Group Health Benefit Plan
for the Employees of
Charleston Community Unit School District #1

January 1, 2010

ERISA Summary Plan Description. This document constitutes the Summary Plan Description required by the Employee Retirement Income Security Act of 1974 ("ERISA") §102.

ERISA Plan Document. Portions of this document also constitute the written plan document for the Charleston Community Unit School District #1 Group Health Benefit Plan (the "Plan") required by ERISA §402.

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1. Introduction

Introduction

Charleston Community Unit School District #1 maintains the Charleston Community Unit School District #1 Group Health Benefit Plan (the "Plan") for the exclusive benefit of and to provide health benefits to its eligible full-time employees (20+ hours), their eligible spouses and other dependents and eligible retirees. These benefits (including information about who is eligible to receive benefits) are summarized in this document.

This document constitutes the Summary Plan Description required by ERISA §102 and the Plan Document required by ERISA §402.

2. General Information About the Plan

Facts

Plan Name:	Charleston Community Unit School District #1 Group Health Benefit Plan
Type of Plan:	A group health plan (a type of welfare benefits plan that is subject to the provisions of ERISA).
Restated Plan Year:	January 1, 2010
Plan Number:	501
Original Effective Date:	January 1, 2008
Funding Medium and Type of Plan Administration:	The Plan is a self-funded group health benefits plan. Plan contributions for employee coverage are made by the District; plan contributions for dependent coverage are made by the District and employee; plan contributions for retiree coverage are made by the Retiree. Plan Sponsor has a contract with PersonalCare Insurance of Illinois, Inc. ("Claims Administrator") to process claims under the Plan. Claims Administrator does not serve as an insurer but merely a claims processor. Claims for benefits are sent to the Claims Administrator. It processes the claims, then requests and receives funds from the Plan to pay the claims. The Plan Sponsor is ultimately responsible for

	providing the plan benefits, not the Claims Administrator
Plan Sponsor:	Charleston Community Unit School District #1 410 West Polk Avenue Charleston, IL 61920
Plan Sponsor's Employer Identification Number:	37-6002687
Plan Administrator:	Charleston Community Unit School District #1 410 West Polk Avenue Charleston, IL 61920
Claims Administrator:	PersonalCare Insurance of Illinois, Inc. 2110 Fox Drive Champaign, Illinois 61820 Toll-free number: 1-866-557-8751 Please contact the Claims Administrator at the telephone number on the back of the Plan identification card for questions or concerns regarding Covered Services or any required procedure. Telephone numbers and addresses to request review of denied claims, register complaints, place requests for Prior Authorization, and submit claims are listed above.
Named Fiduciary:	Charleston Community Unit School District #1 410 Polk Avenue Charleston, IL 61920
Agent for Service of Legal Process:	Charleston Community Unit School District #1 410 Polk Avenue Charleston, IL 61920 Service of legal process may also be made on the Plan Administrator.
Plan Document:	This document constitutes the written plan document required by ERISA §402.

Membership ID Card:	Every Participant receives a membership ID card. Participants need to present their ID card whenever a Participant receives health care services. If a Plan ID card is missing, lost, or stolen, to obtain a replacement, contact the Claims Administrator's Customer Service Department at our toll-free number at 1-866-557-8751.

3. Important Notices

3.1 Important Notice for Mastectomy Patients

If Participant elects breast reconstruction in connection with a mastectomy, Participant is entitled to coverage under this Plan for:

- Reconstruction of the breast on which the mastectomy was performed;
- Surgery and reconstruction of the other breast to produce a symmetrical appearance; and
- Prosthesis and treatment of physical complications at all stages of the mastectomy, including lymph edemas.

Such services will be performed in a manner determined in consultation with the attending physician and the patient. See Section 6 for further detail regarding this coverage.

3.2 Special Rights on Childbirth

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

3.3 Out-of-Network Option

This Plan has an Out-of-Network Option which gives Participants the opportunity to seek care from Non-Participating Providers. Utilizing the Out-of-Network Option will increase the amount the Participant pays for care received. Please read the provisions entitled "Out-of-Network Coverage Option" which appears in Section 6 below or call the Claims Administrator's Customer Service Department with questions.

4. Eligibility and Participation Requirements

4.1 Covered Employee Eligibility

To be eligible to be enrolled in this Plan as a Covered Employee or Retiree, an individual must:

- Be a full-time employee who is regularly scheduled to work at least twenty (20) hours per week; or

- Be a non-certified staff retiree who is participating in IMRF and is eligible for an IMRF pension who was covered under the Plan prior to the date of his or her employment; such retiree can elect to continue coverage at retirement at his or her own expense, and such coverage can remain in effect until the Retiree attains age sixty-five (65) or is eligible for Medicare, whichever occurs first; or

- Be a *grandfathered* certified staff retiree who was covered under the Plan prior to the date of his or her employment; such grandfathered retiree can continue coverage at his or her own expense, and such coverage can remain in effect until the Retiree attains age sixty-five (65) or is eligible for Medicare, whichever occurs first; and

- Be eligible to participate equally in any alternate health benefits plan offered by the Plan Sponsor by virtue of his/her own status with the Plan Sponsor and not by virtue of dependency; and

- Meet any eligibility criteria specified by the Plan Sponsor in this document, including, without limitation, the criteria set forth in Section 1; and

- Obtain an enrollment form from the District Office and complete the form in full, sign it and return it promptly to the District Office.

4.2 Dependent Eligibility

To be eligible to be enrolled under this Plan as a Dependent, an individual must:

- Be the lawful spouse of the Covered Employee; or

- Be an unmarried child of the Covered Employee or the Covered Employee's spouse, as follows:

  - Children under age twenty-six (26) who are either the birth children of the Covered Employee or the Covered Employee's spouse or legally adopted by or placed for adoption with the Covered Employee or Covered Employee's spouse;

  - Children under age twenty-six (26) for whom the Covered Employee or the Covered Employee's spouse is required to provide health care coverage pursuant to a Qualified Medical Child Support Order as defined in ERISA §609(a);

  - Children under age twenty-six (26) for whom the Covered Employee or the Covered Employee's spouse is the court-appointed legal guardian; (proof of guardianship is required at the time of enrollment)

  - Children age twenty-six (26) or older but under the age of thirty (30) who (i) are Illinois residents, (ii) have served as a member of the active

or reserve components of any of the branches of the Armed Forces of the United States, and (iii) have received a release or discharge other than a dishonorable discharged. (To be eligible for coverage as a dependent based upon prior military service, the eligible dependent must submit proof of such service using a DD2-14 (Member 4 or 6) "Certificate of Release or Discharge from Active Duty" form stating the date on which the dependent was released from the service.)

  - Children age twenty-six (26) or older who, except for their age, qualify as a Dependent as specified above, and who are mentally or physically incapable of earning a living and who are chiefly dependent upon the Covered Employee for support and maintenance, provided that: the onset of such incapacity occurred before age twenty-six (26), proof of such incapacity is furnished to the Plan Sponsor by the Covered Employee upon enrollment of the person as a Dependent child or at the onset of the Dependent child's incapacity prior to age twenty-six (26) and upon request thereafter;

- Note: Federal law prohibits a group health plan from terminating a college student's health coverage on the basis of a child taking a medically necessary leave of absence from college or changing to part-time status. Effective this Plan year, the Plan no longer requires children ages 19 to 23 to provide proof they are a full-time student at an accredited educational institution in order to become or remain eligible for coverage under the Plan.

Notwithstanding the above, dependent children may not be covered by more than one employee. Also, if both a husband and a wife are covered employees and the spouse carrying dependent coverage terminates coverage under the Plan, dependent coverage can be transferred to the spouse who remains covered by the Plan provided the employee continues to be an eligible employee. If both a husband and wife are covered employees and one terminates coverage with the Plan, he or she may be covered as a dependent under the remaining spouse's coverage.

Coverage is not provided for foster children, grandchildren (unless the Covered Employee or Covered Employee's spouse is the legal guardian, and documentation has been submitted to Plan Sponsor or Claims Administrator), domestic partners, part-time or temporary employees, retired certified staff (unless grandfathered in), parents or relatives. In addition, a common law spouse qualifies as a spouse under this Plan Document only if his/her spousal status is affirmed by a court of competent jurisdiction. In all cases, Plan Sponsor's determination of eligibility shall be conclusive.

In order to be eligible for coverage under this health benefit plan, individuals must meet these specific eligibility requirements. So long as this Plan is in effect, any change in these eligibility requirements must be approved in advance by the Plan Administrator.

4.3 Qualified Medical Child Support Orders

This Plan will also extend benefits to a Participant's non-custodial child, as required by any qualified medical child support order (QMCSO), as defined in ERISA § 609(a). The Plan has detailed procedures for determining whether an order qualifies as a QMCSO. Participants can obtain, without charge, a copy of such procedures from the Plan Administrator.

4.4 Benefits for Adopted Children

The Plan also will extend benefits to dependent children placed with Participants for adoption under the same terms and conditions as apply in the case of dependent children who are natural children of Participants.

4.5 Medicare Eligibility

A Covered Employee or Covered Employee's spouse who is eligible to be covered under Medicare (Title XVIII of the Social Security Act as amended), except as provided for in Section 7.8, shall enroll in Medicare Part A and B coverage on the later of the date he/she is first eligible for Medicare or the effective date of this Plan in order to be eligible or continue coverage under this Plan. If a Covered Employee or Covered Employee's spouse does not enroll within thirty (30) days of the later of the date he/she is first eligible for Medicare or the effective date of this Plan, his/her coverage under this Plan may be reduced to the amounts that would have been payable (paid) for treatment or service by Medicare Parts A and/or B if he/she had been covered by Medicare.

4.6 Persons Not Eligible to Enroll

4.6.1 A person who fails to meet the eligibility requirements specified in this Plan shall not be eligible to enroll or continue enrollment for coverage under this Plan.

4.6.2 A person whose coverage under this Plan was terminated due to a violation of a material provision of the Plan shall not be eligible to enroll for coverage under this Plan.

4.6.3 Late Enrollees are not eligible to enroll except during the next Annual Enrollment Period.

4.7 Enrollment

4.7.1 **Initial Enrollment Period**: All newly hired employees may enroll for Coverage under this Plan within thirty-one (31) days of becoming eligible. Employees have the option to enroll in either the Gold or the Silver plan for themselves and their eligible dependents. If the employee fails to submit an enrollment form for purposes of enrolling for Coverage under this Plan within thirty-one (31) days of becoming eligible, he/she is not eligible to enroll until the next Annual Enrollment Period unless there is a Special Enrollment Period as set forth in Section 4.8 below.

4.7.2 **Annual Enrollment Period—Non-Certified Staff:** Each year, during the Annual Enrollment Period, non-certified staff have the opportunity to enroll in or to change their health care coverage from one option to another (i.e., from the Gold to the Silver Plan or vice versa). Any benefits which were paid or are payable for covered expenses incurred by or on behalf of the Covered Person while covered under the Gold or Silver Plans will be charged against the corresponding benefit limits of the Gold or Silver Plans and vice versa.

4.7.3 **Annual Enrollment Period—Certified Staff:** Each year, during the Annual Enrollment Period, certified staff have the opportunity to enroll in or to change their health care coverage from one option to another (i.e., from the Gold to the Silver Plan or vice versa). The Annual Enrollment Period is determined by the provisions set forth in the Collective Bargaining Agreement. Any benefits which were paid or are payable for covered expenses incurred by or on behalf of the Covered Person while covered under the Gold or Silver Plans will be charged against the corresponding benefit limits of the Gold or Silver Plans and vice versa.

4.7.4 A special enrollee may enroll for coverage under this Plan as provided below.

4.7.5 Eligible employees or their Dependents who do not enroll during an initial eligibility period, or within thirty-one (31) days of first becoming eligible for Coverage under this Plan, are not eligible to enroll until the next Annual Enrollment Period, unless they are eligible to enroll as a special enrollee, as described in Section 4.8 below.

4.8 Special Enrollment

4.8.1 **Special Enrollment Due to Loss of Other Coverage**. Subject to the conditions set forth below, an employee and his or her Dependents may enroll in this Plan if the employee waived initial coverage under this Plan at the time coverage was first offered because the employee or Dependent had other group health plan or health insurance coverage (as defined by the Federal HIPAA Law) at the time coverage under this Plan was offered and the employee's or Dependent's other coverage was:

- COBRA continuation coverage that has since been exhausted; or,

- If not COBRA continuation coverage, such other group health plan or health insurance coverage terminated due to a loss of eligibility for such coverage or employer contributions toward the other coverage terminated. The term "loss of eligibility for such coverage" includes a loss of coverage due to legal separation, divorce, death, termination of employment, or reduction in the number of hours of employment. It also includes reaching a lifetime limit on all benefits in another group health plan. This term does not include loss of coverage due to failure to timely pay required contributions or premiums or loss of coverage for cause (i.e., fraud or intentional misrepresentation).

Required Length of Special Enrollment. An employee and his or her Dependents must request special enrollment in writing no later than thirty (30) days from the date that the other coverage was lost.

Effective Date of Coverage. If the employee or Dependent enrolls within the thirty-day period, coverage under the Plan will become effective no later than the first (1st) day of the first (1st) calendar month after the date the completed request for special enrollment is received.

4.8.2 **Special Enrollment Due to New Dependent Eligibility**. Subject to the conditions set forth below, an employee and his or her Dependents may enroll in this Plan if the employee has acquired a Dependent through marriage, birth, adoption or placement for adoption.

- **Non-enrolled Employee.** An employee who is eligible but has not yet enrolled may enroll upon marriage or upon the birth, adoption or placement for adoption of his or her child (even if the child does not enroll).
- **Non-participating Spouse.** A Covered Employee's spouse may enroll at the time of marriage to the Covered Employee, or upon the birth, adoption or placement for adoption of the Covered Employee's or non-participating spouse's child (even if the new child does not enroll).
- **New Dependents of Covered Employee.** A child who becomes a Dependent of a Covered Employee as a result of marriage, birth, adoption or placement for adoption or legal guardianship may enroll at that time.
- **New Dependents of Non-enrolled Employee.** A child who becomes a Dependent of a non-enrolled employee as a result of marriage, birth, adoption or placement for adoption or legal guardianship may enroll at that time but only if the non-enrolled employee is eligible for enrollment and enrolls at the same time.

Required Length of Special Enrollment. An employee and his or her Dependents must request special enrollment in writing no later than thirty (30) days from the date of marriage, birth, adoption or placement for adoption or legal guardianship appointment.

Effective Date of Coverage. Coverage shall become effective:

- In the case of marriage, the first (1st) day of the first (1st) calendar month beginning after the date a completed Enrollment Form is received by the Plan; and,
- In the case of a Dependent's birth, the date of such birth; and,
- In the case of a Dependent's adoption or placement for adoption, the date of such adoption or placement for adoption.

4.8.3 **Special Enrollment Pursuant to Termination of Medicaid or CHIP Coverage.** Subject to the conditions set forth below, an employee who is eligible but not enrolled, or the dependents of such Eligible Employee, if eligible but not enrolled, may enroll in the Plan if either of the following two conditions is satisfied:

(1) **Termination of Medicaid or CHIP Coverage.** The Eligible Employee or Dependent may enroll if the Eligible Employee or Dependent is covered under a Medicaid plan under Title XIX of the Social Security Act, or under the State Children's Health Insurance Program ("SCHIP") under Title XXI of the Social Security Act, and coverage of the Eligible Employee or Dependent under either the Medicaid or SCHIP plan is terminated as a result of loss of eligibility under such plan.

(2) **Eligibility for Employment Assistance Under Medicaid or SCHIP**. The Eligible Employee or Dependent may enroll if the Eligible Employee or Dependent becomes eligible for premium or other assistance with respect to coverage under this Plan, pursuant to a Medicaid plan or SCHIP plan (including any waiver or demonstration product conducted under or related to such Medicaid or SCHIP plan).

Required Length of Special Enrollment Notification. An Eligible Employee and/or his or her Dependents must request special enrollment in writing no later than sixty (60) days from the date of termination of the Medicaid/SCHIP eligibility or the date the Eligible Employee or Dependent is determined to be eligible for the premium assistance.

Effective Date of Coverage. Coverage shall become effective on the first day of the month following the month in which the Plan received the request for Special Enrollment.

4.9 Notification of Change in Status

A Covered Employee must notify the Plan of any changes in the Covered Employee's status or the status of any Dependent within thirty (30) days after the date of the qualifying event. This notification must be submitted on a written form required by the Plan to the Plan. Events qualifying as a change in status include, but are not limited to, changes in address, employment, divorce, marriage, dependency status, Medicare eligibility or coverage by another payer.

The Plan should be notified within a reasonable time of the death of any Participant.

4.10 Effective Date for Covered Employees

4.10.1 **During Annual Enrollment Period**: An employee who is eligible for coverage under this Plan and enrolls for such coverage during an Annual Enrollment Period shall be covered under this Plan as of the Participant Effective Date.

4.10.2 **Newly Hired Employees**: A newly hired employee who is eligible for Coverage and enrolls for such Coverage upon becoming employed with the District shall be covered under this Plan as of the date of hire so long as the Plan Sponsor receives the employee's completed Enrollment Form within thirty-one (31) days of the date of employment.

4.10.3 **Newly Eligible Employees**: An employee of the District who becomes newly eligible for Coverage under this Plan shall be covered as of the date that he/she first becomes eligible so long as Plan Sponsor receives the employee's Enrollment Form within thirty-one (31) days of the date that the employee first becomes eligible for Coverage. If an employee is rehired after termination but within twelve (12) months of the termination date, and has had no intervening employment, he or she will be considered eligible for coverage immediately.

4.10.4 **Special Enrollees**: Special enrollees shall be covered under this Plan as provided in Section 4.8 above.

4.11 Member Effective Date for Dependents

4.11.1 Dependents may be enrolled during an Annual Enrollment Period or upon the valid enrollment of a newly hired or newly eligible employee (as provided in Section 4.7 above). In the case of Dependents who are enrolled during the Annual Enrollment Period or upon the valid enrollment of a newly hired or newly eligible employee, the Participant Effective Date shall be the same as the Participant Effective Date for the Covered Employee.

4.11.2 Dependents who are Special Enrollees shall be covered under this Plan when stated in Section 4.8 above; provided, that a newborn child will be covered at birth if Dependent coverage is in effect at that time or if written application is made for Dependent coverage within thirty-one (31) days of the date of birth.

4.11.3 Dependents eligible for coverage as a result of a Qualified Medical Child Support Order shall be covered as of the date specified in the order. If no date is specified in the order, coverage shall be effective as of the date the order is issued by the court.

4.12 Termination of Coverage for Participants

All Plan coverage will terminate on the earliest of the following dates:

- Certified Staff: the following August 31st if they have completed the school year. If the school year is not completed, coverage will terminate at the end of the month following the date of termination.
- Non-Certified Staff: the end of the month following the date employment terminates.
- The end of the month following the date the employee ceases to be in a class of employees eligible for coverage.
- In the case of Dependents, the date the employee's coverage terminates, the Dependent ceases to be a Dependent as defined in this Plan, dependent coverage is discontinued under the Plan, or the date the Dependent becomes covered as an employee.
- In the case of Spouse, the end of the month following the date the employee and spouse are legally separated or divorced.
- The date the Plan is terminated.
- The end of the period for which the employee or dependent made any required contributions, if the employee fails to make any further required contributions.
- The end of the month following the date the employee or dependent enters the armed forces of any country on a full-time active duty basis.
- If an employee is absent from work due to an approved leave of absence, other than a Family and Medical Leave Act leave, coverage terminates six (6) months following the date of the leave of absence.
- If the employee is absent from work due to a disability, coverage terminates at the end of the month following six (6) months from the date of the disability.
- The Plan shall be compliant with the provisions of the Family and Medical Leave Act (FMLA) effective August 5, 1993, as set forth more fully below.
- Following fifteen (15) days' written notice, if the employee or dependent materially violates the terms of the Plan or participates in fraudulent or criminal behavior. Examples of fraudulent or criminal behavior include, but are not limited to:
  - Performing an act or practice that constitutes fraud or intentionally misrepresenting material facts including using an identification card

to obtain goods or services which are not prescribed or ordered for him/her or to which he/she is otherwise not legally entitled. In this instance, coverage for the Covered Employee and all Dependents will be terminated.

  - Allowing any other person to use an identification card to obtain services. If a Dependent allows any other person to use his/her identification card to obtain services, the coverage of the Dependent who allowed the misuse of the card will be terminated. If the Covered Employee allows any other person to use his/her identification card to obtain services, the coverage of the Covered Employee and his/her Dependents will be terminated.
  - Threatening or perpetrating violent acts against the Plan, a Provider, the Claims Administrator, or an employee of the Plan, Provider or Claims Administrator. In this instance, Coverage for the Covered Employee and all Dependents will be terminated.

- If the Employee or Dependent knowingly misrepresents or gives false information on any enrollment application form which is material to the Plan's acceptance of such application.

4.13 Effect of Termination

- If an Employee or Dependent's coverage under this Plan is terminated under Section 4.12, all rights to receive Covered Services shall cease as of the date of termination.
- Identification cards are the property of the Plan and, upon request, shall be returned to the Plan Sponsor within thirty-one (31) days of the date of termination of coverage. Identification cards are for purposes of identification only and do not guarantee eligibility to receive Covered Services.

4.14 Pre-Existing Condition Limitation Provision and Creditable Coverage

A Pre-Existing Condition is a condition for which medical advice, diagnosis, care or treatment was recommended or received within six (6) months of the person's enrollment date. For these purposes, Genetic Information is not a condition. Treatment includes receiving services and supplies, consultations, diagnostic tests, or prescribed medicines. In order to be taken into account, the medical advice, diagnosis, care, or treatment must have been recommended by, or received from, a Physician.

Genetic Information means information about genes, gene products and inherited characteristics that may derive from an individual or a family member. This 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.

Benefits are not payable for expenses related to a Pre-Existing Condition unless the expense is incurred more than twelve (12) consecutive months (eighteen (18) consecutive months if a Late Enrollee) from the Enrollment Date.

The period of the Pre-Existing Condition Limitation must be reduced by the number of days of "Certified Creditable Coverage" an individual has as of the Enrollment Date. The Plan is required to credit periods of previous coverage toward a Pre-Existing Condition period. Therefore, the length of a Pre-Existing Condition Limitation may be reduced or eliminated if an eligible person has Creditable Coverage from another health plan. To receive credit for periods of previous coverage, an eligible individual must not experience a break in coverage of sixty-three (63) days or more (defined as a "significant break in coverage"). Waiting periods are not considered breaks in coverage. Days in a waiting period are not Creditable Coverage.

An eligible person may request a certificate of Creditable Coverage from his prior plan. The Certificate of Creditable Coverage will enable the Plan to determine whether the Pre-Existing Condition Limitation will be reduced or eliminated. The Employer will assist any eligible person in obtaining a certificate of Creditable Coverage from a prior plan.

If, after Creditable Coverage has been taken into account, there will still be a Pre-Existing Conditions Limitation imposed on an individual, that individual will be so notified.

The Pre-Existing Condition Limitation does not apply to:

- Pregnancy;
- To a newborn child within thirty-one (31) days of birth who is covered under Creditable Coverage, or
- To a child who is adopted or placed for adoption before attaining age eighteen (18) and who, as of the last day of the thirty-one (31) day period beginning on the date of the adoption or placement for adoption, is covered under Creditable Coverage;
- Employees and covered Dependents of Employees who are returning from a leave which qualifies under the Family and Medical Leave Act (FMLA) and chose not to retain coverage under the Plan during the leave.

The prohibition on exclusion for newborn, adopted, or pre-adopted children does not apply to an individual after the end of the first sixty-three (63) day period during all of which the individual was not covered under any Creditable Coverage.

5. Continuation Rights

5.1 Continuation of Coverage Under the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA)

COBRA requires that the Plan offer eligible Participants the opportunity to pay for a temporary extension of health care coverage in instances where coverage under the Plan would otherwise end, in accordance with the provisions of federal law. **Note: Continuation coverage for Participants who selected continuation coverage under a prior plan which was replaced by coverage under this Plan shall terminate as scheduled under the prior plan or in accordance with the terminating events set forth below, whichever is earlier.** A Qualified Beneficiary does not have to show that he/she is insurable to choose COBRA continuation coverage. COBRA continuation is provided, subject to the person's eligibility for coverage under the Plan.

5.1.1 Employees

Covered Employees who lose eligibility for health care payment under the following conditions can continue coverage in accordance with this Section 5:

- Termination of employment (except for gross misconduct).
- Layoff or reduction in hours of employment, resulting in loss of coverage.

5.1.2 Spouses

A spouse who is a Dependent of a Covered Employee will have the right to continue coverage in accordance with this Section 5 if coverage is lost for any of the following reasons:

- The death of the Covered Employee.
- Termination of the Covered Employee's employment (other than for gross misconduct) or reduction in the Covered Employee's hours of employment.
- Divorce or legal separation from the Covered Employee.
- The Covered Employee becomes entitled to Medicare.

5.1.3 Dependent Children

The Dependent child of a Covered Employee has the right to continue coverage in accordance with this Section 5 if the coverage is lost for any of the following reasons:

- The death of the Covered Employee.
- Termination of the Covered Employee's employment (other than for gross misconduct) or reduction in the Covered Employee's hours of employment.
- Divorce or legal separation of the Covered Employee.
- The Covered Employee becomes entitled to Medicare.
- The Dependent child ceases to satisfy the Plan Sponsor's eligibility rules for Dependent status.

5.1.4 Newborn or Adopted Children

If, during the period of COBRA coverage, a Covered Employee or an eligible Dependent spouse gives birth to a child, or if a child is placed with a Covered Employee or Dependent spouse for adoption, the Covered Employee may elect COBRA continuation coverage for that child. Coverage for the newborn or adopted child will continue for the same period of time that coverage for any other Dependent children is or could have been provided.

5.1.5 Special Enrollment Rules for Qualified Beneficiaries

A Qualified Beneficiary receiving COBRA continuation coverage is also entitled to enroll family Participants in the Plan under the Special Enrollment rules set forth in this document the same as if the Qualified Beneficiary was an employee or participant within the meaning of those rules.

5.1.6 Length of Coverage

A Qualified Beneficiary's coverage may continue under COBRA as follows:

- Coverage for the Covered Employee and Dependent(s) may be continued for up to eighteen (18) months, if coverage is terminated due to the Covered Employee's:
    1. Termination of employment (other than for gross misconduct) or
    2. Reduced work hours

  The 18-month period of continuation coverage may be extended an additional eleven (11) months for the Covered Employee or family Dependent if, within sixty (60) days from the date of the event described in (1) or (2) above, the Social Security Administration determined that the Covered Employee or family Dependent was disabled. If the disabled individual has non-disabled family Participants who are entitled to COBRA, the non-disabled family Participants are also entitled to extend their COBRA continuation coverage from eighteen (18) to twenty-nine (29) months. The required contribution for the eleven (11) month extension may be increased, up to one hundred fifty percent (150%) of the cost of the Plan Sponsor's cost of providing coverage under the Plan for "similarly situated" covered individuals.

  Proof of disability must be provided within sixty (60) days from the date the Social Security Administration makes the determination and within the initial eighteen (18) month period of continuation coverage.

  If, during the initial eighteen (18) month period, the Social Security Administration determines that the affected individual is no longer disabled, the eleven (11) month extension does not apply. If the Social Security Administration determines that the affected individual is no longer disabled after the initial eighteen (18) month period, the period of continuation coverage ends the first day of the month that begins more than thirty (30) days after the date of the Social Security Administration's determination, provided the period of continuation coverage does not exceed twenty-nine (29) months.
- Coverage for eligible Dependents may be continued up to a maximum of thirty-six (36) months, if coverage is terminated due to:

1. The Covered Employee's death;
2. The Covered Employee's divorce or legal separation; or
3. A Dependent child ceases to satisfy rules for Dependent status.

