higher cost medications.

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

Substance Abuse Services: services or treatment relating to Substance Abuse.

Totally Disabled/Total Disability: the Participant is able to perform none of the usual and customary duties of such Participant's occupation. With respect to a Participant who is a Dependent, the terms refer to disability to the extent that such Participant can perform none of the usual and customary duties or activities of a person in good health of the same age. The Participant must provide a licensed medical doctor's statement of disability upon periodic request by the Group Health Plan.

Transplant: The transfer of organs or tissues, including bone marrow, stem cells and cord blood, from human to human. Transplants are covered only at facilities approved by PAI in writing and include only those procedures that otherwise are not excluded by this Plan of Benefits. Preauthorization is required. Transplant Physician Charges are subject to the Benefit Year Deductible.

Transplant Benefit Period: the period of time that for Transplant of:

1. an organ, the period that begins one day prior to the Admission date for Transplant and continues for a 12-month period. Anti-rejection drugs are not subject to the Transplant Benefit Period;
2. bone marrow, the period that begins one day prior to the date marrow ablative therapy begins, or one day prior to the day the preparative regimen for non-myeloablative Transplant begins and continues for a twelve (12) month period. Mobilization therapy and stem-cell harvest are also included. Anti-rejection drugs are not subject to the Transplant Benefit Period.

Urgent Care: treatment required in order to treat an unexpected illness or injury that is life-threatening and required in order to prevent a significant deterioration of the Participant's health if treatment were delayed.

Urgent Care Claim: any claim for medical care or treatment where making a determination under other than normal time frames could seriously jeopardize the Participant's life or health or the Participant's ability to regain maximum function; or, in the opinion of a medical doctor or oral surgeon with knowledge of the Participant's medical condition, would subject the Participant to severe pain that could not be managed adequately without the care or treatment that is the subject of the claim.

Waiting Period: a period of continuous employment with the Plan Sponsor that an Employee must complete before becoming eligible to enroll in the Plan of Benefits.

INDEX

A

ABA, 38
Accidental Injury, 2, 20, 21, 40
Actively at Work, 41, 42, 44, 51, 66, 76
Admission, 4, 5, 13, 14, 20, 22, 23, 24, 35, 37, 43, 66, 68, 75, 78
Adverse Benefit Determination, 3, 7, 8, 9, 10, 29, 30, 66
Affordable Care Act (ACA), 41
Allowed Amount, 2, 13, 21, 25, 34, 54, 66, 67, 68, 73
Alternate Recipient, 76
Ambulance, 13, 16, 20
Ambulatory Surgical Center, 20, 66
Anesthesia, 14, 74
Annual Enrollment, 41
Autism Spectrum Disorder, 38

B

Benefit, 1, 2, 3, 4, 5, 6, 7, 8, 9, 11, 13, 16, 18, 19, 20, 22, 23, 24, 25, 26, 27, 28, 29, 30, 31, 32, 33, 34, 35, 36, 37, 38, 39, 40, 41, 42, 43, 44, 45, 46, 47, 48, 49, 50, 51, 52, 53, 54, 55, 56, 57, 58, 59, 60, 62, 63, 64, 66, 67, 68, 69, 70, 71, 72, 73, 74, 75, 76, 77, 78, 79
Benefit Year, 2, 13, 19, 20, 26, 32, 48, 67, 73, 77, 78
Benefit Year Deductible, 2, 13, 19, 20, 26, 32, 48, 67, 77, 78
Benefits, 10
Brand Name Drug, 18, 67, 70, 73, 75

C

Cardiac Rehabilitation, 14
Caremark, 18
Centers for Disease Control and Prevention (CDC), 18
Chemotherapy, 16, 24, 25, 36, 37
Child, 17, 23, 33, 36, 37, 39, 40, 41, 42, 43, 44, 45, 48, 49, 54, 57, 67, 68, 69, 71, 72, 76, 77
Child Care, 17
Chiropractic Care, 16, 21
COBRA, 42, 47, 49, 50, 51, 56, 57
Coinsurance, 1, 2, 20, 26, 67, 68, 77
Concurrent Care Claim, 7, 8, 9, 68
Contact Lenses, 21, 36
Continued Stay Review, 4, 20, 43, 68
Copay, 1, 2, 13, 14, 15, 16, 18, 20, 48, 66, 67, 68, 76, 77
Corporation, 10, 52
Cosmetic Procedure, 36
Cosmetic Surgery, 21
Covered Expenses, 1, 2, 6, 13, 20, 21, 22, 23, 24, 25, 26, 32, 43, 46, 48, 62, 63, 67, 68, 73
Credit, 67, 68, 69, 71
Creditable Coverage, 42
Custodial Care, 36, 37, 39, 77

D

Deductible, 1, 2, 13, 19, 20, 26, 32, 48, 66, 67, 77, 78
Dental Benefit, 19, 32
Dental Deductible, 19

Dependent, 2, 3, 5, 26, 27, 32, 33, 37, 41, 42, 43, 44, 46, 47, 49, 50, 51, 54, 56, 57, 62, 67, 68, 70, 71, 73, 77, 78
Detoxification, 25, 68
Durable Medical Equipment, 13, 16, 22, 68

