

CITY OF DALLAS

MEDICAL SUMMARY PLAN DESCRIPTION

\$300 DEDUCTIBLE PPO PLAN

EFFECTIVE JANUARY 1, 2004

GROUP NUMBER: N6940

**THIS REVISED MEDICAL SUMMARY PLAN DESCRIPTION
REPLACES ALL DOCUMENTS DISTRIBUTED PRIOR TO
APRIL 30, 2004**

**FOR CUSTOMER SERVICE, PLEASE CALL THE BENEFITS SERVICE
CENTER: 1-888-873-7692**

TABLE OF CONTENTS

SCHEDULE OF BENEFITS	1
PRECERTIFICATION.....	1
PREFERRED PROVIDER AND FACILITY PLAN OPTION.....	2
UTILIZATION/CASE MANAGEMENT.....	6
PRECERTIFICATION.....	6
PENALTY FOR NOT OBTAINING PRECERTIFICATION	6
SECOND SURGICAL OPINION	7
DISEASE MANAGEMENT.....	7
PREDETERMINATION OF MEDICAL BENEFITS.....	7
MEDICAL DEDUCTIBLE AND COINSURANCE INFORMATION.....	8
MEDICAL COVERED EXPENSES.....	9
INPATIENT HOSPITAL.....	9
OUTPATIENT HOSPITAL.....	9
FREE-STANDING SURGICAL FACILITY.....	9
QUALIFIED PRACTITIONER	9
ROUTINE CARE.....	10
AMBULANCE SERVICE.....	11
HUMANA BEGINNINGS.....	11
PREGNANCY BENEFITS.....	12
NEWBORN BENEFITS.....	12
BIRTHING CENTERS.....	13
SKILLED NURSING FACILITY	13
HOME HEALTH CARE	14
HOSPICE CARE	15
MENTAL DISORDER, CHEMICAL DEPENDENCE OR ALCOHOLISM BENEFIT.....	16
ORGAN TRANSPLANT BENEFIT.....	18
OTHER COVERED EXPENSES.....	22
LIMITATIONS AND EXCLUSIONS.....	24
ELIGIBILITY AND EFFECTIVE DATE OF COVERAGE.....	27
MEMBER ELIGIBILITY.....	27
MEMBER EFFECTIVE DATE OF COVERAGE	27
MEMBER DELAYED EFFECTIVE DATE	27
DEPENDENT ELIGIBILITY	27
DEPENDENT EFFECTIVE DATE OF COVERAGE – WHEN A CHANGE IN THE MEMBER’S LEVEL OF COVERAGE IS NOT REQUIRED	28
DEPENDENT EFFECTIVE DATE OF COVERAGE – WHEN A CHANGE IN THE MEMBER’S LEVEL OF COVERAGE IS REQUIRED.....	28
MEDICAL CHILD SUPPORT ORDERS.....	29
PRE-EXISTING CONDITION LIMITATION.....	29
SPECIAL PROVISIONS FOR NOT BEING IN ACTIVE STATUS.....	30
REINSTATEMENT OF COVERAGE FOLLOWING INACTIVE STATUS.....	31
FAMILY AND MEDICAL LEAVE ACT (FMLA).....	31
SELECTION OF NO COVERAGE DURING ANNUAL ENROLLMENT	31
SURVIVORSHIP COVERAGE.....	31

RETIREE COVERAGE	32
SPECIAL ENROLLMENT.....	33
TERMINATION OF COVERAGE.....	35
IMPORTANT NOTICE FOR EMPLOYEES AND SPOUSES AGE 65 AND OVER.....	36
CONTINUATION OF MEDICAL BENEFITS	37
THE UNIFORMED SERVICES EMPLOYMENT AND REEMPLOYMENT RIGHTS ACT OF 1994 (USERRA)	42
COORDINATION OF BENEFITS.....	43
REIMBURSEMENT/SUBROGATION.....	46
GENERAL PROVISIONS.....	48
CLAIMS PROCEDURES.....	51
DEFINITIONS.....	59

SCHEDULE OF BENEFITS

AN IMPORTANT MESSAGE ABOUT YOUR PLAN

Services are subject to all provisions of the Plan, including the limitations and exclusions.

Italicized terms within the text are defined in the Definitions section of this booklet.

PRECERTIFICATION

Medical Management is a Utilization/Case Management Program provided by the *Plan Manager*.

The Medical Management team will provide *precertification* as required by *your* Plan. Medical Management recommends calling as soon as possible to receive proper *precertification*. Refer to *your* ID card for the phone number to call for *precertification*.

The following benefits require *precertification*:

PRECERTIFICATION		
BENEFIT	REQUIREMENTS	PENALTY
Inpatient Hospitalization, including Mental Disorder, Alcoholism and Chemical Dependency	The <i>Plan Manager</i> must be notified at least 5 working days in advance. If the admission is on an <i>emergency</i> basis, the <i>Plan Manager</i> must be notified within 48 hours or the first business day following admission.	If the admission is not <i>precertified</i> , benefits for both the <i>qualified practitioner</i> and <i>hospital</i> or <i>qualified treatment facility</i> will be subject to a \$250 penalty per <i>confinement</i> . The penalty does not apply to the deductible or out-of-pocket maximums.
Home Health Care	The <i>Plan Manager</i> must be notified prior to <i>services</i> being rendered.	If home health care <i>services</i> are not <i>precertified</i> , benefits will be subject to a \$250 penalty per occurrence. The penalty does not apply to the deductible or out-of-pocket maximums.
Skilled Nursing Facility	The <i>Plan Manager</i> must be notified prior to <i>services</i> being rendered.	If the skilled nursing facility <i>confinement</i> is not <i>precertified</i> , benefits will be subject to a \$250 penalty per occurrence. The penalty does not apply to the deductible or out-of-pocket maximums.
Hospice Care	The <i>Plan Manager</i> must be notified prior to <i>services</i> being rendered.	If hospice care is not <i>precertified</i> , benefits will be subject to a \$250 penalty per occurrence. The penalty does not apply to the deductible or out-of-pocket maximums.
Private Duty Nursing	The <i>Plan Manager</i> must be notified prior to <i>services</i> being rendered.	If private duty nursing is not <i>precertified</i> , benefits will be subject to a \$250 penalty per occurrence. The penalty does not apply to the deductible or out-of-pocket maximums.

PRECERTIFICATION		
BENEFIT	REQUIREMENTS	PENALTY
Durable Medical Equipment over \$750	The <i>Plan Manager</i> must be notified prior to <i>services</i> being rendered.	If durable medical equipment over \$750 is not <i>precertified</i> , benefits will be subject to a \$250 penalty per occurrence. The penalty does not apply to the deductible or out-of-pocket maximums.
Humana Beginnings	<i>You</i> must call the <i>Plan Manager</i> as soon as <i>you</i> learn <i>you</i> are pregnant, in any case within the first three months of <i>your</i> pregnancy.	

PREFERRED PROVIDER AND FACILITY PLAN OPTION

Agreements have been made with certain providers and facilities of health care called Preferred Providers (PAR providers) and Preferred Facilities (PAR facilities). *You* may select any provider to provide *your* medical care.

The Plan Administrator will automatically provide, without charge, information to *you* about how *you* can access a directory of PAR Providers, appropriate to *your* service area. The PAR provider directory will be available either in hard copy as a separate document, or in electronic format. Because health care providers enter and exit networks unpredictably, the *Plan Manager* or Plan Administrator can be contacted for network provider verification.

Covered expenses are payable as shown on the Schedule of Benefits, on a *maximum allowable fee* basis. Any applicable *copayment* or penalty does not apply to the deductible or out-of-pocket limits shown on the Schedule of Benefits.

***Out of Area* members please refer to the Par Provider benefit levels.**

This schedule provides a brief overview of Plan benefits and is not a complete description. Refer to the text for a detailed description of *your* Plan benefits.

MEDICAL DEDUCTIBLE AND COINSURANCE INFORMATION		
Lifetime Maximum	\$2,000,000 per <i>covered person</i> .	
BENEFIT	PAR PROVIDER*	NON-PAR PROVIDER
Deductible:		
Individual	\$300	\$ 600
Family	\$900 aggregate	\$1,800 aggregate
Coinsurance	80% (<i>you pay 20%</i>)	60% (<i>you pay 40%</i>)
Out-of-Pocket Limit (includes deductible):		
Individual	\$2,800	\$ 5,600
Family	\$5,400	\$11,800
<p>When the amount of combined <i>covered expenses</i> paid by <i>you</i> and/or all <i>your covered dependents</i> satisfy the out-of-pocket limits the Plan will pay 100% of <i>covered expenses</i> for the remainder of the <i>calendar year</i>, unless specifically indicated, subject to any <i>calendar year</i> maximums and the lifetime maximum of the Plan.</p> <p>If <i>you</i> and <i>your covered dependents</i> use a combination of PAR and Non-Par providers, the combined out-of-pocket will not exceed the Non-Par provider out-of-pocket limit.</p>		

*PAR Provider means a provider who has signed a direct agreement with the Plan Manager to provide services to all *covered persons* for agreed upon rates.

MEDICAL COVERED EXPENSES		
HOSPITAL SERVICES		
BENEFIT	PAR PROVIDER	NON-PAR PROVIDER
<i>Inpatient Hospital</i>	Subject to deductible and coinsurance.	Subject to deductible and coinsurance after a \$250 <i>copayment</i> .
	<i>Precertification</i> is required. If <i>precertification</i> is not received, benefits are subject to the penalty described on the Schedule of Benefits.	
<i>Outpatient Hospital</i>	Subject to deductible and coinsurance.	Subject to deductible and coinsurance.
<i>Emergency Room</i>	Subject to a \$50 <i>copayment</i> , then payable at 100%.	Subject to a \$50 <i>copayment</i> , then payable at 100%.
PHYSICIAN SERVICES		
BENEFIT	PAR PROVIDER	NON-PAR PROVIDER
<i>Qualified Practitioner (Office Visits)</i>	Subject to deductible and coinsurance.	Subject to deductible and coinsurance.
<i>Qualified Practitioner (Other than Office Visits)</i>	Subject to deductible and coinsurance.	Subject to deductible and coinsurance.
Assisting the Surgeon	20% of the primary surgeon's fee, subject to deductible and coinsurance.	20% of the primary surgeon's fee, subject to deductible and coinsurance.
Physician Assistant	20% of the primary surgeon's fee, subject to deductible and coinsurance.	20% of the primary surgeon's fee, subject to deductible and coinsurance.
Preventive/Routine Care	Subject to deductible and coinsurance.	Subject to deductible and coinsurance.
	Please see text for visit limits.	
ADDITIONAL MEDICAL SERVICES		
BENEFIT	PAR PROVIDER	NON-PAR PROVIDER
<i>Free Standing Surgical Facility</i>	Subject to deductible and coinsurance.	Subject to deductible and coinsurance.
Urgent Care Facility	Subject to deductible and coinsurance.	Subject to deductible and coinsurance.
Ambulance Service	Subject to deductible and coinsurance.	Subject to par provider deductible and then payable at 80%.
Pregnancy Benefits	Subject to deductible and coinsurance.	Subject to deductible and coinsurance.
Newborn Benefits	Subject to deductible and coinsurance.	Subject to deductible and coinsurance.
Birthing Centers	Subject to deductible and coinsurance.	Subject to deductible and coinsurance after a \$250 <i>copayment</i> .

MEDICAL COVERED EXPENSES		
BENEFIT	PAR PROVIDER	NON-PAR PROVIDER
Skilled Nursing Facility	Subject to deductible and coinsurance.	Subject to deductible and coinsurance.
	PAR and Non-PAR <i>covered expenses</i> aggregate to a maximum of 120 days per <i>calendar year</i> . <i>Precertification</i> is required. If <i>precertification</i> is not received, benefits are subject to the penalty described on the Schedule of Benefits.	
Private Duty Nursing (Outpatient Only)	Subject to deductible and coinsurance.	Subject to deductible and coinsurance.
	PAR and Non-PAR <i>covered expenses</i> aggregate to a maximum of 30 visits per <i>calendar year</i> . <i>Precertification</i> is required. If <i>precertification</i> is not received, benefits are subject to the penalty described on the Schedule of Benefits.	
Home Health Care	Subject to deductible and coinsurance.	Subject to deductible and coinsurance.
	PAR and Non-PAR <i>covered expenses</i> aggregate to a maximum of 30 visits per <i>calendar year</i> . <i>Precertification</i> is required. If <i>precertification</i> is not received, benefits are subject to the penalty described on the Schedule of Benefits.	
Hospice Care	Subject to deductible and coinsurance.	Subject to deductible and coinsurance.
	<i>Precertification</i> is required. If <i>precertification</i> is not received, benefits are subject to the penalty described on the Schedule of Benefits.	
<i>Mental Disorder, Chemical Dependence and Alcoholism</i>	Payable as shown in text.	Payable as shown in text.
<i>Durable Medical Equipment (DME)</i>	Subject to deductible and coinsurance.	Subject to deductible and coinsurance.
	<i>Precertification</i> is required for <i>DME</i> over \$750. If <i>precertification</i> is not received, benefits are subject to the penalty described on the Schedule of Benefits.	
Chiropractic Care	Subject to deductible and coinsurance.	Subject to deductible and coinsurance.
	PAR and Non-PAR <i>covered expenses</i> aggregate to a maximum of 20 visits per <i>calendar year</i> .	
Therapy Services	Subject to deductible and coinsurance.	Subject to deductible and coinsurance.
	Please see text for visit limits.	
Other Covered Expenses	Subject to deductible and coinsurance.	Subject to deductible and coinsurance.

UTILIZATION/CASE MANAGEMENT

Utilization management and *case management* are designed to assist *covered persons* in making informed medical care decisions resulting in the delivery of appropriate levels of Plan benefits for each proposed course of treatment. These decisions are based on the medical information provided by the patient and the patient's physician. The patient and his or her physician determine the course of treatment. The assistance provided through these services does not constitute the practice of medicine. Payment of Plan benefits is not determined through these processes.

PRECERTIFICATION

Utilization review includes *precertification* and *concurrent review*.

This provision will not provide benefits to cover a *confinement* or *service* which is not *medically necessary* or otherwise would not be covered under the Plan. *Precertification* is not a guarantee of coverage.

If *you* or *your covered dependent* are to receive a *service* which requires *precertification*, *you* or *your qualified practitioner* must contact the *Plan Manager* by telephone or in writing. Refer to the Schedule of Benefits for time requirements.

After *you* or *your qualified practitioner* have provided the *Plan Manager* with *your* diagnosis and treatment plan, the *Plan Manager* will:

1. Advise *you* in writing if the proposed treatment plan is *medically necessary*;
2. Advise *you* in writing the number of days the *confinement* is initially *precertified*; and
3. Conduct *concurrent review* as necessary.

If *your qualified practitioner* extends *your confinement* beyond the number of days initially *precertified*, the extension must be *precertified* through *concurrent review*.

If it is determined at any time *your* proposed treatment plan, either partially or totally, is not a *covered expense* under the terms and provisions of the Plan, benefits for *services* may be reduced or *services* may not be covered.

PENALTY FOR NOT OBTAINING PRECERTIFICATION

If *you* do not obtain *precertification* for *services* being rendered, *your* benefits for both *qualified practitioner* and *hospital* or *qualified treatment facility* may be reduced. Refer to the Schedule of Benefits for the applicable penalty.

SECOND SURGICAL OPINION

A second surgical opinion may be required, as provided in the Plan, before the *confinement* will be *precertified*. Benefits for the second surgical opinion, including any *medically necessary* x-ray and laboratory tests performed by the second *qualified practitioner*, are payable same as any other *sickness*.

If the two opinions disagree, *you* may obtain a third opinion. Benefits for the third opinion are payable the same as for the second opinion.

The *qualified practitioners* providing the surgical opinions MUST NOT be in the same group practice or clinic. The *qualified practitioner* providing the second or third surgical opinion may confirm the need for *surgery* or present other treatment options. The decision whether or not to have the *surgery* is always *yours*.

DISEASE MANAGEMENT

The Disease Management Programs listed in this section are available to *you* and any eligible *dependents* covered by this Plan. These Disease Management Programs are provided at no cost to *you* or *your qualified practitioner*.