- If a Covered Employee becomes entitled to Medicare, and within eighteen (18) months of becoming entitled to Medicare, he/she becomes entitled to COBRA continuation coverage due to termination of employment (other than for gross misconduct) or reduction in work hours, coverage for the Covered Employee's Dependents may be continued for up to thirty-six (36) months from the date the Covered Employee became entitled to Medicare.

5.1.7 Notification and Election Requirements

Each Covered Employee and each eligible Dependent has the responsibility to inform the Plan Sponsor of a divorce, legal separation, Medicare eligibility or a child losing dependent status under the Plan within sixty (60) days of the qualifying event. Failure to provide this notification within sixty (60) days will result in the loss of continuation coverage rights. A Qualified Beneficiary's failure to notify the Plan Sponsor of a qualifying event within sixty (60) days of the event may result in retroactive cancellation of the Covered Employee's/ Dependent's continuation coverage, and the Plan may seek reimbursement from the Employee/Dependent for any benefits paid after the qualifying event.

The Covered Employee and each eligible Dependent must elect COBRA continuation coverage within sixty (60) days of the date that coverage would end or, if later, within sixty (60) days of the date that their employer first sent notice of the right to elect COBRA continuation coverage.

The Plan Sponsor has the responsibility of notifying the Plan of a Covered Employee's death, termination of employment, reduction in hours, entitlement to Medicare or the Employer's bankruptcy within 30 days of the qualifying event.

The Plan will notify Covered Employees or the qualifying individual of continuation coverage rights within fourteen (14) days of the notice described above. Each qualifying individual will then have sixty (60) days to elect continuation coverage. Failure to elect continuation coverage within sixty (60) days after notification of the qualifying individual will result in loss of continuation coverage rights.

5.1.8 Termination of Coverage

Under federal law and under this Plan, COBRA continuation coverage will end on the first of the following dates:

- The date the Plan Sponsor terminates all group health plans.
- The date a required premium or contribution is due and not paid on time.
- The date a Qualified Beneficiary becomes covered by another group plan without an enforceable preexisting condition exclusion or limitation.
- The date a Qualified Beneficiary becomes entitled to Medicare.
- The date the applicable period of continuation coverage is exhausted.
- The first day of the month that begins more than thirty-one (31) days after the date that the Qualified Beneficiary is no longer disabled, in situations where coverage was extended for eleven (11) months, as long as the period

of COBRA continuation coverage does not exceed twenty-nine (29) months.

- Special continuation periods apply to Retirees and their Dependents if the Plan Sponsor declares bankruptcy under Title 11 of the United States Code, and the Retirees and their Dependents lose substantial coverage within one year before or after the date that the bankruptcy proceedings commenced. Retirees may continue their coverage until their death. For a spouse, surviving spouse, or dependent child of the Retiree, coverage will end at the earlier of the Qualified Beneficiary's death or thirty-six (36) months past the date of the death of the Retiree.

5.1.9 Cost of Continuation Coverage

Except as a higher amount is allowed in accordance with Section 5.7, the Plan may require all Qualified Beneficiaries to pay a premium for continuation coverage of up to one hundred two percent (102%) of the Plan's cost for a "similarly situated" eligible covered individual.

5.1.10 COBRA ARRA Provisions

Effective March 1, 2009, the Plan's provisions concerning COBRA are amended as provided below to allow for (1) payment of reduced premiums and the provision of a second election period by certain COBRA qualified beneficiaries, (2) the provision for additional COBRA notices, and (3) an exception to the rules for crediting certain prior coverage. This amendment does not apply to a health flexible spending account.

The COBRA continuation coverage provisions of the Plan shall be administered in accordance with the requirements of ARRA Section 3001 with respect to "assistance eligible individuals," as defined in ARRA Section 3001(a)(3). Notwithstanding any other Plan provision to the contrary, the Plan shall determine whether an individual has had a 63-day break in coverage for purposes of determining creditable coverage under the Health Insurance Portability and Accountability Act (HIPAA), in accordance with the terms of ARRA Section 3001.

5.2 Continuation of Coverage Under the Trade Act of 1974

Special COBRA rights apply to employees who have been terminated or experienced a reduction of hours and who qualify for a 'trade readjustment allowance' or 'alternative trade adjustment assistance' under a federal law called the Trade Act of 1974. These employees are entitled to a second opportunity to elect COBRA coverage for themselves and certain family Participants (if they did not already elect COBRA coverage), but only within a limited period of sixty (60) days (or less) and only during the six months immediately after their group health plan coverage ended. If you qualify or may qualify for assistance under the Trade Act of 1974, contact the Plan Sponsor for additional information. You must contact the Plan Sponsor promptly after qualifying for assistance under the Trade Act of 1974, or you will lose your special COBRA rights.

5.3 Continuation of Coverage Under the Family and Medical Leave Act of 1993 (FMLA)

Effective January 16, 2009, if a Covered Employee ceases active service due to a Company approved Family Medical Leave of absence in accordance with the requirements of Public Law 103-3 (or in accordance with any state or local law which provides a more generous medical or family leave and requires continuation of coverage during leave), coverage will be continued under the same terms and conditions which would have been provided had the Covered Employee continued active service.

If the Covered Employee does not return to active service after the approved Family Medical Leave or if the Covered Employee has given the employer notice of intent not to return to active service during the leave, or if the Covered Employee has exhausted the FMLA leave entitlement period, coverage may be continued under the Continuation of Coverage (COBRA) provision of this Plan, provided the Covered Employee elects to continue under the COBRA provision. Continuation of Coverage (COBRA) will be provided only if the following conditions have been met:

1. the Covered Employee or Covered Dependent was covered under this Plan on the day before the FMLA leave began or becomes covered during the FMLA leave; and

2. the Covered Employee does not return to active service after an approved FMLA leave; and

3. without COBRA, the Covered Employee or Covered Dependent would lose coverage under this Plan.

However, these conditions do not entitle a Covered Employee to COBRA if the Company eliminates, on or before the last day of the Covered Employee's FMLA leave, coverage under this Plan for the class of Employees (while continuing to employ that class of Employees) to which the Covered Employee would have belonged if the Covered Employee had not taken FMLA leave.

Continuation of Coverage (COBRA) will become effective on the last day of the FMLA leave as determined below:

1. the date a Covered Employee fails to return to active service after an approved family medical leave;

2. the date the Covered Employee informs the Company of intent not to return to active service; or

3. the date a Covered Employee exhausts the FMLA leave entitlement period and does not return to active service.

The Covered Employee will be totally responsible for the contributions during the COBRA continuation if elected. Coverage continued during a family or medical leave will not be counted toward the maximum COBRA continuation period.

If a Covered Employee declines coverage during the FMLA leave period or if the Covered Employee elects to continue coverage during the family or medical leave and fails to pay the required contributions, the Covered Employee is still eligible under the Continuation of Coverage (COBRA) provision at the end of the FMLA

leave. COBRA continuation will become effective on the last day of the FMLA leave.

The pre-existing conditions limitation will not apply if a Covered Employee does not experience a break in coverage of sixty-three (63) days or more (defined as a "significant break in coverage"). The Covered Employee will be totally responsible for the contributions during the COBRA continuation if elected; however, the covered employee is not required to pay any unpaid contributions for the time coverage had lapsed during the leave.

If a Covered Employee voluntarily terminates coverage under this Plan during the FMLA leave or if coverage under this Plan was terminated during an approved family medical leave due to nonpayment of required contributions by the employee and the employee returns to active service immediately upon completion of that leave, coverage will be reinstated as if the employee remained in active service during the leave, including dependent coverage, without having to satisfy any waiting period, pre-existing conditions, limitations or evidence of good health provisions of this Plan, provided the employee makes any necessary contribution and enrolls for coverage within thirty-one (31) days of the return to active service.

5.4 Continuation of Coverage Under the Uniformed Services Employment & Re-employment Rights Act of 1994 (USERRA)

The Uniformed Services Employment and Reemployment Rights Act of 1994 (USERRA) established requirements that employers must meet for certain employees who are involved in the uniformed services (defined below). In addition to the rights that you have under COBRA, you (the Employee) are entitled under USERRA to continue the coverage that you (and your covered Dependents, if any) had under the Medical and/or Dental Plan.

5.4.1 You Have Rights Under Both COBRA and USERRA

Your rights under COBRA and USERRA are similar but not identical. Any election that you make pursuant to COBRA will also be an election under USERRA, and COBRA and USERRA will both apply with respect to the continuation coverage elected. If COBRA and USERRA give you (or your covered spouse or dependent children) different rights or protections, the law that provides the greater benefit will apply.

5.4.2 Definitions

"Uniformed Services" means the Armed Forces, The Army National Guard, and the Air National Guard when engaged in active duty for training, inactive duty training, or full-time National Guard duty (i.e., pursuant to orders issued under federal law), the commissioned corps of the Public Health Service, and any other category of persons designated by the President in time of war or national emergency.

"Service in the uniformed services" or "service" means the performance of duty on a voluntary or involuntary basis in the uniformed services under competent authority, including active duty, active duty for training, initial active duty for training, inactive duty training, full-time National Guard duty,

a period for which a person is absent from employment for an examination to determine his or her fitness to perform any of these duties, and a period for which a person is absent from employment to perform certain funeral honors duty. It also includes certain service by intermittent disaster-response personnel of the National Disaster Medical System.

5.4.3 Duration of USERAA Coverage

General Rule: Twenty-four (24) month maximum. When a Covered Employee takes a leave for service in the uniformed services, USERRA coverage for the Employee (and covered dependents for whom coverage is elected) begins the day after the Employee (and covered dependents) lose coverage under the Plan, and it can continue for up to twenty-four (24) months. However, USERRA coverage will end earlier if one of the following events takes place:

1. A premium payment is not made within the required time;
2. You fail to return to work within the time required under USERRA (see below) following the completion of your service in the uniformed services; or
3. You lose your rights under USERRA as a result of a dishonorable discharge or other conduct specified in USERRA.

Returning to Work: Your right to continue coverage under USERRA will end if you do not notify the District of your intent to return to work within the time required under USERRA following the completion of your service in the uniformed services by either reporting to work (if your uniformed services was for less than thirty-one [31] days) or applying for reemployment (if your uniformed services was for more than thirty [30] days). The time for returning to work depends on the period of uniformed services, as follows:

Period of Service	**Return-to Work Requirement**
Less than 31 days	The beginning of the first regularly scheduled work period on the day following the completion of your service, after allowing for safe travel home and an eight-hour rest period, or if that is unreasonable or impossible through no fault of your own, as soon as is possible.
More than 30 days but less than 181 days	Within 14 days after completion of your service or, if that is unreasonable or impossible through no fault of your own, the first day on which it is possible to do so.
More than 180 days	Within 90 days after completion of your service.
Any period if for purposes of an examination for fitness to perform uniformed service	The beginning of the first regularly scheduled work period on the day following the completion of your service, after allowing for safe travel

	home and an eight-hour rest period, or if that is unreasonable or impossible through no fault of your own, as soon as is possible.
Any period if you were hospitalized for or are convalescing from an injury or illness incurred or aggravated as a result of your service	Same as above (depending on length of service period) except that time periods begin when you have recovered from your injuries or illness rather than upon completion of your service. Maximum period for recovering is limited to two years, but the two-year period may be extended if circumstances beyond your control make it impossible or unreasonable for you to report to work within the above time periods.

COBRA and USERRA coverage are concurrent. This means that COBRA coverage and USERRA coverage begin at the same time. However, COBRA coverage can continue for up to eighteen (18) months (it may continue for a longer period and is subject to early termination, as described in the COBRA section. In contrast, USERRA coverage can continue for up to twenty-four (24) months, as described above.

5.4.4 Premium Payments for USERRA Continuation Coverage

If you elect to continue your health coverage (or your spouse or your dependent children's coverage) pursuant to USERRA, you will be required to pay one hundred two percent (102%) of the full premium for the coverage elected (the same rate as COBRA). However, if your uniformed service period is less than thirty-one (31) days, you are not required to pay more than the amount that you pay as an active employee for that coverage.

5.4.5 Questions

If you have any questions regarding this information or your rights to coverage, you should contact your District Office.

5.4.6 Reinstatement of Coverage

When coverage under this Plan is reinstated, all provisions and limitations of this Plan will apply to the extent that they would have applied if you had not taken military leave and your coverage had been continuous under this Plan. The eligibility waiting period will be waived and the pre-existing condition limitation will be credited as if you had been continuously covered under this Plan from your original effective date. (This waiver of limitations does not provide coverage for any illness or injury caused by or aggravated by your military service, as determined by the VA. For complete information regarding your rights under the Uniformed Services Employment and Reemployment Rights Act, contact your employer).

6. Summary of Plan Benefits

6.1 Deductibles

To receive benefits under the medical plan, you must satisfy the Deductible amount(s) shown on your Schedule of Benefits. A deductible is the dollar amount of medical expenses for Covered Services that a Participant is responsible for paying before benefits subject to the Deductible are payable under this Plan. Certain expenses do not apply towards the Deductible.
Individual Deductible

The individual deductible amount is shown on the Schedule of Benefits and is the total amount of Covered Services that you or your dependents must satisfy in a benefit year before you or your dependents are eligible to begin to receive coverage under the medical plan.

Family Deductible

On plans other than individual only, there are also family deductibles that must be met. On the Gold plan, for a family of two, two people must meet the deductible in order for the family deductible to be met; for a family of three or more, three people must meet the deductible for the family deductible to be met. Partial deductibles do not count towards the family deductible. On the Silver plan, the covered expenses of all family members combine to meet the family deductible. The family deductible will be deemed to be satisfied on the date that the required number of family members have satisfied their deductibles. Once the family deductible has been met, the plan will not apply medical expenses towards the deductible from that date forward to the end of the calendar year.

There is no deductible carryover for either the Gold or Silver Plans.

6.2 Coinsurance

After the deductible(s) have been satisfied, the Plan will pay the applicable percentages of eligible medical expenses as shown on the Schedule of Benefits. Coinsurance amounts, based on the Plan's reimbursement to the Provider, will be billed to Participant at a later time by the Provider.

6.3 Out-of-Pocket Maximum

The individual out-of-pocket maximum is a limit on the amount a Participant must pay out-of-pocket for specified Covered Services in a calendar year. The family out-of-pocket maximum is the limit on the total amount Participants of the same family covered under this Plan must pay for specified Covered Services in a calendar year. Once the out-of-pocket maximums are met, Covered Services are paid at 100% for the remainder of the Plan Year. Certain expenses do not apply towards the out-of-pocket maximums, such as charges in excess of benefit maximums or Maximum Allowable Charges or non-compliance penalties; Deductible amounts do apply towards the out-of-pocket maximums.

There are in-network and out-of-network out-of-pocket maximums which must be met. Expenses from in- and out-of-network providers will be applied equally

towards the satisfaction of both the in- and out-of-network out-of-pocket maximums. On plans other than individual only, there are also family out-of-pocket maximums which must be met. On the Gold Plan, three family members must meet the out-of-pocket maximum in order for the family out-of-pocket maximum to be met. On the Silver Plan, the covered expenses of all family members combine to meet the family out-of-pocket maximum.

With respect to the out-of-network benefit level, even if Participant has reached the out-of-pocket maximum amounts, an out-of-network provider may require that the Participant pay amounts above the Maximum Allowable Charge. Furthermore, amounts above the Maximum Allowable Charge related to out-of-network providers which are paid by the Participant do not count towards the out-of-pocket maximums. The amounts of the out-of-pocket maximums are set forth in the Schedule of Benefits.

6.4 Maximum Lifetime Benefit

The maximum lifetime benefit payable per Participant, if applicable, is listed in the Schedule of Benefits.

6.5 Out-of-Network Coverage Option

A Participant may receive Covered Services from in-network providers included in the network of Providers described in the Provider Directory available to Participants, upon request, in connection with the Plan. The participation status of Providers may change from time to time. Consequently, the Provider Directory will be updated periodically. A copy of the most current Provider Directory can be obtained online or by contacting the Claims Administrator's Customer Service Department.

In addition, Participant may receive certain Covered Services from out-of-network Providers under the Out-of-Network Coverage option. Those Covered Services for which there is not Out-of-Network Coverage are identified in this Plan Document and/or in the Schedule of Benefits. If Participant self-refers to an out-of-network Provider, Participant is responsible for ensuring that the out-of-network Provider complies with Plan's utilization management policies. Participant must in certain situations receive Prior Authorization from Plan prior to receiving a Covered Service. (You should check the Schedule of Benefits or call the Claims Administrator's Customer Service Department to determine when Covered Services require Prior Authorization).

Except for Emergency Services, coverage for Covered Services provided by out-of-network Providers is limited to the Maximum Allowable Charge less applicable Copayments, Coinsurance and Deductibles.

If the amount Participant is charged for a service is equal or less than the Maximum Allowable Charge, the charges should be completely Covered by the Out-of-Network Benefit, except for any Copayment, Deductible and Coinsurance payments. However, if the amount Participant is charged is in excess of the Maximum Allowable Charge for a particular service, Participant must pay the excess. For example, assume the Coinsurance is 20%, the doctor's bill is $150 and the Maximum Allowable Charge is $100. In this example, Plan would pay $80, Participant would pay Coinsurance of $20 plus the $50 in actual charges that exceed the Maximum Allowable Charge. Payments for charges in excess of the

Maximum Allowable Charge do not count towards the annual out-of-pocket maximums.

6.6 Benefits

The Plan provides Participants benefit coverage for certain specified health care services and supplies. A summary of the benefits provided under the Plan is set forth in this document. This Plan will provide benefits in accordance with the applicable requirements of federal laws, such as COBRA, FMLA, the Health Insurance Portability and Accountability Act (“HIPAA”), the Mental Health Parity Act (“MHPA”), the Newborns’ and Mothers’ Health Protection Act (“NMHPA”) and the Women’s Health and Cancer Rights Act (“WHCRA”).

The Plan covers only those health care services and supplies that are deemed Medically Necessary by the Plan and not excluded under the exclusions and limitations set forth in this Section 6. Covered Transplants must be rendered by a Coventry Transplant Network Provider in order to receive coverage.

The following **Schedule of Covered Services** provides the health care services and supplies covered under this Plan. The schedule is provided to assist Participants with determining the level of coverage and authorization procedures, limitations, and exclusions that apply for Covered Services when determined to be Medically Necessary, subject to the exclusions and limitations set forth in this Section 6. All Prior Authorizations and determinations referenced in the Schedule of Covered Services are made by the Plan. If a service is Medically Necessary but not specifically listed and not otherwise excluded, the service is not a Covered Service.

SCHEDULE OF COVERED SERVICES OR SUPPLIES WHEN DETERMINED TO BE MEDICALLY NECESSARY		
SERVICE OR SUPPLY	**CRITERIA AND COVERAGE PROVIDED**	**AUTHORIZATION REQUIREMENTS AND LIMITATIONS**
Abortion	Covered Service only for Medically Necessary abortions.	Limited benefit. Prior Authorization is required. Elective abortions (or any complications thereof) are not covered.
Allergy	Covered Service for allergy testing, diagnosis, treatment, allergy serum, and the administration of allergy shots and injections.	You are not covered for non-Physician allergy services or associated expenses relating to an allergic condition, including, but not limited to, installation of air filters, air purifiers or air ventilation system cleaning. You are also not covered for allergy drops or allergy treatment by a chiropractor.

SCHEDULE OF COVERED SERVICES OR SUPPLIES WHEN DETERMINED TO BE MEDICALLY NECESSARY		
SERVICE OR SUPPLY	**CRITERIA AND COVERAGE PROVIDED**	**AUTHORIZATION REQUIREMENTS AND LIMITATIONS**
Ambulance	Covered Service for charges for Medically Necessary ground or air ambulance transportation to the nearest hospital or medical institution where Medically Necessary care and treatment of an emergent injury or illness can be given, as follows: Emergency transportation by ambulance under the following circumstances: 1. An Emergency Medical Condition exists, and 2. The ambulance is licensed in its state as an emergency vehicle and has the necessary patient care equipment, supplies, and personnel to provide emergency care, and 3. Your medical condition is such that any other form of transportation would be medically unsafe, and 4. Transportation is to the nearest hospital with the appropriate facilities to treat your Emergency Medical Condition. Non-emergency transportation by ambulance under the following circumstances: 1. Transportation is to another hospital, inpatient rehabilitation facility, or skilled nursing facility, where additional treatment is intended to be delivered, and 2. Your medical condition makes other forms of transportation medically unsafe, and 3. The Plan will determine the most cost effective and medically appropriate mode of transportation.	Prior Authorization is not required for ground or air ambulance transportation for an Emergency Medical Condition. However, if it is determined that an Emergency Medical Condition did not exist, claims associated with the ambulance transportation may not be Covered, and the resulting costs will be your financial responsibility. You are not covered for the following ambulance services: 1. Transportation by ambulance because you did not have any other form of transportation. 2. Routine transportation. 3. Transportation for outpatient care.
Autism Spectrum Disorders	Care and services for the diagnosis of and treatment for Autism Spectrum Disorders in children under 21 years of age up to a maximum of $36,000 annually when prescribed, provided, or ordered for a child diagnosed with an Autism Spectrum Disorder by a physician licensed to practice medicine in all its branches or a certified, registered, or licensed health care professional with expertise in treating effects of Autism Spectrum Disorders when the care is determined to be Medically Necessary and ordered by a physician licensed to practice medicine in all of its branches. Covered services for the treatment of Autism Spectrum Disorders shall include the following: 1. Psychiatric care, meaning direct, consultative, or diagnostic services provided by a licensed psychiatrist. 2. Psychological care, meaning direct or consultative services provided by a licensed psychologist.	Prior Authorization required. Subject to a maximum benefit of $36,000 per year; however, payments for care, treatment, intervention, services or items provided for the treatment of a health condition not diagnosed as an autism spectrum disorder shall not be applied towards the annual benefit maximum. Coverage shall be subject to copayment, deductible and coinsurance provisions applicable to other medical services but shall not be subject to any limits on the number of visits to a service provider.

SCHEDULE OF COVERED SERVICES OR SUPPLIES WHEN DETERMINED TO BE MEDICALLY NECESSARY		
SERVICE OR SUPPLY	**CRITERIA AND COVERAGE PROVIDED**	**AUTHORIZATION REQUIREMENTS AND LIMITATIONS**
	3. Habilitative or rehabilitative care, meaning professional, counseling, and guidance services and treatment programs, including applied behavior analysis, that are intended to develop, maintain, and restore the functioning of an individual. "Applied behavior analysis" means the design, implementation, and evaluation of environmental modifications using behavioral stimuli and consequences to produce socially significant improvement in human behavior, including the use of direct observation, measurement, and functional analysis of the relations between environment and behavior. 4. Therapeutic care, including behavioral, speech, occupation-al, and physical therapies that provide treatment in the following areas: (i) self care and feeding, (ii) pragmatic, receptive, and expressive language, (iii) cognitive functioning, (iv) applied behavioral analysis, intervention and modification, (v) motor planning, and (vi) sensory processing.	

SCHEDULE OF COVERED SERVICES OR SUPPLIES WHEN DETERMINED TO BE MEDICALLY NECESSARY		
SERVICE OR SUPPLY	**CRITERIA AND COVERAGE PROVIDED**	**AUTHORIZATION REQUIREMENTS AND LIMITATIONS**
Blood and Blood Products	Covered Service for Medically Necessary blood and blood plasma to the extent not donated or replaced, blood derivatives and blood products, including procurement and administrative charges, in connection with services covered under the Plan.	You are not covered for the following blood and blood products services and supplies: 1. The cost of whole blood and blood products replacement to a blood bank. 2. Services and related expenses for personal blood storage, unless associated with a scheduled surgery for you. 3. Administration costs related to the procurement, processing and storage of blood from a person you designate as a donor. 4. Fetal cord blood harvesting and storage.

<table>
<tr><th colspan="3">SCHEDULE OF COVERED SERVICES OR SUPPLIES
WHEN DETERMINED TO BE MEDICALLY NECESSARY</th></tr>
<tr><th>SERVICE OR SUPPLY</th><th>CRITERIA AND COVERAGE PROVIDED</th><th>AUTHORIZATION REQUIREMENTS AND LIMITATIONS</th></tr>
<tr><td>Breast Reconstruction</td><td>Covered Service for the following breast reconstruction related services and supplies:
1. Breast reconstruction surgery following a Medically Necessary mastectomy. Consistent with the Women's Health and Cancer Rights Act ("WHCRA"), if you elect breast reconstruction after a Medically Necessary mastectomy, Coverage will be provided for:
• Reconstruction of the breast upon which the mastectomy was performed;
• Surgery and reconstruction of the other breast to produce a symmetrical appearance; and
• Prostheses and treatment for physical complications at all stages of the mastectomy, including lymph edemas.
This also includes nipple reconstruction.
2. Inpatient treatment following mastectomy for a length of time to be determined by attending Physician.
3. Availability of post-discharge Physician office visit or in-home nurse visit within 48 hours of discharge.
4. Standard prosthetic breast devices, including surgical implants, external breast prostheses, and post-mastectomy surgical bras, subject to applicable limitations.
5. Removal of breast implants but only if the implants were inserted because of a Medically Necessary mastectomy, and the implants are causing Illness or Injury.
➢ Note: when a mastectomy has been performed and there is no evidence of malignancy, Coverage is limited to the provision of prosthetic devices and Reconstructive Surgery to within two (2) years after the date of the mastectomy.
➢ Note: We will not deny you eligibility or continued eligibility to enroll or to renew Coverage under the terms of the Plan solely for the purpose of avoiding the requirements of this Section. We also will not penalize or reduce or otherwise limit the reimbursement of an attending provider or provide incentives (monetary or otherwise) to an attending Provider to induce the Provider to provide you care in a manner inconsistent with this Section.</td><td>Prior Authorization is required.

You are not covered for the following breast reconstruction related services and supplies or diagnostic testing related to those services and supplies:
1. Reconstructive or Cosmetic surgery of the breast, except as stated.
2. Removal of breast implants if implanted solely for Cosmetic or other non-covered reasons, even if removal is determined to be Medically Necessary.
3. Removal of breast implants, regardless of their indication for placement due to alleged or diagnosed systemic or rheumatologic disorders.
4. Breast enhancement or augmentation mammoplasty, with or without implants, unless associated with breast reconstruction surgery following a Medically Necessary mastectomy incurred secondary to active disease.
5. Breast reduction/reconstruction for male gynecomastia.