E

Effective Date, 1, 20, 41, 42, 46, 64, 69, 73, 75
Electronic Protected Health Information (ePHI), 60, 61
Eligibility, 41, 42, 44, 64, 68, 71, 73, 78
Emergency Admission Review, 4, 20, 43, 68
Emergency Medical Condition, 2, 4, 20, 68, 69, 75
Emergency Room, 14, 22
Employee, 1, 28, 29, 30, 31, 35, 41, 42, 43, 44, 45, 46, 47, 48, 49, 50, 51, 54, 55, 57, 58, 59, 60, 62, 63, 64, 66, 67, 68, 69, 70, 71, 72, 73, 76, 77, 78, 79
Employee Retirement Income Security Act (ERISA), 8, 9, 30, 57, 58, 62
Employer, 4, 28, 29, 30, 41, 69, 75, 77
Enrollment Date, 40, 69
Excepted Benefits, 69
Experimental or Investigational, 8, 9, 36, 66, 69
Explanation of Benefits, 2, 3, 6
Eyeglasses, 21, 36

F

Family and Medical Leave Act (FMLA), 31, 44, 45, 46, 48, 49

G

Generic Drug, 18, 70, 73, 75
Genetic Information, 70
Grace Period, 44, 70
Group Health Plan, 1, 4, 7, 9, 13, 20, 26, 36, 41, 42, 43, 44, 46, 48, 49, 50, 51, 52, 53, 57, 58, 59, 60, 61, 62, 63, 64, 67, 68, 69, 70, 71
Gynecological Exam, 17

H

Health Insurance Coverage, 63, 70
Health Insurance Portability and Accountability Act (HIPAA), 3, 59, 70, 76
Health Status Related Factor, 66, 70
Home Health Agency, 70
Home Health Care, 13, 16, 22, 35, 39, 69, 70
Hospice Care, 13, 16, 22, 35, 70
Hospital, 1, 2, 4, 5, 10, 14, 20, 22, 23, 24, 26, 35, 37, 39, 40, 62, 66, 68, 70, 73, 74, 75, 76, 77, 78

I

Identification Card, 4, 6, 62, 71
Illness, 6, 11, 21, 22, 23, 24, 25, 28, 29, 35, 36, 48, 51, 52, 53, 68, 70, 72, 74, 78
Impacted Teeth, 23, 33
Incapacitated Dependent, 44, 67, 68, 71
Infertility, 16, 23, 36, 39
Injections, 15

Injury, 2, 6, 11, 20, 21, 22, 23, 24, 25, 28, 29, 35, 36, 39, 40, 48,
51, 52, 53, 63, 68, 72, 74, 78
Intensive Care, 14
Intensive Care Unit, 14

L

Laboratory, 14, 15, 25, 36, 70, 74
Late Enrollee, 71
Lifetime Maximum, 19

M

Mail Service Pharmacy, 18, 38, 71
Mammogram, 17
Maternity Care, 12, 16, 23
Maternity Management Program, 71
Maximum Payment, 32, 55, 66, 71
Medicaid, 35, 37, 43, 74
Medical Child Support Order, 57, 67, 71, 72, 76
Medical Necessity, 4, 8, 9, 20, 23, 26, 30, 33, 62, 72, 75
Medical Supplies, 23, 35, 36, 63, 67, 72
Medically Necessary, 5, 12, 13, 20, 22, 24, 25, 35, 36, 37, 39, 40,
66, 67, 68, 72, 75, 77
Medicare, 35, 49, 50, 55, 56, 70, 77
Mental Disorder, 73, 78
Mental Health, 4, 11, 13, 14, 15, 23, 73
Mental Health Condition, 4
Mental Health Services, 4, 11, 23, 73
Midwife, 73
Milieu Therapy, 35, 73

N

Natural Teeth, 21, 33, 34, 73
Newborn, 14, 22, 23, 42, 45, 48
Non-Participating Provider, 2, 13, 63, 66, 73
Non-PPO Provider, 1, 2, 4
Non-Preferred Brand Name, 18, 73
Notice of Determination, 8

O

Obesity, 16, 23, 36, 37
Occupational Therapy, 16, 76
Oral Surgery, 19, 33, 76
Oral Surgical Procedure, 23
Orthodontic, 19, 34, 40
Orthopedic Device, 68, 73
Orthotic Device, 68, 73
Orthotics, 16, 23
Out-of-Pocket Maximum, 13, 67, 73
Over-the-Counter Drug, 73

P

Participant, 2, 3, 4, 6, 7, 8, 9, 11, 12, 13, 18, 19, 20, 22, 23, 24, 25,
26, 32, 33, 35, 36, 37, 39, 40, 41, 43, 44, 46, 48, 49, 50, 52, 53,
54, 55, 56, 57, 59, 60, 62, 63, 66, 67, 68, 69, 70, 71, 72, 73, 74,
75, 76, 77, 78, 79
Participant Effective Date, 20, 73
Participating Provider, 2, 5, 6, 13, 63, 66, 67, 71, 73
Pathology, 14, 15
Periodontic, 19, 33
ClafinUniversityPD2019

