

PLAN DOCUMENT AND SUMMARY PLAN DESCRIPTION FOR:

INTEGRITY HOME CARE + HOSPICE

EMPLOYEE MAJOR MEDICAL PLAN

AMENDED AND RESTATED EFFECTIVE 01/01/2018

Administered by:



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# INTRODUCTION

This document is a description of Integrity Home Care Employee Major Medical Health Care Plan (the Plan). No oral interpretations can change this Plan. The Plan described is designed to protect Plan Participants against certain catastrophic health expenses.

Coverage under the Plan will take effect for an eligible Employee and designated Dependents when the Employee and such Dependents satisfy the Waiting Period and all the eligibility requirements of the Plan.

The Employer fully intends to maintain this Plan indefinitely. However, it reserves the right to terminate, suspend, discontinue or amend the Plan at any time and for any reason.

Changes in the Plan may occur in any or all parts of the Plan including benefit coverage, deductibles, maximums, copayments, exclusions, limitations, definitions, eligibility and the like.

Failure to follow the eligibility or enrollment requirements of this Plan may result in delay of coverage or no coverage at all. Reimbursement from the Plan can be reduced or denied because of certain provisions in the Plan, such as coordination of benefits, subrogation, exclusions, timeliness of COBRA elections, utilization review or other cost management requirements, lack of Medical Necessity, lack of timely filing of claims or lack of coverage. These provisions are explained in this document.

The Plan will pay benefits only for the expenses incurred while this coverage is in force. No benefits are payable for expenses incurred before coverage began or after coverage terminated. An expense for a service or supply is incurred on the date the service or supply is furnished.

No action at law or in equity shall be brought to recover under any section of this Plan until the appeal rights provided have been exercised and the Plan benefits requested in such appeals have been denied in whole or in part.

If the Plan is terminated, amended, or benefits are eliminated, the rights of Covered Persons are limited to Covered Charges incurred before termination, amendment or elimination.

This document summarizes the Plan rights and benefits for covered Employees and their Dependents and is divided into the following parts:

**Eligibility, Funding, Effective Date and Termination.** Explains eligibility for coverage under the Plan, funding of the Plan and when the coverage takes effect and terminates.

**Schedule of Benefits.** Provides an outline of the Plan reimbursement formulas as well as payment limits on certain services.

**Benefit Descriptions.** Explains when the benefit applies and the types of charges covered.

**Cost Management Services.** Explains the methods used to curb unnecessary and excessive charges.

**This part should be read carefully since each Participant is required to take action to assure that the maximum payment levels under the Plan are paid.**

**Defined Terms.** Defines those Plan terms that have a specific meaning.

**Plan Exclusions.** Shows what charges are **not** covered.

**Claim Provisions.** Explains the rules for filing claims and the claim appeal process.

**Coordination of Benefits.** Shows the Plan payment order when a person is covered under more than one plan.

**Third Party Recovery Provision.** Explains the Plan's rights to recover payment of charges when a Covered Person has a claim against another person because of injuries sustained.

**Continuation Coverage Rights Under COBRA.** Explains when a person's coverage under the Plan ceases and the continuation options which are available.

**Responsibilities for Plan Administration.** Explains the responsibilities for the Plan Administrator and includes information about the Plan’s obligations with respect to Participants’ privacy rights under the Health Insurance Portability and Accountability Act (HIPAA) and the Plan’s compliance with the HIPAA Electronic Security Standards. Explains the Plan's structure and the Participants' ERISA rights under the Plan.

**ERISA Information.** Explains the Plan's structure and the Participants' rights under the Plan.

# SCHEDULE OF BENEFITS

**Verification of Eligibility** Contact the Claims Supervisor to verify eligibility for Plan benefits **before** the charge is incurred. (Refer to General Plan Information section for contact information.)

Call this number to verify eligibility for Plan benefits **before** the charge is incurred.

**PREADMISSION CERTIFICATION** (also referred to as **PRECERTIFICATION**) means the review of all Hospital admissions prior to the admission date. This program is designed to help ensure that all Covered Persons receive necessary and appropriate health care while avoiding unnecessary expenses when a Hospital stay is proposed. For example, based on the information provided by the Physician, the Pre- certification Nurse will make an initial assessment of the condition to determine, among other things: if a second surgical opinion is required or recommended; if the admission is to an In-Network facility; if concurrent review by Utilization Review Coordinator is to be initiated; and if Medical Case Management is applicable.

**PRECERTIFICATION REQUIREMENT**: If any part of a Hospital or other Inpatient stay is not precertified per the instructions in the Cost Management Section, *the benefit payment will be reduced by $300*.

The Plan may not, under state or Federal law, restrict benefits for a Hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours for a vaginal delivery or less than 96 hours for a cesarean delivery. (The Hospital stay begins at the time of delivery, or admission if the delivery occurred outside the Hospital.) The attending Physician does not have to obtain precertification from the Plan; however the Covered Person is still required to precertify the Hospital stay to avoid the above precertification penalty. (Refer to the Cost Management Services Section and Medical Benefits Section for complete details.)

**PREAUTHORIZATION** of certain services is requested and may expedite the adjudication of the claim.

All Organ Transplant services, including evaluation, **must** be preauthorized or benefits may otherwise be reduced or denied. Therefore, the Covered Person or his/her physician must call the Utilization Review Coordinator (Refer to General Plan Information section for contact information.) when the Physician first indicates a transplant is recommended. Retransplantation procedures must also have preauthorization.

**CASE MANAGEMENT** is available in certain situations. (Refer to the Cost Management Services Section for complete details.) If the Covered Person fails to follow medical treatment guidelines, *benefit payment will be reduced by 50%.*

**TIMELY FILING OF CLAIMS:** Claims must be filed with the Claims Supervisor within 6 months of the date charges for the service were incurred. If the Plan should terminate, all claims must be filed within six months of the Plan’s termination date. Benefits are based on the Plan's provisions at the time the charges were incurred. Claims filed later than that date may be declined. (Refer to the section entitled "How to Submit a Claim".)

**MEDICAL BENEFITS**

To be considered a Covered Charge under this Plan, treatment, services and/or supplies must meet all of the following criteria:

1. Medically Necessary; **3**. Not excluded under the Plan, and:
2. Ordered by an appropriate Physician; **4**. Meets the standards of care for the diagnosis.

All benefits described in this Schedule are subject to the exclusions and limitations described more fully herein including, but not limited to, the above.

The meanings of these capitalized terms are in the Defined Terms section of this document. The Plan is a plan which contains multiple Participating Provider Organizations.