Coverage for external prostheses is also limited. Contact the Plan's Customer Service Department for current applicable benefit limits.
1. You may elect to purchase a more expensive external breast prosthesis by paying the excess cost.
2. Initial Coverage is limited to one (1) of each external breast prostheses (right and/or left).
3. Coverage for replacement of each external breast prostheses is limited to once every two (2) years.
4. Post-mastectomy surgical bras are limited to the standard model and limited to three (3) bras every six (6) months.</td></tr>
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SCHEDULE OF COVERED SERVICES OR SUPPLIES WHEN DETERMINED TO BE MEDICALLY NECESSARY		
SERVICE OR SUPPLY	**CRITERIA AND COVERAGE PROVIDED**	**AUTHORIZATION REQUIREMENTS AND LIMITATIONS**
Breast-Related Services	Covered Service for the following breast-related services: 1. Services related to the prevention of breast cancer and its early detection. 2. Breast cancer pain medication and pain therapy related to the treatment of breast cancer. Pain therapy means pain therapy that is medically based and includes reasonably defined goals, including, but not limited to, stabilizing or reducing pain, with periodic evaluations of the efficacy of the pain therapy against these goals. 3. Services related to the diagnosis and treatment of abnormalities of the breast. 4. Screening by low-dose mammography, including digital mammography, for all women 35 years of age or older for the presence of occult breast cancer, as follows: a. A baseline mammogram for women 35 to39 years of age. b. An annual mammogram for women 40 years of age or older). c. A mammogram at the age and intervals considered medically necessary by the woman's health care provider for women under 40 years of age and having a family history of breast cancer, prior personal history of breast cancer, positive genetic testing, or other risk factors. d. A comprehensive ultrasound screening of an entire breast or breasts if a mammogram demonstrates heterogeneous or dense breast tissue, when medically necessary as determined by a physician licensed to practice medicine in all of its branches. For purposes of this section, "low-dose mammography" means the x-ray examination of the breast using equipment dedicated specifically for mammography, including the x-ray tube, filter, compression device, and image receptor, with radiation exposure delivery of less than 1 rad per breast for 2 views of an average size breast. The term also includes digital mammography. 5. Clinical breast exams at least every three (3) years for women aged 20-39 and annually for women 40 years of age or older.	Coverage for mammograms under this section shall be provided at no cost to the member and shall not be applied to an annual or lifetime maximum when contracted providers are used. When mammogram services are available through contracted providers and a member receives those services from a non-contracted provider, coverage shall be at least as favorable as for other radiological examinations covered by the Plan

SCHEDULE OF COVERED SERVICES OR SUPPLIES WHEN DETERMINED TO BE MEDICALLY NECESSARY		
SERVICE OR SUPPLY	**CRITERIA AND COVERAGE PROVIDED**	**AUTHORIZATION REQUIREMENTS AND LIMITATIONS**
Cancer Treatment	Covered Service for the following cancer treatment: 1. Services related to the prevention of cancer and its early detection, including those services outlined in the Preventive Services section of this Schedule of Benefits. 2. Services related to the diagnosis and treatment of cancer, including those outlined below and in other sections of this Schedule of Benefits. a) Covered cancer treatments include surgery, chemotherapy, and radiation therapy under the following conditions: i. the treatment must be Medically Necessary; ii. chemotherapeutic drugs used in the treatment of cancer are limited to those drugs (1) which have been approved by the Federal Food and Drug Administration (FDA) and (2) recognized by the medical community for the specific type of cancer or which the drug has been prescribed in one of the following compendia: (a) the American Medical Association Drug Evaluations; (b) the American Hospital Formulary Service Drug Information; or (c) the United States Pharmacopoeia Drug Information or (3) if not in the compendia, recommended for that particular type of cancer in formal clinical studies, the results of which have been published in at least two Peer-Reviewed professional journals published in the United States or Great Britain; iii. the treatment, including treatment combinations and treatment intervals, is considered to be the standard treatment for that particular cancer as recognized by a majority of the national medical community and as published in Peer-Reviewed medical journals. The published results must clearly demonstrate either a survival or quality of life enhancement advantage in clinical trials; iv. the treatment is currently not considered to be Experimental or in clinical trials. 3. Medically Necessary health care services provided as part of a randomized and controlled Phase III clinical trial for the treatment of cancer that is sanctioned by the National Cancer Institute (NCI). ➢ **Note:** You may also have Coverage for certain outpatient prescription drugs and cancer medications used for cancer treatment under a separate prescription drug Rider.	You are not covered for the following cancer treatment: 1. Services related to the diagnosis and treatment of cancer that are not Medically Necessary or are not considered to be consistent with the standard treatment for that particular cancer. 2. Services related to alternative or nutritional treatments for cancer. 3. Phase I and Phase II clinical trials as well as any randomized and controlled Phase III clinical trials for the treatment of cancer that are not sanctioned by the National Cancer Institute (NCI). Note, however, that your Coverage may not be cancelled or non-renewed simply because of your participation in a qualified cancer trial as defined by Illinois law. 4. Services related to an Experimental or Investigational trial or clinical trial. 5. Costs associated with an approved investigational cancer trial that are specifically excluded, including: a) the cost of any clinical trial therapies, regimens or combinations thereof; b) the cost of any drugs or pharmaceuticals in connection with the approved clinical trial; c) the cost of any diagnostic testing which is part of the clinical trial; d) any costs associated with the provision of any goods, services or benefits that are generally furnished without charge in connection with an approved clinical trial program for treatment of cancer; e) any additional costs associated with the provision of any goods, services or benefits that previously have been provided to, paid for, or reimbursed, including diagnostic testing; or any other similar costs; or f) the costs of services provided for the convenience of the Physician or you.

SCHEDULE OF COVERED SERVICES OR SUPPLIES WHEN DETERMINED TO BE MEDICALLY NECESSARY		
SERVICE OR SUPPLY	**CRITERIA AND COVERAGE PROVIDED**	**AUTHORIZATION REQUIREMENTS AND LIMITATIONS**
Cardiac Rehabilitation Therapy	Covered Service for cardiac rehabilitation therapy delivered in an approved, Hospital-based cardiac rehabilitation program under the supervision of a cardiologist. 1. The cardiac rehabilitation therapy must be required and Medically Necessary due to a documented cardiac (heart) condition; 2. You must have a loss of function as a result of the cardiac condition; 3. The cardiac rehabilitation therapy must be significantly likely to substantially improve your functional status and result in either improved pain (angina) control or quality of life within a period of two (2) months; and 4. The cardiac rehabilitation therapy must not be able to be effectively and/or safely provided in a lesser setting (including, but not limited to, a non-monitored exercise program). ➢ Note: Coverage for cardiac rehabilitation therapy is limited to Phases I and II only.	You are not covered for the following: 1. Rehabilitative services provided for long-term, chronic medical conditions. 2. Rehabilitative services whose primary goal is to maintain your current level of function, as opposed to improving your functional status. 3. Rehabilitative services whose primary goal is to return you to a specific occupation or job, such as work-hardening or work-conditioning programs. 4. Educational or vocational therapy, schools or services designed to retrain you for employment. 5. Phases III or IV of a cardiac rehabilitation program. 6. Rehabilitation services that are Experimental or have not been shown to be clinically effective for the medical condition being treated. 7. Alternative rehabilitation services (*e.g.*, massage therapy). 8. Fees or costs associated with services that are primarily exercise. Examples include, but are not limited to, membership fees for health clubs, fitness centers, weight loss centers or clinics, or home exercise equipment.

SCHEDULE OF COVERED SERVICES OR SUPPLIES WHEN DETERMINED TO BE MEDICALLY NECESSARY		
SERVICE OR SUPPLY	**CRITERIA AND COVERAGE PROVIDED**	**AUTHORIZATION REQUIREMENTS AND LIMITATIONS**
Chiropractic Care	You are covered for chiropractic care, including all professional services for the detection and correction by manual or mechanical means (with or without the application of treatment modalities such as, but not limited to, diathermy, ultrasound, heat and cold) of the spinal skeletal system and/or surrounding tissue to restore proper articulation of joints, alignment, of bones or nerve functions. Such chiropractic treatment must be for those musculoskeletal conditions which can be expected to improve with chiropractic therapy under the following circumstances: 1. The chiropractic care must be Medically Necessary, and 2. The medical condition must reasonably be expected to improve with short-term (up to six weeks of) chiropractic treatment.	You are not covered for chiropractic care related to the following: 1. Chiropractic therapy that is preventive in nature or determined to be maintenance palliative. 2. Chiropractic therapy that is long-term in nature or designed to provide for long-term maintenance and/or periodic adjustment of musculoskeletal alignment. 3. Massage therapy. 4. Holistic, homeopathic or naturopathic care. 5. Chiropractic therapy for musculoskeletal conditions that are typically not improved with chiropractic care. Examples include, but are not limited to, any benign or malignant neoplasms; fractures or dislocations; and organic/genetic musculoskeletal diseases and illness, such as muscular dystrophy and osteomyelitis. 6. Chiropractic therapy for all non-musculoskeletal diseases and injuries. Examples include, but are not limited to, diabetes, asthma, obesity, hypertension, allergies, and infections. 7. Chiropractic services not otherwise defined as a Covered Service.
Contraceptive Services and Devices	Covered Service for the following contraceptive services and devices: 1. Outpatient contraceptive services, including consultations, examinations, procedures, and medical services, provided on an outpatient basis and related to the use of contraceptive methods (including natural family planning) to prevent an unintended pregnancy. 2. All outpatient contraceptive devices approved by the Food and Drug Administration You may also have Coverage under a separate prescription drug Rider for outpatient contraceptive prescription drugs approved by the Food and Drug Administration.	The Plan will not impose any Deductible, Coinsurance, waiting period, or other cost-sharing or limitation that is greater than that required for any outpatient service or outpatient prescription drug or device otherwise Covered herein. You are not covered for the following: 1. Elective abortions. 2. Contraceptive devices not approved by the Food and Drug Administration. 3. Over-the-counter or other non-prescribed forms of contraception, such as male and female condoms, spermicidal foams and creams and sponges.

SCHEDULE OF COVERED SERVICES OR SUPPLIES WHEN DETERMINED TO BE MEDICALLY NECESSARY		
SERVICE OR SUPPLY	**CRITERIA AND COVERAGE PROVIDED**	**AUTHORIZATION REQUIREMENTS AND LIMITATIONS**
Dental & Oral Surgical Services	This is a medical insurance policy, not a dental insurance policy. Consequently, Coverage for dental services is significantly limited. Covered Service for the following types of dental and oral surgical services: 1. Emergent and restorative services due to accidental injury or trauma resulting in fracture of the jaw, laceration of the mouth, tongue or gums or injury to sound, natural teeth so long as treatment is rendered within the same calendar year as the accident or the following calendar year. Covered Services include but are not limited to stabilization services necessary to prevent functional deficits, dentures, crowns, crown repair, bridges and repair of broken teeth. In certain situations, two or more dental treatment alternatives may produce comparable results. When alternative options may be utilized, the Plan determines the method which will be eligible for Coverage. ➢ Note: Accidental injury is defined as an injury related to an external trauma to the teeth, gums, or jaw. It does not include injuries resulting from natural function, such as biting, eating or chewing. Additionally, accidental injury is that type of injury which, if left untreated, would result in the loss of the tooth or severe dysfunction. ➢ Note: Sound, natural tooth is defined as a tooth with a normal root structure and no previous restoration (such as root canals, caps, fillings). ➢ Note: The emergent evaluation and treatment related to the accidental injury can be provided by any Provider. Any further treatment to sound natural teeth must be performed by a Provider approved in advance by the Plan. ➢ Note: Coverage for emergent or restorative services ends if your Coverage terminates, even if the time period for services has not yet elapsed. 2. Medical (non-dental) treatment of severe medical Illness or Injury to your jaws, lips, cheeks, tongue, roof and floor of month or surrounding tissues. Examples include: a. Treatment and correction of a pathological condition, such as excision of a cyst, tumor, or foreign body of the oral cavity and related anesthesia, which is not dental in origin. b. Treatment and correction of cleft lip or palate. c. Excision of exostoses of the jaws and hard palate (provided this procedure is not done in preparation for dentures or other prostheses). d. Reduction of dislocation of, or excision of, the temporomandibular joints(TMJ), fractures, neoplasms, or other inflammatory rheumatologic or infectious conditions, such as rheumatoid arthritis, ankylosing spondylitis, disseminated lupus erythematosus, or osteomyelitis. e. Severe medical, but not dental, complications of dental work. 3 Charges incurred, and anesthetics provided, in conjunction with dental care that is provided to a Covered individual in a Hospital or ambulatory surgical treatment center if the Covered Person has a serious medical condition that requires hospitalization. The actual dental services provided while hospitalized or performed in an ambulatory surgical treatment center are not covered.	Limited benefit. Prior Authorization required. You are not covered for the following types of dental and oral surgical services: 1. General dental care. a. General and preventive dental services, including, but not limited to, fillings, root canals, crowns, bridges, dentures, dental X-rays and other routine dental care. b. Dental splints, supplies, appliances (including occlusal splints/orthodontia), dental implants, dental prostheses or any treatment on or to the teeth, gums or jaws and other services customarily provided by a dentist, unless related to trauma treatment. c. Treatment of pain or infection known or thought to be due to a dental cause or in close proximity to the teeth or jaw, including, but not limited to, gum disease such as peridontitis and gingivitis. d. Surgical or non-surgical removal of wisdom teeth or impacted teeth; removal, replacement, repair, artificial restoration of the teeth (either natural or artificial); removal of teeth as a complication of or in preparation for radiation therapy or as a result of radionecrosis. e. Prescription medications written by a dentist or Physician for the purpose of treating a dental condition. 2. Dental care delivered during the treatment of accidental injury to sound, natural teeth that is not related to the accidental injury. 3. Dental implants. 4. Other dental and oral surgery procedures: a. Surgical correction of malocclusion of the teeth and/or jaw, including, but not limited to, maxillofacial orthognathic and prognathic surgery. b. Orthodontic correction of tooth alignment or malocclusion. c. Removal of dentiginous cysts, mandibular tori and odontiod cysts, which are dental in origin. d. Treatment of TMJ or craniomandibular joint disease, resulting from dislocation of the cartilage without dislocation of the mandible or from other dental causes or anomalies, including osteoarthritis. e. Dental-related oral surgical services to correct an overbite or underbite. 5. Hospital costs or related costs resulting from services that are excluded. 6. Emergent and restorative services due to accidental injury to sound, natural teeth rendered at a time greater than the same or subsequent calendar year as the accident or injury or after your insurance Coverage under the Plan has ended.

SCHEDULE OF COVERED SERVICES OR SUPPLIES WHEN DETERMINED TO BE MEDICALLY NECESSARY		
SERVICE OR SUPPLY	**CRITERIA AND COVERAGE PROVIDED**	**AUTHORIZATION REQUIREMENTS AND LIMITATIONS**
Dermatological Services	Covered Service for diagnosis and treatment of diseases of the skin, acne treatment, and the removal of skin lesions that interfere with normal body functions or are suspected to be malignant.	You are not covered for: 1. The removal of benign skin lesions, growths (such as warts), or skin tags. 2. Any dermatological services that are primarily for Cosmetic purposes. 3. Anti-aging services. 4. Salabrasion, chemosurgery, laser surgery or other skin abrasion procedures associated with the removal of scars, tattoos or actinic changes. 5. Services performed for the treatment of acne scarring, even when medical or surgical treatment for acne has been provided by the Plan.
Diabetic Self-Management Training and Education	Covered Service for the prevention, diagnosis and treatment of diabetes, which shall include the following: 1. Services related to the prevention of diabetes and its early detection are Covered as described in the Preventive Services section of this Schedule of Benefits. 2. Services related to the diagnosis and treatment of diabetes as part of this general medical benefit. 3. Outpatient self-management training and education, including medical nutrition education, for the treatment of type 1 diabetes, type 2 diabetes and gestational diabetes mellitus, as part of an office visit, group setting, or home visit, limited to the following: a. Up to 3 Medically Necessary visits to a qualified Participating Provider upon initial diagnosis of diabetes by your Physician; b. Up to 2 Medically Necessary visits to a qualified Participating Provider upon a determination by your Physician that a significant change in your symptoms or medical condition has occurred. ➢ **Note:** A significant change in condition means symptomatic hyperglycemia (greater than 250 mg/dl on repeated occasions), severe hypoglycemia (requiring the assistance of another person), onset or progression of diabetes, or a significant change in your medical condition that would require a significantly different treatment regimen. 4. Diabetic equipment, including blood glucose monitors; blood glucose monitors and cartridges for the legally blind; and lancets and lancing devices. 5. Regular foot care examinations by your Physician or by a Physician to whom your Physician has referred you. 6. Regular eye examinations by your Physician. ➢ **Note:** Diabetic pharmaceuticals and supplies, including insulin, syringes and needles, test strips for glucose monitors, FDA-approved oral agents used to control blood sugar, and glucagon emergency kits, may be Covered under a separate prescription drug Rider.	

SCHEDULE OF COVERED SERVICES OR SUPPLIES WHEN DETERMINED TO BE MEDICALLY NECESSARY		
SERVICE OR SUPPLY	**CRITERIA AND COVERAGE PROVIDED**	**AUTHORIZATION REQUIREMENTS AND LIMITATIONS**
Diagnostic Tests and Procedures	Covered Service for diagnostic tests and procedures (including, but not limited to, laboratory tests, radiographic tests, and other diagnostic procedures) under the following circumstances: 1. The diagnostic test and/or procedure must be Medically Necessary, and 2. The diagnostic test and/or procedure must provide useful information that affects diagnosis and treatment decisions by your Physician, and 3. The diagnostic test and/or procedure must be done because of currently recognized health problems or symptoms.	You are not covered for the following: 1. Diagnostic tests and procedures that are considered to be Experimental or Investigational. 2. Diagnostic tests and procedures that have not demonstrated significant usefulness as recognized by a majority of the national medical community and as published in Peer-Reviewed Medical Literature. 3. Diagnostic tests and procedures that are not done to evaluate current health problems or symptoms (*e.g.,* premarital blood testing, paternity testing, screening for various conditions in the absence of symptoms or significant risk factors.) 4. Diagnostic tests and procedures done to detect genetic abnormalities in the absence of either significant symptoms of, or risks for, the genetic disease in question. 5. Diagnostic tests or screening procedures determined by the Plan to be inappropriate for the delivery to, or screening of, an entire population or subpopulation. Typically, these services or procedures would not have been proven to be of value when applied to a large population or subpopulation. 6. Diagnostic tests and procedures that are part of a non-covered clinical trial.
Dialysis	Covered Service for hemodialysis and peritoneal services provided by qualified outpatient or inpatient facilities or at home. Covered Service for home dialysis, including equipment and supplies.	
Disposable Medical Supplies (DMS)	Covered Service for disposable medical supplies (DMS) under your durable medical equipment (DME) benefit in limited quantities as follows: 1. DMS such as dressings, casts, splints, and other supplies when applied in the physician's office. 2. DMS such as dressings, casts, splints, and other supplies when applied in your home by a Home Health Provider. 3. DMS that are essential for the correct and effective operation of DME and have a direct medical function. The DME for which the DMS will be utilized must have been Prior Authorized. 4. Support hose, elastic stockings, Jobst and TEDS stockings. ➢ **Note:** The Plan maintains a list of covered DMS. You may contact the Claims Administrator's Customer Service Department for coverage information.	You are not covered for the following: 1. Self-administered dressings, splints, and supplies. 2. Supplies that are typically purchased over-the-counter, such as ACE wraps, elastic supports and other supplies. 3. Products that provide for nutritional needs, including, but not limited to, formula, feeding solutions, and supplements, except that non-prescription and specialized amino acid-based elemental formulas administered either by feeding tube or orally for conditions as specified by Illinois law are covered. 4. Disposable supplies that do not perform a medical function or purpose. 5. Other DMS, such as catheters, electrodes, and filters. 6. Clothing or garments, such as foot coverings, corsets, any elastic joint supports (which are not considered orthopedic appliances), or wigs.

<table>
<tr><th colspan="3">SCHEDULE OF COVERED SERVICES OR SUPPLIES
WHEN DETERMINED TO BE MEDICALLY NECESSARY</th></tr>
<tr><th>SERVICE OR SUPPLY</th><th>CRITERIA AND COVERAGE PROVIDED</th><th>AUTHORIZATION REQUIREMENTS AND LIMITATIONS</th></tr>
<tr><td>Durable Medical Equipment (DME)</td><td>Durable medical equipment (DME) is defined as equipment that meets all four of the following criteria:
1. Is primarily and customarily used to serve a medical purpose;
2. Generally is not useful to a person in the absence of illness or injury;
3. Is designed to withstand repeated use; and
4. Is appropriate for use in the home.
(Examples of DME include, but are not limited to, wheelchairs, hospital beds, oxygen equipment, home ventilators, suctions devices, and crutches.)
Covered Service for DME as follows:
1. Your coverage for DME is limited to the standard model equipment that meets your needs, as determined by the Plan. You may decide to purchase a more advanced model of equipment, but you are responsible for any amount in excess of the charge for the standard model, in addition to applicable co-payments, coinsurance, and Deductibles.
2. You are covered for the professional services for delivery, set-up, fitting, and adjusting of your DME.
3. You are covered for the repair, refitting, and/or replacement of your DME so long as it has been properly maintained and not subjected to abuse or misuse and when not covered by product warranty. The Plan will determine if the DME should be repaired or replaced.
4. Oxygen when Medically Necessary.
➢ Note: The Plan will make the decision whether the DME will be rented or purchased.
➢ Note: The Plan maintains a list of covered DME. You may contact the Claims Administrator’s Customer Service Department for coverage information.</td><td>Prior Authorization required for the purchase of all DME over $250 and all rental equipment.
You are not covered for the following DME:
1. Eyeglasses, contact lenses, and other equipment intended to improve vision, except for the first pair of eyeglasses or contact lenses but not both following cataract surgery.
2. Hearing aids, ear molds, and other equipment intended to improve hearing except that cochlear implants are covered.
3. Equipment for environmental control, such as air conditioners, furnaces or heaters, air filters or purifiers, humidifiers or dehumidifiers.
4. Allergenic pillows or mattresses.
5. Improvements or modifications to your home or place of business.
6. Whirlpool baths.
7. Fitness or exercise equipment.
8. Educational materials, books, videotapes.
9. Repair or replacement of DME due to misuse, neglect or loss.
10. DME which may be used by multiple individuals.
11. Electrical continence aids, either anal or urethral.
12. Convenience or comfort items, including, but not limited to, tub grab bars, raised toilet seats, and seat lifts.
13. Items necessary for the operation of DME that are not directly related to the medical function of the equipment.
14. Replacement items, including, but not limited to, replacement batteries, tires, and light bulbs.
15. Replacements of DME when the device being replaced is one that would continue to meet your basic medical needs as determined by the Plan.
16. Cribs, special strollers, standing frames.
17. Cranial caps and helmets, except for certain diagnoses.
Glucometers will be obtained from Coventry Health Care's National Vendor, when available.
Coverage limited to the standard model equipment that meets your needs, as determined by the Plan. Upgrades to the equipment are your financial responsibility.</td></tr>
<tr><td>Elective Sterilization</td><td>Covered Service.</td><td>Prior Authorization required for place of service other than office.
You are not covered for reversals of voluntary sterilizations.</td></tr>
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SCHEDULE OF COVERED SERVICES OR SUPPLIES WHEN DETERMINED TO BE MEDICALLY NECESSARY		
SERVICE OR SUPPLY	**CRITERIA AND COVERAGE PROVIDED**	**AUTHORIZATION REQUIREMENTS AND LIMITATIONS**
Emergency Services for Emergency Medical Conditions	Covered Service for Emergency Services for the evaluation, treatment and stabilization of accidental Injury or emergency Illness that constitutes an Emergency Medical Condition as that term is defined in the Definitions Section and by Illinois law. Emergency Services are Covered in and outside of the Plan’s Service Area 24 hours a day, 7 days a week by a Provider qualified and licensed to provide those types of services. Emergency Services also include outpatient visits and referrals for emergency mental health problems. Emergency Services do not include post-stabilization services. Once your Emergency Medical Condition has been stabilized and the Emergency no longer exists, you must obtain all further care from Participating Providers in order to receive continued Coverage. More specifically, any follow-up care you receive after you have received emergency room treatment should be obtained from Participating Providers in order to receive Coverage. In the event your condition is not an Emergency Medical Condition, you should contact your primary doctor for advice prior to seeking emergency room treatment. Your primary doctor or a Physician covering for him or her is available 24 hours a day, 7 days a week.	While emergency room visits do not require Prior Authorization, if you are admitted to the Hospital following an emergency room visit, you should notify the Plan within 48 hours of admission, the next business day or as soon as reasonably possible after care begins. You are not covered for the following: 1. Visits to a Hospital emergency room when you do not have an Emergency Medical Condition. (This includes follow-up care provided in an emergency room). 2. Visits to the emergency room for services that are otherwise not covered under the Plan (*e.g.*, non-traumatic dental services). 3. Visits to Hospital emergency rooms to renew prescriptions or remove sutures.
Eyeglasses and Corrective Lenses (Vision Services)	Covered Service for Medically Necessary vision services required for the diagnosis and treatment of diseases of, or injuries to, the eye.	Limited benefit. Prior Authorization may be required. Participants are not covered for the following vision services: 1. Contact lenses, eyeglass frames, corrective lenses, tints, or other lenses, services, or treatments, except when necessary for the first pair of eyeglasses or corrective lenses, but not both, following cataract surgery. 2. Routine refractive examinations to determine visual acuity. 3. The measurement, fitting or adjustment, or polishing of eyeglasses or contact lenses. 4. Vision therapy or orthoptics treatment (eye exercises). 5. Surgery for the correction of a refractive disorder, including, but not limited to: radial keratotomy (RK), astigmatic keratotomy (AK), automated lamellar keratoplasty (ALK), (excimer laser) photorefractive keratectomy (PKR), phototherapeutic keratectomy (PTK) and laser assisted in situ keratomieusis (LASIK).

SCHEDULE OF COVERED SERVICES OR SUPPLIES WHEN DETERMINED TO BE MEDICALLY NECESSARY		
SERVICE OR SUPPLY	**CRITERIA AND COVERAGE PROVIDED**	**AUTHORIZATION REQUIREMENTS AND LIMITATIONS**
Family Planning	Covered Service for outpatient contraceptive service, including consultations, examinations, procedures and medical services, provided on an outpatient basis and related to the use of contraceptive methods (including natural family planning) to prevent an unintended pregnancy. Covered Service also for all outpatient contraceptive devices approved by the Food and Drug Administration, such as intra-uterine devices (IUD's), implants, cervical caps and diaphragms. You have Coverage for outpatient FDA-approved contraceptive drugs and devices purchased through a pharmacy under your prescription drug benefit.	You are not covered for the following: 1. Elective abortions. 2. Emergency room treatment for the sole purpose of receiving the "morning after" pill. 3. Outpatient contraceptive devices and/or drugs not approved by the FDA. 4. Over-the-counter contraceptives (e.g., foams, condoms and spermicidal creams). 5. Reversal of a voluntary sterilization. 6. Costs of any services rendered by a surrogate mother.
Genetic Counseling	Covered Service for genetic counseling and studies that are needed for diagnosis or treatment of genetic abnormalities. ➢ Note: Pursuant to the provisions of the Genetic Information Nondiscrimination Act of 2008 ("GINA"), the Plan will not: adjust premium or contribution amounts on the basis of genetic information; request or require an individual or a family member of such individual to undergo a genetic test; or request, require or purchase genetic information for underwriting purposes.	You are not covered for diagnostic tests and procedures done to detect genetic abnormalities in the absence of either significant symptoms of, or risks for, the genetic disease in question.
Growth Hormone	Covered Service when prescribed by a certified endocrinologist or pediatric endocrinologist and when Medically Necessary for the treatment of Members in specified diagnostic categories who meet applicable criteria. Contact the Plan's Customer Service Department for further information. ➢ **Note:** Growth hormones are not covered under your prescription drug benefit.	
Gynecological Examinations	Covered Service for an annual self-referred well-woman examination by a Provider specializing in obstetrics or gynecology or family practice, including services, supplies and related tests in accordance with the current American Cancer Society guidelines. Includes clinical breast exam, mammogram, and cervical smear or Pap smear test for female Members.	