- **Congestive Heart Failure:** This program combines intervention, monitoring and education, which will enable *you* to take a more active role in managing *your* health.
- **Coronary Artery Disease:** This program's objective is to promote good health through education, counseling and support. This program offers educational materials on diet, medication management, exercise, and, if appropriate, smoking cessation.
- **End Stage Renal Disease:** This program is designed to educate *you* and coordinate the multiple facets of *your* care.
- **Neonatal Intensive Care:** This program combines care coordination and parent education to help improve the patient's outcome and reduce stress on the family.
- **Rare Diseases (Cystic Fibrosis, Hemophilia, Multiple Sclerosis, Myasthenia Gravis and Systemic Lupus Erythematosis):** *You* will be educated on the specifics of *your* disease, the possible complications and the treatment options available. The goal is to maintain a high standard of care and help meet *your* medical and psychological needs.

If *you* have any questions regarding the Disease Management Programs listed in this section, contact the Medical Management team at 1-800-626-2738 and one of the nurses will assist *you*.

PREDETERMINATION OF MEDICAL BENEFITS

You or *your qualified practitioner* may submit a written request for a *predetermination of benefits*. The written request should contain the treatment plan, specific diagnostic and procedure codes, as well as the expected charges. The *Plan Manager* will provide a written response advising if the *services* are a *covered* or *non-covered expense* under the Plan, what the applicable Plan benefits are and if the expected charges are within the *maximum allowable fee*. The *predetermination of benefits* is not a guarantee of benefits. *Services* will be subject to all terms and provisions of the Plan applicable at the time treatment is provided.

If treatment is to commence more than 90 days after the date treatment is authorized, the *Plan Manager* will require *you* to submit another treatment plan.

MEDICAL DEDUCTIBLE AND COINSURANCE INFORMATION

Covered expenses are payable, after satisfaction of the deductible, to a *maximum allowable fee* at the coinsurance percentages and up to the maximum benefits shown on the Schedule of Benefits.

DEDUCTIBLE

The deductible applies to each *covered person* each *calendar year*. Only charges which qualify as a *covered expense* may be used to satisfy the deductible. The amount of the deductible is stated on the Schedule of Benefits.

MAXIMUM FAMILY DEDUCTIBLE

The total deductible applied to all *covered persons* in one family in a *calendar year* is subject to the maximum shown on the Schedule of Benefits.

COMMON ACCIDENT DEDUCTIBLE

When two or more *covered persons* in one family incur *covered expenses* due to the same accident, only one deductible per *calendar year* will be applied to the total of all *covered expenses* incurred as a result of that accident.

COINSURANCE

The term coinsurance means the shared financial responsibility for *covered expenses* between the *covered person* and the self-funded plan.

Covered expenses are payable at the applicable percentage rate shown on the Schedule of Benefits after the deductible is satisfied each *calendar year*.

OUT-OF-POCKET LIMIT

When the amount of combined *covered expenses* paid by *you* and/or all *your covered dependents* satisfy the separate PAR and Non-PAR provider deductible and out-of-pocket limits as shown on the Schedule of Benefits, the Plan will pay 100% of *covered expenses* for the remainder of the *calendar year*, unless specifically indicated, subject to any *calendar year* maximums and the lifetime maximum of the Plan.

If *you* and *your covered dependents* use a combination of PAR and Non-PAR providers, the out-of-pocket amounts will track separately, however the combined out-of-pocket will not exceed the Non-PAR provider out-of-pocket limit. Office visit *copayments* are not applied to the out-of-pocket limit.

Covered expenses are subject to any *calendar year* maximums or the lifetime maximum of the Plan.

LIFETIME MAXIMUM

Lifetime maximum means the maximum amount of benefits available while *you* are covered under the Plan. Under no circumstances does lifetime mean during the lifetime of the *covered person*.

MEDICAL COVERED EXPENSES

INPATIENT HOSPITAL

Covered expenses are payable as shown on the Schedule of Benefits and include charges made by a:

1. *Hospital* for daily semi-private, ward, intensive care or coronary care room and board charges for each day of *confinement*. The maximum amount payable is shown on the Schedule of Benefits. Benefits for a private or single-bed room are limited to the *maximum allowable fee* charged for a semi-private room in the *hospital* while a registered bed patient;
2. *Hospital* for *services* furnished for your treatment during *confinement*.

OUTPATIENT HOSPITAL

Covered expenses are payable as shown on the Schedule of Benefits and include charges made by a *hospital* for:

1. Treatment of a *bodily injury*, including the emergency room charge if rendered within 48 hours of an accident;
2. Treatment of a *sickness* following an *emergency*, including the emergency room charge;
3. *Preadmission testing*;
4. A surgical procedure;
5. Regularly scheduled treatment such as chemotherapy, inhalation therapy, radiation therapy as ordered by *your* attending physician.

FREE-STANDING SURGICAL FACILITY

Charges made by a *free-standing surgical facility*, for surgical procedures performed and for *services* rendered in the facility are payable as shown on the Schedule of Benefits.

QUALIFIED PRACTITIONER

Covered expenses are payable as shown on the Schedule of Benefits and include charges made by a *qualified practitioner* when incurred for:

1. Office, home, *emergency* room physician or inpatient *hospital* visits;
2. Diagnostic x-ray or laboratory tests;
3. Professional *services* of a radiologist or pathologist for diagnostic x-ray examination or laboratory tests, including x-ray, radon, radium, and radioactive isotope therapy;
4. Other covered medical *services* received from or at the direction of a *qualified practitioner*;
5. Administration of anesthesia;

Qualified Practitioner Continued

6. A surgical procedure, including pre-operative and post-operative care.

If multiple or bilateral surgical procedures are performed at one operative session, the amount payable for these procedures will be limited to the *maximum allowable fee* for the primary surgical procedure and;

- a. 50% of the *maximum allowable fee* for the secondary procedure; and
- b. 25% of the *maximum allowable fee* for the third and subsequent procedures.

No benefits will be payable for incidental procedures.

7. Assisting the surgeon;

8. Physician assistant;

9. Charges made by a *qualified practitioner* for *services* in performing certain oral surgical operations due to *bodily injury* or *sickness* are covered as follows:

- a. Excision of tumors and cysts of the jaws, cheeks, lips, tongue, roof and floor of the mouth when such conditions require pathological examination;
- b. Surgical procedures required to correct accidental injuries of the jaws, cheeks, lips, tongue, roof and floor of the mouth;
- c. Reduction of fractures and dislocations of the jaw;
- d. External incision and drainage of cellulitis.

ROUTINE CARE

The following expenses are payable for *you* or *your* covered *dependent*, up to the amount shown on the Schedule of Benefits, subject to all terms and provisions of the Plan, except the exclusion for *services* which are not *medically necessary*, if *you* are not confined in a *hospital* or *qualified treatment facility* and if such expenses are not incurred for diagnosis of a specific *bodily injury* or *sickness*.

Benefits include:

1. Routine exams and annual checkups, including routine x-ray and laboratory tests
2. Immunizations;
3. Pap smears and associated exam, 1 (one) per *calendar year*;
4. Mammograms, 1 (one) per *calendar year*;
5. Prostate antigen testing, annually for males ages 35 and up;

Routine Care Continued

6. Colonoscopy, once every 5 years for males and females ages 50 and up.

No benefits are payable under this benefit for:

1. Any dental examinations;
2. Hearing examinations;
3. Medical examination for *bodily injury* or *sickness*;
4. Medical examination caused by or resulting from pregnancy.

AMBULANCE SERVICE

Local professional ambulance service to the nearest *hospital* equipped to provide the necessary treatment is covered as shown on the Schedule of Benefits. Ambulance service must not be provided primarily for the convenience of the patient or the *qualified practitioner*.

HUMANA BEGINNINGS

The "Humana Beginnings Program" is a service provided to *covered persons* by the *Plan Manager*. This program is designed as a special service that helps mothers receive appropriate prenatal care.

- First, call the *precertification* phone number shown on the back of *your* ID card as soon as *your* pregnancy has been confirmed by a *qualified practitioner*. When *you* call, one of the nurses will ask *you* questions such as: *your* estimated date of delivery, if *you* had any problems with previous pregnancies, and *your* ongoing medical conditions, just to name a few. These questions are held in confidence between *you* and the nurse *you* are speaking to. Answers to these questions, along with *your* approval, will help the nurse and *your* doctor decide whether *you* need special care during *your* pregnancy.
- If *you* and/or *your* baby need special care before or after delivery, a nurse is available to assist in managing *your* care. The nurse will obtain the necessary consents from *you* to manage *your* care. The nurse case manager will then monitor the treatment plan and facilitate with *your* health care professional to ensure *you* are receiving the best care while getting the most out of *your* health insurance benefits.
- If *your* health care professional admits *you* to a *hospital* during *your* pregnancy, please follow the *precertification* requirements defined in *your* benefit booklet for *emergency* and planned admissions.

Humana Beginnings Continued

- When you deliver your baby, you may not feel up to calling the *Plan Manager* (or as indicated on your ID card). Remind your partner, relative or health care professional to call for you.

If you have any questions, call the *Plan Manager* (or as indicated on your ID card) and one of our nurses will help you.

PREGNANCY BENEFITS

Pregnancy is a *covered expense* for any covered *employee* or covered spouse payable as shown on the Schedule of Benefits.

Complications of pregnancy are payable as any other covered *sickness* at the point the complication sets in for any *covered person*.

Pregnancy benefits are subject to all terms and provisions of the Plan, with the exception of the *pre-existing condition* limitation as defined within the Definitions section of this booklet.

Group health plans and health insurance issuers 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 issuer for prescribing a length of stay not in excess of 48hours (or 96 hours).

NEWBORN BENEFITS

Benefits for newborns are subject to the Eligibility and Effective Date of Coverage section of this booklet, as well as all terms and provisions of the Plan, with the exception of the *pre-existing condition* limitation as defined within the Definitions section of this booklet.

Covered expenses incurred during a newborn child's initial inpatient *hospital confinement* include *hospital* expenses for room and board and miscellaneous *services*; *qualified practitioner's* expenses for circumcision; and *qualified practitioner's* expenses for routine examination before release from the *hospital*.

BIRTHING CENTERS

A birthing center is a free standing facility, licensed by the state, which provides prenatal care, delivery and immediate postpartum care, and care of the newborn child.

Expense incurred within 48 hours after *confinement* in a birthing center for *services* and supplies furnished for prenatal care and delivery of child(ren) are payable as shown on the Schedule of Benefits.

SKILLED NURSING FACILITY

Covered expenses for a skilled nursing facility *confinement* are payable when the *confinement*:

1. Begins while *you* or an eligible *dependent* are covered under this Plan;
2. Begins within 24 hours after discharge from a hospital *confinement* or a prior covered skilled nursing facility *confinement*;
3. Is necessary for care or treatment of the same *bodily injury* or *sickness* which caused the prior *confinement*; and
4. Occurs while *you* or an eligible *dependent* are under the regular care of the physician who *precertified* the required skilled nursing facility *confinement*.

Skilled nursing facility means only an institution licensed as a skilled nursing facility and lawfully operated in the jurisdiction where located. It must maintain and provide:

1. Permanent and full-time bed care facilities for resident patients;
2. A physician's *services* available at all times;
3. 24-hour-a-day skilled nursing *services* under the full-time supervision of a physician or registered nurse (R.N.);
4. A daily record for each patient;
5. Continuous skilled nursing care for sick or injured persons during their convalescence from *sickness* or *bodily injury*; and
6. A utilization review plan.

A skilled nursing facility is not except by incident, a rest home, a home for care of the aged, or engaged in the care and treatment of *mental disorders*, chemical dependence, or alcoholism.

BENEFITS PAYABLE

Expense incurred for daily room and board and general nursing *services* for each day of *confinement* in a skilled nursing facility is payable as shown on the Schedule of Benefits. The daily rate will not exceed the maximum daily rate established for licensed skilled nursing care facilities by the Department of Health and Social Services.

HOME HEALTH CARE

Expense incurred for home health care as described below is payable as shown on the Schedule of Benefits.

Each visit by a home health care provider for evaluating the need for, developing a plan, or providing *services* under a home health care plan will be considered one home health care visit. Up to 4 consecutive hours of service in a 24-hour period is considered one home health care visit. A visit by a home health care provider of 4 hours or more is considered one visit for every 4 hours or part thereof.

Home health care provider means an agency licensed by the proper authority as a home health agency or *Medicare* approved as a home health agency.

Home health care will not be reimbursed unless the Plan determines:

1. Hospitalization or *confinement* in a skilled nursing facility would otherwise be required if home care were not provided;
2. Necessary care and treatment are not available from a *family member* or other persons residing with *you*; and
3. The home health care *services* will be provided or coordinated by a state-licensed or *Medicare*-certified home health agency or certified rehabilitation agency.

The home health care plan must be reviewed and approved by the *qualified practitioner* under whose care *you* are currently receiving treatment for the *bodily injury* or *sickness* which requires the home health care.

The home health care plan consists of:

1. Care by or under the supervision of a registered nurse (R.N.);
2. Physical, speech, occupational and respiratory therapy and home health aide *services*; and
3. Medical supplies and *durable medical equipment*, laboratory *services* and nutritional counseling, if such *services* and supplies would have been covered if *you* were *hospital* confined.

LIMITATIONS ON HOME HEALTH CARE BENEFITS

Home health care benefits do not include:

1. Charges for mileage or travel time to and from the *covered person's* home;
2. Wage or shift differentials for home health care providers; or
3. Charges for supervision of home health care providers.

HOSPICE CARE

Hospice *services* must be furnished in a hospice facility or in *your* home. A *qualified practitioner* must certify that *covered persons* are terminally ill with a life expectancy of six months or less.

For hospice *services* only, *your* immediate family is considered to be *your* parent, spouse, and *your* children or stepchildren.

Covered expenses are payable as shown on the Schedule of Benefits for the following hospice *services*:

1. Room and board and other *services* and supplies;
2. Part-time nursing care by or supervised by a R.N. for up to 8 hours per day;
3. Counseling *services* by a *qualified practitioner* for the hospice patient and the immediate family;
4. Medical social *services* provided to *covered persons* under the direction of a *qualified practitioner*, which include the following:
 - a. Assessment of social, emotional and medical needs, and the home and family situation,
 - b. Identification of the community resources available, and
 - c. Assistance in obtaining those resources;
5. Nutritional counseling;
6. Physical or occupational therapy;
7. Part-time home health aide service for up to 8 hours in any one day; and
8. Medical supplies, drugs and medicines prescribed by a *qualified practitioner*; and
9. Bereavement counseling *services* by a *qualified practitioner* for *your* immediate family to a 15 visit *maximum benefit*.

LIMITATIONS ON HOSPICE CARE BENEFITS

Hospice care benefits do NOT include: (1) private duty nursing *services* when confined in a hospice facility; (2) a *confinement* not required for pain control or other acute chronic symptom management; (3) funeral arrangements; (4) financial or legal counseling, including estate planning or drafting of a will; (5) homemaker or caretaker *services*, including a sitter or companion *services*; (6) housecleaning and household maintenance; (7) *services* of a social worker other than a licensed clinical social worker; (8) *services* by volunteers or persons who do not regularly charge for their *services*; or (9) *services* by a licensed pastoral counselor to a *member* of his or her congregation when *services* are in the course of the duties to which he or she is called as a pastor or minister.

Hospice Care Continued

Hospice care program means a written plan of hospice care, established and reviewed by the *qualified practitioner* attending the patient and the hospice care agency, for providing palliative and supportive care to hospice patients. It offers supportive care to the families of hospice patients, an assessment of the hospice patient's medical and social needs, and a description of the care to meet those needs.

Hospice facility means a licensed facility or part of a facility which principally provides hospice care, keeps medical records of each patient, has an ongoing quality assurance program and has a physician on call at all times.

A hospice facility provides 24-hour-a-day nursing *services* under the direction of a R.N. and has a full-time administrator.

Hospice care agency means an agency which has the primary purpose of providing hospice *services* to hospice patients. It must be licensed and operated according to the laws of the state in which it is located and meets all of these requirements: (1) has obtained any required certificate of need; (2) provides 24-hours a day, 7 day-a-week service supervised by a *qualified practitioner*; (3) has a full-time coordinator; (4) keeps written records of *services* provided to each patient; (5) has a nurse coordinator who is a R.N., who has four years of full-time clinical experience, of which at least two involved caring for terminally ill patients; and, (6) has a licensed social service coordinator.