PPO name: Mercy Provider Network

Telephone: 877-875-7700

Web site: [www.](http://www/) mercyoptions.net

PPO for Covered Persons outside the above network area: Refer to your ID card for contact information.

Additional information about this network is available at the Human Resources office. A list of Participating Providers is available by calling the PPO at the above phone number or searching for a provider on the PPO’s web site. The phone number and web site are also listed on your ID card. In order to obtain benefits at the higher level, it is the Covered Person’s responsibility to make sure the provider is participating in the network prior to seeking services. Call the PPO to verify the current status of the provider before each visit.

This Plan has entered into an agreement with certain Hospitals, Physicians and other health care providers, which are called Participating Providers. Because these Participating Providers have agreed to charge reduced fees to persons covered under the Plan, the Plan can afford to reimburse a higher percentage of their fees.

The Claims Administrator may also contract directly with certain Hospitals and Physicians. These providers will be considered Participating Providers.

When a Covered Person uses a Participating Provider, that Covered Person will receive a higher payment from the Plan than when a Non-Participating Provider is used. When a Non-participating Provider is used, the Covered Person may be responsible for any amounts above the Plan’s calculation of the Allowed Amount. It is the Covered Person's choice as to which Provider to use.

**The Usual and Customary Allowance for Non-participating Providers is calculated as follows: the Allowed Amount will be the network’s contracted rate (based upon the Mercy contract), negotiated rate or billed amount, whichever is less unless specifically stated otherwise in this Plan. For services rendered by Non-network Providers, the Covered Person will be responsible for the amount above this rate. The amount over the Usual and Customary Allowance amount will not apply towards the Covered Person’s Deductible or Coinsurance Calendar Year maximums. Notwithstanding these allowances, all charges from all providers will be subject to a review for Reasonable allowance.**

Services, as used in this Plan document, means a recognized or standard medical service; it does not mean a specific technique, procedure, or equipment. For example, hip replacement surgery would be considered a recognized or standard medical service; however, the specific technique used by the Physician, i.e., the manner of performing the surgery, is not considered as a service such as to qualify the Covered Person for an exception to the Non-network reimbursement percentage.

Under the following circumstances, the higher Participating Provider benefit will be applied for certain Non-Participating Provider services. For these services the standard Usual and Customary Allowance or out-of-area PPO network allowance will be applied and not the Allowed Amount as calculated above:

**SERVICES WITHIN OR OUTSIDE THE MERCY NETWORK AREA WHEN IT IS THE PRIMARY NETWORK:**

If a Covered Person is outside the PPO network area and requires services Incidental in nature. A referral is not required. However, it may be more cost effective for the Covered Person to seek out a national network Participating Provider in the geographic area where services are to be rendered.

If a Covered Person has no choice of Participating Providers in the specialty required to treat the Illness or Injury: 1) outside the Mercy network area, a national PPO Participating Provider must be utilized in order for the Participating Provider benefit to be applied; or 2) within the Mercy network area, a referral is not required. However, verification of the availability, or lack thereof, of a Participating Provider must be submitted to the Utilization Review Coordinator by the Covered Person or the Physician to review for authorization of payment at the Participating Provider benefit level and the time period for which the services will be approved under this exception..

If a Covered Person is seeking services by a Non-Participating Provider when the services are available by a Participating Provider: 1) outside the Mercy network area, a national PPO Participating Provider must be utilized in order for the Participating Provider benefit to be applied; or 2) within the Mercy network area, a referral from a Participating Provider in that specialty must be submitted prior to seeking services to the Utilization Review Coordinator who will review the situation to determine if the services will be considered under the Participating Provider benefit. A referral is required even if the provider being referred to is in the Mercy extended PPO coverage area outside Southwest Missouri.

**SERVICES WITHIN OR OUTSIDE THE NETWORK AREA:**

If a Covered Person has an Emergency Medical Condition (on an Inpatient or Outpatient basis) evidenced by acute symptoms of sufficient severity so that a prudent layperson, with average knowledge of health and medicine, could reasonably expect that absence of immediate medical attention would place the individual’s health in serious jeopardy or seriously impair bodily functions, bodily organs or parts. This applies to ambulance transport, facility and Physician charges. For an Inpatient admission, in order to continue to receive the higher benefit once the Covered Person’s condition has been stabilized following admission to a Non-Participating facility, the Covered Person must be transferred to a Participating facility.

If a Covered Person receives Physician, diagnostic or anesthesia services by a Non-Participating Provider when the Covered Person did not have a choice of Participating Providers or they were not available while admitted Inpatient or Outpatient at a Participating facility.

If a Covered Person has a specimen for a lab test drawn or an x-ray taken by a Participating Provider but a Non-Participating Provider performs the lab test or reads the x-ray.

If a Covered Person receives treatment, services or supplies by a Non-Participating Provider and the charges for the services were negotiated and/or approved by Mercy Care Management. (Pre-certification is not an approval of the services or a guarantee of payment for the services.) *However*, c*harges for services with discounts accessed through a repricing network in absence of any other exception listed above will be considered at the Non*-*Participating Provider benefit level.*

If the exception is not listed above, the Non-participating Provider benefits will apply as outlined in the following Schedule, i.e., the Covered Person lives outside the network area or the Covered Person intentionally seeks services outside the network area (except as approved above).

**Deductibles/Copayments payable by Plan Participants**

Deductibles/Copayments are dollar amounts that the Covered Person must pay before the Plan pays.

A deductible is an amount of money that is paid by a Covered Person once a Calendar Year. Typically, there is one deductible amount per Plan and it must be paid before any money is paid by the Plan for any Covered Charges. Each January 1st, a new deductible amount is required.

A copayment is the amount of money that is paid each time a particular service is used. Typically, there may be copayments on some services and other services will not have any copayments.