SCHEDULE OF COVERED SERVICES OR SUPPLIES WHEN DETERMINED TO BE MEDICALLY NECESSARY		
SERVICE OR SUPPLY	**CRITERIA AND COVERAGE PROVIDED**	**AUTHORIZATION REQUIREMENTS AND LIMITATIONS**
Habilitative Services	Habilitative services for children under 19 years of age with a congenital, genetic, or early acquired disorder so long as all of the following conditions are me: 1. a physician licensed to practice medicine in all its branches has diagnosed the child's congenital, genetic, or early acquired disorder 2. the treatment is administered by a licensed speech-language pathologist, audiologist, occupational therapist, physical therapist, physician, nurse, optometrist, nutritionist, social worker or psychologist upon the referral of a physician licensed to practice medicine in all its branches. 3. The initial or continued treatment must be Medically Necessary and therapeutic and not Experimental or Investigational. Habilitative services means occupational therapy, physical therapy, speech therapy and other services prescribed by the member's treating physician pursuant to a treatment plan to enhance the ability of a child to function with a congenital, genetic, or early acquired disorder. A congenital or genetic disorder includes, but is not limited to, hereditary disorders. An early acquired disorder refers to a disorder resulting from illness, trauma, injury, or some other event or condition suffered by a child prior to that child developing functional life skills such as, but not limited to, walking, talking, or self-help skills. Congenital, genetic, and early acquired disorders may include, but are not limited to, autism or an autism spectrum disorder, cerebral palsy, and other disorders resulting from early childhood illness, trauma or injury.	Prior authorization may be required. Coverage for habilitative services shall be subject to other general exclusions and limitations of the policy, including coordination of benefits, participating provider requirements, restrictions on services provided by family or household members, utilization review of health care services, including review of medical necessity, case management, experimental and investigational treatments and other managed care provisions. You are not covered for those services that are solely educational in nature or otherwise paid under state or federal law for purely educational services.

SCHEDULE OF COVERED SERVICES OR SUPPLIES WHEN DETERMINED TO BE MEDICALLY NECESSARY		
SERVICE OR SUPPLY	**CRITERIA AND COVERAGE PROVIDED**	**AUTHORIZATION REQUIREMENTS AND LIMITATIONS**
Health Education	Covered Service includes instructions on achieving and maintaining physical and mental health and preventing illness and injury when provided in your Physician's office.	You are not covered for: 1. Charges and fees associated with health education classes, such as stress management and childbirth education classes. 2. Equipment and supplies to promote health and healthy lifestyles including exercise videos, software and equipment, whirlpools and Jacuzzis. 3. Educational materials, books and videotapes. 4. Membership or fees associated with health clubs, weight loss clinics and fitness programs. 5. Educational services for remedial education, including, but not limited to, evaluation and treatment of learning disabilities, minimal brain dysfunction, cerebral palsy, developmental learning disorders and behavioral training. 6. Educational or psychological testing, unless part of a treatment program for Covered Services.
Hearing Services	Covered Service for Medically Necessary hearing services required for the diagnosis and treatment of diseases of, or injuries to, the ears. Coverage is also provided for: an annual hearing screening if performed by your primary Physician; hearing screenings to determine hearing loss; and newborn screening examinations, any necessary re-screening, audiological assessment and any required follow-up.	Prior Authorization may be required for some services. You are not covered for: 1. Hearing aids, ear molds, and other equipment intended to improve hearing, except that cochlear implants are covered. 2. Hearing aid evaluation, hearing aid repair, reconditioning, supplies or batteries. 4. Digital and programmable hearing devices. 5. Hearing therapy and related diagnostic hearing tests.

SCHEDULE OF COVERED SERVICES OR SUPPLIES WHEN DETERMINED TO BE MEDICALLY NECESSARY		
SERVICE OR SUPPLY	**CRITERIA AND COVERAGE PROVIDED**	**AUTHORIZATION REQUIREMENTS AND LIMITATIONS**
Home Health Care	Covered Service for Medically Necessary home health care and/or home infusion services provided in your home under the following circumstances: 1. The services are provided in lieu of hospitalization or placement in a skilled nursing facility or receiving outpatient services outside the home. 2. You must be homebound because of illness or injury and unable to be reasonably transported for necessary medical care, as determined by the Plan. 3. The services have been ordered by your Provider and are directly related to an active treatment plan of care established by your physician. 4. The services provided must be considered to be specific, effective, and reasonable for the treatment of your diagnosis and physical condition and the most cost-effective approach to care. 5. The services are provided on a part-time, intermittent basis. 6. The services must be delivered by or under the supervision of a registered nurse, licensed healthcare professional, or therapist and provided by a licensed and certified agency. 7. Covered services include nursing care, therapy services, medical and surgical supplies, and FDA-approved prescription drugs furnished by the Home Health Care agency or infusion program that are specific to the delivery of the Home Health Care services. 8. Services consist primarily of caring for the patient. 9. Prior to beginning home health care services, a treatment plan was both reviewed and approved by the Plan. ➢ **Note:** Rehabilitation services provided in the home will be covered under the applicable rehabilitative services sections of this Plan Document and will be subject to the applicable Coinsurance and other costs and limitations as described in your Schedule of Benefits.	You are not covered for the following home health care services: 1. Services that are otherwise not a covered benefit of the Plan. 2. Housekeeping services. 3. Health aid services. 4. Home care that is full-time, continuous or long-term. 5. Services provided by a person who ordinarily resides in your home or is in your immediate family. 6. Custodial care. 7. Services to help meet personal, family or domestic needs.

SCHEDULE OF COVERED SERVICES OR SUPPLIES WHEN DETERMINED TO BE MEDICALLY NECESSARY		
SERVICE OR SUPPLY	**CRITERIA AND COVERAGE PROVIDED**	**AUTHORIZATION REQUIREMENTS AND LIMITATIONS**
Hospice	Covered Service when each of the following criteria has been met: 1. Services are ordered by your Physician; 2. Your physician certifies that your life expectancy is six (6) months or less; 3. The care is palliative in nature; and 4. The care is provided through a licensed hospice care provider approved by the Plan. The services covered under hospice include but are not limited to the following: 1. Coordinated home care; 2. Medical supplies and dressings; 3. Dietary counseling; 4. Consultation and case management services; 5. Medications; 6. Nursing services and physician visits; 7. Occupational and physical therapy; 8. Pain management services; 9. Social and spiritual services; and 10. Respite care services.	In-patient hospice programs require Prior Authorization. The following services are not covered under your hospice benefit: 1. Special nursing services; 2. Confinement not required for pain control or other cute chronic symptom management; 3. Funeral arrangements; 4. Financial or legal counseling, including estate planning or will drafting; 5. Homemaker or caretaker services; 6. Sitter or companion services; 7. House cleaning or household maintenance; 8. Services by volunteers or persons who do not regularly charge for their services; 9. Services rendered by or at the direction of a person residing in the Member's household; 10. Services provided by an agency not licensed to provide the services rendered; 11. Services provided by a licensed pastoral counselor to a member of his or her congregation; 12. Home-delivered meals; 13. Traditional medical services provided for the direct care of the terminal illness, disease or condition; 14. Transportation, including but not limited to Ambulance transportation. Notwithstanding the above, there may be clinical situations where short episodes of traditional care would be appropriate even when the patient remains in the hospice setting. While these traditional services are not eligible for coverage under this hospice care section, they may be Covered Services under another section.

SCHEDULE OF COVERED SERVICES OR SUPPLIES WHEN DETERMINED TO BE MEDICALLY NECESSARY		
SERVICE OR SUPPLY	**CRITERIA AND COVERAGE PROVIDED**	**AUTHORIZATION REQUIREMENTS AND LIMITATIONS**
Hospital Care (Inpatient)	Covered Service for Medically Necessary inpatient Hospital Services, including, but not limited to, the following: 1. Pre-admission testing. 2. Semi-private room and board or specialty units, such as intensive care and coronary care. 3. General nursing care. 4. Lab, X-ray, diagnostic tests, medical treatment, and the administration and processing of whole blood and blood plasma. 5. Use of an operating room and related facilities, including anesthesia. 6. Medical supplies used by you during your inpatient stay. 7. Non-experimental, FDA-approved drugs administered to you during your inpatient stay. 8. Therapy services, including rehabilitative therapy, radiation therapy, and inhalation therapy. 9. Oxygen and its administration. Inpatient Hospital Services are Covered only when they are: a. Medically Necessary; and b. can be safely and/or effectively delivered only within a Hospital inpatient setting; ➢ **Note:** As set forth in other sections of this Certificate, Coverage is also provided for inpatient hospitalization following a mastectomy for a length of time determined to be Medically Necessary and in accordance with protocols and guidelines based on sound scientific evidence and upon evaluation of the patient and the Coverage for and availability of a post-discharge Physician office visit or in-home nurse visit to verify the condition of the patient in the first 48 hours after discharge.	Prior Authorization is required unless the admission is Emergent. Prior Authorization is also required for inpatient specialty care programs, such as rehabilitation, hospice, mental health and substance abuse. Consistent with the Plan's utilization management policies, all Acute care Hospital admissions and continued stays are reviewed for Medical Necessity during the inpatient stay. Coverage is dependent on the establishment of Medical Necessity for the care. If the Hospital stay or any portion thereof is determined not to be Medically Necessary, your Provider and you will be notified that Coverage will cease. In addition, you are not covered for the following inpatient hospital care services: 1. Take-home drugs dispensed prior to your release, whether billed directly or separately by the Hospital. You may have benefits as outlined in a prescription drug Rider, if applicable. 2. Expenses incurred prior to your Effective Date of Coverage or after your Coverage has ended. 3. Private duty nursing, unless the attending physician certifies that such nursing care is Medically Necessary. 4. Hospitalization for the purpose of receiving services, such as Cosmetic surgery, that are not covered under this Certificate. 5. Personal comfort or convenience items, such as, but not limited to, in-hospital television, telephone, guest trays and housekeeping. 6. Private rooms, unless one is determined to be Medically Necessary. (You shall be responsible for the payment of the difference between the private room rate and the semi-private room rate if a private room is requested, and it is not Medically Necessary.) 7. Hospital confinement primarily for diagnostic purposes or related to a surgical operation when suitable outpatient facilities are available or solely on account of a surgical operation scheduled the next day. 8. Hospital confinement for the convenience of the patient or because adequate arrangements are not available at home. 9. Any confinement for which the Member is not legally obligated to pay.

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<tr><td>Immunizations</td><td>Covered Service for preventive childhood and adult immunizations to prevent or arrest the further manifestation of human Illness or Injury. These are Covered according to the Plan's recommended immunization schedule guidelines and the guidelines of the Centers for Disease Control (CDC). Copies of recommended immunization schedules are available upon request. This includes, but is not limited to, influenza shots, shingles vaccines (for Members 60 years of age and older) and human papillomavirus ("HPV") vaccines, when applicable criteria are met.</td><td>You are not covered for:
1. Immunizations which are not approved by the FDA and/or recommended by the CDC or other nationally recognized entities whose role it is to establish eligibility guidelines and recommend preventive guidelines.
2. Immunizations where you do not meet the recommended eligibility guidelines.
3. Immunizations for non-health related reasons, such as for travel, education or employment.
4. Immunizations for unexpected mass immunizations directed at or ordered by public health officials for general population groups.</td></tr>
<tr><td>Infertility</td><td>Covered Service related to the diagnosis and/or treatment of infertility including, but not limited to, in-vitro fertilization, uterine embryo lavage, embryo transfer, artificial insemination, gamete intrafallopian tube transfer, zygote intrafallopian tube transfer, low tubal ovum transfer and injectable medication and infertility drugs.

➢ Note: Infertility shall mean the inability to conceive a child after one (1) year of unprotected sexual intercourse or the inability to sustain a successful pregnancy.

Benefits for in-vitro fertilization, gamete intrafallopian tube transfer or zygote intrafallopian tube transfer procedures will be provided only when:
a. The Covered Person has been unable to attain or sustain a successful pregnancy through reasonable, less costly, medically appropriate infertility treatment;
b. The Covered Person has not undergone four (4) completed oocyte retrievals, except, if a live birth followed a completed oocyte retrieval, two (2) or more oocyte retrievals shall be covered. In no event will more than six (6) oocyte retrievals be covered by this Plan.

In addition, if in-vitro fertilization, gamete intrafallopian tube transfer or zygote intrafallopian tube transfer procedures for the treatment of infertility are received, the procedures must be performed at medical facilities that conform to the American College of Obstetric and Gynecology guidelines for in-vitro fertilization clinics or the American Fertility Society minimal standards for programs of in-vitro fertilization.</td><td>Prior Authorization is required.

You are not covered for:
1. Use of donor egg or sperm or associated costs;
2. Elective termination of pregnancy (embryo or fetus), including selective termination of an embryo;
3. Costs associated with cryopreservation and storage of sperm, oocytes and embryos except for those procedures which use a cryopreserved substance;
4. Sterilization reversals;
5. Surrogate motherhood services and supplies, including, but not limited to, all services and supplies relating to the conception and pregnancy of a Participant acting as a surrogate mother.</td></tr>
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SCHEDULE OF COVERED SERVICES OR SUPPLIES WHEN DETERMINED TO BE MEDICALLY NECESSARY		
SERVICE OR SUPPLY	**CRITERIA AND COVERAGE PROVIDED**	**AUTHORIZATION REQUIREMENTS AND LIMITATIONS**
Injectables	You are covered for injectable pharmaceuticals (including those medications intended to be self-administered) but only if each of the following criteria is met: 1. The injectable pharmaceutical must be Medically Necessary and appropriate for your diagnosis or condition; 2. The injectable pharmaceutical must be FDA-approved and non-experimental; 3. Because of your medical condition, the pharmaceutical can only be administered, or most effectively and appropriately be administered, by an injection, and an appropriate oral alternative drug does not exist; and 4. Your Provider arranges for, and/or provides, the injectable pharmaceutical. ➢ **Note:** To be consistent with changes in medical technology, the Plan maintains a list of covered and non-covered injectable pharmaceuticals and the medical conditions for which they are approved for coverage. Coverage can be verified by calling the Claims Administrator's Customer Service Department. ➢ **Note:** Insulin is also covered under your prescription drug plan.	You are not covered for the following injectables: 1. Drugs related to the treatment of non-covered services. 2. Experimental or investigational drugs or drugs that have not been proven safe and effective for a specific disease or approved for a mode of treatment by the FDA. 3. Certain classes of injectable medications, such as anabolic steroids when used for performance enhancement, immunizations required for travel and injectable contraceptives. 4. Self-administered injectable medications (which may be covered by a separate prescription drug plan, if applicable.)
Laboratory Services	Covered Service for outpatient preventive (*e.g.*, routine laboratory testing or screening in conjunction with well-child and annual adult physical examinations and for colorectal cancer) and diagnostic laboratory tests, services and studies.	You are not covered for the following laboratory services: 1. Laboratory and pathology services that are considered Experimental or Investigational in nature. 2. Laboratory and pathology services that have not demonstrated significant usefulness as recognized by a majority of the national medical community and as published in Peer-Reviewed Medical Literature. 3. Laboratory and pathology services that are not done to evaluate current health problems or symptoms (*e.g.*, premarital blood testing, paternity testing, screening for various conditions in the absence of symptoms or significant risk factors) unless as part of the preventive health guidelines. 4. Laboratory and pathology services done to detect genetic abnormalities in the absence of either significant symptoms of, or risks for, the genetic disease in question. 5. Laboratory and pathology services determined by the Plan to be inappropriate for the delivery to, or screening of, an entire population or subpopulation. Typically, these services or procedures would not have been proven to be of value when applied to a large population or subpopulation.

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<tr><td>Maternity Services</td><td>Covered Service for the following maternity services:
1. Prenatal, natal and postnatal care provided by a licensed physician, certified nurse mid-wife acting under the direction of a licensed physician and/or his or her staff.
2. Clinical preventative services for prenatal care as set forth in the preventive care guidelines.
3. X-rays, laboratory, and other diagnostic tests.
4. Inpatient care, including covered, Medically Necessary operations and special procedures for the mother and the eligible newborn child, up to forty-eight (48) hours following a normal vaginal delivery and up to ninety-six (96) hours following a Caesarean section. Your physician may determine after consultation with you that a shorter length of stay is appropriate. This decision must be made in accordance with the protocols and guidelines developed by the American College of Obstetrics/ Gynecology or the American College of Pediatrics. In the event of a shorter length of stay as described above, coverage shall be provided for a post-discharge visit at your Provider's office or an in-home nurse visit to verify the condition of the infant in the first forty-eight (48) hours after discharge.
5. Coverage is also provided for complications of pregnancy.
➢ Note: Your newborn infant is covered for routine care and Medically Necessary treatment of illness or injury, subject to eligibility requirements and other policy limitations. (See the Eligibility section of this Plan Document for further information).
➢ Note: During your prenatal care, if you are admitted for complications or any medical condition other than your delivery, your inpatient Co-payment or Coinsurance will apply for each admission.</td><td>Notification to the plan is required for a normal delivery and inpatient stay (48 hours for vaginal delivery and 96 hours for a Cesarean section). For stays beyond these time frames, Prior Authorization is required.
You are not covered for the following:
1. Abortions that are directly intended to terminate pregnancy before viability or directly intended to destroy a viable fetus.
2. X-rays, laboratory tests, diagnostic tests, or other procedures that are not Medically Necessary. (Examples include, but are not limited to, testing to determine the sex or paternity of your unborn child, excessive testing for unlikely illness or disease or testing that does not add value to the management of the case).
3. Planned home deliveries.
4. Maternity care delivered by non-physicians, such as doulas.
5. Personal comfort or convenience items.
6. Delivery by Caesarean section scheduled for your convenience and not because it is Medically Necessary.</td></tr>
<tr><td>Medical Complications</td><td>Covered Service for complications arising from Medically Necessary surgery regardless of Plan membership status at the time of surgery.</td><td>Prior Authorization may be required.
You are not covered if the medical complications occurred because you did not follow the course of treatment prescribed by your Provider.
You are also not covered if the medical complications arose from non-covered services, even if the requested service may be Medically Necessary.</td></tr>
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<tr><td>Mental Health/ Substance Abuse Services</td><td>Covered service for the following mental health, alcohol and substance abuse services:
1. Medically Necessary individual outpatient mental health or substance abuse visits to qualified Physicians, duly licensed clinical psychologists or clinical social workers as may be necessary and appropriate for evaluation, short-term treatment and crisis intervention services. Outpatient visits for mental health and substance abuse are covered under the same terms and conditions as outpatient visits for the treatment of physical illness.
2. Treatment in a planned therapeutic treatment program of a hospital or substance abuse treatment facility in which patients with mental health or substance abuse spend days or nights, provided that admission to the program occurs within 72 hours of discharge from hospital confinement or admission for which benefits were available under the Plan.
3. Medically Necessary inpatient mental health or rehabilitation care at an inpatient facility or hospital. Coverage for inpatient hospital services is the same as coverage for non-mental health inpatient services for any other illness, condition, or disorder.
4. Shock therapy treatments.
5. Diagnosis, detoxification and treatment of the medical complications of the abuse of or addiction to alcohol or drugs on either an inpatient or outpatient basis.</td><td>Prior Authorization required for inpatient admissions unless resulting from an Emergency admission. Admissions following an emergency room visit require notification to the Plan. All inpatient admissions are subject to utilization management.

You are not covered for the following mental health services:
1. Care or treatment of marital or family problems; social, occupational, religious, or other social maladjustments; sex therapy; chronic situational reactions; or family retreats. Services for the treatment of those circumstances which are not considered mental illness based on standard diagnostic classifications.
2. Mental health services which are primarily non-medical in nature, including, but not limited to, social work, teaching, Custodial Care and chronic rehabilitative services.
3. Psychiatric or court-ordered evaluations or therapy when related to judicial or administrative proceedings or orders, when employer requested or when required for school.
4. Mental health care in lieu of detention or correctional placement or that is required to be treated in a public facility.
5. Institutional care which is for the primary purpose of controlling or changing your environment.
6. Milieu therapy, biofeedback, behavior modification therapy, sensitivity training, hypnosis, electrohypnosis, electrosleep therapy or electronarcosis.
7. Mental illness resulting from the use of a controlled substance or cannabis in violation of the law.</td></tr>
<tr><td>Morbid Obesity Surgery</td><td>Charges for care, treatment, morbid obesity surgery (or complications from such surgery), services or supplies that are primarily for obesity are not covered, unless caused by an organic condition.</td><td>The following are also not covered:
1. Weight reduction or dietary control.
2. Vitamins
3. Diet supplements
4. Enrollment in health, athletic or similar clubs or exercise programs, whether formal or informal and whether or not recommended by a Physician.</td></tr>
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SCHEDULE OF COVERED SERVICES OR SUPPLIES WHEN DETERMINED TO BE MEDICALLY NECESSARY		
SERVICE OR SUPPLY	**CRITERIA AND COVERAGE PROVIDED**	**AUTHORIZATION REQUIREMENTS AND LIMITATIONS**
Newborn Care	Covered Service for the following newborn care services: 1. Illness or Injury and premature birth. 2. Congenital defects and birth abnormalities and Reconstructive Surgery related to the same, when specific criteria are met. (See Reconstructive Surgery Section for further details). 3. Preventive care for all eligible newborns according to published preventive care guidelines and for them to be tested or screened for phenylketonuria ("PKU") and such other common metabolic or genetic diseases. 4. Newborn hearing screening examinations, any necessary re-screening, audiological assessment and any requisite follow-up. 5. Nursery charges. 6. Routine care of a newborn provided by a Pediatrician while in the Hospital, including circumcision. ➢ **Note:** Coverage for children shall be granted immediately with respect to a newly born child from the moment of birth but is subject to eligibility requirements and other policy limitations. (See the Eligibility section of this Evidence of Coverage (Certificate) for further information).	Some services may require Prior Authorization. Contact the Plan's Customer Service Department for further information.
Nutritional Counseling	Covered Service when provided (1) by a Registered Dietician or Physician and (2) in connection with morbid obesity, diabetes, coronary artery disease and hyperlipidemia.	Limited benefit. You are not covered for: 1. Food or food supplements, including amino acid-based elemental formulas for the diagnosis and treatment of eosinophilic disorders and short bowel syndrome. 2. Nutritional supplements. 3. Health education classes. 4. Non-FDA approved drugs, vitamins, minerals or supplements. 5. Diet pills, diet programs, weight reduction therapy, services, tests, examinations or supplies. 6. Exercise or fitness equipment or other equipment used to promote health or wellness. 7. Gym or fitness club memberships.

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<tr><td>Orthotics and Orthotic Appliances (OA)</td><td>Orthotic or Orthopedic Appliance (OA) is defined as an appliance or device that is used to support, align, or correct an orthopedic deformity or to improve the function of a moving body part. (Examples include orthopedic braces.)

You are covered for Orthotics and Orthopedic Appliances (OA) as follows:
1. Your coverage for OA is limited to the standard model that meets your needs as determined by the Plan. You may decide to purchase a more advanced model, but you will be responsible for any amount in excess of the charge for the standard model, in addition to applicable co-payments, coinsurance, and Deductibles.
2. You are covered for the professional services for the fitting and adjusting your OA.
3. You are covered for the repair, refitting, and/or replacement of your OA so long as it has been properly maintained and not subjected to abuse or misuse and when not covered by product warranty. The Plan will determine if the OA should be repaired or replaced.

➢ Note: The OA must be Medically Necessary.
➢ Note: The Claims Administrator maintains a list of covered OA. You may contact its Customer Service Department for coverage information.
➢ Note: For your applicable coinsurance for OA, please refer to the Durable Medical Equipment benefit listed on your Schedule of Benefits.</td><td>Limited benefit.

You are not covered for the following:
1. Orthopedic shoes (except when an integral part of a lower body brace), diabetic shoes, foot or shoe inserts, shoe lifts, shoe orthotics, special shoe accessories, arch supports, heel lifts, heel cups, heel or sole wedges, heel pads, insoles (whether custom-made or prefabricated) or other similar items.
2. OA where the primary purpose is to allow you to participate in sports and/or recreational activities.
3. Convenience items or model enhancements.
4. Repair or replacement of OA due to misuse, neglect or loss.
5. Replacement of OA when the device being replaced is one that would continue to meet your basic medical needs as determined by the Plan.
6. Over-the-counter items, such as ACE wraps or bandages, elastic supports, finger splints, foot orthotics, braces and the like.</td></tr>
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SERVICE OR SUPPLY	**CRITERIA AND COVERAGE PROVIDED**	**AUTHORIZATION REQUIREMENTS AND LIMITATIONS**
Outpatient Rehabilitative Therapy	Covered Service for speech therapy, physical therapy and occupational therapy outpatient visits directed at improving physical functioning of the Member. The therapy must be delivered by, or under the direct supervision of, a licensed occupational, physical and/or speech therapist, and each of the following conditions must be met: 1. The therapy must be required and Medically Necessary due to a documented medical condition; 2. You must have a loss of function as a result of the medical condition; 3. The therapy must be significantly likely to substantially improve your functional status and result in either improved pain control or quality of life within a period of two (2) months; and 4. The therapy must not be able to be effectively and/or safely provided in a lesser setting (including, but not limited to, a home exercise program or school speech therapy program). Covered Service also for Medically Necessary preventive physical therapy for those diagnosed with multiple sclerosis. For purposes of this section, preventive physical therapy means physical therapy that is prescribed by a Physician licensed to practice medicine in all of its branches for the purpose of treating parts of the body affected by multiple sclerosis, but only where the physical therapy includes reasonably defined goals, including, but not limited to, sustaining the level of function the person has achieved, with periodic evaluation of the efficacy of the physical therapy against those goals. Also, see the Covered Services sections on Autism and Habilitative Services for additional coverage information.	Limited benefit. Please refer to your Schedule of Benefits for benefit maximums. Except as otherwise specifically provided for under the Plan, you are not covered for: 1. Rehabilitative services provided for long-term, chronic medical conditions. 2. Rehabilitative services whose primary goal is to maintain your current level of function, as opposed to improving your functional status. 3. Rehabilitative services whose primary goal is to return you to a specific occupation or job, such as work-hardening or work-conditioning programs. 4. Educational or vocational therapy, schools or services designed to retrain you for employment. 5. Rehabilitative services whose purpose is to treat or improve a developmental/ learning disability or delay or congenital anomalies. 6. Rehabilitation services that are Experimental or have not been shown to be clinically effective for the medical condition being treated. 7. Alternative medical treatment and rehabilitation services, such as holistic medicine, craniosacral therapy, yoga, homeopathy, movement therapy, naturopathy, tai chi chuan, chelation (metallic ion therapy), rolfing, reiki, reflexology, therapeutic touch, massage therapy, herbal therapy, and hypnotherapy. 8. Fees, costs or similar services associated with services that are primarily exercise. Examples include, but are not limited to, membership fees for health clubs, fitness centers, weight loss centers or clinics, or home exercise equipment. 9. Speech therapy or voice training when prescribed for stuttering or chronic hoarseness. 10. Sports-related services designed to affect performance or physical conditioning programs such as athletic training, body-building, exercise fitness, flexibility and diversion.

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SERVICE OR SUPPLY	**CRITERIA AND COVERAGE PROVIDED**	**AUTHORIZATION REQUIREMENTS AND LIMITATIONS**
Outpatient Services	Covered Service for the following outpatient services: 1. Outpatient surgical procedures that are not otherwise excluded from coverage. This includes the use of an operating room and related facilities, including appropriate anesthesia. 2. Treatment for established Illnesses, such as chemotherapy, inhalation therapy, dialysis, and radiation therapy. 3. Other procedures for the diagnosis or treatment of disease or Illness, such as colonoscopy, endoscopy or laparoscopy and intravenous therapy. 4. Medical supplies administered to, or used by, you as part of the provided outpatient services. ➢ **Note:** Outpatient services are Covered only when they can be safely and/or effectively delivered in an outpatient setting. ➢ **Note:** You may also have Coverage for certain outpatient prescription medications under your prescription drug Rider.	Prior Authorization may be required for some services, including outpatient surgical services. You are not covered for the following: 1. Outpatient services that are considered to be Experimental or Investigational. 2. Outpatient services that have not demonstrated significant usefulness in the Peer-Reviewed Medical Literature. 3. Outpatient services otherwise not covered under this Summary Plan Document.
Podiatry	Covered Service for regular foot exams if you have diabetes metabolic or peripheralvascular disease or for Medically Necessary treatment of conditions associated with the foot and ankle.	Prior Authorization may be required. You are not covered for the following: 1. Treatment of corns, calluses or the clipping of toenails, unless at least a part of the nail root is removed unless necessary for the treatment of diabetes metabolic or peripheralvascular disease. 2. Treatment of weak, strained, flat, unstable or unbalanced feet, fallen arches, or chronic foot strain. 3. Metatarsalgia or bunions (except an open cutting operation or procedure). 4. Medical or surgical treatment of onychomycosis (nail fungus) for Cosmetic reasons. Coverage is not excluded for the treatment of nail fungus for Members who have metabolic peripheral vascular disease or diabetes. 5. Foot or shoe inserts and other non-covered orthotic devices. (See the Orthotics section for further information.)