A hospice care agency will establish policies for the provision of hospice care, assess the patient's medical and social needs and develop a program to meet those needs. It will provide an ongoing quality assurance program, permit area medical personnel to use its *services* for their patients, and use volunteers trained in care of and *services* for non-medical needs.

MENTAL DISORDER, CHEMICAL DEPENDENCE OR ALCOHOLISM BENEFIT

Expense incurred by *covered persons* during a plan of treatment for *mental disorder*, chemical dependence or alcoholism is payable for:

1. Charges made by a *qualified practitioner*;
2. Charges made by a *hospital*;
3. Charges made by a *qualified treatment facility*;

INPATIENT MENTAL DISORDER BENEFITS

Covered expenses while confined as a registered bed patient in a *hospital* or *qualified treatment facility* are payable as shown below:

PAR PROVIDER	NON-PAR PROVIDER
Subject to deductible then payable at 80%.	Subject to deductible then payable at 60%.
PAR and Non-PAR inpatient treatment of a <i>mental disorder</i> aggregate to a <i>maximum benefit</i> of 30 days per <i>calendar year</i> .	

Covered expenses for inpatient treatment do not aggregate toward the coinsurance and out-of-pocket limits described on the Schedule of Benefits.

OUTPATIENT MENTAL DISORDER BENEFITS

Covered expenses for outpatient treatment received while not confined in a *hospital* or *qualified treatment facility* are payable as shown below:

PAR PROVIDER	NON-PAR PROVIDER
Subject to deductible then payable at 80%.	Subject to deductible then payable at 60%.
PAR and Non-PAR outpatient treatment of a <i>mental disorder</i> aggregate to a <i>maximum benefit</i> of 20 visits per <i>calendar year</i> .	

Covered expenses for outpatient treatment do not aggregate toward the coinsurance and out-of-pocket limits described on the Schedule of Benefits.

INPATIENT AND OUTPATIENT ALCOHOLISM AND CHEMICAL DEPENDENCY BENEFITS

Covered expenses while confined as a registered bed patient in a *hospital* or *qualified treatment facility* or for outpatient treatment received while not confined in a *hospital* or *qualified treatment facility* are payable as shown below:

PAR PROVIDER	NON-PAR PROVIDER
Subject to deductible then payable at 80%.	Subject to deductible then payable at 60%.
PAR and Non-PAR inpatient and outpatient treatment of alcoholism and chemical dependency aggregate to a <i>maximum benefit</i> of three series of treatments for each <i>covered person</i> per lifetime.	

Covered expenses for inpatient and outpatient treatment do not aggregate toward the coinsurance and out-of-pocket limits described on the Schedule of Benefits.

INPATIENT AND OUTPATIENT *SERIOUS MENTAL ILLNESS* BENEFITS

Covered expenses while confined as a registered bed patient in a *hospital* or *qualified treatment facility* or for outpatient treatment received while not confined in a *hospital* or *qualified treatment facility* are payable as shown below:

PAR PROVIDER	PAR PROVIDER
Payable the same as any other <i>sickness</i> .	Payable the same as any other <i>sickness</i> .
PAR and Non-PAR inpatient treatment of <i>serious mental illness</i> aggregate to a <i>maximum benefit</i> of 45 days per <i>calendar year</i> . PAR and Non-PAR outpatient treatment of <i>serious mental illness</i> aggregate to a <i>maximum benefit</i> of 60 visits per <i>calendar year</i> .	

Covered expenses for treatment do not aggregate toward the coinsurance and out-of-pocket limits described on the Schedule of Benefits.

LIMITATIONS ON MENTAL DISORDER, CHEMICAL DEPENDENCE OR ALCOHOLISM BENEFITS

No benefits are payable under this provision for marriage counseling, treatment of nicotine habit or addiction, or for treatment of being obese or overweight.

Treatment must be provided for the cause for which benefits are payable under this provision of the Plan.

ORGAN TRANSPLANT BENEFIT

The Plan will pay benefits for the expense of a transplant as defined below when incurred by a *covered person* and approved in advance by the *Plan Manager*, subject to those terms, conditions and limitations described below and contained in the Plan. Please contact the *Plan Manager* when in need of these *services*.

COVERED ORGAN TRANSPLANTS

Only the *services*, care, and treatment received for or in connection with the pre-approved transplant of the organs identified hereafter, which are determined by the *Plan Manager* to be *medically necessary services* and which are not *experimental, investigational or for research purposes*. The transplant includes pre-transplant, transplant inclusive of any chemotherapy and associated *services*, post-discharge *services*, and treatment of complications after transplantation of the following organs or procedures only:

1. Heart;
2. Lung(s);
3. Heart-lung;
4. Liver;
5. Kidney;
6. Bone Marrow;
7. Intestine;
8. Simultaneous pancreas/kidney;
9. Pancreas following kidney;
10. Any organ not listed above required by state or federal law.

Organ Transplant Benefit Continued

The term bone marrow identified in the foregoing transplant definition refers to the transplant of human blood precursor cells which are administered to a patient following high-dose, ablative or myelosuppressive chemotherapy. Such cells may be derived from bone marrow, circulating blood, or a combination of bone marrow and circulating blood obtained from the patient in an autologous transplant or from a matched related or unrelated donor or cord blood. If chemotherapy is an integral part of the treatment involving a transplant of bone marrow, the term bone marrow includes the harvesting, the transplantation and the chemotherapy components. Storage of cord blood and stem cells will not be covered unless as an integral part of a transplant of bone marrow approved by the *Plan Manager*.

Corneal transplants and porcine heart valve implants, which are tissues rather than organs, are considered part of regular plan benefits and are subject to other applicable provisions of the Plan.

For a transplant to be considered fully approved, prior written approval from the *Plan Manager* is required in advance of the transplant. *You or your qualified practitioner* must notify the *Plan Manager* in advance of *your* need for an initial evaluation for the transplant in order for the *Plan Manager* to determine if the transplant will be covered. For approval of the transplant itself, the *Plan Manager* must be given a reasonable opportunity to review the clinical results of the evaluation before rendering a determination.

ORGAN TRANSPLANT EXCLUSIONS

No benefit is payable for or in connection with a transplant if:

1. It is *experimental, investigational or for research purposes* as defined elsewhere in the Plan.
2. The *Plan Manager* is not contacted for authorization prior to referral for evaluation of the transplant, unless such authorization is waived by the *Plan Manager*.
3. The *Plan Manager* does not approve coverage for the transplant, based on its established criteria.
4. Expenses are eligible to be paid under any private or public research fund, government program except Medicaid, or another funding program, whether or not such funding was applied for or received.
5. The expense relates to the transplantation of any non-human organ or tissue, unless otherwise stated in the Plan.
6. The expense relates to the donation or acquisition of an organ for a recipient who is not covered by the Plan.
7. A denied transplant is performed; this includes the pre-transplant evaluation, the transplant procedure, follow up care, immunosuppressive drugs, and complications of such transplant.
8. The *covered person* for whom a transplant is requested has not met pre-transplant criteria as established by the *Plan Manager*.

Once the transplant is approved, the *Plan Manager* will advise the *covered person's qualified practitioner*. Benefits are payable only if the pre-transplant *services*, the transplant and post-discharge *services* are approved by the *Plan Manager*.

Organ Transplant Benefit Continued

COVERED ORGAN TRANSPLANT SERVICES

For approved transplants, and all related complications, the *Plan Manager* will cover only the following expenses:

1. *Hospital* benefits shown in the Schedule of Benefits under the *Hospital* Benefit section of this Plan will be paid at: (a) 80%, after deductible, of *covered expenses* if received at a PAR *hospital* designated by the *Plan Manager* as an approved transplant facility; and (b) 60%, after deductible, of *covered expenses* if received at a Non-PAR *hospital*.

Qualified practitioner benefits shown in the Schedule of Benefits under the *Qualified Practitioner* section of this Plan will be paid at (a) 80%, after deductible, of *covered expenses* if received from a PAR *qualified practitioner* designated by the *Plan Manager* as an approved transplant provider; and (b) 60%, after deductible, of *covered expenses* if received from a Non-PAR *qualified practitioner*.

Any out-of-pocket limits or deductible(s) in the Plan do not apply to the benefits shown in this section of the Plan. Any out-of-pocket limits, including *copayments*, directly related to the benefit in this section of the Plan do not apply toward any out-of-pocket limits or deductible(s) shown elsewhere in the Plan.

2. Organ acquisition and donor costs. Except for bone marrow transplants, donor costs are not payable under the Plan if they are payable in whole or in part by any other group plan, insurance company, organization or person other than the donor's family or estate. Coverage for bone marrow transplants procedures will include costs associated with the donor-patient to the same extent and limitations associated with the *covered person*, except the reasonable costs of searching for the donor may be limited to the immediate *family members* and the National Bone Marrow Donor Program.
3. Direct, non-medical costs* for the *covered person* receiving the transplant will be paid for: (a) transportation to and from the *hospital* where the transplant is performed; and (b) temporary lodging at a prearranged location up to \$75 per day when requested by the *hospital* and approved by the *Plan Manager*. Transportation costs for the *covered person* to and from the *hospital* where the transplant is performed will be paid at: (a) 80%, after deductible, of *covered expenses* if the transplant is received at a PAR *hospital* designated by the *Plan Manager* as an approved transplant facility; or, (b) 60%, after deductible, of *covered expenses* if the transplant is received at a Non-PAR *hospital*. These direct, non-medical costs are only available if the *covered person* lives more than 100 miles from the transplant facility.

Organ Transplant Benefit Continued

4. Direct, non-medical costs* for one *member* of the *covered person's* immediate family (two *members* if the patient is under age 18 years) will be paid for: (a) transportation to and from the approved facility where the transplant is performed; and, (b) temporary lodging at a prearranged location during the *covered person's confinement* in a *hospital*, not to exceed \$75 per day. Transportation costs for the *covered person's* immediate *family member(s)* to and from the *hospital* where the transplant is performed will be paid at: (a) 80%, after deductible, of *covered expenses* if the transplant is received at a PAR *hospital* designated by the *Plan Manager* as an approved transplant facility; or, (b) 60%, after deductible, of *covered expenses* if the transplant is received at a Non-PAR *hospital*. These direct, non-medical costs are only available if the *covered person's* immediate *family member(s)* live more than 100 miles from the transplant facility.

*All direct, non-medical expenses for the *covered person* receiving the transplant and his/her *family member(s)* are limited to a combined *maximum benefit* of \$10,000 per transplant.

OTHER COVERED EXPENSES

The following are other *covered expenses* payable as shown on the Schedule of Benefits:

1. Blood and blood plasma are payable as long as it is NOT replaced by donation, and administration of blood and blood products including blood extracts or derivatives;
2. Oxygen and rental of equipment for its administration;
3. Initial prosthetic devices or supplies, including but not limited to, limbs, and eyes. Coverage will be provided for prosthetic devices necessary to restore minimal basic function. Replacement is a *covered expense* if due to pathological changes. *Covered expense* includes repair of the prosthetic device if not covered by the manufacturer;
4. Casts, trusses, crutches, splints except for dental splints, and braces except for orthodontic braces;
5. Supplies, up to a 30-day supply, when prescribed by *your* attending physician;
6. Initial contact lenses or eyeglasses following cataract *surgery*;
7. The rental, up to but not to exceed the purchase price, of a wheelchair, hospital bed, ventilator, hospital type equipment or other *durable medical equipment (DME)*. The Plan, at its option, may authorize the purchase of *DME* in lieu of its rental, if the rental price is projected to exceed the purchase price. Repair, maintenance, or duplicate *DME* rental is not considered a *covered expense*. *Precertification* is required for *DME* over \$750. If *precertification* is not received, benefits are subject to the penalty described on the Schedule of Benefits;
8. Chiropractic care for treatment of a *bodily injury* or *sickness*, limited to 20 visits per *calendar year*. *Maintenance care* is not covered;
9. Extraction and initial replacement of a *sound natural tooth* lost due to a *dental injury*. *Services* must begin within 6 months and be completed within 6 months after the date of the *dental injury*. Benefits will be paid only for *expense incurred* for the least expensive *service* that will, in the *Plan Manager's* opinion, produce a professionally adequate result;
10. Installation and use of an insulin infusion pump, diabetic self-management education programs and other equipment or supplies in the treatment of diabetes;
11. Surgical or non-surgical treatment including but not limited to, appliances and therapy, for any jaw joint problem including any temporomandibular joint disorder, craniomaxillary, craniomandibular disorder or other conditions of the joint linking the jaw bone and skull; surgical treatment of the facial muscles used in expression and mastication functions, for symptoms including but not limited to, headaches. These expenses do not include charges for orthodontic *services*;
12. Reconstructive *surgery* due to *bodily injury*, infection or other disease of the involved part which occurs while *you* are covered under this Plan, or congenital disease or anomaly of a covered *dependent* child which resulted in a functional defect;

Other Covered ExpensesContinued

13. Reconstructive *services* following a covered mastectomy, including but not limited to:
 - a. reconstruction of the breast on which the mastectomy was performed;
 - b. reconstruction of the other breast to achieve symmetry;
 - c. prosthesis; and
 - d. treatment of physical complications of all stages of the mastectomy, including lymphedemas;
14. Speech, occupational, and physical therapy, each therapy for PAR and Non-Par *covered* expenses aggregate to a maximum of 20 visits per *calendar year*;
15. Vision therapy, PAR and Non-Par *covered expense* aggregate to a maximum of 20 visits per lifetime for employees and their spouses, and 30 visits per lifetime for children 16 years of age and under;
16. Chemotherapy, respiratory and radiation therapy;
17. Cardiac rehabilitation, limited to phases I and II;
18. *Services for morbid obesity*, when qualified as *morbid obesity* and *medically necessary*;
19. Private Duty Nursing (outpatient only).
20. Elective sterilizations;
21. Birth control devices and contraceptive implant systems including their removal.

LIMITATIONS AND EXCLUSIONS

The Plan does not provide benefits for:

1. *Services*:
 - a. Not furnished by a *qualified practitioner* or *qualified treatment facility*;
 - b. Not authorized or prescribed by a *qualified practitioner*;
 - c. Not covered by this Plan whether or not prescribed by a *qualified practitioner*;
 - d. Which are not provided;
 - e. For which no charge is made, or for which *a covered person* would not be required to pay if *a covered person* were not covered under this Plan unless charges are received from and reimbursable to the United States Government or any of its agencies as required by law; or
 - f. Furnished by or payable under any plan or law through any government or any political subdivision (this does not include *Medicare* or *Medicaid*);
 - g. Furnished for a military service connected *sickness* or *bodily injury* by or under an agreement with a department or agency of the United States Government, including the Department of Veterans Affairs;
 - h. Performed in association with a *service* that is not covered under this Plan;
 - i. Performed as a result of a complication arising from a *service* that is not covered under this Plan;
2. Routine eye exams, *services* to correct eye refractive disorders, eyeglass frames and lenses or contact lenses, the fitting or repair of eyeglass frames and lenses or contact lenses, unless specifically indicated in Other Covered Expenses #6;
3. Routine hearing exams, hearing aids, the fitting, or repair of hearing aids;
4. Routine physical exams and related *services*, including those for occupation, employment, school, travel, purchase of insurance or premarital tests or examinations, unless specifically provided under this Plan;
5. Elective abortions, unless the pregnancy is a life-threatening physical condition of the covered female person;
6. *Services* related to gender change;

Limitations and Exclusions Continued

7. *Services* for a reversal of sterilization;
8. Any *bodily injury* or *sickness* arising from or sustained in the course of any occupation or employment for compensation, profit or gain for which:
 - a. Benefits are provided or payable under any Workers' Compensation or Occupational Disease Act or Law, or
 - b. Coverage was available under any Workers' Compensation or Occupational Disease Act or Law regardless of whether such coverage was actually purchased;
9. *Services* for *cosmetic surgery*;
10. Dental *services* or appliances for the treatment of the teeth, gums, jaws or alveolar processes, including but not limited to, implants and related procedures, and orthodontic procedures, unless specifically provided under this Plan;
11. Any loss caused by or contributed to:
 - a. War or any act of war, whether declared or not, or
 - b. Any act of armed conflict, or any conflict involving armed forces of any authority;
12. The treatment of *mental disorders*, chemical dependence or alcoholism unless specifically provided under this Plan;
13. Any drug, medicine or device which does not have the United States Food and Drug Administration formal market approval through a New Drug Application, Premarket Approval, 510K, or PLA;
14. Any *service* which is *experimental, investigational or for research purposes*, unless specifically indicated in Other Covered Expenses;
15. *Pre-existing conditions* to the extent specified in the Definitions section;
16. *Custodial care* and *maintenance care*;
17. *Services* provided by a person who ordinarily resides in a *covered person's* home or who is a *family member*;
18. Charges in excess of the *maximum allowable fee* for the *service*;
19. Any *expense incurred* prior to a *covered person's* effective date under the Plan or after the date *your* coverage under the Plan terminates, except as specifically described in this Plan;

Limitations and Exclusions Continued

20. Any expense due to commission or attempt to commit a civil or criminal battery or felony;
21. *Services not medically necessary* for diagnosis and treatment of a *bodily injury* or *sickness*;
22. Private duty nursing, unless specifically provided under this Plan;
23. *Expenses incurred* for which a *covered person* is entitled to receive benefits under a previous dental or medical plan;
24. All fertility testing or *services* (other than diagnostic testing or services), including any artificial means to achieve pregnancy or ovulation, such as artificial insemination, in vitro fertilization, spermatogenesis, gamete intra fallopian transfer (GIFT), zygote intra fallopian transfer (ZIFT), tubal ovum transfer, embryo freezing or transfer and sperm banking;
25. Prescription drugs dispensed at any given time in excess of a 30-day supply;
26. Therapy and testing for treatment of allergies, including but not limited to, *services* related to clinical ecology, environmental allergy and allergic immune system dysregulation and sublingual antigen(s), extracts, neutralization test and/or treatment UNLESS such therapy or testing is approved by:
 - a. The American Academy of Allergy and Immunology, or
 - b. The Department of Health and Human Services or any of its offices or agencies;
27. Professional pathology or radiology charges, including but not limited to, blood counts, multi-channel testing, and other clinical chemistry tests, when:
 - a. The *services* do not require a professional interpretation, or
 - b. The *qualified practitioner* did not provide a specific professional interpretation of the test results of the *covered person*;
28. *Services* for the treatment of obesity, unless specifically indicated in Other Covered Expenses;
29. Birth control pills and contraceptive injections;
30. Smoking cessation products;
31. Diagnosis and/or treatment of sexual dysfunction/impotence, unless due to an underlying medical condition or bodily injury.