# MEDICAL BENEFITS SCHEDULE

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
|  | | **PARTICIPATING PROVIDERS** | | **NON-PARTICIPATING PROVIDERS** |
| Note: The maximums listed below are the total for Participating and Non-Participating Provider expenses. For example, if a maximum of 60 days is listed twice under a service, the Calendar Year maximum is 60 days total which may be split between and Non- Providers. | | | | |
| **DEDUCTIBLE, PER CALENDAR YEAR** | | | | |
| Per Covered Person  Per Family Unit | | $1,000.00  $3,000.00 | | $1,000.00  $3,000.00 |
| The Calendar Year Deductible is waived for the following Covered Charges:  -Preventive Care (as listed) -Physician Visits (as listed) | | | | |
| **COPAYMENTS** | | | | |
| Physician & Urgent Care visits  Prescriptions at the Pharmacy | | $30.00  Refer to Prescription Benefits | | N/A  Refer to Prescription Benefits |
| Note: The Copayment only applies to the visit charge, the urgent care visit and after hours charge. Regular Plan benefits apply to other charges. | | | | |
| **MAXIMUM OUT OF POCKET AMOUNT** (Deductible, Coinsurance, & Copayments) **PER CALENDAR YEAR** | | | | |
| Per covered Person  Per Family Unit | | $6,600.00  $13,200.00 | | No Maximum  No Maximum |
| The Plan will pay the designated percentage of Covered Charges until out-of-pocket amounts are reached, at which time the Plan will pay 100% of the remainder of Covered Charges for the rest of the Calendar Year unless stated otherwise.  The following charges do not apply toward the Out-of-Pocket maximum and are never paid at 100%.  -Cost containment penalties  -Amounts over Usual and Customary Allowance  -Charges excluded by the Plan | | | | |
| Note: The maximum amounts an individual can contribute to the in-network deductible and coinsurance family maximums are amounts up to the in-network “Per Covered Person” maximums. Therefore, if the individual has out-of-network services, only the amount up to the in-network maximum will be counted toward reaching the family’s in-network maximum. For example, an individual has Out-of-Network Covered Charges of $1,200. $1,000 will be applied to the Out-of-Network deductible The individual In-Network deductible amount will also be credited $1,000 for calculating their In-Network deductible and the family unit maximum. | | | | |
| **COVERED CHARGES** | | | | |
| **Ambulance Service** | 80% after deductible | | 80% after deductible | |
| **Contact Lenses or Glasses** | 80% after deductible  $300 maximum per surgery | | 40% after deductible  $300 maximum per surgery | |
| Note: When required following cataract surgery. Refer to the Medical Benefit section for further details of this benefit. | | | | |
| **Diagnostic Testing (X-ray & Lab, including Pre-Admission**  **Testing)** | 80% after deductible | | 40% after deductible | |
| **Durable Medical Equipment** | 80% after deductible | | 40% after deductible | |
| **Emergency Room Visit** | 80% after deductible | | 80% after deductible | |
| **Home Health Care** | 80% after deductible | | 40% after deductible | |
| 100 visits Calendar Year Maximum | | | | |
| **Hospice Care** | 100% deductible waived | | 40% after deductible | |
| **Hospital Services** | | | | |
| Room and Board | 80% after deductible  the semiprivate room rate | | 40% after deductible  the semiprivate room rate | |
| Intensive Care Unit | 80% after deductible Hospital's ICU Charge | | 40% after deductible Hospital's ICU Charge | |
| Newborn Nursery Care | 80% after deductible  the semiprivate room rate | | 40% after deductible  the semiprivate room rate | |
| Other Outpatient Services not listed herein | 80% after deductible | | 40% after deductible | |
| **Jaw Joint/TMJ** | 80% after deductible | | 40% after deductible | |
| Note: Orthodontic treatment is not covered under this medical Plan. Only surgical treatment is covered. | | | | |
| **Mental Disorders** | | | | |
| Inpatient | 80% after deductible | | 40% after deductible | |
| Outpatient | 80% after deductible | | 40% after deductible | |
| Counseling & Office Visits | $30 copayment, then 100% | | 40% after deductible | |
| MDLive MA/MS level provider (effective 02/01/2017) | $85 consultation fee | | Services not covered | |
| MDLive PhD level provider (effective 02/01/2017) | $95 consultation fee | | Services not covered | |
| **Organ Transplants** | Designated Transplant Facility:  80% after deductible  These services are only covered  under the Mercy Approved  Transplant Network including the Optum Transplant Network Facilities. All Transplant services require prior authorization and a Transplant Case Manager must be assigned to the case. | | Non-Designated Transplant Facility:  Not Covered | |
| Mercy Transplant Network  The network designated by the Plan Administrator as the sole and exclusive network to provide transplant services under the Plan. The Mercy Transplant Network is composed of the Mercy-approved Transplant Center including the Optum Transplant Network. Covered Health Services for the following organ and tissue transplants when ordered by a Physician at a Plan Administrator designated Transplant facility. For Network Benefits, transplant services must be received at an approved facility in the designated transplant network.  Benefits are available for the transplants listed below when the transplant is Medically Necessary and is not an Experimental, Investigational or Unproven Service:  •Bone marrow transplants (either from You or from a compatible donor) and peripheral stem cell transplants, with or without high dose Chemotherapy. Not all bone marrow transplants meet the definition of a Covered Health Services.  •Heart transplants  •Heart/lung transplants  •Lung transplants  •Kidney transplants  •Kidney /pancreas transplants  •Kidney/liver  •Liver transplants  •Liver/small bowel transplants  •Pancreas transplants  •Small bowel transplants  •Cornea transplants that are provided by a Physician at a Hospital.  The Plan Administrator does not require that cornea transplants be performed at a Designated Mercy Approved Transplant Network Facility in order for You to receive Network Benefits. Corneal transplant does not require Prior Authorization. | | | | |
| **Orthotics** | 80% after deductible | | 40% after deductible | |
| **Outpatient Private Duty Nursing** | 80% after deductible | | 40% after deductible | |
| **Physician Services** | | | | |
| Inpatient Visits | 80% after deductible | | 40% after deductible | |
| Primary Care (visit charge) | $30 copayment, then 100% | | 40% after deductible | |
| Specialist (visit charge) | $50 copayment, then 100% | | 40% after deductible | |
| Urgent Care | $75 copayment | | 40% after deductible | |
| Surgery | 80% after deductible | | 40% after deductible | |
| All other Physician services | 80% after deductible | | 40% after deductible | |
| Allergy testing | 80% after deductible | | 40% after deductible | |
| Allergy Serum & Injections | 80% after deductible | | 40% after deductible | |
| MDLive (effective 02/01/2017) | $20 consultation fee | | Services not covered | |
| **Pregnancy** | 80% after deductible | | 40% after deductible | |
| Note: Two ultrasounds will be considered eligible expenses for a routine Pregnancy for the following: to determine gestational age and for routine screening. The Physician’s global fee is billed by the Physician upon delivery even though the Physician may require monthly payments from the patient. Other services are billed separately upon the service being rendered. | | | | |
| **Preventive Care** | | | | |
| Routine Adult Well Care | 100%, deductible waived | | Services not covered | |
| Benefit restricted to those recommended preventive services under the Affordable Care Act (ACA). The ACA follows services recommended by the United States Preventive Services Task Force (categories A and B), as well as recommendations and guidelines of the Advisory Committee on Immunization Practices (ACIP), and the Health Resources and Services Administration (HRSA). A current listing of recommended preventive services under the Affordable Care Act can be accessed at [www.HealthCare.gov/center/regulations/prevention.html](http://www.HealthCare.gov/center/regulations/prevention.html).  Additional preventive care services for women are covered with no cost-sharing when rendered by Participating Providers/Pharmacies. View a current listing of required preventive services at <http://www.hrsa.gov/womensguidelines/>. Contact the Pharmacy Benefit Manager at the phone number on your health care plan ID card for specific information about medications which qualify for this benefit.  Any non-ACA services performed in conjunction with category “Routine” diagnosis codes in the current ICD book are not covered.  Note: Certain immunizations available from the Pharmacy will be covered. Contact the Pharmacy Benefit Manager or Claims Supervisor for further details. Contact the Health Department for availability of any immunizations free of charge. | | | | |
| Routine Well Child Care | 100%, deductible waived | | Services not covered | |
| Benefit restricted to those recommended by the United States Preventive Services Task Force categories A and B, such as certain laboratory tests and cancer screenings. A current listing of required preventive care can be accessed at www.HealthCare.gov/center/regulations/prevention.html. Revised recommendations by the Task Force will be made applicable to the Plan when required by law. (Through age 18.)  Any non-ACA services performed in conjunction with category “Routine” diagnosis codes in the current ICD book are not covered.  Certain immunizations available from the Pharmacy will be covered. Contact the Pharmacy Benefit Manager or Claims Supervisor for further details. Contact the Health Department for availability of any immunizations free of charge. | | | | |
| **Prosthetics** | 80% after deductible | | 40% after deductible | |
| **Second Surgical Opinion, Voluntary** | 80% after deductible | | 40% after deductible | |
| **Skilled Nursing Facility** | 80% after deductible  the facility's semiprivate room rate | | 40% after deductible  the facility's semiprivate room rate within 14 days of a 3 day stay | |
| 100 days Calendar Year Maximum | | | | |
| **Spinal Manipulation/Chiropractic Services** | 80% after deductible | | 40% after deductible | |
| $1000 Calendar Year Maximum  Note: All services rendered by a Chiropractor are subject to these maximums. | | | | |
| **Sterilization (Employees and Spouses Only)** | 80% after deductible | | 40% after deductible | |
| This applies to males only. Females are covered under Preventive Care services. | | | | |
| **Substance Abuse** | | | | |
| Inpatient | 80% after deductible | | 40% after deductible | |
| Outpatient | 80% after deductible | | 40% after deductible | |
| Counseling & Office Visits | $30 copayment, then 100% | | 40% after deductible | |
| **Therapies** | | | | |
| Cardiac Therapy  36 visits in 12 consecutive weeks per event | 80% after deductible | | 40% after deductible | |
| Pulmonary Therapy  36 visits in 12 consecutive weeks per event | 80% after deductible | | 40% after deductible | |
| Occupational Therapy  20 visit limit per calendar year | 80% after deductible | | 40% after deductible | |
| Physical Therapy  20 visit limit per calendar year | 80% after deductible | | 40% after deductible | |
| Speech Therapy  20 visit limit per calendar year | 80% after deductible | | 40% after deductible | |
| **Teeth**: Replacement of teeth removed for the medical management of a hazardous medical condition | 80% after deductible | | 40% after deductible | |
| $1,500 Lifetime Maximum | | | | |
| **Weight Management** | 80% after deductible | | 40% after deductible | |
| **Wigs** | 80% after deductible | | 40% after deductible | |
| **All other Covered Charges not excluded or limited in this Plan Document:** | 80% after deductible | | 40% after deductible | |