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SERVICE OR SUPPLY	**CRITERIA AND COVERAGE PROVIDED**	**AUTHORIZATION REQUIREMENTS AND LIMITATIONS**
Preventive Services	The Plan has developed a comprehensive list of covered preventive services. That list is published annually and distributed to all participants. You may obtain a copy of that list by contacting the Claims Administrator's Customer Service Department. Examples of types of covered preventive services include the following: 1. Well-baby care from birth to one and routine pediatric health evaluations and immunizations to prevent or arrest further manifestation of human Illness or Injury. 2. Annual health evaluations and immunizations for adults to prevent or arrest further manifestation of human Illness or Injury; periodic physical examinations, medical history, hearing and vision testing provided by your primary doctor in his or her office, routine laboratory testing or screening, cholesterol screening and blood pressure testing. 3. Annual pelvic exam and Pap smear test or cervical smear for women. 4. Surveillance tests for ovarian cancer for females who are at risk for ovarian cancer. 5. Complete and thorough clinical breast exam to check for lumps and other changes for the purpose of early detection and prevention of breast cancer. 6. Screening by low-dose mammography for the presence of occult breast cancer as follows: baseline mammogram for women 35 to 39 years of age; annual mammogram for women 40 years of age or older; mammography at age/intervals considered Medically Necessary for women under 40 having a family history of breast cancer, prior personal history of breast cancer, positive genetic testing or other risk factors; and a comprehensive ultrasound screening of breasts if a mammogram demonstrates heterogeneous or dense breast tissue. 7. Annual digital rectal examination and prostate-specific antigen test for men upon the recommendation of a physician for (a) asymptomatic men age 50 and over; (b) African-American men age 40 and over; and (c) men age 40 and over with a family history of prostate cancer. 8. Colorectal cancer screening and laboratory tests for colorectal cancer in accordance with guidelines on colorectal cancer screening as published by the American Cancer Society or other nationally recognized societies or agencies. 9. Medically Necessary bone mass measurement for the diagnosis and treatment of osteoporosis.	You are not covered for the following preventive services: 1. Unexpected mass immunizations directed or ordered by federal, state or local public health officials for general population groups. 2. Preventive chiropractic services, including, but not limited to, long-term or periodic manipulation of bones or joints, massage therapy, or holistic or alternative medicine. 3. Membership or service fees associated with health clubs, weight loss clinics and fitness programs. 4. Charges and fees for health education classes, such as for stress management and childbirth education. 5. Equipment and supplies to promote health or exercise, including, but not limited to, exercise equipment, videos, software, whirlpools, Jacuzzis, air conditioners, air purifiers, humidifiers, and dehumidifiers. 6. Hearing examinations, except for the treatment and diagnosis of diseases of, or injury to, the ear. 7. Certain services or diagnostic or screening procedures determined by the Plan to be inappropriate for the delivery to, or screening of, an entire population or subpopulation. Typically, these services or procedures would not have been proven to be of value when applied to a large population or subpopulation. 8. Comprehensive preventive clinics or spas.

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<tr><td>Primary Care Services</td><td>You are covered for the following primary care services:
1. Office visits for covered Illness or Injury.
2. Inpatient and outpatient hospital visits for Covered Services and approved stays.
3. Preventive care services and immunizations (provided in accordance with the Preventive Services section of this Plan Document).
4. Covered office diagnostic testing.
5. Surgical procedures for Covered Services.
6. Covered injections and medications administered during an office visit.
7. Hearing and vision screening or testing by your Physician.
➢ Note: Coinsurance or other charges may apply to office visits when you are seen by a Physician, physician assistant, nurse practitioner or nurse.</td><td>You are not covered for the following primary care services:
1. Physical examinations, immunizations, evaluations, or preparation of reports required by third parties and/or not required for health reasons. Examples may include, but are not limited to, services to secure insurance, meet employment requirements, obtain licenses, for foreign travel, to allow participation in recreational activities, or to comply with a court order.
2. Services or charges for which workers compensation is the primary payor.
3. Services, treatments or supplies that are not Medically Necessary for the treatment of an injury or illness or are outside generally accepted health care practice as determined by the Plan.
4. Services, treatments or supplies that are otherwise not a covered benefit under this Plan Document.
5. Telephone, computer or Internet consultations between your provider and you or between your provider and other providers; telephone assessments.
6. Any appointment you did not attend or failed to cancel on a timely basis.</td></tr>
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<tr><td>Prostheses, Prosthetic Appliances and Implants (PA)</td><td>Prosthesis, Prosthetic Appliances and Implant (PA) is defined as an appliance or device that replaces all or part of a body organ, or all or part of the function of a permanently inoperative, absent, or malfunctioning body part. The device may be external to, or implanted surgically into, the body. (Examples include, but are not limited to, artificial limbs, eyes, post-mastectomy prostheses, hips, knees, pacemakers, surgical implants, and lens implants required as a replacement for natural lenses.)

Covered Service for Prostheses, Prosthetic Appliances, and Implants (PA) for the initial purchase of a PA following the onset or initial diagnosis of the condition for which the device is required, subject to the following conditions:
a. The PA, or the repair of the PA, must be prescribed by a Physician.
b. The PA must be custom-fitted for the sole benefit of the Member and must not have any use other than in connection with the use of such device.
c. Your Coverage for PA is limited to the PA which meets the minimum requirements or specifications Medically Necessary for treatment.
d. Your Coverage for PA is also limited to the basic functional device which will restore the lost body function or part that meets your needs as determined by the Plan. You may decide to purchase a more advanced model, but you will be responsible for any amount in excess of the charge for the standard model, in addition to applicable Coinsurance and Deductibles.

You are also Covered for the following PA:
1. The professional services for fitting and adjusting your PA.
2. The repair, refitting, and/or replacement of your PA which becomes non-functional or non-repairable due to normal, routine wear and tear. Your PA must have been properly maintained and not subjected to abuse or misuse and when not covered by product warranty. The Plan will determine if the PA should be repaired or replaced.
3. Ostomy supplies in limited quantities for patients that are colostomy or illiostomy status.

➢ Note: The Plan maintains a list of covered PA. You may contact the Claims Administrator’s Customer Service Department for coverage information.
➢ Note: Please refer to other specific subject headings in this Schedule of Covered Services (such as Breast-Related Services) for Coverage of specific items.</td><td>You are not covered for the following:
1. Eyeglasses, contact lenses, and other equipment intended to improve vision (except for the first pair of eyeglasses or contact lenses, but not both, following cataract surgery).
2. Hearing aids, ear molds, and other equipment intended to improve hearing (except cochlear implants are covered).
3. Dentures; dental implantology techniques, including prosthetic devices related to such techniques.
4. Implants for Cosmetic purposes.
5. Wigs, hair-pieces or prostheses, toupees, hair transplants and/or other equipment or supplies for the treatment of the loss of hair.
6. Prosthetic devices that are non-durable, such as support garments, clothing and like items.
7. Repair or replacement of PA due to misuse, neglect or loss.
8. Replacement of PA when the device being replaced is one that would continue to meet your basic medical needs as determined by the Plan.</td></tr>
</table>

SCHEDULE OF COVERED SERVICES OR SUPPLIES WHEN DETERMINED TO BE MEDICALLY NECESSARY		
SERVICE OR SUPPLY	**CRITERIA AND COVERAGE PROVIDED**	**AUTHORIZATION REQUIREMENTS AND LIMITATIONS**
Pulmonary Rehabilitation Therapy	Covered Service when delivered in an approved, hospital-based pulmonary rehabilitation program under the direct supervision of a licensed therapist or pulmonologist, and each of the following conditions has been met: 1. The pulmonary rehabilitation must be required and Medically Necessary due to a documented pulmonary (lung) condition; 2. You must have a loss of function as a result of the pulmonary condition; 3. The pulmonary rehabilitation must be significantly likely to substantially improve your functional status and result in either improved symptom control or quality of life within a period of two (2) months; and 4. The pulmonary rehabilitation must not be able to be effectively and/or safely provided in a lesser setting.	You are not covered for: 1. Rehabilitative services provided for long-term, chronic medical conditions. 2. Rehabilitative services whose primary goal is to maintain your current level of function, as opposed to improving your functional status. 3. Rehabilitative services whose primary goal is to return you to a specific occupation or job, such as work-hardening or work-conditioning programs. 4. Educational or vocational therapy, schools or services designed to retrain you for employment. 5. Rehabilitation services that are Experimental or have not been shown to be clinically effective for the medical condition being treated. 6. Alternative rehabilitation services (*e.g.,* massage therapy). 7. Fees or costs associated with services that are primarily exercise. Examples include, but are not limited to, membership fees for health clubs, fitness centers, weight loss centers or clinics, or home exercise equipment.
Radiology	Covered Service for diagnostic radiology procedures, such as X-rays, MRI's, CT scans and PET scans.	You are not covered for the following radiology services: 1. Radiology services that are considered Experimental or Investigational in nature. 2. Radiology services that have not demonstrated significant usefulness as recognized by a majority of the national medical community and as published in Peer-Reviewed Medical Literature. 3. Radiology services that are not done to evaluate current health problems or symptoms (*e.g*., screening for conditions in the absence of symptoms or significant risk factors) unless as part of the preventive health guidelines. 4. Radiology services done to detect genetic abnormalities in the absence of either significant symptoms of, or risks for, the genetic disease in question. 5. Radiology services determined by the Plan to be inappropriate for the delivery to, or screening of, an entire population or subpopulation. Typically, these services or procedures would not have been proven to be of value when applied to a large population or subpopulation.

SCHEDULE OF COVERED SERVICES OR SUPPLIES WHEN DETERMINED TO BE MEDICALLY NECESSARY		
SERVICE OR SUPPLY	**CRITERIA AND COVERAGE PROVIDED**	**AUTHORIZATION REQUIREMENTS AND LIMITATIONS**
Reconstructive Surgery	Covered Service for the following types of reconstructive surgery: 1. Reconstructive surgery performed to correct a seriously disfiguring condition resulting from accidental injury or injury: a. A functional defect must also exist, and the disfiguring condition must have a major effect on your appearance. b. The reconstructive surgery must be started within one (1) year of the accidental injury and must be completed within two (2) additional years, unless delay is directly related to Medically Necessity. c. The condition must reasonably be able to be corrected by surgery. 2. Reconstructive surgery performed to correct a seriously disfiguring condition resulting from surgery: a. The injury must occur as a result of a surgical procedure that is otherwise a covered benefit under this Plan Document. b. A functional defect must also exist and the disfiguring condition must have a major effect on your appearance. c. The reconstructive surgery must be started within one (1) year of the surgery which results in a seriously disfiguring condition and must be completed within two (2) additional years, unless delay is directly related to Medical Necessity. d. The condition must reasonably be able to be corrected by surgery. 3. Reconstructive surgery performed on a covered child to correct a seriously disfiguring condition resulting from a congenital disease or anomaly. a. The disfiguring condition must have a major effect on your child's appearance. b. The reconstructive surgery must be started within one (1) year of birth or delayed for medical reasons documented in the first year of life, until a later age. Reconstruction must be completed within five (5) additional years. c. The condition must reasonably be able to be corrected by surgery. See also Breast Reconstruction for benefits for breast reconstruction surgery following a mastectomy.	Prior Authorization is required. You are not covered for the following: 1. Any surgery from which no significant improvement in physiologic function could be reasonably expected or that does not meaningfully promote the proper function of the body or prevent or treat Illness or disease or is done primarily to improve the appearance or diminish an undesirable appearance of any portion of the body. 2. Any medical or surgical treatment, drug or hospitalization for plastic or Cosmetic surgery and/or which is undertaken to improve your appearance. 3. Pharmacological regimens, plastic surgery and non-Medically Necessary dermatological procedures, 4. Procedures, services and supplies related to sex transformation operations regardless of any diagnosis of gender role disorientation or psychosexual orientation; hormonal support for sex transformation is also excluded. 5. Reconstructive Surgery that occurs after your Coverage is no longer effective under the Plan, whether or not the surgery has been Prior Authorized. 6. The removal of benign skin lesions, growths, or skin tags primarily for Cosmetic purposes. 7. Surgery to remove excess skin, including pannus, and services of a similar nature resulting from morbid obesity surgery or severe weight loss.
Second Surgical Opinion	Covered Service for a second medical opinion from or consultation with another Participating Provider in order to determine if a recommended treatment, surgery, service or supply is Medically Necessary. The second opinion will be at no additional cost to you beyond what you would otherwise pay for an initial medical opinion or consultation.	No Prior Authorization required.

SCHEDULE OF COVERED SERVICES OR SUPPLIES WHEN DETERMINED TO BE MEDICALLY NECESSARY		
SERVICE OR SUPPLY	**CRITERIA AND COVERAGE PROVIDED**	**AUTHORIZATION REQUIREMENTS AND LIMITATIONS**
Sexual Assault or Abuse	You are covered for emergency medical services, including care for injury and trauma, sustained as a victim of sexual assault or sexual abuse or an attempt to commit such offense. Covered Services include, but are not limited to, examination and testing to establish whether sexual contact occurred and the presence or absence of a sexually transmitted disease or infection; and examination and treatment of injury and trauma sustained as a victim of such offense. Coinsurance for services received in the emergency room for sexual assault or abuse will be waived if you are a victim of such offense.	No Prior Authorization required.
Skilled Nursing Facility Services	Covered Service for services, including room and board in a semi-private accommodation, provided at an institution operated as a skilled nursing facility to restore the health of a sick or injured Member under the care and supervision of a Physician, but only if the following conditions have been met: 1. The services must be provided at a facility licensed by the State of Illinois and approved as a Skilled Nursing Facility under the Medicare Program and the Plan; and 2. The medical services delivered must be required to be provided by a licensed professional health personnel (*i.e.*, registered nurse or licensed physical therapist); and 3. The required medical services cannot be consistently and safely provided in a less intense setting (*i.e.*, at home or in a custodial nursing home); and 4. The medical care is required on a daily basis (at least five (5) days per week); and 5. The medical care is actually received by you; and 6. At least one of the following is a goal of the skilled nursing care: a) Your medical condition requires services to be provided or supervised by a professional to meet your needs, promote recovery, and ensure your medical safety following debilitation as a result of a prolonged Acute or chronic Illness. The services must be: i. temporary in nature; and ii. lead to rehabilitation and increased ability to function; and iii. not intended only to maintain your current level of functioning; and iv. You must continue to have documented improvement in your function during the course of your stay. b) Your medical condition requires teaching and training from skilled nursing or rehabilitation personnel on how to manage a treatment regimen. c) Even if the prognosis for your medical condition is such that partial recovery is not possible, a skilled service or nursing assessment and intervention is needed to alleviate pain or treat Acute symptoms.	Limited benefit. Prior Authorization is required. Please refer to your Schedule of Benefits for visit limits and/or benefit maximums. You are not covered for the following: 1. Custodial, convalescent, or domiciliary Care in a Hospital, skilled nursing facility, or any other facility. This includes care that assists Members in the activities of daily living, like walking, getting in and out of bed, bathing, dressing, feeding and using the toilet. 2. Charges for services or supplies which are for the primary purpose of controlling or changing your environment or providing you with a rest cure or respite care. 3. Private duty nursing, except when the attending physician certifies that such nursing care is Medically Necessary. 4. Private inpatient room, unless Medically Necessary or if a semi-private room is unavailable. 5. Take-home drugs dispensed prior to your release from the skilled nursing facility. 6. Preparation of special diets and supervision of medication that is usually self-administered regard-less of who orders the services. 7. Personal comfort or convenience items or services such as television, telephone, barber or beauty service, guest service and similar incidental services and supplies. 8. Services and supplies which are otherwise not a Covered Benefit under this Evidence of Coverage. 9. Charges in connection with treatments or medications where you are either non-compliant with or are discharged from a Hospital or skilled nursing facility against medical advice.
Sleep Studies	Covered Service for referral to a pulmonologist or ENT for an evaluation and for a sleep study to diagnose and treat sleep disorders.	You are not covered for the following: 1. Sleep studies provided within the home. 2. Alternative therapies, such as sleep therapies.

SCHEDULE OF COVERED SERVICES OR SUPPLIES WHEN DETERMINED TO BE MEDICALLY NECESSARY		
SERVICE OR SUPPLY	**CRITERIA AND COVERAGE PROVIDED**	**AUTHORIZATION REQUIREMENTS AND LIMITATIONS**
Specialty Care Services	Covered Service for the following specialty care services which are beyond the scope of services provided by your primary Physician: 1. Office visits for Covered Illness or Injury. 2. Inpatient and outpatient Hospital visits for Covered Services and approved stays. 3. Preventive care services and immunizations (provided in accordance with the Preventive Services section of this Summary Plan Document). 4. Covered office diagnostic testing. 5. Surgical procedures for Covered Services. 6. Covered injections and medications administered during an office visit. ➢ **Note:** Coinsurance will apply to office visits when you are seen by a Specialty Care Physician, or a covering Physician, physician assistant, nurse practitioner or nurse.	You are not covered for the following specialty care services: 1. Specialty care services that are redundant or duplicative. 2. Specialty services, treatments or supplies that are not Medically Necessary for the treatment of an injury or illness or are outside generally accepted health care practice. 3. Specialty services, treatments or supplies that are otherwise not a Covered Benefit under other sections of this Plan Document. 4. Physical examinations, immunizations, evaluations, or preparation of reports required by third parties and/or not required for health reasons. Examples may include, but are not limited to, services to secure insurance, meet employment requirements, obtain licenses, for foreign travel, to allow participation in recreational activities, or to comply with a court order. 5. Services or charges for which workers compensation is the primary payor. 6. Telephone, computer or Internet consultations between your Provider and you or between your Provider and other Providers; telephone assessments. 7. Services performed by an assistant surgeon in connection with a surgical procedure are subject to applicable limitations. 8. Any appointment you did not attend or failed to cancel on timely basis.
Substance Abuse Services	See Covered Services Section for Mental Health/Substance Abuse Services for further information regarding this coverage category.	
Temporomandibular Joint Dysfunction and Related Disorders	Covered Service for the diagnosis and treatment of temporomandibular joint dysfunction (TMJ). Covered services include diagnostic services, orthopedic devices, adjustments to devices and therapeutic injections into the temporomandibular joing.	Limited benefit. Prior Authorization may be required. Please refer to your Schedule of Benefits for benefit maximums.

SCHEDULE OF COVERED SERVICES OR SUPPLIES
WHEN DETERMINED TO BE MEDICALLY NECESSARY

SERVICE OR SUPPLY	CRITERIA AND COVERAGE PROVIDED	AUTHORIZATION REQUIREMENTS AND LIMITATIONS
Transplants	Covered Service for Physician, Hospital, surgical and medical services for evaluation for organ and tissue transplant as well as organ or tissue procurement, acquisition, harvesting, transplantation and storage, under the following conditions: 1. The organ or tissue transplant must be Medically Necessary and the most appropriate treatment for your medical condition. 2. The transplant must be needed to aid the function of a body organ or replace tissue lost due to Illness or Injury. 3. The transplant must be provided from a human donor to living human recipient. 4. The organ or tissue transplant must not be Experimental or Investigational in nature. 5. The organ or tissue transplant must have a high likelihood of success in treating your medical condition long term. 6. The organ or tissue transplant must be performed at a Coventry Transplant Network Participating facility approved by the Plan to perform that specific organ or tissue transplant. Donor screening tests are also Covered when performed at a Coventry Transplant Network Participating facility approved by the Plan. ➢ **Note:** when both the donor and recipient are Covered by the Plan, each is entitled to benefits. ➢ **Note:** when only the recipient is Covered by the Plan, the donor's benefits for care and complications will be limited to those not available to the donor from any other source, be charged against the recipient's Coverage under the Plan and will last only for the duration of the Coverage of the recipient when approved by the Plan. ➢ **Note:** when only the donor is Covered by the Plan, the cost of any care, including complications, arising from an organ donation is excluded for both donor and recipient.	Prior Authorization is required. **Transplant services must be performed at a Coventry Transplant Network Participating facility. You do not have any out-of-network coverage for transplants.** You are not covered for the following: 1. Animal transplants or transplants that involve artificial or mechanical devices designed to replace human organs. 2. Organ or tissue transplants which are considered to be Experimental or Investigational or not considered to be clinically acceptable. 3. Organ donor treatment or services, including the treatment of surgical or medical complications of the organ or tissue procurement process, where you serve as the organ donor and the recipient is not covered under the Plan. 4. Organ and tissue procurement, evaluation and transplantation provided by a Provider not Participating in the Coventry Transplant Network.
Urgent Care Services	Covered Service for care for an unexpected Illness or Injury that does not qualify as an Emergency Medical Condition but requires prompt medical attention when provided at an alternate facility, such as an Urgent Care center, after hours facility or convenient care clinic. Some examples of cases involving Urgent Care include but are not limited to: • High fever; • Non-severe bleeding; • Sprains Your primary Physician can help you determine whether your condition is urgent and/or whether you need to receive care at an alternate facility.	Your applicable coinsurance for Urgent Care services will depend upon whether you receive Urgent Care services at an urgent care division of a Hospital or at a convenient care clinic.

6.7 Exclusions and Limitations:

The items and expenses listed below are excluded from Coverage by the Plan. Therefore, no payment will be made by the Plan for any of the following items or expenses:

1. **Abortions** – elective abortions, and the complications thereof, are not covered.
2. **Allergy services –** those non-physician allergy services or associated expenses relating to an allergic condition, including, but not limited to, installation of air filters, air purifiers, air ventilation system cleaning, carpet cleaning, treatment of environmental factors such as mold, hypo-allergenic pillows, mattresses and blankets, allergy drops and allergy treatment by a chiropractor.
3. **Alternative therapies** – alternative therapies, including, but not limited to, holistic, homeopathic or naturopathic care, aroma or massage therapy, acupressure, milieu, recreational, wilderness, educational, music, or sleep therapies, biofeedback (except in limited circumstances), ecological or environmental medicine, ayurveda and ayruvedic nutrition, craniosacral therapy, yoga, aquatic classes, movement therapy tai chi chuan, visualization sessions and other programs with an objective to provide complete personal fulfillment or harmony, chelation (metallic ion) therapy, rolfing, reiki, reflexology, therapeutic touch, colon therapy, herbal or vitamin therapy and hypnotherapy or hypnosis, any treatment that is provided to enhance the life style of a person without treating an Injury or Illness.
4. **Ambulance service** – Non-emergency and non-medically appropriate ambulance services, regardless of who requested the services, including ambulance transport due to the absence of other transportation for the Member; charges for general travel to and/or from a healthcare Provider or facility; routine transportation; transportation for outpatient care; travel out of the U.S. when the travel is for the sole purpose of obtaining medical care.
5. **Autopsies** – services and associated expenses related to the performance of autopsies.
6. **Behavior modification** – those behavioral or educational disorder services and associated expenses related to confirmation of diagnosis, progress, staging or treatment of: behavioral conduct problems, ADD, ADHD, oppositional defiant disorder, learning disabilities, developmental delay, mental retardation, anoxic birth injuries, birth defects, cerebral Injury, non-Acute head injuries or cerebral palsy, except as otherwise specifically covered herein.
7. **Biofeedback** - unless as part of the treatment for fecal/urinary incontinence.
8. **Blood** – the cost of whole blood and blood products replacement to a blood bank; services and related expenses for personal blood storage, unless associated with a scheduled surgery; administration costs related to the procurement, processing and storage of blood from a designated donor; and

fetal cord blood harvesting and storage.

9. **Charges** – charges resulting from the failure to appropriately cancel a scheduled appointment or in connection with treatments or medications where the Member is either non-compliant or is discharged from a facility against medical advice; charges for non-healthcare related items, such as shipping charges, copying charges and postage; charges for copying of medical records; charges for chart reviews and other assessments where the Member is not physically present; charges for services or supplies which are not otherwise specifically stated to be a Covered benefit in this Plan Document; charges for services or supplies provided before or after the Member's Effective Date of Coverage; charges for services or supplies that are prohibited by federal, state or local law; charges for services or supplies that have not been prescribed or ordered by a Physician; charges for lost or stolen items, such as durable medical equipment or injectable medications; services or supplies for which no charge is made or for which no payment would have been made absent this Coverage.

10. **Chiropractic services –** chiropractic services not otherwise defined as a Covered benefit in the Schedule of Covered Services; spinal manipulations for all non-musculoskeletal diseases and injuries or musculoskeletal disorders that are not improved with short-term chiropractic care, except as otherwise specifically Covered herein.

11. **Clinical trials –** any product, service or supply that is the subject of a clinical trial that meets criteria for Phase I, II or III as set forth by FDA regulations, except as specifically Covered herein.

12. **Cosmetic services** – those services, associated expenses and the complications resulting from Cosmetic services or surgeries that alter or improve physical appearance but do not correct or materially improve a physiological function and are not Medically Necessary for the prompt repair of accidental Injury or Illness or to improve the function of a congenital anomaly. These services include, but are not limited to, pharmacological regimens, plastic surgery, rhinoplasty, Cosmetic procedures, non-Medically Necessary dermatological procedures, implantation and/or removal of breast implants for Cosmetic or other non-covered reasons, even if the implant removal is considered Medically Necessary; breast enhancement or augmentation mammoplasty; breast reduction or reconstruction for male gynecomastia; removal of benign skin lesions, growths (such as warts) or skin tags; anti-aging services; salabrasion, chemosurgery, laser surgery or other skin abrasion procedures associated with the removal of scars, tattoos or actinic changes; services for the treatment of acne scarring; elective or voluntary enhancement procedures, services and medications (growth hormones and testosterone), such as weight loss, hair growth, sexual performance, athletic performance; however, Reconstructive Surgery and expenses mandated by the Women's Health and Cancer Rights Act of 1998 are Covered.

13. **Counseling** – services and treatment related to religious counseling, marital or relationship counseling, vocational or employment counseling and sex counseling or therapy.

14. **Court-ordered services** –court-ordered services or services that are a

condition of probation or parole.