ELIGIBILITY AND EFFECTIVE DATE OF COVERAGE

MEMBER ELIGIBILITY

You are eligible for coverage if the following conditions are met:

1. *You* are an *employee* in active status who meets the eligibility requirements of the *employer*; or
2. *You* are a retired employee who meets the eligibility requirements of the *employer* (see page 66 for retiree definition); or
3. *You* are a Council Member or Mayor and;
4. All eligible *members* must reside in the United States.

Your eligibility date is the date immediately following *your* completion of any eligibility period.

MEMBER EFFECTIVE DATE OF COVERAGE

You must enroll by accessing the HRIS Self Evident Application (SEA) via the City of Dallas Intranet or City of Dallas Internet site at <http://cod.dtolawsonportal.com/lawson/portal/>. *You* must have an HRIS User ID and password which will be assigned within approximately two weeks of *your* eligibility date. Or, enroll by calling the Benefits Service Center at 1-888-873-7692 between 8:00 AM and 5:00 PM CST.

1. If your enrollment is completed before *your* eligibility date or within 31 days after *your* eligibility date, as determined by *your employer*, coverage is effective on *your* eligibility date.
2. If your enrollment is completed more than 31 days after *your* eligibility date, as determined by *your employer*, *you* are a *late applicant* and *you* will not be eligible for coverage under this Plan until the next annual open enrollment period. *Your* coverage will be subject to the *pre-existing condition* limitation as defined within the Definitions section of this booklet.

MEMBER DELAYED EFFECTIVE DATE

If the *employee* is not in *active status* on the effective date of coverage, coverage will be effective the day the *employee* returns to *active status*. The *employer* must notify the *Plan Manager* in writing of the *employee's* return to *active status*.

DEPENDENT ELIGIBILITY

Each *dependent* is eligible for coverage on:

1. The date the *member* is eligible for coverage, if he or she has *dependents* who may be covered on that date; or
2. The date of the *member's* marriage for any *dependent* acquired on that date; or
3. The date of birth of the *member's* natural-born child; or
4. The date a child is placed for adoption under the *member's* legal guardianship, or the date which the *member* incurs a legal obligation for total or partial support in anticipation of adoption; or

Eligibility and Effective Date of Coverage Continued

5. The date a covered *member's* child is determined to be eligible as an alternate recipient under the terms of a medical child support order.

The covered *member* may cover *dependents* only if the *member* is also covered. Check with *your employer* immediately on how to enroll for *dependent* coverage. Late enrollment will result in denial of *dependent* coverage until the next annual open enrollment period. *Your dependents'* coverage will be subject to the *pre-existing condition* limitation as defined within the Definitions section of this booklet

In any event, no person may be simultaneously covered as both a *member* and a *dependent*. If both parents are eligible for coverage, only one may enroll for *dependent* coverage.

DEPENDENT EFFECTIVE DATE OF COVERAGE – WHEN A CHANGE IN THE MEMBER’S LEVEL OF COVERAGE IS NOT REQUIRED

If the *member* wishes to add a newborn *dependent* to the Plan and a change in the *member's* level of coverage is not required, the newborn dependent must be added to the Plan by calling the Benefits Service Center at 1-888-873-7692 between 8:00 AM and 5:00 PM CST. Please see *your employer* for further details on the enrollment process.

The newborn *dependent* will be covered on the date he or she is eligible.

If the *member* wishes to add a *dependent* (other than a newborn) to the Plan and a change in the *member's* level of coverage is not required, the *dependent's* effective date of coverage is determined as follows:

1. If your enrollment is completed before the *dependent's* eligibility date or within 31 days after the *dependent's* eligibility date, that *dependent* is covered on the date he or she is eligible.
2. If your enrollment is completed more than 31 days after the *dependent's* eligibility date, the *dependent* is a *late applicant*. The *dependent* will not be eligible for coverage under this Plan until the next annual open enrollment period. The *dependent's* coverage will be subject to the *pre-existing condition* limitation as defined within the Definitions section of this booklet.

No *dependent's* effective date will be prior to the covered *member's* effective date of coverage. A *dependent* child who becomes eligible for other group coverage through any employment is no longer eligible for coverage under this Plan. If *your dependent* child becomes an eligible *member* of the *employer*, he or she is no longer eligible as *your dependent* and must make application as an eligible *member*.

DEPENDENT EFFECTIVE DATE OF COVERAGE – WHEN A CHANGE IN THE MEMBER’S LEVEL OF COVERAGE IS REQUIRED

If the *member* wishes to add a *dependent* to the Plan and a change in the *member's* level of coverage is required, *you* must enroll *your dependent* to the plan by calling the Benefits Service Center at 1-888-873-7692 between 8:00 AM and 5:00 PM CST. Please see *your employer* for further details on the enrollment process.

The *dependent's* effective date of coverage is determined as follows:

1. If your enrollment is completed before the *dependent's* eligibility date or within 31 days after the *dependent's* eligibility date, that *dependent* is covered on the date he or she is eligible.

Eligibility and Effective Date of Coverage Continued

2. If your enrollment is completed more than 31 days after the *dependent's* eligibility date, the *dependent* is a *late applicant*. The *dependent* will not be eligible for coverage under this Plan until the next annual open enrollment period. The *dependent's* coverage will be subject to the *pre-existing condition* limitation as defined within the Definitions section of this booklet.

No *dependent's* effective date will be prior to the covered *member's* effective date of coverage. A *dependent* child who becomes eligible for other group coverage through any employment is no longer eligible for coverage under this Plan. If *your dependent* child becomes an eligible *employee* of the *employer*, he or she is no longer eligible as *your dependent* and must make application as an eligible *employee*.

MEDICAL CHILD SUPPORT ORDERS

An individual who is a child of a *covered person* shall be enrolled for coverage under the Plan in accordance with the direction of a National Medical Support Notice (NMSN).

An NMSN is a notice issued by an appropriate agency of a state or local government that requires coverage under the Plan for the dependent child of a non-custodial parent who is (or will become) a *covered person* by a domestic relations order that provides for health care coverage.

Procedures for determining the qualified status of medical child support orders are available at no cost upon request from the Plan Administrator.

PRE-EXISTING CONDITION LIMITATION

Benefits for *pre-existing conditions* are limited under the Plan. *Pre-existing condition* is defined in the Definitions section of this booklet.

Once *you* or *your dependents* obtain health plan coverage, *you* are entitled to use evidence of that coverage to reduce or eliminate any *pre-existing condition* limitation period that might otherwise be imposed when *you* become covered under a subsequent health plan. Evidence may include a certificate of prior *creditable coverage*. The length of any *pre-existing condition* limitation period under the subsequent health plan must be reduced by the number of days of *creditable coverage*.

Prior to imposing a *pre-existing condition* limitation, the *Plan Manager* will:

1. Notify *you* in writing of the existence and terms of any *pre-existing condition* limitation;
2. Notify *you* of *your* right to request a certificate of *creditable coverage* from any applicable prior plans;

Eligibility and Effective Date of Coverage Continued

3. Notify *you* of *your* right to submit evidence of *creditable coverage* to the *Plan Manager* to reduce the length of any *pre-existing condition* limitation; and
4. Offer to request a certificate of prior *creditable coverage* on *your* behalf.

If, after receiving evidence of *creditable coverage*, the *Plan Manager* determines the *creditable coverage* is not sufficient to completely offset the Plan's *pre-existing condition* limitation period, the *Plan Manager* will:

1. Notify *you* in writing of its determination;
2. Notify *you* of the source and substance of any information on which it relied; and
3. Provide an explanation of appeal procedures and allow a reasonable opportunity to submit additional evidence of *creditable coverage*.

The *Plan Manager* may modify an initial determination of *creditable coverage* if it determines the individual did not have the claimed *creditable coverage*, provided the *Plan Manager*:

1. Notifies *you* of such reconsideration in writing disclosing its determination;
2. Notifies *you* with the source and substance of any information on which it relied; and
3. Provides an explanation of appeal procedures and allows a reasonable opportunity to submit additional evidence of *creditable coverage*.

Alternate means of providing evidence of *creditable coverage* may include an explanation of benefits, correspondence from a plan, pay stubs showing a payroll deduction of premium for health plan coverage, third party statements verifying period(s) of coverage, information obtained by telephone, and any other relevant document providing evidence of period(s) of health coverage.

SPECIAL PROVISIONS FOR NOT BEING IN ACTIVE STATUS

Employees on an approved leave of absence and who are not receiving a regular paycheck, should make arrangements to pay their premiums while off work. If premium payments are not made when due, past due premiums will accrue in arrears and be deducted from the *employee's* paycheck upon return to work. Coverage will be canceled for non-payment and claims will not be processed for the time period when premiums are past due beyond 60 days. *Employees* on Military leave have the option to retain or cancel coverage by contacting the Benefit Service Center (BSC) within thirty-one days. The *employee* returning from Military leave must call BSC within thirty-one days of return to work in order to reinstate coverage.

Eligibility and Effective Date of Coverage Continued

REINSTATEMENT OF COVERAGE FOLLOWING INACTIVE STATUS

If *your* coverage under the Plan was terminated after a period of layoff, approved leave of absence or during part-time status, and *you* are now returning to work, *your* coverage is effective immediately on the day *you* return to work. The *pre-existing condition* limitation will be waived with respect to the reinstatement of *your* coverage.

If *your* coverage under the Plan was terminated due to a period of *total disability* or service in the uniformed services covered under the Uniformed Services Employment and Reemployment Rights Act of 1994, *your* coverage is effective immediately on the day *you* return to work. Both the eligibility period requirement and the *pre-existing condition* limitation will be waived with respect to the reinstatement of *your* coverage.

FAMILY AND MEDICAL LEAVE ACT (FMLA)

If *you* are granted a leave of absence (Leave) by the *employer* as required by the Federal Family and Medical Leave Act, *you* may continue to be covered under the Plan for the duration of the Leave under the same conditions as other *employees* who are in *active status* and covered by the Plan. If *you* choose to terminate coverage during the Leave, or if coverage terminates as a result of nonpayment of any required contribution, coverage may be reinstated on the date *you* return to *active status* immediately following the end of the Leave. Charges incurred after the date of reinstatement will be paid as if *you* had been continuously covered.

SELECTION OF NO COVERAGE DURING ANNUAL ENROLLMENT

Employees are given the option of selecting no coverage for the following *calendar year* during the annual enrollment period. An *employee* selecting no coverage has effectively waived all coverages, offered by the *employer*, for the *employee* and any *dependents* for the next *calendar year*, except as otherwise provided in the Plan.

An *employee* who during the annual enrollment period has selected no coverage for the following *calendar year* may not reenroll in any health plan offered by the *employer* until the next succeeding annual enrollment period, except as otherwise provided in the Plan.

SURVIVORSHIP COVERAGE

If the *employee* dies while covered under the Plan, the surviving spouse and any eligible *dependents* may continue coverage under the Plan until the end of the month following a period of 90 days subsequent to the *employee's* date of death. After the initial 90 days following the *employee's* date of death, coverage is then available to the surviving spouse and any eligible *dependents* through the COBRA provision, except for a surviving spouse of an active uniformed officer killed in the line of duty. A surviving spouse of an active uniformed officer may continue coverage on the existing plan at active rates. If a surviving spouse remarries, coverage under the Plan will terminate.

A surviving spouse who is covered under a retiree Plan may continue coverage as long as he/she is eligible for pension benefits. Any dependents acquired through the remarriage of a *retired employee's* surviving spouse will not be eligible for coverage under the Plan.

Eligibility and Effective Date of Coverage Continued

RETIREE COVERAGE

Retired employees are eligible for the benefits as described below on the first of the month following their employment termination date and must enroll within thirty-one days after their date of retirement. Otherwise, the *retired employee* will be considered to have waived retiree coverage and will not be eligible for future coverage.

As a *retired employee*, benefits under this Plan are continued. The continued coverage will be the same coverage as for active *employees*, except as described below.

The continued benefits for *Medicare* eligibles are modified as shown in Special Rule Involving Employee's Entitlement to Medicare Benefits.

A surviving spouse and eligible *dependents* of a *retired employee* may remain in the Plan after the death of the *retired employee*:

- If the person was covered as a *dependent* spouse of the deceased *retired employee* at the time of the *retired employee's* death and is eligible to receive pension benefits;
- If carried as a *dependent* child, the person remains a *dependent* of the surviving spouse, but only if the spouse is receiving monthly survivor's benefits from one of the retirement funds.

Coverage for all surviving *dependents* ceases if coverage for the surviving spouse stops because of death, termination of monthly benefits, or any other reason.

A *retired employee*, or a surviving spouse or *dependent* who is eligible for *Medicare* participation by reason of age or disability or any other reason, must enroll and remain enrolled in *Medicare* Parts A and B in order to retain eligibility in the Plan.

The City will pay the *Medicare* Part A monthly premium on behalf of the *retired employees* and spouses of *retired employees* who are not otherwise qualified for *Medicare*. *Retired employees* are responsible for notifying the City, otherwise, they will be responsible for payment of the *Medicare* Part A premium. The *retired employee* and *retired employee's* spouse are responsible for payment of all *Medicare* Part B premiums.

If a *retired employee* is enrolled in this Plan on January 1, 2004 and elects to discontinue coverage in this Plan, the *retired employee* will not be eligible to enroll at a later date or in a subsequent plan.

Eligibility and Effective Date of Coverage Continued

SPECIAL ENROLLMENT

If *you* are a covered *member* or an otherwise eligible *member* who previously declined coverage under this Plan for *yourself* or any eligible *dependents*, due to the existence of other health coverage (including COBRA) at the time of initial eligibility, and that coverage is now lost, this Plan permits *you*, *your dependent* spouse, and any eligible *dependents* to be enrolled for medical benefits under this Plan due to any of the following qualifying events:

1. Loss of eligibility for the coverage due to any of the following:
 - a. Legal separation, annulment or change in legal custody;
 - b. Divorce;
 - c. Death;
 - d. Termination of employment;
 - e. Reduction in the number of hours of employment;
 - f. Any loss of eligibility after a period that is measured by reference to any of the foregoing.
 - g. Changes in status, including marital status, number of dependents, employment status of a *member's* spouse or dependent, dependent status, and change in the place of residence of the *member*, spouse or dependent.