Pharmacy, 18, 39, 68, 70, 71, 73, 75
Pharmacy Benefit Manager, 39, 68, 70, 71, 73, 75
Physical Exam, 17
Physical Rehabilitation Facility, 14, 23
Physical Therapy, 16, 76
Physician, 5, 10, 12, 14, 15, 18, 21, 22, 23, 24, 25, 26, 28, 29, 31,
35, 36, 37, 38, 39, 40, 45, 62, 66, 70, 72, 73, 74, 77, 78
Plan, i, 1, 2, 3, 4, 5, 6, 7, 8, 9, 11, 13, 14, 15, 18, 20, 22, 23, 24, 25,
26, 29, 30, 31, 32, 33, 34, 35, 36, 37, 38, 39, 40, 41, 42, 43, 44,
45, 46, 47, 48, 49, 50, 51, 52, 53, 54, 55, 56, 57, 58, 59, 60, 61,
62, 63, 64, 66, 67, 68, 69, 70, 71, 72, 73, 74, 75, 76, 77, 78, 79
Plan Administrator, 11, 29, 30, 34, 46, 49, 50, 55, 57, 58, 64, 75
Plan of Benefits, 1, 2, 6, 8, 9, 11, 13, 15, 20, 22, 23, 26, 32, 36, 38,
40, 41, 42, 43, 44, 46, 47, 48, 49, 50, 51, 52, 53, 54, 55, 59, 60,
62, 63, 64, 66, 67, 68, 69, 70, 72, 73, 74, 75, 76, 77, 78, 79
Plan Supervisor, 71
Planned Administrators, Inc. (PAI), 1, 2, 3, 4, 5, 6, 7, 8, 9, 11, 16,
20, 23, 26, 32, 39, 40, 46, 53, 55, 59, 62, 63, 67, 68, 69, 71, 72,
73, 74, 75, 78
Post-Service Claim, 7, 9, 75
Preadmission Review, 4, 20, 43, 75
Preadmission Testing, 14, 24
Preauthorization, 4, 5, 13, 14, 16, 20, 22, 23, 26, 39, 43, 63, 75, 78
Preferred Brand Name, 18, 73, 75
Preferred Provider, 1
Preferred Provider Organization, 1, 2, 4, 14, 15, 16, 17
Premium, 43, 44, 45, 46, 50, 51, 62, 63, 70, 75
Prescription Drug, 18, 22, 35, 37, 38, 39, 67, 68, 70, 71, 73, 75, 76,
77, 78
Prescription Drug Copay, 76
Pre-Service Claim, 7, 8, 9, 75, 76
Primary Plan, 54, 55, 76
Private Duty Nursing, 16, 24
Probationary Period, 51
Prostate, 17
Prosthetic Device, 68, 76
Prosthodontic, 19, 33
Protected Health Information, 3, 59, 60, 76
Provider, 1, 2, 3, 4, 5, 6, 11, 13, 15, 20, 23, 26, 53, 62, 63, 66, 67,
68, 71, 72, 73, 76

Q

Qualified Medical Child Support Order, 67, 76
Qualifying Event, 41, 49, 57, 76

R

Radiation Therapy, 16, 24, 25, 37
Radiology, 14, 15

S

Schedule of Benefits, 4, 13, 19, 20, 24, 25, 26, 29, 32, 35, 36, 37,
38, 39, 54, 67, 68, 73, 75, 76, 77
Second Opinion, 25, 77
Second Surgical Opinion, 16
Secondary Plan, 54, 55, 78
Skilled Nursing Facility, 4, 14, 22, 23, 24, 35, 39, 66, 74, 76, 78
Special Enrollment, 41, 42, 43, 71, 78
Specialist, 2, 78
Specialty Drug, 78
Speech Therapy, 16, 25, 70, 76
Substance Abuse, 4, 11, 13, 14, 15, 25, 35, 37, 73, 78

Substance Abuse Services, 4, 11, 35, 73, 78
Supplies, 1, 2, 5, 15, 16, 21, 22, 23, 26, 35, 36, 37, 38, 39, 40, 63,
67, 69, 72
Surgical Procedures, 23, 25, 66, 69
Surgical Services, 26, 74

T

Temporomandibular Joint Disorder (TMJ), 16
Termination, 8, 20, 29, 31, 40, 42, 43, 44, 46, 49, 50, 60, 64, 66,
76
Totally Disabled, 28, 29, 78
Transplant, 2, 5, 13, 16, 22, 26, 27, 78
Transplant Benefit Period, 78

U

Uniformed Services Employment and Re-employment Rights Act
(USERRA), 51
Urgent Care, 3, 7, 9, 15, 63, 78, 79
Urgent Care Benefit, 7
Urgent Care Claim, 3, 7, 9, 79

W

Waiting Period, 41, 42, 46, 47, 51, 69, 79

X

X-ray, 14, 15, 17, 25, 33, 34, 36