# PRESCRIPTION DRUG BENEFIT SCHEDULE

|  |  |  |
| --- | --- | --- |
|  | **PARTICIPATING PROVIDERS** | **NON-PARTICIPATING PROVIDERS** |
| **PRESCRIPTION DRUG DEDUCTIBLE, PER CALENDAR YEAR** | | |
| Per Covered Person | $100 | |
| **Retail Prescriptions- (Per 30-day supply)** | | |
| Generic Drugs | $7 copayment after prescription drug deductible is satisfied | See below. |
| Single-Source Brand Name  Drugs | $25 copayment plus 10% after  prescription drug deductible is satisfied | See below. |
| Multi-Source Brand Name Drugs | $25 copayment + 10% + difference between cost of brand Name and  Generic Drugs after prescription drug deductible is satisfied | See below. |
| (Multi-source Brand Name drugs have a generic equivalent available.) | | |
| **Mail Order or Participating Pharmacies- (Per 90-day supply)** | | |
| Generic Drugs | $14 copayment after prescription drug  deductible is satisfied | Not Applicable |
| Single-Source Brand Name Drugs | $60 copayment after prescription drug deductible is satisfied | Not Applicable |
| Multi-Source Brand Name  Drugs | $60 + difference between cost of  brand Name and Generic Drugs after prescription drug deductible is satisfied | Not Applicable |
| Prior authorization is required for any prescription over $1,000 (30-day) or $2,000 (90-day). | | |
| **Generic Incentive:**  Covered Expenses will be limited to the cost of a Generic drug if an equivalent Generic drug is available when a Multi-source Brand Name drug is dispensed. In addition to the copayment, the Covered Person must pay the difference between the cost of the Generic drug and the Multi- source Brand Name drug. However, the Multi-source Brand Name drug will be considered a covered expense without the cost difference penalty if the Physician writes “DAW” (dispense as written) on the prescription. | | |
| **Filing receipts when PBM card is not used:**  *If this is your primary plan*, all prescriptions should be filed through the Pharmacy Benefit Manager (PBM). If the Pharmacy charges less than the Pharmacy’s discount price through the PBM, purchase the prescription without the card and submit the receipt with the claim form to the PBM and state the situation on the form.  The reimbursement (based upon the network allowance less a small processing fee) will be sent to the Covered Employee. Some exceptions to the network allowance may be made for extenuating circumstances. Typically, a pharmacy can refile a claim within 14 days if a problem existed in filing the claim electronically. The PBM help desk is available to assist the pharmacy with rejected claims. Refer to the phone number on your ID card.  *If this is your secondary plan,* submit your receipt and/or explanation of benefits from your primary plan to Mercy. The coordination of benefits provision applies and benefits are payable under the medical benefits of this Plan. The billed amount will be the amount listed on the receipt (total amount allowed or copayment, if total allowed is not listed).  A claim form may be obtained from [www.mercyoptions.net](http://www.mercyoptions.net). The PBM claim form may be obtained from their web site or by calling the number on the ID card. | | |
| **Refer to the Prescription Drug Section for details on the Prescription Drug benefit.** | | |