15. **Custodial Care** – Custodial, convalescent, sanitarium, extended care facility charges or domiciliary care, respite care or rest care. This includes care that assists Members in the activities of daily living, like walking, getting in and out of bed, bathing, dressing, feeding, and using the toilet; preparation of special diets and supervision of medication that is usually self-administered, regardless of who orders the services.
16. **Dental services** – dental services provided by a Doctor of Dental Surgery ("DDS"), a Doctor of Medical Dentistry ("DMD") or a Physician licensed to perform dental-related oral surgical procedures, including, but not limited to general and preventive dental services (fillings, root canals, crowns, bridges, dentures, dental X-rays and other routine dental care), services for overbite or underbite, dental splints, supplies, appliances (including occlusal splints/orthodontia), orthodontia and related services; dental implants and dental implantology techniques, including prosthetic devices related to such techniques, dental prostheses, treatment of pain or infection known or thought to be due to a dental cause or in close proximity to the teeth or jaw, gum disease such as peridontitis and gingivitis; prescription medication written by a dentist or Physician for the purpose of treating a dental condition; dental care delivered during the treatment of accidental injury to sound natural teeth that is not related to the accidental injury.
17. **Dental or oral surgery**. - surgical or non-surgical removal of wisdom teeth or impacted teeth; removal, replacement, repair, artificial restoration of the teeth (either natural or artificial); removal of teeth as a complication of or in preparation for radiation therapy or as a result of radionecrosis; dental implants; services related to surgery for cutting through the lower or upper jaw bone, removal of dentiginous cysts, mandibular tori and odontoid cysts; surgical correction of malocclusion of the teeth and/or jaw, such as maxillofacial, orthognathic and prognathic surgery; orthodontic correction of tooth alignment or malocclusion; dental related oral surgical services to correct an overbite or underbite.
18. **Diagnostic tests** – diagnostic tests, laboratory tests and procedures that are considered to be Experimental or Investigational; that have not demonstrated significant usefulness as recognized by a majority of the national medical community and as published in Peer-Reviewed Medical Literature; that are not done to evaluate current health problems or symptoms; that are done to detect genetic abnormalities in the absence of either significant symptoms of or risks for the genetic disease in question; that are inappropriate for the delivery to or screening of an entire population or subpopulation; prophylactic procedures to prevent a sickness that has not yet occurred.
19. **Disposable medical supplies** – self-administered dressings, splints and supplies; supplies that are typically purchased over the counter, such as ACE wraps, elastic supports and other supplies; supplies that do not perform a medical function; filters; paper or fabric face masks, irrigating kits; clothing and garment items, such as foot coverings, corsets and any elastic joint supports (which are not considered orthopedic appliances).

20. **Durable medical equipment –** equipment for environmental control, such as air conditioners, furnaces, heaters, heat lamps, room heaters; air filters or air purifiers, humidifiers or dehumidifiers; improvements or modifications to a home or place of business; whirlpool baths; fitness or exercise equipment; repair or replacement of durable medical equipment due to misuse, neglect or loss; durable medical equipment which may be used by multiple individuals; electrical continence aids, either anal or urethral; convenience or comfort items, such as tub grab bars and raised toilet seats; items necessary for the operation of the durable medical equipment that are not directly related to the medical function of the equipment; replacement items, such as batteries, tires and light bulbs; replacement of the durable medical equipment when the existing one continues to meet basic medical needs; vans and van lifts; cribs, special strollers, standing frames; cranial caps and helmets, except in limited circumstances; electronically controlled cooling compression therapy devices (such as polar ice packs, Ice Man Cool Therapy, water circulation cold pads with pumps or Cryo-cuff); home traction units.
21. **Education –** educational materials, books, videotapes; educational testing or training; vocational testing or training; educational services for remedial education, such as evaluation or treatment of learning disabilities, minimal brain dysfunction, cerebral palsy, mental retardation, developmental and learning disorders and behavioral training; health education classes, such as risk-factor modification, smoking cessation, stress management and childbirth education classes.
22. **Emergency –** visits (including follow-up care) to a Hospital emergency room when no Emergency Medical Condition exists (*e.g*., remove sutures, renew prescriptions); care at an emergency room for non-covered services (such as dental conditions).
23. **Examinations –** physical, psychiatric, educational or psychological examinations or testing (unless part of a treatment program for a Covered Service), vaccinations, immunizations or treatments when such services are for purposes of obtaining, maintaining or otherwise relating to career, camp, sports, education, travel, employment, insurance, licensing, adoption, premarital, marital or those ordered by a third party; exams directed or requested by a court of law.
24. **Exercise –** exercise or fitness equipment or supplies or equipment used to promote health and fitness; exercise videos, software and equipment; membership or fees associated with health and athletic club memberships, weight loss clinics and fitness programs; services for weight control or weight reduction; dietary consultations or programs; body composition or underwater weighing procedures; exercise therapy weight control or reduction programs; hot tubs, steam rooms, swimming pools and saunas.
25. **Experimental or Investigational –** any procedure or treatment that are determined to be Experimental or Investigational as that term is defined herein.
26. **Eyes -** contact lenses, eyeglass frames, corrective lenses, tints or other lenses, services or treatments, except for the first pair of eyeglasses or corrective lenses (but not both) following cataract surgery; contact lenses

except for bandage contact lenses for the treatment of keratoconus; refractive eye examinations; measurement, fitting, adjustment or polishing of eyeglasses and contact lenses; eye exercises, video equipment, vision therapy (orthoptics), radial keratotomy, astigmatic keratotomy, automated lamellar keratoplasty, photorefractive keratectomy, phototherapeutic keratectomy and laser assisted in situ keratomieusis and similar surgeries for the correction of a refractive disorder and other equipment intended to improve vision.

27. **Family planning –** outpatient contraceptive drugs and devices not approved by the FDA; over-the-counter contraceptives, such as foams, condoms, and spermicidal creams; reversal of a voluntary sterilization; payment for services rendered to a surrogate.
28. **Food or food supplements -** products that provide nutritional needs, such as formulas, feeding solutions and supplements, vitamins and dietary foods and programs.
29. **Foot care –** foot care, including the treatment of weak, strained, flat, unstable or unbalanced feet, fallen arches or chronic foot strain; metatarsalgia or bunions (except open cutting operations); treatment of corns, calluses or toenails (except in the treatment of diabetes or metabolic or peripheralvascular disease); foot or shoe inserts or other non-covered orthotic devices.
30. **Genetic counseling –** genetic testing and counseling done to detect genetic abnormalities in the absence of either significant symptoms of or risks for the genetic disease in question.
31. **Hair care –** services relating to the analysis of hair unless used as a diagnostic tool to determine poisoning; hairstyling, hairpieces, hair transplants and hair prostheses or wigs; treatment of hair loss or alopecia, including drugs and treatments to promote hair growth, whether or not prescribed by a Physician.
32. **Hearing –** hearing aids, ear molds, and other equipment intended to improve hearing, except that cochlear implants are covered; hearing aid evaluation; hearing aid repair, reconditioning, supplies or batteries; digital and programmable hearing devices; hearing therapy and related diagnostic hearing tests.
33. **Home health –** housekeeping, house cleaning or household maintenance services; health aid services; home care that is full-time, continuous or long-term; services provided by a relative of the Member or who ordinarily resides in the home of the Member; Custodial Care; services to help meet personal, family or domestic needs; homemaker or caretaker services; sitter or companion services; services by volunteers or persons who do not regularly charge for their services; services provided by an agency not licensed to provide the services rendered.
34. **Hospitalization –** hospitalization for the purpose of receiving non-covered services or primarily for diagnostic purposes or related to a surgical operation when suitable outpatient facilities can be safely utilized; hospitalization solely because of a surgical procedure scheduled the next day; Hospital confinement for the convenience of the patient or because adequate arrangements are not available at home; any confinement for

which the Member is not legally obligated to pay; personal comfort or convenience items, such as television, telephone, guest trays and housekeeping services; private rooms, unless one is determined to be Medically Necessary; take home drugs; charges for services or supplies provided before or after your Effective Date of Coverage.

35. **Illegal acts –** Any expenses for medical services or supplies for the treatment of Illness or Injury arising out of the commission or attempt to commit a Serious Illegal Act. For purposes of this section, a Serious Illegal Act shall mean any act or series of acts that, if prosecuted as a criminal offense, a sentence to a term of imprisonment in excess of one (1) year could be imposed. It is not necessary that criminal charges be filed or that a sentence of imprisonment for a term in excess of one (1) year actually be imposed. This exclusion does not apply if the Injury or Illness resulted from an act of domestic violence or a Covered medical (including both physical and mental health) condition. It also does not apply if the expenses were incurred as a result of and related to an Injury or Illness acquired while the Member is intoxicated or under the influence of any narcotics, regardless of whether the intoxicant or narcotic is administered on the advice of a health care practitioner.
36. **Immunizations –** immunizations which are not approved by the FDA and/or recommended by the CDC or other nationally recognized entity whose role it is to establish eligibility guidelines and recommend preventive guidelines; immunizations where the recommended eligibility guidelines are not met; immunizations for non-health related reasons, such as for travel, education or employment; immunizations for unexpected mass immunizations directed at or ordered by public health officials for general population groups.
37. **Infertility –** use of donor egg or sperm or costs associated with an egg or sperm donor; selective termination of an embryo or fetus (provided, however, that where the life of the mother would be in danger were all embryos to be carried to full term, said termination shall be covered); costs associated with cryo preservation and storage of sperm, eggs and embryos; reversals of voluntary sterilization; surrogate motherhood services and supplies, including, but not limited to, all services and supplies relating to the conception and pregnancy of a participant acting as a surrogate mother.
38. **Injectables –** injectable medications that are related to the treatment of a non-covered service or are Experimental or Investigational; injectable medications, such as anabolic steroids, when used for performance enhancement.
39. **Learning disabilities –** treatment for disorders relating to learning, motor skills, communication, and pervasive developmental conditions, such as autism and autism related disorders, except as otherwise specifically Covered herein.
40. **Maternity services –**X-rays, laboratory tests, diagnostic tests or other procedures that are not Medically Necessary; planned home deliveries; doulas; delivery by Caesarean section scheduled for the convenience of the Member and not because it is Medically Necessary.
41. **Medical complications –** medical complications that arose from a non-

covered service, even if the requested service is Medically Necessary; medical complications which occurred because the Member did not follow the course of treatment prescribed by the Physician.

42. **Medical Necessity –** any procedure, service or supply that is determined not to be Medically Necessary, as that term is defined herein: those services, supplies, equipment and facility charges that are provided to a Member, not excluded under this Agreement and are determined by the Plan to be:

    a. Medically appropriate, so that the expected health benefits (such as but not limited to increased life expectancy, improved functional capacity, prevention of complications, relief of pain) exceed the expected health risks;

    b. Necessary to meet your health needs, improve physiological function and required for a reason other than improving appearance;

    c. Rendered in the most cost-efficient manner and setting appropriate for the delivery of the service;

    d. Consistent in type, frequency and duration of treatment with scientifically-based guidelines of national medical research, professional medical specialty organizations or governmental agencies that are accepted as national authorities on the services, supplies, equipment or facilities for which Coverage is requested;

    e. Consistent with the diagnosis of the condition at issue;

    f. Required for reasons other than your comfort or the comfort and convenience of your Physician; and

    g. Of demonstrated value based on clinical evidence reported by Peer-Reviewed Medical Literature and by generally recognized academic medical experts; not Experimental or Investigational as determined by the Plan under the Plan's Experimental Procedures Determination Policy.

43. **Mental health -** care or treatment of marital problems; social, occupational, religious, or other social maladjustments; sex therapy; chronic situational reactions; or family retreats; services for the treatment of those circumstances which are not considered mental illness based on standard diagnostic classifications; any form of therapy or treatment for mental retardation and/or developmental and/or learning disabilities or delays, including autism, except as otherwise specifically Covered herein; mental health services which are primarily non-medical in nature, including, but not limited to, social work, teaching, Custodial Care and chronic rehabilitative services; psychiatric or court-ordered evaluations or therapy when related to judicial or administrative proceedings or orders, when employer requested or when required for school; mental health care in lieu of detention or correctional placement or that is required to be treated in a public facility; institutional care which is for the primary purpose of controlling or changing your environment; milieu therapy, biofeedback, behavior modification, sensitivity training, hypnosis, electrohypnosis, electrosleep therapy or electronarcosis; surgery performed solely to address psychological or emotional factors; treatment of mental

retardation, unless otherwise Covered as a mental illness.

44. **Military health services** – those services for treatment of military or service-connected disabilities when the Member is legally entitled to other coverage and for which facilities are reasonably available to the Member; those services for any otherwise Eligible Employee or Dependent who is on active military duty except as required by the Uniformed Services Employment and Reemployment Rights Act; services received as a result of war or any act of war, whether declared or undeclared or caused during service in the armed forces of any country.
45. **Miscellaneous charges** – telephone, computer or Internet consultations between Provider and Member or between Provider and another Provider; telephone assessments in general.
46. **Non-covered service** – any service or supply that is not a Covered Service or that is directly or indirectly a result of receiving a non-covered service.
47. **Non-FDA approved items** – any drugs, vitamins, minerals or supplements not approved by the FDA; any medical procedure or drug that is approved for use but is not used for the specific indication that led to its approval.
48. **No Physician care or prescription** – services or supplies provided while you were not under the care of a Physician or which were not authorized or prescribed by a Physician.
49. **Orthotics** – foot orthotics; orthopedic shoes (except when an integral part of a lower body brace), diabetic shoes, foot or shoe inserts, shoe lifts, shoe orthotics, other special shoe accessories, arch supports, heel lifts, heel cups, heel or sole wedges, heel pads, insoles (whether custom-made or prefabricated) and other similar items; braces, supports and other orthotic appliances needed for sports or athletic participation, recreational activities or employment; convenience items or model enhancements; repair or replacement of orthotic appliances due to misuse, neglect or loss; replacement of orthotic appliances when the device being replaced is one that would continue to meet your basic medical needs as determined by the Plan; over-the-counter items, such as ACE wraps or bandages, elastic supports, finger splints, foot orthotics, braces and the like.

50. **Outpatient rehabilitation services** - rehabilitative services provided for long-term, chronic medical conditions, except as provided for herein; rehabilitative services whose primary goal is to maintain current level of function, as opposed to improving functional status; rehabilitative services whose primary goal is to return to a specific occupation or job, such as work-hardening or work-conditioning programs; educational or vocational therapy, schools or services designed to retrain for employment; rehabilitative services whose purpose is to treat or improve a developmental/learning disability or delay or congenital anomalies, including autism, except as otherwise specifically Covered herein; rehabilitation services that are Experimental or have not been shown to be clinically effective for the medical condition being treated; speech therapy or voice training when prescribed for stuttering or hoarseness; sports-related services designed to affect performance or physical conditioning programs such as athletic training, body-building, exercise fitness, flexibility and diversion.
51. **Primary plan** – any charges that would have been paid by a primary plan had you complied with all of the pre-certification guidelines or requirements of that plan.
52. **Prohibited services --** charges for services or supplies that are prohibited by federal, state or local law.
53. **Relative care** – charges for services or supplies ordered by, or care rendered to you by, a Family Member or relative or someone who ordinarily resides with you in your home.
54. **Replacement items** – replacement items, such as batteries, tires and light bulbs.
55. **Sex transformation** -- services and associated expenses for sex transformation operations regardless of any diagnosis of gender role disorientation or psychosexual orientation, including any treatment or studies related to sex transformation; hormonal support for sex transformation; any changes for, related to or resulting from sex change operations; sex transformation procedures, treatments or studies.
56. **Sleep studies** – sleep studies provided within the home.
57. **Smoking cessation** – services and supplies for smoking cessation programs.
58. **Sports-related services** – services or devices specifically used as safety items or to affect performance primarily in sports-related activities; all expenses related to physical conditioning programs, such as athletic training, body-building, exercise, fitness, flexibility, and diversion or general motivation, including braces and orthotics.
59. **Substance abuse** – long-term or prolonged rehabilitation services in a specialized inpatient or residential facility; care or treatment of marital or family problems; social, occupational, religious, or other social maladjustments; sex therapy; chronic situational reactions; or family retreats; alcohol or substance abuse services which are primarily non-medical in nature, including, but not limited to, social work, teaching, Custodial Care and chronic rehabilitative services; court-ordered

intoxication evaluations, programs or treatments or therapy related to judicial or administrative proceedings or orders, when employer requested or when required for school; care in lieu of detention or correctional placement or that is required to be treated in a public facility; institutional care which is for the primary purpose of controlling or changing your environment; milieu therapy, biofeedback, behavior modification, sensitivity training, hypnosis, electrohypnosis, electrosleep therapy or electronarcosis.

60. **Third party liability** – services for which a third party has primary liability, such as when services are covered by any governmental agency as a primary plan, coordination of benefits, workers' compensation and claims under policies of automobile or homeowner insurance.
61. **Transplants** – animal transplants or transplants that involve artificial or mechanical devices designed to replace human organs; organ or tissue transplants which are considered to be Experimental or Investigational or not considered to be clinically acceptable; organ donor treatment or services, including the treatment of surgical or medical complications of the organ or tissue procurement process, where you serve as the organ donor and the recipient is not covered under the Plan; organ and tissue procurement, evaluation and transplantation provided by a Provider not Participating in the Coventry Transplant Network.
62. **Travel** – travel or transportation expenses, even if prescribed by a Provider.
63. **Weight or Obesity services** – charges for care, treatment, surgery (including complications thereof), services or supplies that are primarily for obesity ***not caused by an organic condition***, weight reduction or dietary control, including, but not limited to, vitamins, diet supplements, or enrollment in health, athletic or similar clubs or exercise programs, whether formal or informal and whether or not recommended by a Physician.
64. **Work** – work-hardening or work-conditioning programs; vocational therapy.
65. **Work-related Injury or Illness** – any Injury or Illness arising from or sustained in the course of any occupation or employment for pay, profit or gain. This will only apply when benefits are available or payable under any workers compensation or occupational disease act or law, regardless of whether a claim was filed for such benefits.

6.8 Prescription Drug Benefit Program

You must present your Plan Identification Card for each prescription purchase. Your card contains information needed to process your transaction. The pharmacist will ask you to pay your prescription Co-payment or Coinsurance at the time it is filled. If you do not present your Plan Identification Card, you may be asked to pay the full retail price of your prescription and submit your itemized receipt for reimbursement.

Participating pharmacies have contracted with the Plan to charge Covered Persons reduced fees for Covered Prescription Drugs. Medco is the pharmacy

benefit manager that manages the retail pharmacy program and specialty prescription drug benefits for the Plan. Only participating pharmacies should be utilized in order to obtain coverage. To find out if a pharmacy is participating in the network, call the Claims Administrator's Customer Service Department at the number listed on the back of your Plan Identification Card or visit the website.

Covered Prescription Drugs

1. All drugs prescribed by a Physician that require a prescription either by federal or state law. This excludes any drugs not covered under the Plan.
2. All compounded prescriptions containing at least one prescription ingredient in a therapeutic quantity.
3. Legend drugs (drugs that require a prescription to obtain).
4. Compound prescriptions.
5. Insulin, glucagon emergency kits, syringes and needles, oral legend agents for controlling blood sugar, test strips for glucose monitors and lancets and other diabetic supplies.
6. Prenatal and infant vitamins.
7. Self-administered injectables and syringes.
8. Over-the-counter Prilosec, Loratadine (Claritan), Zyrtec and Prevacid ODT with a prescription from your physician.
9. Contraceptive drugs and devices, including oral pills, patches, rings, contraceptive kits, and injectables.
10. Infertility drugs, including oral and injectable infertility drugs.
11. Smoking cessation drugs, including prescribed and over-the-counter, with a prescription from your physician up to a maximum of $1,500 lifetime. (Coverage limited to GOLD plan only.)

Limits to the Prescription Drug Benefit

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

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

Prescription Drug Expenses Not Covered

The following types of charges are not covered under the Prescription Drug Program:

1. **Abuse.** Any drug determined to be abused or otherwise misused by you
2. **Acne Drugs**, including medications and creams under specified ages.
3. **Administration.** Any charge for the administration of a covered Prescription Drug.

4. **Appetite suppressants**. A charge for appetite suppressants, dietary supplements, or weight loss drugs.
5. **Consumed on premises.** Any drug or medicine that is consumed or administered at the place where it is dispensed.
6. **Contraceptives.** Any type of over-the-counter contraceptives, such as foams or spermicidal creams.
7. **Cosmetic Drugs.** Charges for drugs used for cosmetic purposes, such as anabolic steroids, Retin A, depigmenting agents or medications for hair growth or removal.
8. **Devices.** Devices of any type (except contraceptive devices), even though such devices may require a prescription. These include but are not limited to therapeutic devices, artificial appliances, braces, support garments or any similar device.
9. **Erectile Dysfunction.** Erectile dysfunction drugs, including oral, intraurethral and injectables.
10. **Experimental.** Experimental drugs and medicines, even though a charge is made to the Covered Person.
11. **FDA.** Any drug not approved by the Food and Drug Administration.
12. **Growth hormones.** Charges for drugs to enhance athletic performance or appearance.
13. **Immunization.** Immunization agents or biological sera.
14. **Inpatient medication.** A drug or medicine that is to be taken by the Covered Person, in whole or in part, while Hospital confined. This includes being confined in any institution that has a facility for the dispensing of drugs and medicines on its premises.
15. **Investigational.** A drug or medicine labeled: "Caution – limited by federal law to investigational use."
16. **Medical exclusions.** A charge excluded under Medical Plan Exclusions.
17. **No charge.** A charge for Prescription Drugs which may be properly received without charge under local, state or federal programs.
18. **Non-legend drugs**. A charge for FDA-approved drugs that are prescribed for non-FDA approved uses.
19. **No prescription**. A drug or medicine that can legally be bought without a prescription.
20. **Not Medically Necessary**. Prescription drugs that are not considered to be Medically Necessary, in accordance with accepted medical and surgical practices and standards approved by the Plan.
21. **Oral fluoride** preparations and other dental prescriptions prescribed by a dentist to treat a dental condition, except where Medically Necessary.
22. **Prilosec, Loratadine (Claritan), Prevacid and Zyrtec.** The generic and brand name prescription strengths of these drugs are not covered; these drugs are only covered over-the-counter with a prescription from your

physician.

23. **Refills**. Any refill that is requested more than one year after the prescription was written or any refill that is more than the number of refills ordered by the Physician. Prescriptions refilled before 75 percent of the previously dispensed supply should have been consumed when taken as prescribed.
24. **Replacement** of lost, destroyed or stolen medication and any supplies for convenience.
25. **Workers' compensation**. Prescription drugs for which the cost is recoverable under any workers' compensation or occupational disease law or from any state or governmental agency.
26. **Vitamins**. Vitamins, whether prescribed or over-the-counter, except that prescribed prenatal or infant vitamins are covered.

Self-Administered Injectables

Some self-administered injectable prescription drugs that are not obtainable at a retail pharmacy are covered when provided by Accredo specialty vendor. Coverage is subject to a prior written order by your Physician.

To be consistent with changes in medical technology, the Plan will maintain a list of covered specialty injectable prescription drugs and the medical conditions for which they are approved for coverage. Some examples of specialty injectable prescription drugs include Interferons, Erythropoetin and granulocyte colony stimulating factor (G-CSF). Coverage can be verified by calling the Claims Administrator's Customer Service Department at the number listed on the back of your Plan Identification Card.

Prescription Drug Limitations

Certain prescription drugs may be subject to drug limitations based on FDA-approved dosage recommendations. The purpose of these limitations is to encourage safe and cost-effective use of drug therapies.

Prior Authorization and Specific Quantity Limits.

Regardless of where a Prescription Order or Refill is filled, Covered Services under this benefit may be subject to Prior Authorization and quantity limits. Self-administered Injectable medications may require Prior Authorization in order for them to be Covered Services. In order for Prescription Drugs that require Prior Authorization to be covered under this benefit, the Authorized Prescriber must call the Plan before a Prescription Order or Refill for a drug requiring Prior Authorization is filled, and Prior Authorization must be issued by the Plan. Some medications may also be subject to specific quantity limits. You can contact the Claims Administrator's Customer Service Department for more information.

Defined Terms

Ancillary Charge means the charge a Participant may be required to pay to a Pharmacy for Prescription Drugs when the Member or the Member's physician requests that a Brand Name drug be dispensed when a Generic substitution is

available. The Ancillary Charge, if any, is the difference between the Health Plan contracted price for the Brand Name drug and the contracted price for the Generic Drug.

Annual Maximum means the limit, if any, the Participant may meet during the contract year after which Prescription Drugs are not covered. Calculation of the Annual Maximum includes only the cost to Health Plan and does not include any of the following Member payments:

- Co-payments or Coinsurance,
- Self-Administered Injectable Drug Co-payment or Coinsurance,
- Pharmacy Deductibles, or
- Ancillary Charges.

Authorized Prescriber means any:

- Licensed dentist,
- Licensed physician,
- Licensed podiatrist,
- Certified nurse midwife to the extent permitted by applicable law,
- Certified nurse practitioner to the extent permitted by applicable law, or other individual authorized by law to prescribe prescription or nonprescription drugs or devices.

Coinsurance means the percentage stated in the Schedule of Benefits, if any, that you must pay to the Participating Retail or Specialty Pharmacy to fill any Prescription or Refill. The Plan calculates Coinsurance based on the negotiated rate between the Plan and the Participating Pharmacy.

Co-payment means the flat dollar amount as specified in the Schedule of Benefits that will be charged to the member by the Participating Retail or Specialty Pharmacy to dispense any Prescription Order or Refill. The Participant is required to pay one Co-payment per each Prescription Order or Refill to a Participating Retail or Specialty Pharmacy at the time of service. Co-payment amounts are not applied to:

- Pharmacy Deductible, if any,
- Annual Maximum, or
- Ancillary Charges.

Covered Drugs means Prescription Drugs that are:

- Listed in the Drug Formulary or Non-Formulary Drugs that are covered pursuant to Schedule of Benefits.
- Prescribed by an Authorized Prescriber, and
- Approved by the Plan.

Drug Formulary means a list of Prescription Drugs that the Claims Administrator’s Pharmacy and Therapeutics Committee has approved for coverage under this Program. This list is subject to periodic review and modification by the Committee. The Drug formulary is available for review:

- In the Participating Prescriber's office,
- By contacting the Claims Administrator's Customer Services Department, or
- On the Internet at www.PersonalCare.org.

Drugs not listed on the Drug Formulary are covered at the Non-Formulary Co-payment or Coinsurance.

Experimental Drugs means pharmacological regimens that are not approved by the Food and Drug Administration for use or for the prescribed use/dosage.

Formulary Brand Name Drugs means those drugs on the Drug Formulary which are marketed under a specific trade name by a pharmaceutical manufacturer. In most cases, these drugs are still under patent protection.

Formulary Generic Drugs means those drugs on the Drug Formulary that are copies of the Brand Name Drugs and are not marketed under a specific trade name. Generic Drugs contain the same active ingredients in the same strength as the Brand Name Drugs, are equally effective as the Brand Name Drugs at treating the medical condition, and meet the same Federal requirements as the Brand Name Drugs.

Legend Medication means a drug that, by law, can be obtained only by prescription and that is labeled "Caution: federal law prohibits dispensing without a prescription."

Maintenance Drug means a drug anticipated to be required for 6 months or more to treat a chronic condition, such as high blood pressure.

Narrow Therapeutic Index. A drug is said to have a narrow therapeutic index when small variances in a Participant's blood levels can change the effectiveness or toxicity of the drug. Safe and effective use of these drugs requires careful dosage adjustment and patient monitoring, regardless of whether the generic or brand name product is used.

Non-Formulary Drugs means a Prescription Drug that is

- Not listed in the Formulary, and
- Not excluded from Coverage.

Non-Participating Pharmacy means any registered, licensed pharmacy with which the Plan has not contracted to dispense Prescription Drugs to Participants.

Participating Pharmacy means a Participating Retail Pharmacy or Specialty Pharmacy, as applicable.

Participating Prescriber means any physician, dentist or other Participating Health Care Provider who is duly licensed to prescribe Prescription Drugs in the ordinary course of his or her professional practice, and has contracted with the Plan to provide medical services including prescribing Prescription Drugs to Participants.

Participating Retail Pharmacy means a registered, licensed retail pharmacy with which the Plan has contracted to dispense Covered Drugs to Members.

Pharmacy and Therapeutic Committee means the Claims Administrator's panel of physicians, pharmacists, nurses, and other health care professionals who are responsible for all pharmacy management activities, such as managing, updating and administering the Drug Formulary.