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

2. Employer contributions towards the other coverage have been terminated. Employer contributions include contributions by any current or former employer (of the individual or another person) that was contributing to coverage for the individual.
3. COBRA coverage under the other plan has since been exhausted.

The previously listed qualifying events apply only if *you* stated in writing at the previous enrollment the other health coverage was the reason for declining enrollment, but only if *your employer* requires a written waiver of coverage which includes a warning of the penalties imposed on late enrollees.

If *you* are a covered *member* or an otherwise eligible *member*, who either did not enroll or did not enroll *dependents* when eligible, *you* now have the opportunity to enroll *yourself* and/or any previously eligible *dependents* or any newly acquired *dependents* when due to any of the following family status changes:

1. Marriage;
2. Birth; or
3. Adoption or placement for adoption.

You may elect coverage under this Plan provided enrollment is within 31 days from the qualifying event. *You* MUST provide proof that the qualifying event has occurred due to one of the reasons listed before coverage under this Plan will be effective. Coverage under this Plan will be effective the date immediately following the date of the qualifying event, unless otherwise specified in this section.

Eligibility and Effective Date of Coverage Continued

In the case of a *dependent's* birth, enrollment is effective on the date of such birth.

In the case of a *dependent's* adoption or placement for adoption, enrollment is effective on the date of such adoption or placement for adoption.

If *you* become eligible for coverage under this Plan through the special enrollment provision, benefits under the Plan will be subject to the *pre-existing condition* limitation as defined within the Definitions section of this booklet.

If *you* apply more than 31 days after a qualifying event, *you* are considered a *late applicant* and will not be eligible for coverage under this Plan until the next annual open enrollment period. Coverage will be subject to the *pre-existing condition* limitation as defined within the Definitions section of this booklet.

Please see *your employer* for more details.

TERMINATION OF COVERAGE

Coverage terminates on the earliest of the following:

1. The date the Plan terminates;
2. The end of the period for which any required contribution was due and not paid;
3. The end of the calendar month *you* enter full-time military, naval or air service, except coverage may continue during an approved military leave of absence as indicated in the Special Provisions For Not Being in Active Status provision;
4. The end of the calendar month *you* fail to be in an eligible class of persons according to the eligibility requirements of the *employer*; or
5. For all *covered persons*, the end of the calendar month in which *you* terminate employment with *your employer*;
6. For any benefit, the date the benefit is removed from the Plan;
7. For *your dependents*, the date *your* coverage terminates;
8. For a *dependent*, the end of the calendar month the *dependent* enters full-time military, naval or air service;
9. For a *dependent*, the end of the calendar month such *covered person* no longer meets the definition of *dependent*; or
10. The end of the calendar month *you* request termination of coverage to be effective for yourself and/or *your dependents*.

IF *YOU* OR ANY OF *YOUR COVERED DEPENDENTS* NO LONGER MEET THE ELIGIBILITY REQUIREMENTS, *YOU* AND *YOUR EMPLOYER* ARE RESPONSIBLE FOR NOTIFYING THE *PLAN MANAGER* OF THE CHANGE IN STATUS. COVERAGE WILL NOT CONTINUE BEYOND THE LAST DATE OF ELIGIBILITY EVEN IF NOTICE HAS NOT BEEN GIVEN TO THE *PLAN MANAGER*.

IMPORTANT NOTICE FOR EMPLOYEES AND SPOUSES AGE 65 AND OVER

Federal law may affect *your* coverage under this Plan. The *Medicare* as Secondary Payer rules were enacted by an amendment to the Social Security Act. Also, additional rules which specifically affect how a large group health plan provides coverage to *employees* (or their spouses) over age 65 were added to the Social Security Act and to the Internal Revenue Code.

Generally, the health care plan of an *employer* that has at least 20 *employees* must operate in compliance with these rules in providing plan coverage to plan participants who have "current employment status" and are *Medicare* beneficiaries, age 65 and over.

Persons who have "current employment status" with an *employer* are generally *employees* who are actively working and also persons who are NOT actively working as follows:

- Individuals receiving disability benefits from an *employer* for up to 6 months, or
- Individuals who retain employment rights and have not been terminated by the *employer* and for whom the *employer* continues to provide coverage under this Plan. (For example, *employees* who are on an approved leave of absence.)

If *you* are a person having "current employment status" who is age 65 and over (or the dependent spouse age 65 and over of an *employee* of any age), *your* coverage under this Plan will be provided on the same terms and conditions as are applicable to *employees* (or dependent spouses) who are under the age of 65. *Your* rights under this Plan do not change because *you* (or *your* dependent spouse) are eligible for *Medicare* coverage on the basis of age, as long as *you* have "current employment status" with *your employer*.

You have the option to reject plan coverage offered by *your employer*, as does any eligible *employee*. If *you* reject coverage under *your employer's* Plan, coverage is terminated and *your employer* is not permitted to offer *you* coverage that supplements *Medicare* covered services.

If *you* (or *your* dependent spouse) obtain *Medicare* coverage on the basis of age, and not due to disability or end-stage renal disease, this Plan will consider its coverage to be primary to *Medicare* when *you* have elected coverage under this Plan and have "current employment status".

If *you* have any questions about how coverage under this Plan relates to *Medicare* coverage, please contact *your employer*.

IMPORTANT! – MEDICARE ENROLLMENT REQUIREMENTS

When this Plan pays benefits first, without regard to *Medicare*, and the retired *covered person* wants or their *dependent spouse Medicare* to pay after this Plan, the retired *covered person* or their *dependent spouse* must enroll for *Medicare* Parts A and B at age 65 or post retirement. If the retired *covered person* or their *dependent spouse* does not enroll for *Medicare* when he or she is first eligible, the retired *covered person* or their *dependent spouse* must enroll during the special enrollment period which applies to that person when the person stops being eligible under this Plan.

When *Medicare* pays benefits first, benefits available under *Medicare* are deducted from the amounts payable under this Plan, whether or not the person has enrolled for *Medicare*. If *Medicare* pays first, the retired *covered person* or their *dependent spouse* should enroll for both Parts A and B of *Medicare* when that retired *covered person* or their *dependent spouse* is first eligible; otherwise, the expenses may not be covered by the Plan or *Medicare*.

CONTINUATION OF MEDICAL BENEFITS

THE CONSOLIDATED OMNIBUS BUDGET RECONCILIATION ACT OF 1986 (COBRA)

CONTINUATION OF BENEFITS

On April 7, 1986, the Consolidated Omnibus Budget Reconciliation Act (COBRA) was signed into law. This federal law applies to *employers* with 20 or more *employees*. The law requires that *employers* offer *employees* and/or their *dependents* continuation of medical and dental coverage at group rates in certain instances where there is a loss of group insurance coverage.

ELIGIBILITY

A qualified beneficiary under COBRA law means an *employee*, *employee's* spouse, or *dependent* child covered by the Plan on the day before a qualifying event. A qualified beneficiary under COBRA law also includes a child born to the *employee* during the coverage period or a child placed for adoption with the *employee* during the coverage period.

EMPLOYEE: An *employee* covered by the *employer's* Plan has the right to elect continuation coverage if coverage is lost due to one of the following qualifying events:

- Termination (for reasons other than gross misconduct) of the *employee's* employment or reduction in the hours of *employee's* employment; or
- Termination of retiree coverage when the former *employer* discontinues retiree coverage within one year before or one year after filing for Chapter 11 bankruptcy.

SPOUSE: A spouse covered by the *employer's* Plan has the right to elect continuation coverage if the group coverage is lost due to one of the following qualifying events:

- The death of the *employee*;
- Termination of the *employee's* employment (for reasons other than gross misconduct) or reduction of the *employee's* hours of employment with the *employer*;
- Divorce or legal separation from the *employee*;
- The *employee* becomes entitled to *Medicare* benefits; or
- Termination of a retiree spouse's coverage when the former *employer* discontinues retiree coverage within one year before or one year after filing for Chapter 11 bankruptcy.

DEPENDENT CHILD: A *dependent* child covered by the *employer's* Plan has the right to continuation coverage if group coverage is lost due to one of the following qualifying events:

- The death of the *employee* parent;
- The termination of the *employee* parent's employment (for reasons other than gross misconduct) or reduction in the *employee* parent's hours of employment with the *employer*;
- The *employee* parent's divorce or legal separation;
- Ceasing to be a "*dependent* child" under the Plan;
- The *employee* parent becomes entitled to *Medicare* benefits; or
- Termination of the retiree parent's coverage when the former *employer* discontinues retiree coverage within one year before or one year after filing for Chapter 11 bankruptcy.

COBRA Continued

LOSS OF COVERAGE

Coverage is lost in connection with the foregoing qualified events, when a covered *employee*, spouse or *dependent* child ceases to be covered under the same Plan terms and conditions as in effect immediately before the qualifying event (such as an increase in the premium or contribution that must be paid for *employee*, spouse or *dependent* child coverage).

If coverage is reduced or eliminated in anticipation of an event (for example, an *employer's* eliminating an *employee's* coverage in anticipation of the termination of the *employee's* employment, or an *employee's* eliminating the coverage of the *employee's* spouse in anticipation of a divorce or legal separation), the reduction or elimination is disregarded in determining whether the event causes a loss of coverage.

A loss of coverage need not occur immediately after the event, so long as it occurs before the end of the maximum coverage period.

NOTICES AND ELECTION

The Plan provides that coverage terminates, for a spouse due to legal separation or divorce or for a child when that child loses *dependent* status. Under the law, the *employee* or qualified beneficiary has the responsibility to inform the Plan Administrator (see Plan Description Information) if one of the above events has occurred. The *employee* or a *family member* must give this notice within 60 days after the event occurs. (For example, an ex-spouse should make sure that the Plan Administrator is notified of his or her divorce, whether or not his or her coverage was reduced or eliminated in anticipation of the event). When the Plan Administrator is notified that one of these events has happened, it is the Plan Administrator's responsibility to notify the qualified beneficiary of the right to elect continuation coverage.

For an *employee* or *family member* who is determined under the Social Security Act to be disabled at any time during the first 60 days of COBRA coverage, the continuation coverage period may be extended 11 additional months. The disability that extends the 18-month coverage period must be determined under Title II (Old Age, Survivors, and Disability Insurance) or Title XVI (Supplemental Security Income) of the Social Security Act. To be entitled to the extended coverage period, the disabled qualified beneficiary must provide notice to the Plan Administrator within the initial 18-month coverage period and within 60 days after the date of the determination of disability under the Social Security Act. Failure to provide this notice will result in the loss of the right to extend the COBRA continuation period.

For termination of employment, reduction in work hours, the death of the *employee*, the *employee* becoming covered by *Medicare* or loss of retiree benefits due to bankruptcy, it is the Plan Administrator's responsibility to notify the qualified beneficiary of the right to elect continuation coverage.

Under the law, continuation coverage must be elected within 60 days after Plan coverage ends, or if later, 60 days after the date of the notice of the right to elect continuation coverage. If continuation coverage is not elected within the 60-day period, the right to elect coverage under the Plan will end.

A covered *employee* or the spouse of the covered *employee* may elect continuation coverage for all covered *dependents*, even if the covered *employee* or spouse of the covered *employee* or all covered *dependents* are covered under another group health plan (as an *employee* or otherwise) prior to the election. The covered *employee*, his or her spouse and *dependent* child, however, each have an independent right to elect continuation coverage. Thus a spouse or *dependent* child may elect continuation coverage even if the covered *employee* does not elect it.

COBRA Continued

Coverage will not be provided during the election period. However, if the individual makes a timely election, coverage will be provided from the date that coverage would otherwise have been lost. If coverage is waived before the end of the 60-day election period and the waiver revoked before the end of the 60-day election period, coverage will be effective on the date the election of coverage is sent to the Plan Administrator.

MAXIMUM COVERAGE PERIOD

Coverage may continue up to:

- 18 months for an *employee* and/or *dependent* whose group coverage ended due to termination of the *employee's* employment or reduction in hours of employment;
- 36 months for a spouse whose coverage ended due to the death of the *employee* or retiree, divorce, or the *employee* becoming entitled to *Medicare* at the time of the initial qualifying event;
- 36 months for a *dependent* child whose coverage ended due to the divorce of the *employee* parent, the *employee* becoming entitled to *Medicare* at the time of the initial qualifying event, the death of the *employee*, or the child ceasing to be a *dependent* under the Plan;
- For the retiree, until the date of death of the retiree who is on continuation due to loss of coverage within one year before or one year after the *employer* filed Chapter 11 bankruptcy;
- 29 months for all qualified beneficiaries if an *employee* or family member is determined to be disabled under the Social Security Act at any time during the first 60 days of continuation coverage (remaining from the date of termination of employment or reduction in hours). The qualified beneficiary must provide notice of such determination prior to the end of the initial 18-month continuation period to be entitled to the additional 11 months of coverage. For the purpose of COBRA, family member means the *employee* and any eligible *dependent*.

If a second qualifying event occurs (for example, the *employee* dies or becomes divorced) within the 18 month or 29 month coverage period, the maximum coverage period becomes 36 months from the date of the termination or reduction in hours.

The maximum coverage period is measured from the date of the qualifying event even if the qualifying event does not result in a loss of coverage under the Plan until some later date. However, if alternative coverage (i.e. state continuation) is provided after a qualifying event without regard to COBRA continuation and such coverage does not satisfy all the requirements of COBRA continuation, the *employer* must offer the covered qualified beneficiary the right to elect COBRA continuation. If COBRA coverage is rejected in favor of the alternative coverage, COBRA coverage need not be offered at the end of the alternative coverage period.

SPECIAL RULE INVOLVING EMPLOYEE'S ENTITLEMENT TO MEDICARE BENEFITS

A special rule exists where the *employee* is entitled to *Medicare* at the time of an initial qualifying event due to termination or reduction of hours worked, or becomes entitled to *Medicare* within the initial 18 or 36 month continuation period following an initial qualifying event. If the *employee* is entitled to *Medicare* at the time of an initial qualifying event due to termination or reduction of hours worked, then the period of continuation for other qualified beneficiaries is the later of 36 months from the date of *Medicare* entitlement, or 18 months from the date of the qualifying event. If, on the other hand, the *employee* becomes entitled to *Medicare* during the initial continuation period of 18 months following the original qualifying event, then the other qualified beneficiaries will be entitled to continuation not to exceed 36 months from the date of the original qualifying event.

COBRA Continued

TERMINATION BEFORE THE END OF MAXIMUM COVERAGE PERIOD

Continuation coverage will terminate before the end of the maximum coverage period for any of the following reasons:

- The *employer* no longer provides group health coverage to any of its *employees*;
- The premium for continuation is not paid timely;
- The individual on continuation becomes covered under another group health plan (as an *employee* or otherwise); however, if the new plan coverage contains any exclusion or limitation with respect to any pre-existing condition, then continuation coverage will end for this reason only after the exclusion or limitation no longer applies or prior creditable coverage satisfies the exclusion or limitation;
- NOTE: the federal Health Insurance Portability and Accountability Act of 1996 requires portability of health care coverage effective for plan years beginning after June 30, 1997, an exclusion or limitation under the other group health plan may not apply at all to the qualified beneficiary, depending on the length of his or her prior creditable coverage. Portability means once *you* obtain health insurance, *you* will be able to use evidence of that insurance to reduce or eliminate any pre-existing medical condition limitation period (under certain circumstances) when *you* move from one health plan to another;
- The individual on continuation becomes entitled to *Medicare* benefits;
- If there is a final determination under Title II or XVI of the Social Security Act that an individual is no longer disabled; however, continuation coverage will not end until the month that begins more than 30 days after the determination;
- The occurrence of any event (e.g. submission of a fraudulent claim) permitting termination of coverage for cause under the Plan.

TYPE OF COVERAGE; PREMIUM PAYMENT

If continuation coverage is elected, the coverage must be identical to the coverage provided under the *employer's* Plan to similarly situated non-COBRA beneficiaries. This means that if the coverage for similarly situated non-COBRA beneficiaries is modified, coverage for the individual on continuation will be modified.

The initial premium payment for continuation coverage is due by the 45th day after coverage is elected. The initial premium includes charges back to the date the continuation coverage began. All other premiums are due on the first of the month for which the premium is paid, subject to a 31-day grace period. The *employer* must provide the individual with a quote of the total monthly premium.