# ELIGIBILITY, FUNDING, EFFECTIVE DATE AND TERMINATION PROVISIONS

## ELIGIBILITY

**Eligible Classes of Employees.** Active office staff and professional (licensed) field staff of the Employer.

**Eligibility Requirements for Employee Coverage**. A person is eligible for Employee coverage once he or she satisfies all of the following (refer to the EFFECTIVE DATE section*)*:

* 1. New Employee
     1. Non-variable Hour Employee
        1. is a Full-time, Active Employee of the Employer (has begun working for the Employer). An Employee is considered to be Full-time if he or she works at least 30 Hours of Service/benefit units per week and is on the regular payroll of the Employer for that work.
        2. is in a class eligible for coverage.
        3. completes the employment Waiting Period with an average of 30 Hours of Service/benefit units worked per week as an Active Employee. A "Waiting Period" is the time beginning on the first day of employment as an Active Employee eligible for coverage and ends at midnight on the last day of the first full month (as long as remaining eligible). Coverage will begin on the first day of the 2nd calendar month. For example, an Active Employee who has met all eligibility requirements as of the 20th of the month will have coverage beginning on the first day of the 2nd calendar month.
     2. Non-variable Hour Employee experiencing a change in employment status to Variable Hour Employee
        1. Completed the Non-variable Hour Employee employment Waiting Period with an average of 30 Hours of Service/benefit units worked per week as an Active Employee. Coverage will continue until one full standard measurement period has been completed. Retesting for eligibility will be performed at that time. A “Waiting Period” is the time beginning on the first day of employment as an Active Employee eligible for coverage and ends at midnight on the last day of the first full month (as long as remaining eligible). Coverage will begin on the first day of the 2nd calendar month. For example, an Active Employee who has met all eligibility requirements as of the 20th of the month will have coverage beginning on the first day of the 2nd calendar month. If the Non-variable Hour Employee Waiting Period was not completed, eligibility will be determined utilizing the monthly measurement period method until one full standard measurement period is completed.
        2. is in a class eligible for coverage.
     3. Variable Hour Employee- Professional or Para Professional Hospice Aides
        1. Completes the employment Waiting Period with an average of 30 Hours of Service/benefit units worked per week as an Active Employee. Coverage will continue until one full standard measurement period has been completed. Retesting for eligibility will be performed at that time. Coverage will begin on the first day of the calendar month thereafter. For example, an Active Employee who has met all eligibility requirements as of the 20th of the month will have coverage beginning on the first of the 2nd calendar month. If the Employee fails to average 30 or more hours per week during the first two months, they would continue with their initial measurement period, and following its completion you would offer or not based on average hours of service over the initial measurement period. A “Waiting Period” is the time beginning on the first day of employment as an Active Employee eligible for coverage and ends on the last day of the first full month (as long as remaining eligible).
        2. is in a class eligible for coverage.
     4. Variable Hour Employee-Para Professional (other than Para Professional Hospice Aides), Part-time Employee or Seasonal Employee
        1. during the Initial Measurement Period, based on Hours of Service, the Employee has been determined during the New Employee Administrative Period to be a Full-time Employee of the Employer. An Employee is considered to be Full-time if he or she average 30 or more Hours of Service per week (130 Hours of Service or more in a month) during the Initial Measurement Period.
        2. is in a class eligible for coverage.
  2. Ongoing Employee
     1. based on Hours of Service during the Standard Measurement Period, has been determined, during the Ongoing Employee Administrative Period to be a Full-time Employee of the Employer. An Employee is considered to be Full-time if he or she averaged 30 or more Hours of Services per week (130 Hours of Service or more in a month) during the Standard Measurement Period.
     2. is in a class eligible for coverage.

Capitalized terms used above that are not included in the Defined Terms section of the Plan Document can be found in the Plan’s Eligibility Appendix. If you wish to review a copy of the Appendix, please contact the Plan Administrator.

Note: Coverage under this Plan is available to Employees age sixty-five (65) and over and to spouses age sixty-five (65) and over of Employees under the same conditions as coverage is available to Employees and their spouses under age sixty-five (65). Nonetheless, Employees over age sixty-five (65) are entitled to select primary coverage under Medicare. To do so, they must decline all coverage under this Plan.

The Employee or spouse must apply for Medicare coverage at their local Social Security office before submitting claims for Medicare benefits. Contact the local Social Security office with any questions about enrollment or eligibility.

If coverage under the Plan lapses because the Employee or spouse elects to decline coverage after reaching age sixty-five (65), they may become covered again only by filling out a request for reinstatement with the Plan Administrator. For dependents, the Employee must successfully re-enroll as well. All other Plan provisions will apply, i.e., open enrollment, etc.).

**Eligibility Requirements for Dependent Coverage.** A family member of an Employee will become eligible for Dependent coverage on the first day that the Employee is eligible for Employee coverage and the family member satisfies the requirements for Dependent coverage. At any time, the Plan may require proof that a Spouse or a child qualifies or continues to qualify as a Dependent as defined by this Plan.

**Eligible Classes of Dependents.** A Dependent is any one of the following persons:

1. A covered Employee's Spouse.

The term "Spouse" shall mean the person recognized as the covered Employee's husband or wife under the laws of the state where the covered Employee lives or was married and shall only include a common law marriage if recognized in the state where the covered Employee lives. The person is no longer considered an eligible Spouse if a Legal Separation or Divorce occurs.

The Plan Administrator may require documentation proving a legal marital relationship. Proof of marriage is established by one of the following:

* 1. a copy or abstract of the public record of marriage, or a copy of the church record of marriage, containing sufficient data to identify the parties, the date and place of marriage;
  2. an affidavit of the clergyman or magistrate who officiated; or
  3. an original certificate of marriage, if the Plan Administrator is satisfied it is genuine and free from alteration.

In addition, the Spouse will only be eligible for coverage if the Spouse cannot obtain through his/her employer a group medical plan meeting the minimum value standard of benefits as defined under the Affordable Care Act. The Employee must sign a statement indicating that spousal coverage is not available to the spouse through their employer prior to enrollment into the plan and as may be required annually.