Pharmacy Deductible means the amount, if any, that a Participant must pay for Prescription Drugs each Calendar Year before a Participant may receive coverage for Prescription Drugs under the Plan. When the Pharmacy Deductible is met, the Participant is responsible for the Co-payment or Coinsurance per prescription order or refill. The Pharmacy Deductible does not include Co-payments or any Ancillary Charges.

Prescription Drug means a drug approved by the FDA for a specific outpatient use and that is dispensed only pursuant to a Prescription Order or Refill (a Legend Medication) under applicable law. Prescription Drugs include contraceptive drugs and devices and some over-the-counter medications or disposable medical supplies specified by the Plan (for example, insulin and certain diabetic supplies).

Prescription Order or Refill means the authorization for a Prescription Drug issued by an Authorized Prescriber.

Self-Administered Injectable Drugs means injectable Prescription Drugs that are commonly and customarily administered by the Participant. Examples of Self-Administered Injectable Drugs include but are not limited to the following: multiple sclerosis agents, growth hormones, colony stimulating factors given more than once monthly, chronic medications for hepatitis C, certain rheumatoid arthritis medications, certain injectable HIV drugs, certain osteoporosis agents, and heparin products. Self-Administered Injectable Drugs are obtained from a Specialty Pharmacy. The following are not considered Self-Administered Injectable Drugs because they are not obtained from a Specialty Pharmacy: insulin, glucagon, bee sting kits, Imitrex.

Specialty Pharmacy means a pharmacy that:

- Has a contract with the Health Plan, and
- Is designated as a Specialty Pharmacy by the Health Plan for Members to obtain Self-Administered Injectable Drugs.

General Provisions

Each Participant authorizes and directs any pharmacy that filled a Prescription Order or Refill covered under this benefit to make available to the Plan information relating to all Prescription Orders or Refills, copies thereof and other records as needed by the Plan to implement and administer the terms of this benefit, conduct appropriate quality review or investigate possible substance abuse or criminal activity. Each Participant, by accepting coverage under this Benefit Plan, agrees that the Plan and any of its designees shall have the right to release any and all records concerning health care services which are necessary to

implement and administer the terms of this benefit, conduct appropriate quality review or investigate possible substance abuse or criminal activity.

The Plan shall not be liable for any claim, injury, demand or judgment based on tort or other grounds (including warranty of drugs) arising out of or in connection with the sale, compounding, dispensing, manufacturing, or use of any Prescription Drug or insulin whether or not covered under this Plan.

This benefit or coverage under this benefit shall terminate when a Participant's coverage under the Plan ends.

Nothing contained herein shall be held to vary, alter, waive, or extend any of the terms, conditions, provisions, agreements, or limitations of the Plan, other than as stated above.

The following do not apply toward fulfillment of any Out-of-Pocket Maximum specified in Your Health Plan Schedule of Benefits:

- Co-payments,
- Coinsurance, or
- Pharmacy Deductible, if any.

The following do not apply toward fulfillment of any Out-of-Pocket Maximums specified in the Schedule of Benefits:

- Ancillary Charge, or
- Amounts in excess of the Out-of-Network Rate.

7. Coordination with Other Coverages

7.1 Introduction

This coordination of benefits ("**COB**") provision applies when a participant has health care coverage under more than one Plan. "Plan" is defined below. The order of benefit determination rules below determine which Plan will pay as the Primary Plan. The Primary Plan that pays first pays without regard to the possibility that another Plan may cover some expenses. A Secondary Plan pays after the Primary Plan and may reduce the benefits it pays so that payments from all group Plans do not exceed 100% of the total Allowable Expense.

7.2 Definitions

"Allowable Expense" means any necessary, reasonable and customary item of expense for heath care (excluding prescription drugs), at least a portion of which is covered by one or more Plans covering the person for whom the claim is made. The difference between the cost of a private hospital room and the cost of a semi-private hospital room is not considered an Allowable Expense unless the patient's stay in a private hospital room is Medically Necessary either in terms of generally accepted medical practice or as specifically defined in the Plan. When a Plan provides benefits in the form of services, the reasonable cash value of each service rendered will be considered both an Allowable Expense and a benefit paid.

"**Claim Determination Period**" means a calendar year. However, it does not include any part of a year during which a person has no coverage under This Plan or any part of a year before the date this coordination of benefits section or a similar provision takes effect.

"**Plan**", for purposes of this coordination of benefits section only, means any of the following which provides benefits or services for care or treatment:

- Group insurance or group-type coverage, whether insured or uninsured. This includes pre-payment, group practice or individual practice coverage. It also includes coverage other than school accident-type coverage.
- Coverage under a governmental Plan or coverage that is 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 (42 USCA 301, *et seq.*) as amended from time to time). It also does not include any Plan whose benefits, by law, are excess to those of any private insurance program or other non-governmental program. In the event Medicaid or any other social program directs services, the Plan will cover the resulting charges only if you have followed the requirements as set forth in this Plan Document.
- Each contract or other arrangement for coverage under the above two paragraphs is a separate Plan. Also, if an arrangement has two parts and coordination of benefits rules apply only to one of the two, each of the parts is a separate Plan.
- Plan also includes the medical benefits coverage, including any funds available under uninsured motorist or underinsured motorist provisions, in group automobile contracts, in group or individual automobile "no-fault" contracts, in traditional automobile "fault" type contracts, individual or otherwise, to the extent benefits provided under such contracts must be determined without taking the existence of any other Plan into consideration.

"**Primary Plan/Secondary Plan**" is defined by the order of benefit determination rules, which state whether This Plan is a Primary Plan or Secondary Plan (another Plan covering the Member). When This Plan is a Primary Plan, its benefits are determined before those of the other Plan and without considering the other Plan's benefits. When This Plan is a Secondary Plan, its benefits are determined after those of the other Plan and may be reduced because of benefits received from the Primary Plan. When there are more than two Plans covering the person, This Plan may be a Primary Plan as to one or more other Plans and may be a Secondary Plan as to a different Plan or Plans.

"**This Plan**" means the Plan offered by the Plan Sponsor that provides benefits for health care expenses as described in this Plan Document.

7.3 Effect on Benefits

If the order of benefit determination rules as set for below are applied and it is determined that This Plan determines its benefits before another Plan, the benefits of This Plan shall not be reduced and shall be paid without regard to the other Plan.

If the order of benefit determination rules are applied and it is determined that another Plan determines its benefits first, the benefits of This Plan will be reduced when the sum of:

- The benefits that would be payable for the Allowable Expense under This Plan in the absence of this coordination of benefits section; and
- The benefits that would be payable for the Allowable Expense under the other Plans, in the absence of provisions with a purpose like that of this coordination of benefits section, whether or not claim is made, exceeds those Allowable Expenses in a Claim Determination Period. In that case, the benefits of This Plan will be reduced so that they and the benefits payable under the other Plans do not total more than those Allowable Expenses.

When the benefits of This Plan are reduced as described above, each benefit is reduced in proportion. It is then charged against any applicable benefit limit of This Plan.

➢ **Note:** Reimbursement will not exceed one hundred percent of the total Allowable Expenses incurred under This Plan and any other Plan.

7.4 Order of Benefit Determination Rules.

This Plan determines its order of benefits using the first of the following rules which applies:

7.4.1 **Plan with No Coordination of Benefits Provisions**. A Plan which contains no provisions for coordination of benefits is considered to pay its benefits before a Plan that contains such a provision.

7.4.2 **Non-Dependent/Dependent**. The benefits of a Plan which covers the person as an employee, participant or Subscriber (that is, other than as a Dependent) shall be primary over a Plan which covers the person as a Dependent, except that if the person is also a Medicare beneficiary, Medicare is:

i. Secondary to the Plan covering the person as a Dependent; and
ii. Primary to the Plan covering the person as other than a Dependent (for example, a retired employee)

7.4.3 **Dependent Child/Parents Not Separated or Divorced.** Except as stated in subparagraph 7.4.4 below, when This Plan and another Plan cover the same child as a Dependent of different persons called "parents":

i. The benefits of the Plan of the parent whose birthday falls earlier in a year are determined before those of the Plan of the parent whose birthday falls later in that year; but
ii. If both parents have the same birthday, the benefits of the Plan, which covered one parent longer, are determined before those of the Plan which covered the other parent for a shorter period of time.

However, if the other Plan does not have the rule described in subsection (i) immediately above, but instead has a rule based upon the gender of the parent, 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.

7.4.4 **Dependent Child/Separated or Divorced**. 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:

i. First, the Plan of the parent with custody of the child;

ii. Then, the Plan of the spouse of the parent with custody of the child; and

iii. Finally, the Plan of the parent not having custody of the child.

However, if the specific terms of a court decree state that one of the parents is responsible for the health care expense of the child, and the entity obligated to pay or provide the benefits of the Plan of that parent has actual knowledge of those terms, the benefits of that Plan are determined first. The Plan of the other parent shall be the Secondary Plan. This paragraph does not apply to any Claim Determination Period or contract year during which any benefits are actually paid or provided before the entity has actual knowledge.

7.4.5 **Dependent Child/Joint Custody**. If the specific terms of a court decree state that the parents shall share joint custody without stating that one of the parents is responsible for the health care expenses of the child, the Plans covering the child shall follow the order of benefit determination rules outlined in subparagraph 7.4.3 above.

7.4.6 **Active/Inactive Employee**. The benefits of a Plan which covers a person as an employee who is neither laid off nor retired (or as that employee's dependent) are determined before those of a Plan which 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 a result, the Plans do not agree on the order of benefits, this rule will be ignored.

7.4.7 **Continuation Coverage**. If a person whose coverage is provided under a right of continuation pursuant to federal or state law is also covered under another Plan, the following shall be the order of benefit determination:

i. The Plan covering the person as an employee, participant or Subscriber (or as that person's dependent) will be primary;

ii. The benefits under the continuation coverage will be secondary.

7.4.8 **Longer/Shorter Length of Coverage**. If none of the above rules determines the order of benefits, the benefits of the Plan which covered an employee, Participant or Subscriber longer are determined before the benefits of the Plan which covered that person for the shorter term.

7.5 Right to Necessary Information

The Plan may need certain facts in order to apply the above coordination of benefits rules. The Plan has the right to decide which facts it needs. You or any other person claiming benefits under This Plan agree to notify the Plan of the existence of any other group coverage and to provide any information Plan may need to coordinate the insurance benefits and pay the claim. The Plan may get needed facts from or give them to any other organization or person, with or without the consent of any person.

7.6 Right to Recover

If the amount of the payments made by the Plan through its Claims Administrator is more than it should have paid under this coordination of benefits provision, it has the right to recover the excess from any person or organization to whom, or for whom, the excess payment has been made. The “amount of the payments made” includes the reasonable cash value of any benefits provided in the form of services.

7.7 Facility of Payment

Sometimes a payment made under another Plan may include an amount, which should have been paid under This Plan. If this happens, the Plan may adjust the payment and specifically reserves the right to pay that amount to the organization which made that payment. Any amount paid to the organization will then be treated as a benefit paid under This Plan. Neither the Plan nor the Claims Administrator will not be liable for payment of that amount again. The term “payment made” includes providing benefits in the form of services, in which case “payment made” means reasonable cash value of the benefits provided in the form of services.

7.8 Coordination of Benefits with Medicare

7.8.1 Active Employees and Spouses Age 65 and Older

If an employee is eligible for Medicare and works for an employer with fewer than 20 employees for each working day in each of 20 or more calendar weeks in the current or preceding Health Plan Year, then Medicare will be the primary payor. Medicare will pay its benefits first. This Health Plan will pay benefits on a secondary basis.

If an employee works for an employer with more than 20 employees for each working day in each of 20 or more calendar weeks in the current or preceding Health Plan Year, the Health Plan will be primary. However, an Employee may decline coverage under this Health Plan and elect Medicare as primary. In this instance, this Health Plan, by law, cannot pay benefits secondary to Medicare for Medicare covered services.

You will continue to be covered by this Health Plan as primary unless you (a) notify us, in writing, that you do not want benefits under this Health Plan or (b) otherwise cease to be eligible for benefits under this Health Plan.

7.8.2 Disability

If you are under age 65 and eligible for Medicare due to disability, and actively work for an employer with fewer than 100 employees, then Medicare is the primary payor. This Health Plan will pay benefits on a secondary basis.

If you are age 65 or older and actively work for an employer with at least 100 employees and you become entitled to benefits under Medicare due to disability (other than ESRD as discussed below) this Health Plan will be primary for you and your eligible Dependents and Medicare will pay benefits on a secondary basis.

7.8.3 End Stage Renal Disease (ESRD)

If you are entitled to Medicare due to End Stage Renal Disease (ESRD), this Health Plan will be primary for the first 30 months. If this Health Plan is currently paying benefits as secondary, this Health Plan will remain secondary upon your entitlement to Medicare due to ESRD.

7.8.4 Coordination of Benefits for Retirees

If you are retired and you or one of your Dependents is covered by Medicare Part A and/or Part B (or would have been covered if complete and timely application had been made), benefits otherwise payable for treatment or services described in this Agreement will be paid after:

- Amounts payable are paid for treatment or services by Medicare Parts A and/or Part B;
- Amounts that would have been payable (paid) for treatment or service by Medicare Parts A and/or Part B, if you or your Dependents had been covered by Medicare; or
- Amounts paid under all other Plans in which you participate.

7.9 Right to Receive and Release Needed Information

By accepting Coverage under this Agreement, you agree to:

- Provide the Plan with information about other coverage and promptly notify us of any coverage changes;
- Give the Plan the right to obtain information as needed from others to coordinate benefits; and
- Return any excess amounts to the Plan if it through its Claims Administrator makes a payment and later find that the other Coverage should have been primary.

7.10 Subrogation/Right of Recovery

When the Plan pays for expenses that were either the result of the alleged negligence of, or which arise out of any claim or cause of action which may accrue against any third party responsible for injury or death to the Covered Employee or Dependent of the Covered Employee (hereinafter named the Covered Person) by reason of their eligibility for benefits under the Plan, the Plan has a right to equitable restitution and will advance benefits if the Covered Person agrees to the following.

The Covered Person will reimburse the Plan out of the Covered Person's recovery for all benefits paid by the Plan. The Plan will be reimbursed in full prior to the Covered Person receiving any monies recovered from any party or their insurer as a result of judgment, settlement or otherwise. The duty and obligation to reimburse the Plan also applies to any insurance. The Covered Person is obligated to repay the Plan out of the Covered Person's recovery even if the Covered Person is not fully compensated or made-whole from any money they receive. The Covered Person agrees to include the Plan's name as a co-

payee on any settlement check. The Plan is paying benefits in reliance upon the Covered Person's agreement to the terms contained in this section.

The Plan has the right to the Covered Person's full cooperation in any case involving the alleged negligence of a third party. In such cases, the Covered person is obligated to provide the Plan with whatever information, assistance, and records the Plan may require to enforce the rights in this provision. The Covered Person further agrees that in the event that the Plan has reason to believe that the Plan may have a subrogation lien, the Plan will require the Covered Person to complete a subrogation questionnaire, sign an acknowledgment of the Plan's Subrogation rights and an agreement to provide ongoing information; before the Plan pays, or continues payments of claims according to its terms and conditions. Upon receipt of the requested materials, the Plan will commence, or continue, payments of claims according to its terms and conditions provided that said payment of claims in no way prejudices the Plan's rights. If the Covered Person does not agree to the terms and conditions of the Plan's Subrogation Provision, related claims may be subject to disqualification, denial or loss of benefits.

The Plan may, but is not obligated to, take any legal action it sees fit against the third party or the Covered Person, to recover the benefits the Plan has paid. The Plan's exercise of this right will not affect the Covered Person's right to pursue other forms of recovery, unless the Covered Person and his legal representative consent otherwise.

In the event that the Claims Payer determines that a subrogation recovery exists, the Claims Payer retains the right to employ the services of an attorney to recover money due to the Plan. The Covered Person agrees to cooperate with the attorney who is pursuing the subrogation recovery. The compensation that the Plan's attorney receives will be paid directly from the dollars recovered for the Plan.

The Plan specifically rejects the "common fund" doctrine, whereas, it has no duty or obligation to pay a fee to the Covered Person's attorney for the attorney's services in making any recovery on behalf of the Covered Person.

The covered Person is obligated to inform their attorney of the subrogation lien and to make no distributions from any settlement or judgment which will in any way result in the Plan receiving less than the full amount of its lien without the written approval of the Plan. The Covered Person further agrees that he will not release any third party or their insurer without prior written approval from the Plan, and will take no action which prejudices the Plan's subrogation right.

The Covered Person agrees to refrain from characterizing any settlement in any manner so as to avoid repayment of the Plan's lien or right to reimbursement. The Plan Administrator retains discretionary authority to interpret this and all other plan provisions and the discretionary authority to determine the amount of the lien.

The Plan pays secondary to any and all PIP, Med-Pay or No-Fault coverage. The Plan has no duty of obligation to pay any claims until PIP, Med-Pay or No-Fault coverage is exhausted. In the event that the Plan pays claims that should have

been paid by PIP, Med-Pay or No-Fault coverage under this provision, then the Plan has a right of recovery from the PIP, Med-Pay or No-Fault carrier.

In the case of a Michigan insured who is covered by Michigan No-Fault coverage, the Plan will not pay claims until and unless all of the No-Fault coverage is exhausted first.

Under the terms of the Plan, it is the absolute obligation of the Covered Person to reimburse the Plan out of the Covered Person's recovery if the Covered Person recovers from the other party or insurer, without the Plan's knowledge, for the amount of benefits paid by the Plan for the Injury, Illness or Death.

Failure to reimburse the Plan shall permit the Plan to offset the amount due against the Covered Persons' future claims submitted by covered members of his or her family. This Plan's subrogation right is subject to ERISA, which preempts individual state law.

8. How the Plan Is Administered

8.1 Plan Administration

The administration of the Plan is under the supervision of the Plan Administrator. Jim Littleford, Superintendent of the Plan Sponsor, is the person who has been designated to act on behalf of the Plan Administrator.

The principal duty of the Plan Administrator is to see that the Plan is carried out, in accordance with its terms, for the exclusive benefit of persons entitled to participate in the Plan. The administrative duties of the Plan Administrator include, but are not limited to, interpreting the Plan, prescribing applicable procedures, determining eligibility for and the amount of benefits, and authorizing benefit payments and gathering information necessary for administering the Plan. The Plan Administrator may delegate any of these administrative duties among one or more persons or entities, provided that such delegation is in writing, expressly identifies the delegate(s) and expressly describes the nature and scope of the delegated responsibility.

The Plan Administrator has the discretionary authority to interpret the Plan in order to make eligibility and benefit determinations as it may determine in its sole discretion. The Plan Administrator also has the discretionary authority to make factual determinations as to whether any individual is entitled to receive any benefits under the Plan. The Plan may also delegate its discretionary authority.

The Plan Sponsor will bear its incidental costs of administering the Plan.

8.2 Power and Authority of Claims Administrator

Plan Sponsor has contracted with PersonalCare Insurance of Illinois, Inc. ("Claims Administrator") to administer the Plan's group health benefits. The Claims Administrator is responsible for (1) initial determination of the amount of any benefits payable under the Plan, and (2) prescribing claims procedures to be

followed and the claim forms to be used by Participants. Plan Sponsor is ultimately responsible for providing Plan benefits.

8.3 Questions

If Participant has any general questions regarding the Plan, please contact the Plan Administrator.

If Participant has questions concerning eligibility for, or the amount of, any benefit payable under the Plan, please contact the Claims Administrator.

9. Amendment or Termination of the Plan

9.1 Amendment or Termination

Plan Sponsor has the right to amend or terminate the Plan at any time.

The Plan may be amended or terminated by a written instrument duly adopted by the Plan Sponsor or any of its delegates. No change in this document shall be valid unless approved by an officer of the Plan Sponsor and evidenced by endorsement on this document and/or by amendment to this document. Such amendment will be incorporated into this document.

Jim Littleford, Superintendent of the Plan Sponsor, may sign contracts for this Plan (including contracts with the Claims Administrator) on behalf of the Plan Sponsor, including amendments to those contracts, and may adopt (by written instrument) amendments to the Plan that he considers to be administrative in nature or advisable to comply with applicable law.

10. Claims Procedures

10.1 Notice of Benefit Determination

10.1.1 Urgent Care Claims. When the Plan receives a request for Urgent Care that is not an Emergency Service and that satisfies the requirements of the Urgent Care Claims definition, the Plan will notify the Participant and/or Authorized Representative of the decision by telephone within one (1) business day and in writing no later than forty-eight (48) hours after the request is received. This notification will be made whether or not there is an Adverse Benefit Determination. If there is insufficient information for the Plan to make a decision, the Plan will notify the Participant and/or Authorized Representative no later than twenty-four (24) hours after receiving the request for Urgent Care. The notice will detail the information that is needed to make the decision. The Participant and/or Authorized Representative has forty-eight (48) hours to provide the requested information. The Plan will make the decision within forty-eight (48) hours after the earlier of:

- The receipt of the additional information; or
- The end of the forty-eight (48) hour period in which the Participant or Authorized Representative has to provide the information.

10.1.2 Pre-Service Claims. When the Plan receives a request for Prior Authorization of a hospital admission or other service that is not an Urgent Care Claim, the Plan will notify the Participant and/or Authorized Representative of the authorization decision, in the case of an Adverse Benefit Determination, no later than two (2) business days after the request and all necessary information are received by the Plan; and, in the case of all other requests, no later than fifteen (15) days after the request and all necessary information are received by the Plan. This notification will be made whether or not there is an Adverse Benefit Determination. If the Plan does not have all the necessary information to make the authorization decision, the Plan will notify the Participant and/or Authorized Representative and explain in detail what information is required. The Plan must receive the information requested within forty-five (45) days from the Participant's and/or Authorized Representative's receipt of the notice to provide the additional information.

If the Prior Authorization procedures are not followed, the Plan will notify the Participant and/or Authorized Representative of the failure to follow the procedures within five (5) days of the request. The notice will include the proper procedures for requesting Prior Authorization.

10.1.3 Post-Service Claims. The Plan will send a notice of an Adverse Benefit Determination (in an Explanation of Benefits) to the Participant or Authorized Representative within thirty (30) days after Claims Administrator receives the claim for payment. If Claims Administrator does not have the necessary information to make a payment determination, Claims Administrator will notify the Participant or the Authorized Representative of the need for an extension before the end of the initial thirty (30) days. The extension notice will explain in detail what information is required. The Participant or Authorized Representative has forty-five (45) days from the receipt of the notice to provide the requested information. The Plan has fifteen (15) days from receipt of the clarifying information or the end of the forty-five (45) day period, whichever is earlier, to make a determination.

10.1.4 Ongoing Treatment. The Plan does not reduce or terminate coverage for care that is Pre-Authorized, as long as the information the Plan was provided to obtain the Prior Authorization is accurate and the Participant remains enrolled in the Plan. If the Plan receives a request to extend care beyond what the Plan has Pre-Authorized, the Plan will follow the Urgent Care Claims process above.

10.1.5 Appeal Rights. If an Urgent Care Claim, a Pre-service Claim or a Post-service Claim results in an Adverse Benefit Determination, the Participant or Authorized Representative may appeal the decision as described below.

10.2 Informal Inquiry Process

Most Appeals begin as an informal inquiry. Participants should direct informal inquiries to the Plan via the Claims Administrator Customer Service Department Monday through Friday from 8:00 a.m. to 6:00 p.m. C.S.T. at the following telephone numbers: (866) 557-8751.

A Customer Service Associate will review, research and resolve the inquiry. The Participant will be informed of the resolution within thirty (30) days. At the time of resolution, if the decision is adverse to the Participant, the Participant will be advised of his/her right to request a formal Appeal. Participants also have the right to bypass the informal inquiry procedures and immediately file a formal Appeal.

10.3 Appeal Process

An Appeal is a request by a Participant or Participant's Authorized Representative for reconsideration of an Adverse Benefit Determination of a health service request or a benefit that the Participant believes he or she is entitled to receive. There are two different types of Appeals:

- **Healthcare Service Appeals.** A health care service appeal is an Appeal to change a previous decision made by the Health Plan where the denial has been issued for Medical Necessity or medical appropriateness or which relates to a medical decision.
- **Administrative Appeals.** An administrative appeal involves non-healthcare related issues, such as coverage issues, which are administrative in nature.

There are also three different categories of Appeals:

- **Pre-Service Appeals.** Pre-service appeals are those appeals for which a requested service requires Prior Authorization, an Adverse Benefit Determination has been rendered, and the requested service has not been provided.
- **Post-Service Appeals.** Post-service appeals are those appeals for which an Adverse Benefit Determination has been rendered for a service that has already been provided.
- **Urgent Care Appeals.** An urgent care appeal is an appeal that must be reviewed under an expedited appeal process because the application of non-urgent care appeal time frames could seriously jeopardize: (a) the life or health of the Participant; or (b) the Participant's ability to regain maximum function. In determining whether an appeal is an urgent care appeal, the Health Plan will apply the judgment of a prudent layperson who possesses an average knowledge of health and medicine. An urgent care appeal is also an appeal involving: (a) care that the treating physician deems urgent in nature; or (b) the treating physician determines that a delay in the care would subject the Participant to severe pain that could not be adequately managed without the care or treatment that is being requested.

Throughout the procedures outlined in this Section 10, if the Participant or Authorized Representative fails to file any Appeal within the required timeframes, the Participant loses the right to continue the internal appeal process. Participants have the right, but are not required to, appear in person or to be represented by an attorney during any stage of the inquiry or Appeal procedure. In each step of the inquiry and Appeal procedure, Participants should be as specific as possible as to the remedy sought (e.g., claim denied – remedy sought is payment).

Pre-Service and Post-Service Appeals

If you are dissatisfied with an Adverse Benefit Determination and wish to file a pre-service or post-service appeal with the Plan, you have the right to request such an appeal. Your or your Authorized Representative has one hundred eighty (180) days after the Participant's receipt of the initial notice of Adverse Benefit Determination to file an Appeal with the Plan. Requests received after such one hundred eighty (180) day period will not be eligible for the internal Appeal process.

In order to request a pre-service or post-service appeal from the Plan, you or your Authorized Representative must submit a written request to the Claims Administrator at the address above, Attention: Member Appeals and include the following:

- Your name;
- Provider name;
- Date(s) of service;
- Your mailing address and/or the mailing address of your Authorized Representative;
- Clear indication of the remedy or corrective action being sought and an explanation of why the Health Plan should reverse the Adverse Benefit Determination; and

- Copy of documentation to support the reversal of the decision.

You or your Authorized Representative may also include written comments, documents, records and other information relevant to the appeal. The Plan will notify you or your Authorized Representative within three (3) business days from receipt of the appeal of any additional information it will need to evaluate your appeal.

Your appeal will be investigated and reviewed by the Plan. For both administrative and healthcare service appeals, your appeal will be reviewed by individuals who were not involved in any previous reviews and are not the subordinate of an individual who made any prior Adverse Benefit Determination. For health care service appeals based in whole or in part upon a medical judgment, your appeal will be handled in consultation with a health care professional who has appropriate training and experience in the field of medicine involved in the medical judgment.

The Plan will notify you or your Authorized Representative in writing of the decision on appeal within fifteen (15) business days after receipt of all required information but no later than thirty (30) calendar days (pre-service) or sixty (60) calendar days (post-service) from receipt of your initial appeal request. The notice will contain all information as required by applicable state and federal laws and regulations. In addition, you have the right to receive, upon request and free of charge, reasonable access to and/or copies of all documents, records and other information relevant to your appeal.

Urgent Care Appeals

If you have an appeal which meets the definition of an urgent care appeal as set forth above, you or your Authorized Representative may request an expedited appeal. Such an appeal can be requested in writing, or orally, by contacting the Claims Administrator's Customer Service Department at (866) 557-8751 at any time. The request can also be made by a provider acting as your Authorized Representative.