Premium for continuation coverage may be increased, however, the premium may not be increased more than once in any determination period. The determination period is a 12-month period which is established by the Plan.

COBRA Continued

The monthly premium payment to the Plan for continuing coverage must be submitted directly to the *COBRA Service Provider*. This monthly premium may include the *employee's* share and any portion previously paid by the *employer*. The monthly premium must be a reasonable estimate of the cost of providing coverage under the Plan for similarly situated non-COBRA beneficiaries. The premium for COBRA continuation coverage may include a 2% administration charge. Qualified beneficiaries who do not take the additional 11 months of special coverage will pay the up to 102% premium cost.

OTHER INFORMATION

Employees should contact the *COBRA Service Provider* at 1-800-877-7994 for any question regarding continuation coverage.

THE UNIFORMED SERVICES EMPLOYMENT AND REEMPLOYMENT RIGHTS ACT OF 1994 (USERRA)

CONTINUATION OF BENEFITS

Effective October 13, 1994 federal law requires that health plans must offer to continue coverage for *employees* who are absent due to service in the uniformed services and/or their *dependents*. Coverage may continue for up to 18 months after the date the *employee* is first absent due to uniformed service.

ELIGIBILITY

An *employee* is eligible for continuation under USERRA if absent from employment because of voluntary or involuntary performance of duty in the Armed Forces, Army National Guard, Air National Guard, or the commissioned corps of the Public Health Service. Duty includes absence for active duty, active duty for training, initial active duty for training, inactive duty training and for the purpose of an examination to determine fitness for duty.

An *employee's dependents* who have coverage under the Plan immediately prior to the date of the *employee's* covered absence are eligible to elect continuation under USERRA.

PREMIUM PAYMENT

If continuation of Plan coverage is elected under USERRA, the *employee* or *dependent* is responsible for payment of the applicable cost of coverage. If the *employee* is absent for not longer than 31 days, the cost will be the amount the *employee* would otherwise pay for coverage. For absences exceeding 31 days, the cost may be up to 102% of the cost of coverage under the Plan. This includes the *employee's* share and any portion previously paid by the *employer*.

DURATION OF COVERAGE

Elected continuation coverage under USERRA will continue until the earlier of:

- 18 months beginning the first day of absence from employment due to service in the uniformed services; or
- the day after the *employee* fails to apply for or return to employment as required by USERRA, after completion of a period of service.

Under federal law, the period of coverage available under USERRA shall run concurrently with the COBRA period available to an *employee* and/or eligible *dependents*.

OTHER INFORMATION

Employees should contact their *employer* with any questions regarding coverage normally available during a military leave of absence or continuation coverage and notify the *employer* of any changes in marital status, or a change of address.

COORDINATION OF BENEFITS

BENEFITS SUBJECT TO THIS PROVISION

Benefits described in this Plan are coordinated with benefits provided by other plans under which *you* are also covered. This is to prevent duplication of coverage and a resulting increase in the cost of medical coverage.

For this purpose, a plan is one which covers medical or dental expenses and provides benefits or *services* by group, franchise or blanket insurance coverage. This includes group-type contracts not available to the general public, obtained and maintained only because of the *covered person's* membership in or connection with a particular organization or group, whether or not designated as franchise, blanket, or in some other fashion. Plan also includes any coverage provided through the following:

1. Employer, trustee, union, employee benefit, or other association; or
2. Governmental programs, programs mandated by state statute, or sponsored or provided by an educational institution.

This Coordination of Benefits provision does not apply to any individual policies or Blanket Student Accident Insurance provided by or through an educational institution. Allowable expense means any eligible expense, a portion of which is covered under one of the plans covering the person for whom claim is made. Each plan will determine what is an allowable expense according to the provisions of the respective plan. When a plan provides benefits in the form of *services* rather than cash payments, the reasonable cash value of each *service* rendered will be deemed to be both an allowable expense and a benefit paid.

EFFECT ON BENEFITS

One of the plans involved will pay benefits first. This is called the primary plan. All other plans are called secondary plans.

When this Plan is the secondary plan, the sum of the benefit payable will not exceed 100% of the total allowable expenses incurred under the Plan and any other plans included under this provision.

HOW THIS PLAN PAYS WHEN MEDICARE IS PRIMARY

If *Medicare* pays benefits first, the Plan pays benefits as described below. This method of payment only applies to *Medicare* eligibles. It does not apply to any *covered person* unless that *covered person* becomes eligible under *Medicare* and *Medicare* is the primary payer.

First, this Plan determines the amount payable according to the benefits under the Plan. However, the amount of *covered expenses* is based on the amount of charges allowed under *Medicare* rules instead of the *maximum allowable fee* as defined by the Plan. Then, this Plan subtracts the amount payable under *Medicare* for the same expenses from Plan benefits. This Plan pays only the difference (if any) between Plan benefits and *Medicare* benefits.

Services that are billed to Medicare as primary may not require you to submit claims to this Plan. For additional information please see *your employer*.

Coordination of Benefits Continued

ORDER OF BENEFIT DETERMINATION

In order to pay claims, it must be determined which plan is primary and which plan(s) are secondary. A plan will pay benefits first if it meets one of the following conditions:

1. The plan has no coordination of benefits provision;
2. The plan covers the person as an *employee*;
3. For a child who is covered under both parents' plans, the plan covering the parent whose birthday (month and day) occurs first in the *calendar year* pays before the plan covering the other parent. If the birthdates of both parents are the same, the Plan which has covered the person for the longer period of time will be determined the primary plan;

If a plan other than this Plan does not include provision 3., then the gender rule will be followed to determine which plan is primary.

4. In the case of *dependent* children covered under the plans of divorced or separated parents, the following rules apply:
 - a. The plan of a parent who has custody will pay the benefits first;
 - b. The plan of a stepparent who has custody will pay benefits next;
 - c. The plan of a parent who does not have custody will pay benefits next;
 - d. The plan of a stepparent who does not have custody will pay benefits next.

There may be a court decree which gives one parent financial responsibility for the medical or dental expenses of the *dependent* children. If there is a court decree, the rules stated above will not apply if they conflict with the court decree. Instead, the plan of the parent with financial responsibility will pay benefits first.

5. If a person is laid off or is retired or is a *dependent* of such person, that plan covers after the plan covering such person as an active *employee* or *dependent* of such *employee*. 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.

If the above rules do not apply or cannot be determined, then the plan that covered the person for the longest period of time will pay first.

COORDINATION OF BENEFITS WITH MEDICARE

In all cases, Coordination of Benefits with *Medicare* will conform with Federal Statutes and Regulations. In the case of *Medicare* each individual who is eligible for *Medicare* will be assumed to have full *Medicare* coverage (i.e. Part A hospital insurance and Part B voluntary medical insurance) whether or not the individual has enrolled for full coverage. *Your* benefits under the Plan will be coordinated to the extent benefits would otherwise have been paid under *Medicare* as allowed by Federal Statutes and Regulations.

Coordination of Benefits Continued

RIGHT OF RECOVERY

The Plan reserves the right to recover benefit payments made for an allowable expense under the Plan in the amount which exceeds the maximum amount the Plan is required to pay under these provisions. This right of recovery applies to the Plan against:

1. Any person(s) to, for or with respect to whom, such payments were made; or
2. Any other insurance companies, or organizations which according to these provisions, owe benefits due for the same allowable expense under any other plan.

The Plan alone will determine against whom this right of recovery will be exercised.

REIMBURSEMENT/SUBROGATION

Subrogation applies when another party (person or organization) is, or may be, considered responsible for causing *bodily injury* or for payment of benefits due to a *covered person's bodily injury* or *sickness* for which benefits under the Plan have been provided or paid. To the extent of such benefits, the Plan is subrogated to all rights and claims for recovery the *covered person* has against any party (including a health care carrier) responsible for the *bodily injury* or for payment to the *covered person* on account of the *bodily injury*.

Also, the Plan has a right of reimbursement. If payment (by settlement, judgment or any other manner) is made, or may be made, in the future by, or on behalf of, a responsible party to the *covered person*, expenses arising from the *covered person's bodily injury* or *sickness* are not covered by the Plan.

However, if a claim is filed for which benefits would be payable in the absence of a responsible party as described above, benefits will be paid subject to the following conditions:

1. The Plan will automatically have a lien to the extent of benefits advanced upon any recovery, by settlement, judgement or otherwise that *you* receive from the responsible party, or any person or organization making payment on behalf of the responsible party, including first party, undercovered and uncovered motorist coverage. The lien will be in the amount of benefits provided or paid by the Plan for the treatment of the condition for which the third party is responsible.
2. *You* agree to notify the Plan, in writing, within 60 days of your claim against the responsible party and to take such action, furnish such information, cooperate generally, and execute any documents as the Plan may be required to facilitate enforcement of the Plan's rights.

Exclusively at the Plan's option and choice, and without any waiver of any other rights of the Plan, in the event of prejudice, non-cooperation or breach of this Plan, payments may be withheld, deducted, or retracted to or on behalf of the *covered person*.

AGREEMENT AND COOPERATION REQUIRED

Covered persons under the Plan must agree to the following obligations in return for the payment of *covered expenses* by the Plan in accordance with its provisions.

The *covered person* shall cooperate by providing information and executing any documents to preserve the Plan's right and shall have the affirmative obligation of notifying the Plan that claims are being made against responsible parties to recover for injuries for which the Plan has paid. If the *covered person* enters into litigation or settlement negotiations regarding the obligations of the other party, the *covered person* must not prejudice, in any way, rights to recover an amount equal to any benefits that have provided or paid for the *bodily injury* or *sickness*. Failure of the *covered person* to provide such notice or cooperation, or any action by the *covered person* resulting in prejudice to the Plan's rights will be a material breach of this Plan and will result in the *covered person* being personally responsible to make repayment. In such an event, the *Plan Manager* may deduct from any pending or subsequent claim made under the Plan any amounts the *covered person* owes the Plan until such time as cooperation is provided and the prejudice ceases.

Reimbursement/Subrogation Continued

The Plan's right of reimbursement and the Plan's subrogation rights shall be to the fullest extent allowed by law and the provisions of this Plan shall control in the absence of any laws to the contrary. Any such right of reimbursement or subrogation provided to the Plan shall not apply or shall be limited to the extent that the Federal Statutes eliminate or restrict such rights.

GENERAL PROVISIONS

The following provisions are to protect *your* legal rights and the legal rights of the Plan.

CONTESTABILITY

The Plan has the right to contest the validity of *your* coverage under the Plan at any time.

RIGHT TO REQUEST OVERPAYMENTS

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

1. Made in error; or
2. Made to *you* or any party on *your* behalf where the Plan determines the payment to *you* or any party is greater than the amount payable under this Plan.

The Plan has the right to recover against *you* if the Plan has paid *you* or any other party on *your* behalf.

WORKERS' COMPENSATION NOT AFFECTED

The Plan is not issued in lieu of, nor does it affect any requirement for coverage by any Workers' Compensation or Occupational Disease Act or Law.

WORKERS' COMPENSATION

If benefits are paid by the Plan and the Plan determines *you* received Workers' Compensation for the same incident, the Plan will exercise its right to recover against *you* even though:

1. The Workers' Compensation benefits are in dispute or are made by means of settlement or compromise;
2. No final determination is made that *bodily injury* or *sickness* was sustained in the course of or resulted from *your* employment;
3. The amount of Workers' Compensation due to medical or health care is not agreed upon or defined by *you* or the Workers' Compensation carrier;
4. The medical or health care benefits are specifically excluded from the Workers' Compensation settlement or compromise.

You hereby agree that, in consideration for the coverage provided by the Plan, *you* will notify the *Plan Manager* of any Workers' Compensation claim *you* make, and that *you* agree to reimburse the Plan as described above.

General Provisions Continued

MEDICAID

This Plan will not take into account the fact that an *employee* or *dependent* is eligible for medical assistance or Medicaid under state law with respect to enrollment, determining eligibility for benefits, or paying claims.

If payment for Medicaid benefits has been made under a state Medicaid plan for which payment would otherwise be due under this Plan, payment of benefits under this Plan will be made in accordance with a state law which provides that the state has acquired the rights with respect to a covered *employee* to the benefits payment.

CONSTRUCTION OF PLAN TERMS

The Plan has the sole right to construe and prescribe the meaning, scope and application of each and all of the terms of the Plan, including, without limitation, the benefits provided thereunder, the obligations of the *beneficiary* and the recovery rights of the Plan; such construction and prescription by the Plan shall be final and uncontestable.

PRIVACY OF PROTECTED HEALTH INFORMATION

In order for the Plan to operate, it may be necessary from time to time for health care professionals, the Plan Administrator, individuals who perform Plan-related functions under the auspices of the Plan Administrator, the *Plan Manager* and other service providers that have been engaged to assist the Plan in discharging its obligations with respect to delivery of benefits, to have access to what is referred to as *protected health information*.

A *covered person* will be deemed to have consented to use of *protected health information* about him or her by virtue of enrollment in the Plan. Any individual who may not have intended to provide this consent and who does not so consent must contact the Plan Administrator prior to filing any claim for Plan benefits, as coverage under the Plan is contingent upon consent.

Individually identifiable health information will only be used or disclosed for purposes of Plan operation or benefits delivery. In that regard, only the minimum necessary disclosure will be allowed. The Plan Administrator, *Plan Manager*, and other entities given access to *protected health information*, as permitted by applicable law, will safeguard *protected health information* to ensure that the information is not improperly disclosed.

Disclosure of *protected health information* is improper if it is not allowed by law or if it is made for any purpose other than Plan operation or benefits delivery. Disclosure for Plan purposes to persons authorized to receive *protected health information* may be proper, so long as the disclosure is allowed by law and appropriate under the circumstances. Improper disclosure includes disclosure to the *employer* for employment purposes, *employee* representatives, consultants, attorneys, relatives, etc. who have not executed appropriate agreements effective to authorize such disclosure.

The *Plan Manager* will afford access to *protected health information* in its possession only as necessary to discharge its obligations as a service provider, within the restrictions noted above. However, Plan records that include *protected health information* are the property of the Plan. Information received by the *Plan Manager* is information received on behalf of the Plan.

General Provisions Continued

The *Plan Manager* will afford access to *protected health information* as reasonably directed in writing by the Plan Administrator, which shall only be made with due regard for confidentiality. In that regard, the *Plan Manager* has been directed that disclosure of *protected health information* may be made to a designated representative of the *Employer*.

Individuals who have access to *protected health information* in connection with their performance of Plan-related functions under the auspices of the Plan Administrator will be trained in these privacy policies and relevant procedures prior to being granted any access to *protected health information*. The *Plan Manager* and other Plan service providers will be required to safeguard *protected health information* against improper disclosure through contractual arrangements.

In addition, *you* should know that the *employer* / Plan sponsor may legally have access, on an as-needed basis, to limited health information for the purpose of determining Plan costs, contributions, Plan design, and whether Plan modifications are warranted. In addition, federal regulators such as the Department of Health and Human Services and the Department of Labor may legally require access to *protected health information* to police federal legal requirements about privacy.

Covered persons may have access to *protected health information* about them that is in the possession of the Plan, and they may make changes to correct errors. *Covered persons* are also entitled to an accounting of all disclosures that may be made by any person who acquires access to *protected health information* concerning them and uses it other than for Plan operation or benefits delivery. In this regard, please contact the Plan Administrator.

Covered persons are urged to contact the originating health care professional with respect to medical information that may have been acquired from them, as those items of information are relevant to medical care and treatment. And finally, *covered persons* may consent to disclosure of *protected health information*, as they please.

CLAIMS PROCEDURES

SUBMITTING A CLAIM

This section describes what a *covered person* (or his or her authorized representative) must do to file a claim for Plan benefits.