1. A covered Employee's Child(ren).

An Employee's "Child" includes his natural child, stepchild, adopted child, a child placed with the Employee for adoption or a child for whom the Employee is the Legal Guardian. An Employee's Child will be an eligible Dependent until reaching the limiting age of 26, without regard to student status, marital status, financial dependency or residency status with the Employee or any other person. When the child reaches the applicable limiting age, coverage will end on the last day of the child's birthday month,

However, for Plan Years beginning before January 1, 2014, an Employee's Child is not an eligible Child if the Child is eligible to enroll in an employer-sponsored health plan other than the group health plan of a parent of the Child, i.e., through the employer of the Dependent Child or Dependent Child’s spouse.

The phrase "placed for adoption" refers to a child whom a person intends to adopt, whether or not the adoption has become final, who has not attained the age of 18 as of the date of such placement for adoption. The term "placed" means the assumption and retention by such Person of a legal obligation for total or partial support of the child in anticipation of adoption of the child. The child must be available for adoption and the legal process must have commenced.

For Coordination of Benefits purposes, the following must be provided to the Claims Supervisor: Custody, guardianship and adoption must be established by valid court order or decree entered after the petition for same has been filed. Custodial parent is the parent awarded physical custody by a court decree or, in the absence of a court decree, is the parent with whom the child resides more than one half of the Calendar Year excluding any temporary visitation.

Any child of an Employee who is an alternate recipient under a qualified medical child support order shall be considered as having a right to Dependent coverage under this Plan as of the date of the request on the QMCSO*.* The Employee may elect coverage if not already covered under this Plan. (Refer to the Special Enrollment section.)

If a covered Employee is the Legal Guardian of a child or children, these children may be enrolled in this Plan as covered Dependents.

Custody, guardianship and adoption must be established by valid court order or decree entered after the petition for same has been filed. Custodial parent is the parent awarded physical custody by a court decree or, in the absence of a court decree, is the parent with whom the child resides more than one half of the Calendar Year excluding any temporary visitation.

A participant of this Plan may obtain, without charge, a copy of the procedures governing qualified medical child support order (QMCSO) determinations from the Plan Administrator.

In all cases, to qualify as an eligible Dependent under the Plan, the child must be a dependent of the Employee. The Plan Administrator may require documentation proving dependency. Proof that a child is your dependent is established by one (1) of the following types of evidence:

* 1. For a natural child born to married parents, a copy of the public record of birth showing the Employee was named as parent of the child. For a natural child born to unmarried parents, a copy of the public record of birth showing the Employee was named as parent of the child, as well as any other documentation that the Plan Sponsor may require, including but not limited to DNA testing;
  2. For an adopted child or a child Legally Placed for Adoption, except in jurisdictions where petition must be made to the court for release of adoption documents or information, or where release of such documents or information is prohibited, evidence of relationship will include a copy of the decree of adoption or as copy of the adoptive placement agreement and such other evidence as may be necessary. In jurisdictions where petition must be made to the court for release of adoption documents or information, or where release of such documents or information is prohibited, a copy of the child’s revised birth certificate will be accepted to establish the fact of adoption;
  3. For a step-child, i) evidence of relationship of a step-child will consist of proof of birth as required for a natural child plus proof of marriage of the Employee to the natural parent of the child, and ii) evidence that either the child is a member of the Employee’s household or there is a Qualified Medical Child Support Order (provide copy) stipulating that coverage is required by the natural parent and the natural parent;
  4. For Legal Guardianship, a copy of the public record showing the Employee and/or spouse was named as Legal Guardian of the child. In the event there is a change in status of any Employee’s Dependent covered under the Plan following the initial eligibility determination, the Employee must inform the Plan Administrator of the change in status and provide documentation to the Plan Administrator that substantiates such a change in status. In the event of death or divorce, a copy of the death certificate or divorce decree will be required. In the event of adoption or placement for adoption, or acquisition of a step-child, documentation described above for each such situation will be required.

1. A covered Dependent child, who prior to reaching the limiting age, is Totally Disabled, incapable of self-sustaining employment by reason of mental or physical handicap, primarily dependent upon the covered Employee for support and maintenance and unmarried. A Dependent child who becomes Totally disabled after reaching the limiting age is not eligible to be enrolled on this Plan. A new Employee will not be able to enroll a Dependent child who is over the limiting age and is Totally Disabled. A terminated Employee who is rehired is considered a new Employee for the purposes of this provision. The Plan Administrator may require, at reasonable intervals continuing proof of the Total Disability and dependency.

The Plan Administrator reserves the right to have such Dependent examined by a Physician of the Plan Administrator's choice, at the Plan's expense, to determine the existence of such incapacity.

These persons are excluded as Dependents: other individuals living in the covered Employee's home, but who are not eligible as defined; and the Legally Separated or divorced former Spouse of the Employee. (Refer to Continuation of Coverage Rights under COBRA section.)

If a Dependent Child of an Employee is also a Full-Time Employee, the Dependent Child will only be eligible as an Employee. As of the Dependent Child’s effective date as an Employee immediately following their Waiting Period, the (Dependent Child) Employee will no longer be eligible as a Dependent of the parent who is an Employee.

In the case of Employees married to one another without Dependents, the Employees will be covered as separate Employees.

In the case of Employees married to one another with Dependents, one of the Employees must be covered as a Dependent of the other Employee along with the Dependent Children.

If both parents of a Dependent Child are not married to each other and are Employees, the Dependent Child will only be enrolled under one of the Employees, not under both.

If a person covered under this Plan changes status from Employee to Dependent or Dependent to Employee, and the person is covered continuously under this Plan before, during and after the change in status, credit will be given for deductibles and all amounts applied to maximums depending upon the coverages elected and which Covered Persons elect those coverages.

## FUNDING

**Cost of the Plan.** Integrity Home Care shares the cost of Employee and Dependent coverage under this Plan with the covered Employees. The enrollment application for coverage will include a payroll deduction authorization. This authorization must be filled out, signed and returned with the enrollment application.

The level of any Employee contributions is set by the Plan Administrator. The Plan Administrator shall from time to time evaluate the costs of the Plan and determine the amount to be contributed by the Employer and Employee, if any, and reserves the right to change the level of Employee contributions.

Notwithstanding any other provision of the Plan, the Employer’s obligation to pay claims otherwise allowable under the terms of the Plan shall be limited to its obligation to make contributions to the Plan as set forth in the preceding paragraphs. Payment of said claims in accordance with these procedures shall discharge completely the Employer’s obligation with respect to such payment.