If the appeal constitutes an urgent care appeal, we will call you or your Authorized Representative within twenty-four (24) hours from receipt of the appeal to provide notice of any additional information we will need to evaluate your appeal. Your urgent care appeal will be investigated and reviewed by the Plan. Your appeal will be reviewed by individuals who were not involved in any previous reviews and are not the subordinate of an individual who made any prior adverse benefit determination. For health care service appeals based in whole or in part upon a medical judgment, your urgent care appeal will be handled in consultation with a health care professional who has appropriate training and experience in the field of medicine involved in the medical judgment.

The Plan will notify you or your Authorized Representative of its decision on appeal as expeditiously as possible but not later than seventy-two (72) hours from receipt of your initial urgent care appeal request. If the initial decision is not conveyed to you orally, we will provide written confirmation to you within three calendar days thereafter. The notice will contain all information as required by applicable state and federal laws and regulations.

10.4 Other Appeal Rights

As a participant or beneficiary of an employee welfare benefit plan under ERISA, Participants may have the right to bring a civil action under ERISA Section 502(a). Participants may exercise this right to recover Covered Services due under the Plan, enforce the Participant's rights under the Plan, or to clarify rights to future Covered Services under the terms of the Plan. Participants must exhaust the internal Appeal process before bringing a civil action under ERISA Section 502(a).

11. HIPAA Privacy & Security

HIPAA Privacy

In fulfillment of the requirements of Section 504(f)(2) of the privacy rule found in 45 C.F.R. Part 164 (the "Privacy Rule") promulgated pursuant to the federal Health Insurance Portability and Accountability Portability Act of 1996, Public Law 104-191 ("HIPAA"), the Plan provides as follows:

11.1 Consistent with the HIPAA Privacy Rule, persons holding positions with the Plan Sponsor or its affiliates and who have access to individually identifiable health information deemed "protected health information" ("PHI") under the Privacy Rule are identified in Section 11.2, below, and are restricted to using and disclosing PHI for Plan administrative purposes such as those described as "payment" and "health care operations" under the Privacy Rule. More particularly, such uses and disclosures may include: evaluating the Plan's claims experience; seeking proposals for insurance or reinsurance of Plan benefits; reporting to stop-loss carriers; administering case, quality and utilization management programs; determining the application of Plan provisions to particular claims; and assisting participants and beneficiaries with the filing of claims.

11.2 The classes of positions within the workforce of the Plan Sponsor that may receive, use or disclose PHI for the purposes set forth in Section 11.1 are:

11.2.1 Human Resources Department personnel

11.2.2 Finance Department personnel

11.2.3 Executive Department personnel

11.2.4 Legal Counsel

11.3 Employees in the job functions described in Section 11.2 will have access to Plan Participants' PHI only for the purposes described in Section 11.1 (*i.e.,* administrative functions performed for the Plan).

11.4 Participants or beneficiaries of the Plan with knowledge that:

11.4.1 Employees of the Plan Sponsor, other than employees in the positions identified in Section 11.2, have used or disclosed Plan PHI;

11.4.2 Employees in the positions identified in Section 11.2 have used or disclosed the PHI outside the scope of Plan administration (as more fully

described in Section 11.1); or

11.4.3 Employees of the Plan Sponsor have acted contrary to the Plan Sponsor covenants described in Section 11.5, below, may report such non-conforming activity to Judy Adair, the Plan's privacy contact person, who will work with appropriate Plan and Plan Sponsor personnel to correct the breach or deficiency, mitigate the effect of the breach or deficiency, and impose appropriate disciplinary sanctions.

11.5 The Plan will not disclose PHI to employees of the Plan Sponsor for the administrative purposes described herein without obtaining a certification (the "Certification") from the Plan Sponsor to the effect that the Plan Sponsor will:

11.5.1 Not use or further disclose individually identifiable health information created in connection with the Plan except as required by law or for Plan administrative purposes as described in Section 11.1, above, as such administrative purposes may be amended from time to time;

11.5.2 Arrange for any agents or subcontractors of the Plan Sponsor that receive PHI to use and disclose PHI consistent with the Certification;

11.5.3 Not use or disclose the PHI for employment related actions or in connection with any other benefits or benefit plans;

11.5.4 Report to the Plan any use or disclosure of the information that is inconsistent with the uses or disclosures provided for in Section 11.1, which it becomes aware of;

11.5.5 Make available to the Plan any PHI in any "designated record set" (as such term is defined in the Privacy Rule) related to Plan participants or beneficiaries that the Plan Sponsor has control of in accordance with the access requirements of the Privacy Rule;

11.5.6 Make available for amendment, to the extent required by the Privacy Rule, the PHI in a designated record set which is related to Plan participants or beneficiaries and incorporate any amendment as required by the Privacy Rule;

11.5.7 Make information available to the Plan for, or provide the Plan with, an accounting of PHI disclosures (to the extent required by the Privacy Rule, e.g., other than for treatment, payment, health care operations or other exempt purposes) related to Plan participants or beneficiaries in response to such person's exercise of his/her rights under such section;

11.5.8 Make its internal practices, books and records relating to the use and disclosure of PHI received from the Plan available to the Secretary of the Department of Health and Human Services to assist the Secretary in determining the Plan's compliance with the Privacy Rule;

11.5.9 Where feasible, return to the Plan or destroy any PHI received from the Plan when such PHI is no longer needed by the Plan Sponsor for the purpose which permitted the Plan to make the disclosure and, where such return or destruction of PHI is not feasible, to limit its future use of the PHI to the situations that make the return or destruction of the PHI not feasible; and

11.5.10 Limit access of its employees to the Plan's PHI (other than as subjects of the PHI or subscribers to the payment), except where such employees are in job classifications which have been designated above as assisting in Plan administration and thus engaging in the use or disclosure of PHI for treatment, payment and health care operations purposes.

HIPAA Security

In fulfillment of the requirements of the security standards for the protection of electronic protected health information as found in 45 CFR Part 164.300 et seq. (the "Security Standards") promulgated pursuant to the federal Health Insurance Portability and Accountability Portability Act of 1996, Public Law 104-191 ("HIPAA"), the Plan provides as follows:

1. The Employer agrees to implement reasonable and appropriate administrative, physical and technical safeguards to protect the confidentiality, integrity and availability of Electronic Protected Health Information that the Employer creates, maintains or transmits on behalf of the Plan. "Electronic Protected Health Information" shall have the same definition as set out in the Security Standards, but generally shall mean Protected Health Information that is transmitted by or maintained in electronic media.
2. The Employer shall ensure that any agent or subcontractor to whom it provides Electronic Protected Health Information shall agree, in writing, to implement reasonable and appropriate security measures to protect the Electronic Protected Health Information.
3. The Employer shall ensure that reasonable and appropriate security measures are implemented to comply with the conditions and requirements set forth in Compliance with HIPAA Privacy Standards provisions (3) Authorized Employees and (4) Certification of Employers.

12. Statement of ERISA Rights

12.1 Your Rights

As a Participant in the Plan you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 ("ERISA"). ERISA provides that all participants shall be entitled to:

- Examine, without charge, at the Plan Administrator's office and at other specified locations, such as worksites, all documents governing the plan and a copy of the latest annual report (form 5500 Series), if any, filed by the Plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Employee Benefits Security Administration.
- Obtain, on written request to the Plan Administrator, copies of documents governing the operation of the Plan, including any collective bargaining agreements, and an updated summary plan description. The Plan Administrator may make a reasonable charge for the copies.
- Receive a summary of the Plan's annual financial report. The Plan Administrator is required by law to furnish each Participant with a copy of any required summary annual report.
- **COBRA**, continue health care coverage for yourself and Dependents if there is a loss of coverage under the Plan as a result of a qualifying event: You or your Dependents may have to pay for such coverage. Review this documents governing your COBRA continuation coverage rights.
- **HIPAA**, reduction or elimination of exclusionary periods of coverage periods of coverage for preexisting conditions under your group health plan, if you have creditable coverage from another plan: If you are enrolled in a health plan before your coverage under this Plan begins, you should be provided a certificate of creditable coverage, free of charge, from your prior group health plan or health insurance issuer when you lose coverage under that group health plan, when you become entitled to elect COBRA continuation coverage under the prior plan, when your prior plan's COBRA continuation coverage ceases, if you request it before losing your prior coverage, or if you request it up to 24 months after losing the prior coverage.

12.2 Prudent Actions by Plan Fiduciaries

In addition to creating rights for plan participation, ERISA imposes duties on the people who are responsible for the operation of the employee benefit plan. The people who operate your Plan, called "fiduciaries" of the Plan, have a duty to do so prudently and in the interest of you and other Plan Participants and beneficiaries. No one, including your employer or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a plan benefit or exercising your rights under ERISA.

12.3 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 these rights. For instance, if you request materials from the Plan Administrator and do not receive

them within 30 days, you may file suit in federal court. In such a 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 a state or federal court.

If it should happen that a fiduciary misuses 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 (for example, if the court finds your claim is frivolous), the court may order you to pay these costs and fees.

12.4 No Discrimination

No one, including the Plan Sponsor or any other person, may fire you or discriminate against you in any way with the purpose of preventing you from obtaining welfare benefits or exercising your rights under ERISA.

12.5 Right to Review

If your claim for a welfare benefit is denied in whole or in part, you must receive a written explanation of the reason for the denial. You have a right to have the Plan Administrator, or its designee, review and reconsider your claim.

12.6 Assistance with Your Questions

If you have any questions about your plan, you should contact the Plan Administrator. If you have any questions about this statement or about your rights under ERISA or HIPAA, 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 on the Department of Labor's website at http://www.dol.gov/ebsa/aboutebsa/org_chart.html#section13, 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.

13. Miscellaneous

13.1 No Contract of Employment

The Plan is not intended to be, and may not be construed as constituting, a contract or other arrangement between you and Charleston Community Unit School District #1 to the effect that you will be employed for any specific period of time.

13.2 Applicability

The provisions of this document shall apply equally to the Covered Employee and Dependents and all benefits and privileges made available to Covered Employee shall be available to Covered Employee's Dependents.

13.3 Exhaustion of Administrative Remedies

Participant may not bring a cause of action hereunder in a court or other governmental tribunal unless and until all administrative remedies set forth in this document have first been exhausted.

13.4 Nontransferable

No person other than Participant is entitled to receive health care service coverage or other benefits to be furnished by Plan. Such right to health care service coverage or other benefits is not transferable.

13.5 Relationship Among Parties

The relationship between Claims Administrator and Participating Providers is that of independent contractors. Participating Providers are not agents or employees of Claims Administrator, nor is Claims Administrator or any employee of Claims Administrator an employee or agent of Participating Providers. Participating Providers shall maintain the provider-patient relationship with Participant and are solely responsible to Participant for all Participating Provider services.

Neither the Plan Sponsor nor Participant is an agent or representative of Claims Administrator, and neither shall be liable for any acts or omissions of Claims Administrator for the performance of services under this document.

13.6 Reservations and Alternatives

Plan and Claims Administrator reserve the right to contract with other corporations, associations, partnerships, or individuals for the furnishing and rendering of any of the services or benefits described herein.

13.7 Severability

In the event that any provision of this document is held to be invalid or unenforceable for any reason, the invalidity or unenforceability of that provision shall not affect the remainder of this document, which shall continue in full force and effect in accordance with its remaining terms.

13.8 Waiver

The failure of Claims Administrator, the Plan Sponsor, or Participant to enforce any provision of this document shall not be deemed or construed to be a waiver of the enforceability of such provision. Similarly, the failure to enforce any remedy arising from a default under the terms of this document shall not be deemed or construed to be a waiver of such default.

13.9 Entire Agreement

This document shall constitute the entire agreement between the parties.

14. Definitions

Any capitalized terms listed in this Section shall have the meaning set forth below whenever the capitalized term is used in this document.

14.1 "Adverse Benefit Determination"

A denial of a request for service or failure to provide or make payment (in whole or part) for a Covered Service. Adverse Benefit Determination also includes any reduction or termination of a Covered Service.

14.2 "Appeal"

A request by a Participant or the Participant's Authorized Representative for consideration of an Adverse Benefit Determination.

14.3 "Authorization/Prior Authorization"

Plan has given approval for payment for certain services to be performed and an Authorization Number has been assigned. Upon Authorization, all inpatient Hospital stays are then subject to concurrent review criteria established by the Plan. Authorization does not guarantee payment if Participant is not eligible for Covered Services at the time the service is provided.

14.4 "Authorized Representative"

An individual authorized by the Participant or state law to act on the Participant's behalf to submit appeals and file claims. A Provider may act on behalf of a Participant with the Participant's express consent, or without the Participant's express consent in an urgent care situation.

14.5 "Claims Administrator"

PersonalCare Insurance of Illinois, Inc.

14.6 "Coinsurance"

The percentage amount Participant must pay above the specified benefit payable as a condition of the receipt of certain services as provided in this Plan. Coinsurance amounts are set forth in the Schedule of Benefits.

14.7 "Co-payment"

A specified dollar amount Participant must pay as a condition of the receipt of certain Covered services. Co-payments are set forth in the Schedule of Benefits.

14.8 "Cosmetic Services and Surgery"

Plastic or reconstructive surgery: (i) from which no significant improvements in physiologic function could be reasonably expected; or (ii) that does not meaningfully promote the proper function of the body or prevent or treat illness or disease; or (iii) done primarily to improve the appearance or diminish an undesired appearance of any portion of the body.

14.9 "Coverage" or "Covered"

The entitlement by a Participant to Covered Services under the Plan subject to the terms, conditions, limitations and exclusions contained in this document and the Schedule of Benefits, including the following conditions: (a) health services must be provided prior to the date that any of the termination conditions listed under Section 3 of this document occur; and (b) health services must be provided only when the recipient is a Participant and meets all eligibility requirements specified in this document; and (c) health services must be Medically Necessary.

14.10 "Covered Employee"

The eligible employee of Charleston Community Unit School District #1, or any of its subsidiaries, as described in Section 1 of this document and who has elected coverage under the Plan through the submission of all necessary Enrollment Information to the Plan Sponsor.

14.11 "Covered Services"

The services or supplies provided to Participant for which Plan Sponsor will make payment, as described in the document.

14.12 "Coventry Transplant Network"

A Provider designated by the Claims Administrator to provide transplant services and treatment to Participants.

14.13 "Deductible"

The dollar amount of medical expenses for Covered Services that Participant is responsible for paying before benefits subject to the Deductible are payable under this Plan. Deductibles are set forth in the Schedule of Benefits.

14.14 "Dependent"

Any member of a Covered Employee's family who meets the eligibility requirements as outlined in this Plan.

14.15 "Emergency Medical Condition"

A condition manifesting itself by acute symptoms of sufficient severity (including, but not limited to, 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 individual (or, with respect to a pregnant woman, the health of a woman or her unborn child) in serious jeopardy; (2) serious impairment to bodily functions; or (3) serious dysfunction of any bodily organ or part.

14.16 "Emergency Services"

Transportation services, including, but not limited to, ambulance services, and Covered inpatient and outpatient hospital services furnished by a Provider qualified to furnish those services that are needed to evaluate or stabilize an Emergency Medical Condition. It does not mean post-stabilization medical services.

14.17 “Enrollment Information”

All information required by the Plan Sponsor and needed for enrollment in the Plan.

14.18 “Experimental or Investigational”

A health product or service is deemed experimental or investigational if one or more of the following conditions are met:

i. Any drug not approved for use by the FDA; any drug that is classified as IND (investigational new drug) by the FDA; any drug requiring Prior Authorization that is proposed for off-label prescribing;

ii. Any health product or service that is subject to Investigational Review Board (IRB) review or approval;

iii. Any health product or service that is the subject of a clinical trial that meets criteria for Phase I, II or III as set forth by FDA regulations (unless otherwise provided for herein);

iv. Any health product or service that is considered not to have demonstrated value based on clinical evidence reported by Peer-Review Medical Literature and by generally recognized academic experts.

14.19 “Formulary”

A listing of prescription drugs approved by Plan Administrator for coverage under the Plan. These are dispensed through a pharmacy to Participants. This list is subject to periodic review and change by Plan Administrator. The Formulary is available for review in Participating Provider offices or by contacting the Claims Administrator.

14.20 “Group Open Enrollment Period”

Shall mean a period of time occurring at least once annually during which time any eligible employee may enroll with Plan Sponsor coverage under this Plan.

14.21 “Hospital”

An institution, operated pursuant to law, which: (a) is primarily engaged in providing health services on an inpatient basis for the care and treatment of injured or sick individuals through medical, diagnostic and surgical facilities by or under the supervision of one or more Physicians; (b) has twenty-four (24) hour nursing services on duty or on call; and (c) is accredited as a Hospital by the Joint Commission on Accreditation of Healthcare Organizations or the American Osteopathic Hospital Association, or certified under Title XVIII of the Social Security Act (the Medicare program). A facility that is primarily a place for rest, custodial care or care of the aged, a nursing home, convalescent home, or similar institution is not a Hospital.

14.22 “Infertility”

The inability of a woman to conceive a pregnancy after one (1) year of unprotected intercourse or the inability of a woman to carry a pregnancy to live birth.

14.23 "Late Enrollees"

Shall mean individuals who fail to enroll with the Plan Sponsor for coverage under the Plan during the required thirty-one (31) day period when they first become eligible for coverage. This term does not include Special Enrollees.

14.24 "Medical Director"

The Physician specified by Plan Administrator or Claims Administrator as the Medical Director or other staff designated to act for, under the general guidance of, and in consultation with the Medical Director.

14.25 "Medically Necessary or Medical Necessity"

Those services, supplies, equipment and facilities charges that: are not expressly excluded under the Plan and determined by the Plan, in its sole discretion to be:

i. Medically appropriate, so that expected health benefits (such as, but not limited to, increased life expectancy, improved functional capacity, prevention of complications, relief of pain) materially exceed the expected health risks;
ii. Necessary to meet health needs of the Participant, improve physiological function and required for a reason other than improving appearance;
iii. Rendered in the most cost-efficient manner and setting appropriate for the delivery of the health service;
iv. Consistent in type, frequency and duration of treatment with scientifically-based guidelines of national medical research, professional medical specialty organizations or governmental agencies that are generally accepted as national authorities on the services, supplies, equipment or facilities for which coverage is requested;
v. Consistent with the diagnosis of the condition at issue;
vi. Required for reasons other than comfort or the comfort and convenience of the Participant or his or her Physician; and
vii. Not Experimental or Investigational as determined by the Plan under our Experimental Procedures Determination Policy. (A copy of the Experimental Procedures Determination Policy is available upon request from the Claims Administrator's Member Services Department.)

14.26 "Non-Participating Provider"

A Provider who has no direct or indirect written agreement with the Claims Administrator to provide health services to Participants

14.27 "Notice of Benefit Determination"

A notice of approval, denial, reduction or termination of benefits, or the failure to provide or pay for benefits.

14.28 "Out-of Network Coverage Option"

Covered Services provided to Participants by a Non-Participating Provider. These Covered Services may still require Prior Authorization.

14.29 "Out-of-Network Rate"

The amount the Plan pays for Covered Services rendered by a Non-Participating Provider under the Out-of-Network Coverage Option.

14.30 "Participant"

Any Covered Employee or Dependent or Qualified Beneficiary (as that term is defined under COBRA) who enrolled for coverage under this Plan in accordance with its terms and conditions.

14.31 "Participant Effective Date"

The date entered on Plan records as the date when coverage for a Participant under the Plan begins in accordance with the terms of this document, which coverage shall begin at 12:01 a.m. on such date.

14.32 "Participating Provider"

A Provider who has entered into a direct or indirect written agreement with Claims Administrator to provide health services to Participants. "Participating" refers only to those Providers included in the network of Providers described in the Provider Directory of Health Care Providers automatically delivered to Participants, without charge, in connection the Plan. The participation status of Providers may change from time to time.

14.33 "Physician"

Any Doctor of Medicine, "M.D.", or Doctor of Osteopathy, "D.O.", who is duly licensed and qualified under the law of the jurisdiction in which treatment is received

14.34 "Plan"

Charleston Community Unit School District #1 Group Health Benefit Plan

14.35 "Plan Sponsor"

Charleston Community Unit School District #1

14.36 "Plan Year"

The period during which the total amount of yearly benefits is calculated. The plan year is the period of twelve (12) consecutive months commencing on the date specified in Section 2 and each subsequent anniversary.

14.37 "Post-service Claim"

A claim for payment for medical care that the Participant has already received.

14.38 "Post-service Appeal"

An Appeal regarding an Adverse Benefit Determination for a Post-Service Claim.

14.39 "Pre-service Claim"

A request for a benefit that has not yet been received and for which Prior Authorization is required. Pre-service Claims do not include Urgent Care Claims.

14.40 "Pre-service Appeal"

An Appeal for which a requested service requires Prior Authorization, an Adverse Benefit Determination has been rendered, and the requested service has not been provided."

14.41 "Provider/Provider Network"

A Physician, Hospital, skilled nursing facility, home health agency, hospice, pharmacy, podiatrist, optometrist, chiropractor or other health care institution or practitioner, licensed, certified or otherwise authorized pursuant to the law of the jurisdiction in which care or treatment is received.

14.42 "Qualified Beneficiary"

Shall have the meaning set forth in COBRA.

14.43 "Schedule of Covered Services"

Description of Covered Services contained in the chart in Section 6.

14.44 "Schedule of Benefits"

Shall mean the Schedule of Benefits provided with this document.

14.45 "Special Enrollment Period"

The period set forth in Section 3 of this document.

14.46 "Specialty Care Physician/Specialist"

A Physician who provides medical services to Participants within the range of a medical specialty.

14.47 "Urgent Care Claim"

A claim for payment for medical care or treatment that meets one of the following conditions:

i. The application of the time periods for making non-urgent care determinations could: (a) seriously jeopardize the life or health of the Participant, or the Participant's ability to regain maximum function; or (b) in the opinion of a physician with knowledge of the Participant's medical condition, would subject the Participant to severe pain that cannot be adequately managed without the care or treatment that is the subject of the claim; or

ii. The Plan determines that a prudent layperson who possesses an average knowledge of health and medicine would have judged the situation to require Emergency Service; or

iii. A Physician with knowledge of the Participant's medical condition determines that the claim involves Emergency Service; or

iv. The claim occurs during the course of a treatment or Hospital stay and is subject to concurrent review, which is a review of all reasonably necessary supporting information during a Hospital stay or course of treatment as the treatment is being rendered that results in a decision by the Plan to approve or deny payment for ongoing or additional treatment.

14.48 "Urgent Care Appeal"

An Appeal that must be reviewed under the expedited Urgent Care Appeal process because the application of non-Urgent Care Appeal timeframes could seriously jeopardize the life or health of the Participant or the Participant's ability to regain maximum function. In determining whether an appeal should be expedited, the Plan will apply the judgment of a prudent layperson who possesses an average knowledge of health and medicine. An Urgent Care Appeal is also an Appeal involving care that the treating physician deems urgent in nature, or the treating physician determines that a delay in care would subject the Participant to severe pain that could not be adequately managed without the care or treatment that is being requested.

BY THIS AGREEMENT, the Charleston Community Unit School District #1 Group Health Care Plan Summary Plan Document is hereby adopted as shown.

IN WITNESS WHEREOF, this instrument is executed for the Charleston Community Unit School District #1 Group Health Care Plan on or as of the day and year below written.

Approved:

By ____

Title ____

Date ____

Attested:

By ____

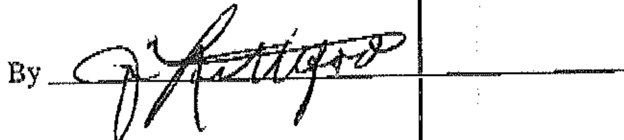
Title ____

Date ____

BY THIS AGREEMENT, the Charleston Community Unit School District #1 Group Health Care Plan Summary Plan Document is hereby adopted as shown.

IN WITNESS WHEREOF, this instrument is executed for the Charleston Community Unit School District #1 Group Health Care Plan on or as of the day and year below written.

Approved:

By 

Title Superintendent

Date February 1, 2010

Attested:

By ____________________

Title ____________________

Date ____________________

GENERAL PLAN INFORMATION

Comment [MIB6]: Client – please complete

TYPE OF ADMINISTRATION

The Plan is a self-funded group health Plan and the administration is provided through a Third Party Claims Administrator. The funding for the benefits is derived from the funds of the Employer and contributions made by covered Employees. The Plan is not insured.

PLAN NAME

Charleston Community Unit School District #1 Employee Benefits Plan

PLAN NUMBER:

Comment [n7]: Client – Enter Federal Plan Number

TAX ID NUMBER: 37-6002687

PLAN EFFECTIVE DATE: 1/1/2010

PLAN YEAR ENDS: 12/31

EMPLOYER INFORMATION

Charleston Community Unit School District #1

PLAN ADMINISTRATOR

Charleston Community Unit School District #1

NAMED FIDUCIARY

The Employer
Charleston Community Unit School District #1

AGENT FOR SERVICE OF LEGAL PROCESS

Plan Administrator
Charleston Community Unit School District #1

CLAIMS ADMINISTRATOR

Coventry Dental

BY THIS AGREEMENT, Charleston Community Unit School District #1 Employee Benefits Plan is hereby adopted as shown.

IN WITNESS WHEREOF, this instrument is executed for Charleston Community Unit School District #1 on or as of the day and year first below written.

By [signature]
Charleston Community Unit School District #1

Date February 1, 2010

Witness [signature: Judy Adair]

Date February 1, 2010

DRAFT

SCHEDULE I

[The following members of Charleston Community Unit School District #1's workforce are designated as authorized to receive Protected Health Information from Charleston Community Unit School District #1 Employee Benefits Plan ("the Plan") in order to perform their duties with respect to the Plan:

Comment [MIB8]: Client - insert designated HIPAA Officers

IN WITNESS WHEREOF this Agreement has been executed on behalf of Charleston Community Unit School District #1, effective January 1, 2010.

By ______________________
Charleston Community Unit School District #1

Witness ______________________

DRAFT

HIPAA SECURITY AMENDMENT

CHARLESTON COMMUNITY UNIT SCHOOL DISTRICT #1
EMPLOYEE BENEFITS PLAN

BY THIS AGREEMENT, Charleston Community Unit School District #1 Employee Benefits Plan, the medical plan(s) (herein called the "Plan") is hereby amended as follows, effective as of 1/1/2010.

COMPLIANCE WITH HIPAA ELECTRONIC SECURITY STANDARDS. Under the Security Standards for the Protection of Electronic Protected Health Information (45 CFR Part 164.300 et. seq., the "Security Standards"), the Plan documents must be amended to reflect certain obligations required of the Employer.

Therefore, the Employer is amending the Plan as follows:

(1) The Employer agrees to implement reasonable and appropriate administrative, physical and technical safeguards to protect the confidentiality, integrity and availability of Electronic Protected Health Information that the Employer creates, maintains or transmits on behalf of the Plan. "Electronic Protected Health Information" shall have the same definition as set out in the Security Standards, but generally shall mean Protected Health Information that is transmitted by or maintained in electronic media.

(2) The Employer shall ensure that any agent or subcontractor to whom it provides Electronic Protected Health Information shall agree, in writing, to implement reasonable and appropriate security measures to protect the Electronic Protected Health Information.

(3) The Employer shall ensure that reasonable and appropriate security measures are implemented to comply with the conditions and requirements set forth in Compliance With HIPAA Privacy Standards provisions (3) Authorized Employees and (4) Certification of Employers.

IN WITNESS WHEREOF, this Agreement has been executed on behalf of Charleston Community Unit School District #1, effective on January 1, 2010.

By ______________________
Charleston Community Unit School District #1

Witness ______________________