- A claim must be filed with the *Plan Manager* by mail or courier.
- Claims must be submitted to the *Plan Manager* at the address indicated in the documents describing the Plan or *claimant's* identification card. Claims will not be deemed submitted for purposes of these procedures unless and until received at the correct address.
- Also, claims submissions must be in a format acceptable to the *Plan Manager* and compliant with any applicable legal requirements. Claims that are not submitted in accordance with the requirements of applicable federal law respecting privacy of protected health information and/or electronic claims standards will not be accepted by the Plan.
- Claims submissions must be timely. Claims must be filed as soon as reasonably possible after they are incurred, and in no event later than 12 months after the date of loss, except if *you* were legally incapacitated. Plan benefits are only available for claims that are incurred by a *covered person* during the period that he or she is covered under the Plan.
- Claims submissions must be complete. They must contain, at a minimum:
 - ◆ The name of the *covered person* who incurred the *covered expense*;
 - ◆ The name and address of the health care provider;
 - ◆ The diagnosis of the condition;
 - ◆ The procedure or nature of the treatment;
 - ◆ The date of and place where the procedure or treatment has been or will be provided;
 - ◆ The amount billed and the amount of the covered expense not paid through coverage other than Plan coverage, as appropriate;
 - ◆ Evidence that substantiates the nature, amount, and timeliness of each *covered expense* in a format that is acceptable according to industry standards and in compliance with applicable law.

A general request for an interpretation of Plan provisions will not be considered to be a claim. Requests of this type, such as a request for an interpretation of the eligibility provisions of the Plan, should be directed to the Plan Administrator.

Medical claims and correspondence should be mailed to:

Humana Claims Office
P.O. Box 14601
Lexington, KY 40512-4601

Claims Procedures Continued

MISCELLANEOUS MEDICAL CHARGES

If *you* accumulate bills for medical items *you* purchase or rent yourself, send them to the *Plan Manager* at least once every three months during the year (quarterly). The receipts must include the patient name, name of item, date item purchased or rented and name of the provider of *service*.

PROCEDURAL DEFECTS

If a *pre-service claim* submission is not made in accordance with the Plan's procedural requirements, the *Plan Manager* will notify the *claimant* of the procedural deficiency and how it may be cured no later than within five (5) days (or within 24 hours, in the case of an *urgent care claim*) following the failure. A *post-service claim* that is not submitted in accordance with these claims procedures will be returned to the submitter.

ASSIGNMENTS AND REPRESENTATIVES

A *covered person* may assign his or her right to receive Plan benefits to a health care provider only with the consent of the *Plan Manager*, in its sole discretion, except as may be required by applicable law. Assignments must be in writing. If a document is not sufficient to constitute an assignment, as determined by the *Plan Manager*, then the Plan will not consider an assignment to have been made. An assignment is not binding on the Plan until the *Plan Manager* receives and acknowledges in writing the original or copy of the assignment before payment of the benefit.

If benefits are assigned in accordance with the foregoing paragraph and a health care provider submits claims on behalf of a *covered person*, benefits will be paid to that health care provider.

In addition, a *covered person* may designate an authorized representative to act on his or her behalf in pursuing a benefit claim or appeal. The designation must be explicitly stated in writing and it must authorize disclosure of Protected Health Information with respect to the claim by the Plan, the *Plan Manager* and the authorized representative to one another. If a document is not sufficient to constitute a designation of an authorized representative, as determined by the *Plan Manager*, then the Plan will not consider a designation to have been made. An assignment of benefits does not constitute designation of an authorized representative.

- Any document designating an authorized representative must be submitted to the *Plan Manager* in advance, or at the time an authorized representative commences a course of action on behalf of a *claimant*. At the same time, the authorized representative should also provide notice of commencement of the action on behalf of the *claimant* to the *claimant*, which the *Plan Manager* may verify with the *claimant* prior to recognizing the authorized representative status.
- In any event, a health care provider with knowledge of a *claimant's* medical condition acting in connection with an *urgent care claim* will be recognized by the Plan as the *claimant's* authorized representative.

Covered persons should carefully consider whether to designate an authorized representative. An authorized representative may make decisions independent of the *covered person*, such as whether and how to appeal a claim denial.

Claims Procedures Continued

CLAIMS DECISIONS

After submission of a claim by a *claimant*, the *Plan Manager* will notify the *claimant* within a reasonable time, as follows:

PRE-SERVICE CLAIMS

The *Plan Manager* will notify the *claimant* of a favorable or adverse determination within a reasonable time appropriate to the medical circumstances, but no later than 15 days after receipt of the claim by the Plan.

However, this period may be extended by an additional 15 days, if the *Plan Manager* determines that the extension is necessary due to matters beyond the control of the Plan. The *Plan Manager* will notify the affected *claimant* of the extension before the end of the initial 15-day period, the circumstances requiring the extension, and the date by which the Plan expects to make a decision.

If the reason for the extension is because of the *claimant's* failure to submit information necessary to decide the claim, the notice of extension will describe the required information. The *claimant* will have at least 45 days from the date the notice is received to provide the specified information.

URGENT CARE CLAIMS

The *Plan Manager* will determine whether a claim is an *urgent care claim*. This determination will be made on the basis of information furnished by or on behalf of a *claimant*. In making this determination, the *Plan Manager* will exercise its judgment, with deference to the judgment of a physician with knowledge of the *claimant's* condition. Accordingly, the *Plan Manager* may require a *claimant* to clarify the medical urgency and circumstances that support the *urgent care claim* for expedited decision-making.

The *Plan Manager* will notify the *claimant* of a favorable or adverse determination as soon as possible, taking into account the medical exigencies particular to the *claimant's* situation, but not later than 72 hours after receipt of the *urgent care claim* by the Plan.

However, if a claim is submitted that does not provide sufficient information to determine whether, or to what extent, expenses are covered or payable under the Plan, notice will be provided by the *Plan Manager* as soon as possible, but not more than 24 hours after receipt of the *urgent care claim* by the Plan. The notice will describe the specific information necessary to complete the claim.

- The *claimant* will have a reasonable amount of time, taking into account his or her circumstances, to provide the necessary information but not less than 48 hours.
- The *Plan Manager* will notify the *claimant* of the Plan's *urgent care claim* determination as soon as possible, but in no event more than 48 hours after the earlier of:
 1. The Plan's receipt of the specified information; or
 2. The end of the period afforded the *claimant* to provide the specified additional information.

Claims Procedures Continued

CONCURRENT CARE DECISIONS

The *Plan Manager* will notify a *claimant* of a *concurrent care decision* that involves a reduction in or termination of benefits that have been pre-authorized. The *Plan Manager* will provide the notice sufficiently in advance of the reduction or termination to allow the *claimant* to appeal and obtain a determination on review of the adverse determination before the benefit is reduced or terminated.

A request by a *claimant* to extend a course of treatment beyond the period of time or number of treatments that is a claim involving urgent care will be decided by the *Plan Manager* as soon as possible, taking into account the medical exigencies. The *Plan Manager* will notify a *claimant* of the benefit determination, whether adverse or not within 24 hours after receipt of the claim by the Plan, provided that the claim is submitted to the Plan at least 24 hours prior to the expiration of the prescribed period of time or number of treatments.

POST-SERVICE CLAIMS

The *Plan Manager* will notify the *claimant* of a favorable or adverse determination within a reasonable time, but not later than 30 days after receipt of the claim by the Plan.

However, this period may be extended by an additional 15 days, if the *Plan Manager* determines that the extension is necessary due to matters beyond the control of the Plan. The *Plan Manager* will notify the affected *claimant* of the extension before the end of the initial 30-day period, the circumstances requiring the extension, and the date by which the Plan expects to make a decision.

If the reason for the extension is because of the *claimant's* failure to submit information necessary to decide the claim, the notice of extension will describe the required information. The *claimant* will have at least 45 days from the date the notice is received to provide the specified information. The *Plan Manager* will make a decision no later than 15 days after the earlier of the date on which the information provided by the *claimant* is received by the Plan or the expiration of the time allowed for submission of the additional information.

TIMES FOR DECISIONS

The periods of time for claims decisions presented above begin when a claim is received by the Plan, in accordance with these claims procedures.

PAYMENT OF CLAIMS

The *Plan Manager* will make direct payment to the *hospital*, clinic, or physician's office, unless the *Plan Manager* is advised in writing that *you* have already paid the bill. If *you* have paid the bill, please indicate on the original statement, "paid by *member*," and send it directly to the *Plan Manager*. *You* will receive a written explanation of the benefit determination. The *Plan Manager* reserves the right to request any information required to determine benefits or process a claim. *You* or the provider of *services* will be contacted if additional information is needed to process *your* claim.

When a *member's* child is subject to a medical child support order, the *Plan Manager* will make reimbursement of eligible expenses paid by *you*, the child, the child's non-employee custodial parent, or legal guardian, to that child or the child's custodial parent, or legal guardian, or as provided in the medical child support order.

Claims Procedures Continued

Payment of benefits under this Plan will be made in accordance with an assignment of rights for *you* and *your dependents* as required under state Medicaid law.

Benefits payable on behalf of *you* or *your covered dependent* after death will be paid, at the Plan's option, to any *family member(s)* or *your* estate.

The *Plan Manager* will rely upon an affidavit to determine benefit payment, unless it receives written notice of valid claim before payment is made. The affidavit will release the Plan from further liability.

Any payment made by the *Plan Manager* in good faith will fully discharge it to the extent of such payment.

Payments due under the Plan will be paid upon receipt of written proof of loss.

INITIAL DENIAL NOTICES

Notice of a claim denial (including a partial denial) will be provided to *claimants* by mail, postage prepaid, by FAX, or by e-mail, as appropriate, within the time frames noted above.

However, notices of adverse decisions involving *urgent care claims* may be provided to a *claimant* orally within the time frames noted above for expedited *urgent care claim* decisions. If oral notice is given, written notification will be provided to the *claimant* no later than 3 days after the oral notification.

A claims denial notice will state the specific reason or reasons for the adverse determination, the specific Plan provisions on which the determination is based, and a description of the Plan's review procedures and associated timeline. The notice will also include a description of any additional material or information necessary for the *claimant* to perfect the claim and an explanation of why such material or information is necessary.

The notice will also disclose any internal Plan rule, protocol or similar criterion that was relied on to deny the claim. A copy of the rule, protocol or similar criterion relied upon will be provided to a *claimant* free of charge upon request.

If the adverse determination is based on *medical necessity, experimental, investigational or for research purposes*, or similar exclusion or limit, the notice will provide either an explanation of the scientific or clinical judgment for the determination, applying the terms of the Plan to the *claimant's* medical circumstances, or a statement that such explanation will be provided free of charge upon request.

In the case of an adverse decision of an *urgent care claim*, the notice will provide a description of the Plan's expedited review procedures applicable to such claims.

Claims Procedures Continued

APPEALS OF ADVERSE DETERMINATIONS

A *claimant* must appeal an adverse determination within 180 days after receiving written notice of the denial (or partial denial). With the exception of *urgent care claims* and *concurrent care decisions*, the Plan uses a two level appeals process for all adverse determinations. The *Plan Manager* will make the determination on the first level of appeal. If the *claimant* is dissatisfied with the decision on this first level of appeal, or if the *Plan Manager* fails to make a decision within the time frame indicated below, the *claimant* may appeal to the Plan Administrator. *Urgent care claims* and *concurrent care decisions* are subject to a single level appeal process only, with the *Plan Manager* making the determination.

A first level appeal must be made by a *claimant* by means of written application, in person, or by mail (postage prepaid), addressed to:

A first level appeal must be made by a *claimant* by means of written application, in person, or by mail (postage prepaid), addressed to:

Humana – G&A
P.O. Box 14546
Lexington, KY 40512 - 4546

A second level appeal must be made by a *claimant* by means of written application, in person, or by mail (postage prepaid), addressed to:

Humana – G&A
P.O. Box 14546
Lexington, KY 40512 - 4546

Appeals of denied claims will be conducted promptly, will not defer to the initial determination, and will not be made by the person who made the initial adverse claim determination or a subordinate of that person. The determination will take into account all comments, documents, records, and other information submitted by the *claimant* relating to the claim.

A *claimant* may review relevant documents and may submit issues and comments in writing. A *claimant* on appeal may, upon request, discover the identity of medical or vocational experts whose advice was obtained on behalf of the Plan in connection with the adverse determination being appealed, as permitted under applicable law.

If the claims denial is based in whole, or in part, upon a medical judgment, including determinations with regard to whether a particular treatment, drug, or other item is *experimental, investigational, or for research purposes*, or not *medically necessary* or appropriate, the person deciding the appeal will consult with a health care professional who has appropriate training and experience in the field of medicine involved in the medical judgment. The consulting health care professional will not be the same person who decided the initial appeal or a subordinate of that person.

Claims Procedures Continued

Time Periods for Decisions on Appeal -- First Level

Appeals of claims denials will be decided and notice of the decision provided as follows:

<i>Urgent Care Claims</i>	As soon as possible, but not later than 72 hours after the <i>Plan Manager</i> receives the appeal request (if oral notification is given, written notification will follow in hard copy or electronic format within the next 3 days).
<i>Pre-Service Claims</i>	Within a reasonable period, but not later than 15 days after the <i>Plan Manager</i> receives the appeal request.
<i>Post-Service Claims</i>	Within a reasonable period but no later than 30 after days after the <i>Plan Manager</i> receives the appeal request.
<i>Concurrent Care Decisions</i>	Within the time periods specified above, depending upon the type of claim involved.

Time Periods for Decisions on Appeal -- Second Level

Appeals of claims denials will be decided and notice of the decision provided as follows:

<i>Pre-Service Claims</i>	Within a reasonable period, but not later than 15 days after the <i>Plan Manager</i> receives the appeal request.
<i>Post-Service Claims</i>	Within a reasonable period but no later than 30 days after the <i>Plan Manager</i> receives the appeal request.

APPEAL DENIAL NOTICES

Notice of a benefit determination on appeal will be provided to *claimants* by mail, postage prepaid, by FAX, or by e-mail, as appropriate, within the time frames noted above.

A notice that a claim appeal has been denied will convey the specific reason or reasons for the adverse determination and the specific plan provisions on which the determination is based.

The notice will also disclose any internal Plan rule, protocol or similar criterion that was relied on to deny the claim. A copy of the rule, protocol or similar criterion relied upon will be provided to a *claimant* free of charge upon request.

If the adverse determination is based on a *medical necessity* or experimental treatment or similar exclusion or limit, the notice will provide either an explanation of the scientific or clinical judgment for the determination, applying the terms of the Plan to the *claimant's* medical circumstances, or a statement that such explanation will be provided free of charge upon request.

Claims Procedures Continued

In the event of a denial of an appealed claim, the *claimant* on appeal will be entitled to receive, upon request and without charge, reasonable access to and copies of any document, record or other information:

1. Relied on in making the determination.
2. Submitted, considered or generated in the course of making the benefit determination.
3. That demonstrates compliance with the administrative processes and safeguards required with respect to such determinations.
4. That constitutes a statement of policy or guidance with respect to the Plan concerning the denied treatment, without regard to whether the statement was relied on.

RIGHT TO REQUIRE MEDICAL EXAMS

(Applies only to medical Plans)

The Plan has the right to require that a medical exam be performed on any *claimant* for whom a claim is pending as often as may be reasonably required. If the Plan requires a medical exam, it will be performed at the Plan's expense. The Plan also has a right to request an autopsy in the case of death, if state law so allows.

EXHAUSTION

Upon completion of the appeals process under this section, a *claimant* will have exhausted his or her administrative remedies under the Plan. If the *Plan Manager* or Plan Administrator fails to complete a claim determination or appeal within the time limits set forth above, the *claimant* may treat the claim or appeal as having been denied, and the *claimant* may proceed to the next level in the review process.

LEGAL ACTIONS AND LIMITATIONS

A civil action may not be brought with respect to Plan benefits until all remedies under the Plan have been exhausted.

DEFINITIONS

Active status means performing on a regular, full-time or part-time basis all customary occupational duties, for not less than 20 hours per week, at the *employer's* business locations or when required to travel for the *employer's* business purposes. Each day of a regular paid vacation and any regular non-working holiday will be deemed *active status* if you were in an *active status* on your last regular working day prior to the vacation or holiday.

Beneficiary means you and your covered dependent(s), or legal representative of either, and anyone to whom the rights of you or your covered dependent(s) may pass.

Bodily injury means injury due directly to an accident and independent of all other causes.

Calendar year means a period of time beginning on January 1 and ending on December 31.

Case management means the process of assessing whether an alternative plan of care would more effectively provide *medically necessary* health care services in an appropriate setting.

Claimant means a *covered person* (or authorized representative) who files a claim.