In the event that the Employer terminates this Plan, then as of the termination date, the Employer and Employees shall have no further obligation to make additional contributions to the Plan.

**ELECTION TO DECLINE COVERAGE**

This is an advisory statement for those individuals who decline coverage explaining the impact of that decision and the "special events" circumstances that would offer him/her "Special Enrollment Periods" in the future.

If you are declining enrollment for yourself or your dependent(s), which includes your spouse, because of other health insurance coverage (including, but not limited to, Medicare, Medicaid, COBRA, group health plans and some individual policies), you may in the future be able to enroll yourself or your dependents in this plan, provided that you request enrollment within thirty (30) days after your other coverage ends. In addition to the above, if you have a new dependent as a result of marriage, birth, adoption or placement for adoption or Legal Guardianship, you may be able to enroll yourself or your dependents, provided that you request enrollment within thirty (30) days after the marriage, birth, adoption or placement for adoption or Legal Guardianship. If you apply for coverage other than at the above mentioned situations, you will be subject to the Late Enrollment provisions of the Plan.

**IF YOU DECLINE COVERAGE UNDER THIS HEALTH PLAN AND DO NOT DIVULGE TO THE PLAN THAT THIS REASON IS DUE TO OTHER HEALTH INSURANCE COVERAGE, AND SUBSEQUENTLY HAVE A HEALTH COVERAGE CHANGE (SEE SPECIAL ENROLLMENT DEFINITIONS), SPECIAL ENROLLMENT PERIODS THAT MIGHT OTHERWISE HAVE BEEN AVAILABLE TO YOU DUE TO THAT HEALTH COVERAGE CHANGE WOULD NOT APPLY. AS A RESULT, YOU AND/OR YOUR DEPENDENT(S) WILL BE SUBJECT TO THE LATE ENROLLEE/ENROLLMENT PROVISIONS OF THE PLAN.**

## ENROLLMENT

**Enrollment Requirements.** An Employee must enroll for Employee and Dependent coverage by filling out and signing an enrollment application along with the appropriate payroll deduction authorization. Enrollment can occur at the end of the Waiting Period, following a Special Enrollment event or during the open enrollment period.

**Enrollment Requirements for Newborn Children.**

A newborn child of a covered Employee will be enrolled as of the date of birth as long as the enrollment form is received by the Plan Administrator within 30 days of the date of birth. If the Covered Employee applies for the newborn’s coverage after the initial 30 days, the newborn is considered to be a Late Enrollee. The newborn will be subject to the Late Enrollment provision of this Plan. There will be no payment by the Plan for charges incurred prior to the Enrollment Date. The covered parent will be responsible for all costs.

Such coverage for a newborn includes: routine nursery care (Refer to Routine Well Newborn Nursery/Physician Care in the Schedule of Benefits); or the necessary care or treatment of medically diagnosed congenital defects, birth abnormalities or complications resulting from prematurity (Refer to Hospital Services and Physician Services in the Schedule of Benefits).

Charges for covered Routine Well Newborn Nursery Care will be applied toward the Plan of the newborn child.

Charges for covered Routine Well Newborn Physician Care will be applied toward the Plan of the newborn child.

## TIMELY AND LATE ENROLLMENT

1. **Timely Enrollment** - The enrollment will be "timely" if the completed form is received by the Plan Administrator no later than 30 days after the person becomes eligible for the coverage, either initially or under a Special Enrollment Period.

If two Employees (mother and father) are covered under the Plan and the Employee who is covering the Dependent children terminates coverage, the Dependent coverage may be continued by the other covered Employee with no Waiting Period as long as coverage has been continuous.

1. **Late Enrollment/Open Enrollment** - An enrollment is "late" if it is not made on a "timely basis" or during a Special Enrollment Period. Late Enrollees and their Dependents who are not eligible to join the Plan during a Special Enrollment Period may join only during open enrollment which is for a specific period of time typically in November.

Details about the annual open enrollment period will be announced by the Employer. During this time, Employees and their Dependents who are Late Enrollees will be able to enroll in the Plan. Benefit choices for Late Enrollees made during the open enrollment period will become effective January 1st.

If an individual loses eligibility for coverage as a result of terminating employment or a general suspension of coverage under the Plan, then upon becoming eligible again due to resumption of employment or due to resumption of Plan coverage, only the most recent period of eligibility will be considered for purposes of determining whether the individual is a Late Enrollee.

The time between the date a Late Enrollee first becomes eligible for enrollment under the Plan and the first day of coverage is not treated as a Waiting Period. Coverage begins on January 1st.

**SPECIAL ENROLLMENT RIGHTS**

Federal law provides Special Enrollment provisions under some circumstances. If an Employee is declining enrollment for himself or herself or his/her dependents (including their spouse) because of other health insurance or group health plan coverage, there may be a right to enroll in this Plan if there is a loss of eligibility for that other coverage (or if the employer stops contributing towards the other coverage). However, a request for enrollment must be made within 30 days after the coverage ends (or after the employer stops contributing towards the other coverage).

In addition, in the case of a birth, marriage, adoption or placement for adoption, there may be a right to enroll in this Plan. However, a request for enrollment must be made within 30 days after the birth, marriage, adoption or placement for adoption.

The Special Enrollment rules are described in more detail below. To request Special Enrollment or obtain more detailed information of these portability provisions, contact the Plan Administrator*.*

**SPECIAL ENROLLMENT PERIODS**

The Enrollment Date for anyone who enrolls under a Special Enrollment Period is the first date of coverage. Thus, the time between the date a special enrollee first becomes eligible for enrollment under the Plan and the first day of coverage is not treated as a Waiting Period.