Complications of pregnancy means:

1. Conditions whose diagnoses are distinct from pregnancy but adversely affected by pregnancy or caused by pregnancy. Such conditions include: acute nephritis, nephrosis, cardiac decompensation, hyperemesis gravidarum, puerperal infection, toxemia, eclampsia and missed abortion;
2. A nonelective cesarean section surgical procedure;
3. Terminated ectopic pregnancy; or
4. Spontaneous termination of pregnancy which occurs during a period of gestation in which a viable birth is not possible.

Complications of pregnancy does not mean:

1. False labor;
2. Occasional spotting;
3. Prescribed rest during the period of pregnancy;
4. Conditions associated with the management of a difficult pregnancy but which do not constitute distinct *complications of pregnancy*; or
5. An elective cesarean section.

Concurrent care decision means a decision by the Plan to reduce or terminate benefits otherwise payable for a course of treatment that has been approved by the Plan (other than by Plan amendment or termination) or a decision with respect to a request by a *claimant* to extend a course of treatment beyond the period of time or number of treatments that has been approved by the Plan.

Definitions Continued

Concurrent review means the process of assessing the continuing *medical necessity*, appropriateness, or utility of additional days of *hospital confinement*, outpatient care, and other health care *services*.

Confinement means being a resident patient in a *hospital* or a *qualified treatment facility* for at least 15 consecutive hours per day. Successive *confinements* are considered one *confinement* if:

1. Due to the same *bodily injury* or *sickness*; and
2. Separated by fewer than 30 consecutive days when *you* are not confined.

Copayment (medical) means the amount to be paid by *you* for each applicable medical *service*.

Cosmetic surgery means *surgery* performed to reshape structures of the body in order to change *your* appearance or improve self-esteem.

Covered expense means *services* incurred by *you* or *your* covered *dependents* due to *bodily injury* or *sickness* for which benefits may be available under the Plan. *Covered expenses* are subject to all provisions of the Plan, including the limitations and exclusions.

Covered person means the *employee*, council member or mayor, *retired employee*, or any of their covered *dependents*.

Creditable coverage means the total time of prior continuous health plan coverage periods used to reduce the length of any *pre-existing condition* limitation period applicable to *you* or *your dependents* under this Plan where these prior continuous health coverage(s) existed with no more than a 63-consecutive day lapse in coverage.

Custodial care means *services* provided to assist in the activities of daily living which are not likely to improve *your* condition. Examples include, but are not limited to, assistance with dressing, bathing, toileting, transferring, eating, walking and taking medication. These *services* are considered *custodial care* regardless if a *qualified practitioner* or provider has prescribed, recommended or performed the *services*.

Dental injury is an injury caused by a sudden, violent, and external force that could not be predicted in advance and could not be avoided. *Dental injury* does not include chewing injuries.

Dependent means a covered *member's*:

1. Legally recognized spouse;
2. Unmarried natural blood related child, stepchild, legally adopted child or child for which the *employee* has legal guardianship whose age is less than the limiting age. Each child must legally qualify as a *dependent* as defined by the United States Internal Revenue Service.

The limiting age for each *dependent* child is 25 years if such child is dependent upon the *member* for support and in regular full-time attendance at an accredited secondary school, college or university. The *dependent* child must be enrolled for sufficient course credits to maintain full-time status as defined by that school. A *dependent* child continues to be eligible for coverage for up to four months following the close of a school term only if enrolled as a full-time student for the following school term.

Definitions Dependent Continued

Adopted children and children placed for adoption are subject to all terms and provisions of the Plan, with the exception of the *pre-existing condition* limitation.

3. A covered *member's* child whose age is less than the limiting age and is entitled to coverage under the provisions of this Plan because of a medical child support order;
4. Grandchild, as long as the *member's* covered *dependent*, who is the parent of the grandchild, is not yet age 18.

You must furnish satisfactory proof to the *Plan Manager* upon request that the above conditions continuously exist. If satisfactory proof is not submitted to the *Plan Manager*, the child's coverage will not continue beyond the last date of eligibility.

A covered *dependent* child who attains the limiting age while covered under the Plan will remain eligible for benefits if all of the following exist at the same time:

1. Mentally retarded or permanently physically handicapped;
2. Incapable of self-sustaining employment;
3. The child meets all of the qualifications of a *dependent* as determined by the United States Internal Revenue Service;
4. Declared on and legally qualify as a *dependent* on the *member's* federal personal income tax return filed for each year of coverage; and
5. Unmarried.

You must furnish satisfactory proof to the *Plan Manager* that the above conditions continuously exist on and after the date the limiting age is reached. The *Plan Manager* may not request such proof more often than annually after two years from the date the first proof was furnished. If satisfactory proof is not submitted to the *Plan Manager*, the child's coverage will not continue beyond the last date of eligibility.

Durable medical equipment (DME) means equipment that is *medically necessary* and able to withstand repeated use. It must also be primarily and customarily used to serve a medical purpose and not be generally useful to a person except for the treatment of a *bodily injury* or *sickness*.

Emergency means an acute, sudden onset of a *sickness* or *bodily injury* which is life threatening or will significantly worsen without immediate medical or surgical treatment.

Employee means *you*, as an *employee*, when *you* are permanently employed and paid a salary or earnings and are in an *active status* at your *employer's* place of business.

Definitions Continued

Employer means the sponsor of the Group Plan or any subsidiary(s).

Expense incurred means the fee charged for *services* provided to *you*. The date a *service* is provided is the *expense incurred* date.

Experimental, investigational or for research purposes:

A *service* is *experimental, investigational or for research purposes* if the *Plan Manager* determines;

1. The *service* cannot be lawfully marketed without approval of the U.S. Food and Drug Administration and approval for marketing has not been given at the time the *service* is furnished; or
2. The *service* or *your* informed consent document utilized with the *service* was reviewed and approved by the treating facility's Institutional Review Board or other body serving a similar function, or if federal law requires such review and approval; or
3. Reliable evidence shows that the *service* is the subject of on-going phase I or phase II clinical trials; is the research, experimental, study or investigational arm of ongoing phase III clinical trials; or is otherwise under study to determine its maximum tolerated dose, its toxicity, its safety, its efficacy, or its efficacy as compared with a standard means of treatment or diagnosis; or
4. Reliable evidence shows that the prevailing opinion among experts regarding the *service* is that further studies or clinical trials are necessary to determine its maximum tolerated dose, its toxicity, its safety, its efficacy or its efficacy as compared with a standard means of treatment or diagnosis.

Reliable evidence will mean only published reports and articles in the authoritative medical and scientific literature; the written protocol or protocols used by the treating facility or the protocol(s) of another facility studying substantially the same *service*; or the written informed consent used by the treating facility or by another facility studying substantially the same *service*.

Family member means *you* or *your* spouse, or *you* or *your* spouse's child, brother, sister, parent, grandchild or grandparent.

Free-standing surgical facility means a public or private establishment licensed to perform *surgery* and which has permanent facilities that are equipped and operated primarily for the purpose of performing *surgery*. It does not provide *services* or accommodations for patients to stay overnight.

Hospital means an institution which:

1. Maintains permanent full-time facilities for bed care of resident patients;
2. Has a physician and surgeon in regular attendance;
3. Provides continuous 24 hour a day nursing *services*;
4. Is primarily engaged in providing diagnostic and therapeutic facilities for medical or surgical care of sick or injured persons;
5. Is legally operated in the jurisdiction where located; and

Definitions Hospital Continued

6. Has surgical facilities on its premises or has a contractual agreement for surgical *services* with an institution having a valid license to provide such surgical *services*; or
7. Is a lawfully operated *qualified treatment facility* certified by the First Church of Christ Scientist, Boston, Massachusetts.

Hospital does not include an institution which is principally a rest home, skilled nursing facility, convalescent home or home for the aged. *Hospital* does not include a place principally for the treatment of alcoholism, chemical dependence, or *mental disorders*.

Late applicant means an *employee* and/or an *employee's* eligible *dependent* who applies for medical coverage more than 31 days after the eligibility date.

Maintenance care means any *service* or activity which seeks to prevent *bodily injury* or *sickness*, prolong life, promote health or prevent deterioration of a *covered person* who has reached the maximum level of improvement or whose condition is resolved or stable.

Maximum allowable fee for a *service* means the lesser of:

1. The fee most often charged in the geographical area where the *service* was performed;
2. The fee most often charged by the provider;
3. The fee which is recognized as reasonable by a prudent person;
4. The fee determined by comparing charges for similar *services* to a national data base adjusted to the geographical area where the *services* or procedures were performed; or
5. The fee determined by using a national relative value scale. Relative value scale means a methodology that values medical procedures and *services* relative to each other that includes, but is not limited to, a scale in terms of difficulty, work, risk, as well as the material and outside costs of providing the *service*, as adjusted to the geographic area where the *services* or procedures were performed.

Maximum benefit means the maximum amount that may be payable for each *covered person*, for *expense incurred*. The applicable *maximum benefit* is shown on the Schedule of Benefits. No further benefits are payable once the *maximum benefit* is reached.

Medically necessary or medical necessity means the extent of *services* required to diagnose or treat a *bodily injury* or *sickness* which is known to be safe and effective by the majority of *qualified practitioners* who are licensed to diagnose or treat that *bodily injury* or *sickness*. Such *services* must be:

1. Performed in the least costly setting required by *your* condition;
2. Not provided primarily for the convenience of the patient or the *qualified practitioner*;
3. Appropriate for and consistent with *your* symptoms or diagnosis of the *sickness* or *bodily injury* under treatment;
4. Furnished for an appropriate duration and frequency in accordance with accepted medical practices, and which are appropriate for *your* symptoms, diagnosis, *sickness* or *bodily injury*; and

Definitions Medically Necessary or Medical Necessity Continued

5. Substantiated by the records and documentation maintained by the provider of *service*.

Medicare means Title XVIII, Parts A and B of the Social Security Act, as enacted or amended.

Member means *employee*, retiree, council member, or mayor covered by this plan.

Mental disorder means a mental, nervous, or emotional disease or disorder of any type as classified in the Diagnostic and Statistical Manual of Mental Disorders, regardless of the cause or causes of the disease or disorder.

Morbid obesity means morbid or clinically severe obesity correlated with a Body Mass Index (BMI) of 40 kg/m² or with being 100 pounds over ideal body weight and 30% over his/her ideal body weight with underlying medical conditions.

Out of area members mean a *covered person* who resides outside the geographical area where participating providers are available and accessible. For additional information, *you* may contact the *Plan Manager's* customer service department at the phone number located on *your* identification card.

Plan Manager means Humana Insurance Company (HIC). The *Plan Manager* provides services to the Plan Administrator, as defined under the Plan Management Agreement. The *Plan Manager* is not the Plan Administrator or the Plan Sponsor.

Plan year means a period of time beginning on the Plan anniversary date of any year and ending on the day before the same date of the succeeding year.

Post-service claim means any claim for a benefit under a group health plan that is not a *pre-service claim*.

Pre-service claim means a claim with respect to which the terms of the Plan condition receipt of a Plan benefit, in whole or in part, on approval of the benefit by the *Plan Manager* in advance of obtaining medical care.

Preadmission testing means only those outpatient x-ray and laboratory tests made within seven days before admission as a registered bed patient in a *hospital*. The tests must be for the same *bodily injury* or *sickness* causing the patient to be *hospital* confined. The tests must be accepted by the *hospital* in lieu of like tests made during *confinement*. *Preadmission testing* does not mean tests for a routine physical check-up.

Precertification means the process of assessing the *medical necessity*, appropriateness, or utility of proposed non-emergency *hospital* admissions, surgical procedures, outpatient care, and other health care *services*.

Predetermination of benefits means a review by the *Plan Manager* of a *qualified practitioner's* treatment plan, specific diagnostic and procedure codes and expected charges prior to the rendering of *services*.

Pre-existing condition means a physical or mental condition for which *you* have received medical attention (medical attention includes, but is not limited to: *services* or care) during the six month period immediately prior to the enrollment date of *your* medical coverage under the Plan. *Pre-existing conditions* are covered after the end of a period of twelve months after the enrollment date (first day of coverage or, if there is a waiting period, the first day of the waiting period).

Pre-existing condition limitations will be waived or reduced for *pre-existing conditions* that were satisfied under previous *creditable coverage*.

Definitions Continued

Protected health information means individually identifiable health information about a *covered person*, including: (a) patient records, which includes but is not limited to all health records, physician and provider notes and bills and claims with respect to a *covered person*; (b) patient information, which includes patient records and all written and oral information received about a *covered person*; and (c) any other individually identifiable health information about *covered persons*.

Qualified practitioner means a practitioner, professionally licensed by the appropriate state agency to diagnose or treat a *bodily injury* or *sickness*, and who provides *services* within the scope of that license.

Qualified treatment facility means only a facility, institution or clinic duly licensed by the appropriate state agency, and is primarily established and operating within the scope of its license.

Retired employee means an eligible employee who meets all of the following:

- A former *employee* who has retired and is either (a) drawing benefits under either the Employees Retirement Fund of the City of Dallas or the Dallas Police and Fire Pension System; or (b) contributing to Deferred Retirement Option Plan (“DROP”). An *employee* who terminates with the vested interest in one of these retirement plans but who is not yet eligible for pension benefits is not classified as a retiree under the plan; **and**
- The *employee* was covered under this Plan or a continuation of this Plan (COBRA) on the day before the date of retirement.

Retired employee also means:

- A former *employee* who was within two years of reaching pension eligibility and was terminated through Reduction in Force (“RIF”) as defined under the City of Dallas Civil Service rules; **or**
- A former *employee* who had earned 30 years’ pension service credit but did not have sufficient age to qualify as a retiree;

And (in either of the above)

- Was covered under this Plan on the day before the “RIF” or termination, who subsequently becomes eligible, because of age, to receive retirement benefits from the Employees’ Retirement Fund or the City of Dallas (“ERF”) or the Dallas Police and Fire Pension System (“DPFP”), or elects to defer the pension benefit payment to a Deferred Retirement Option Plan (“DROP”) account established by DPFP.

In order to be eligible for retiree medical coverage, a *retired employee* must have been enrolled on this plan or a previous City of Dallas Health Benefits Plan on December 31, 2003.

Serious mental illness means the following psychiatric illnesses as defined by the American Psychiatric Association in the Diagnostic and Statistical Manual (DSM) III-R:

1. Schizophrenia;
2. Paranoid and other psychotic disorders;
3. Bipolar disorders (hypomanic, manic, depressive, and mixed);
4. Major depressive disorders (single episodes or recurrent);

Definitions Serious Menal Illness Continued

5. Schizo-affective disorders (bipolar or depressive);
6. Pervasive development disorders;
7. Obsessive-compulsive disorders; and
8. Depression in childhood and adolescence.

Services means procedures, surgeries, exams, consultations, advice, diagnosis, referrals, treatment, tests, supplies, drugs, devices or technologies.

Sickness means a disturbance in function or structure of *your* body which causes physical signs or symptoms and which, if left untreated, will result in a deterioration of the health state of the structure or system(s) of *your* body.

Sound natural tooth means a tooth that:

1. Is organic and formed by the natural development of the body (not manufactured);
2. Has not been extensively restored;
3. Has not become extensively decayed or involved in periodontal disease; and
4. Is not more susceptible to injury than a whole natural tooth.

Surgery means excision or incision of the skin or mucosal tissues, or insertion for exploratory purposes into a natural body opening. This includes insertion of instruments into any body opening, natural or otherwise, done for diagnostic or other therapeutic purposes.

Timely applicant means an *employee* and/or an *employee's* eligible *dependent* who applies for medical coverage within 31 days of the eligibility date.

Urgent care claim means a claim for medical care or treatment with respect to which the application of the time periods for making non-urgent care determinations:

- Could seriously jeopardize the life or health of the *claimant* or the ability of the *claimant* to regain maximum function; or
- In the opinion of a physician with knowledge of the *claimant's* medical condition, would subject the *claimant* to severe pain that cannot be adequately managed without the care or treatment that is the subject of the claim.
- Generally, whether a claim is a claim involving urgent care will be determined by the *Plan Manager*. However, any claim that a physician with knowledge of a *claimant's* medical condition determines is a “claim involving urgent care” will be treated as a “claim involving urgent care.”

Utilization review means the process of assessing the *medical necessity*, appropriateness, or utility of *hospital* admissions, surgical procedures, outpatient care, and other health care *services*. *Utilization review* includes *precertification* and *concurrent review*.

You and your means *you* as the *employee* and any of *your* covered *dependents*, unless otherwise indicated.