1. **Individuals losing other coverage creating a Special Enrollment right.** An Employee or Dependent who is eligible, but not enrolled in this Plan, may enroll if loss of eligibility for coverage meets all of the following conditions:
   1. The Employee or Dependent was covered under a group health plan or had health insurance coverage at the time coverage under this Plan was previously offered to the individual.
   2. If required by the Plan Administrator, the Employee stated in writing at the time that coverage was offered that the other health coverage was the reason for declining enrollment.
   3. The coverage of the Employee or Dependent who had lost the coverage was under COBRA and the COBRA coverage was exhausted, or was not under COBRA and either the coverage was terminated as a result of loss of eligibility for the coverage (including as a result of Legal Separation, divorce, death, termination of employment or reduction in the number of hours of employment) or because employer contributions towards the coverage were terminated. Coverage will begin no later than the first day of the first calendar month following the date the completed enrollment form is received, unless agreed upon by the Employee and Plan Administrator for financial or payroll reasons.
   4. The Employee or Dependent requests enrollment in this Plan not later than 30 days after the date of exhaustion of COBRA coverage or the termination of non-COBRA coverage due to loss of eligibility or termination of employer contributions, described above. Coverage will begin no later than the first day of the first calendar month following the date the completed enrollment form is received, unless agreed upon by the Employee and Plan Administrator for financial or payroll reasons.
2. For purposes of these rules, a loss of eligibility occurs if one of the following occurs:
   1. The Employee or Dependent has a loss of eligibility due to the plan no longer offering any benefits to a class of similarly situated individuals (i.e.: part-time employees).
      1. The Employee or Dependent has a loss of eligibility due to the plan no longer offering any benefits to a class of similarly situated individuals (i.e.: part-time employees).
      2. The Employee or Dependent has a loss of eligibility as a result of legal separation, divorce, cessation of dependent status (such as attaining the maximum age to be eligible as a dependent child under the plan), death, termination of employment, or reduction in the number of hours of employment or contributions towards the coverage were terminated.
      3. The Employee or Dependent has a loss of eligibility when coverage is offered through an HMO, or other arrangement, in the individual market that does not provide benefits to individuals who no longer reside, live or work in a service area, (whether or not within the choice of the individual).
      4. The Employee or Dependent has a loss of eligibility when coverage is offered through an HMO, or other arrangement, in the group market that does not provide benefits to individuals who no longer reside, live or work in a service area, (whether or not within the choice of the individual), and no other benefit package is available to the individual.

If the Employee or Dependent lost the other coverage as a result of the individual's failure to pay premiums or required contributions or for cause (such as making a fraudulent claim or an intentional misrepresentation of a material fact in connection with the plan), that individual does not have a Special Enrollment right.

1. **Dependent beneficiaries.** If the Employee is a participant under this Plan (or has met the Waiting Period applicable to becoming a participant under this Plan and is eligible to be enrolled under this Plan but for a failure to enroll during a previous enrollment period), and:
   1. A person(s) becomes a Dependent of the Employee through marriage, then the new Dependent(s) (Spouse and step-children) and if not otherwise enrolled, the Employee may be enrolled under this Plan as a Covered Person; or
   2. A person becomes a Dependent of the Employee through birth, Legal Guardianship, Qualified Medical Child Support Order (QMCSO), adoption or placement for adoption, then the new Dependents may be enrolled under this Plan as a covered Dependent of the covered Employee. The Spouse of the covered Employee may be enrolled as a Dependent of the covered Employee if the Spouse is otherwise eligible for coverage.

Eligible Dependents other than those described in (a) or (b) who were not enrolled when first eligible are not eligible to enroll during this Special Enrollment event. They may enroll as Late Enrollees during the open enrollment period.

If the Employee is not enrolled in the Plan, he or she may enroll as a Special Enrollee as a result of the Special Enrollment events listed in (a) and (b) above. The newly eligible Dependents may not enroll if the Employee does not elect coverage.

The Dependent Special Enrollment Period is a period of 30 days and begins on the date of the marriage, birth, adoption or placement for adoption or Legal Guardianship or the commencement of the school term. To be eligible for this Special Enrollment Period, the Employee must request enrollment of the Plan Administrator during this period. Otherwise, the person is considered a Late Enrollee and will be subject to the Late Enrollment provisions under this Plan. The exception may be the enrollment of newborns. Refer to the Enrollment Requirements of Newborn Children in this Enrollment section.

The coverage of the Dependent enrolled in the Special Enrollment Period will be effective no later than the following unless agreed upon by the Employee and Plan Administrator for financial or payroll reasons:

1. in the case of marriage, no later than the first day of the first month beginning after the

date the completed request for enrollment is received (i.e., marriage occurred on January 10. If enrollment form is received January 10-31, the effective date will be no later than February 1. If enrollment form is received February 1-9, the effective date will be no later than March 1.);

1. in the case of a Dependent's birth, as of the date of birth; or
2. in the case of a Dependent's adoption or placement for adoption or Legal Guardianship, the date of the adoption or placement for adoption or Legal Guardianship.
3. **Medicaid and State Child Health Insurance Programs.** An Employee or Dependent who is eligible, but not enrolled in this Plan, may enroll if:
   1. The Employee or Dependent is covered under a Medicaid plan under Title XIX of the Social Security Act or a State child health plan (CHIP) under Title XXI of such Act, and coverage of the Employee or Dependent is terminated due to loss of eligibility for such coverage, and the Employee or Dependent requests enrollment in this Plan within 60 days after such Medicaid or CHIP coverage is terminated.
   2. The Employee or Dependent becomes eligible for assistance with payment of Employee contributions to this Plan through a Medicaid or CHIP plan (including any waiver or demonstration project conducted with respect to such plan), and the Employee or Dependent requests enrollment in this Plan within 60 days after the date the Employee or Dependent is determined to be eligible for such assistance.

## EFFECTIVE DATE

**Effective Date of Employee Coverage.** An Employee will be covered under this Plan as of the first day of the calendar month following the date that the Employee satisfies all of the following:

1. The Eligibility Requirement.
2. The Active Employee Requirement.
3. The Enrollment Requirements of the Plan.

**Active Employee Requirement.**

An Employee must be an Active Employee (as defined by this Plan) for this coverage to take effect.

**Effective Date of Dependent Coverage.** A Dependent's coverage will take effect on the day that the Eligibility Requirements are met; the Employee is covered under the Plan; and all Enrollment Requirements are met.

## TERMINATION OF COVERAGE

**When coverage under this Plan stops, Plan Participants will receive a certificate that will show the period of Creditable Coverage under this Plan. The Plan maintains written procedures that explain how to request this certificate. Please contact the Plan Administrator for a copy of these procedures and further details.**

**The Employer or Plan has the right to rescind any coverage of the Employee and/or Dependents for cause, making a fraudulent claim or an intentional material misrepresentation in applying for or obtaining coverage, or obtaining benefits under the Plan. The Employer or Plan may either void coverage for the Employee and/or covered Dependents for the period of time coverage was in effect, may terminate coverage as of a date to be determined at the Plan's discretion, or may immediately terminate coverage. If coverage is to be terminated or voided retroactively for fraud or misrepresentation, the Plan will provide at least 30 days' advance written notice of such action. The Employer will refund all contributions paid for any coverage rescinded; however, claims paid will be offset from this amount. The Employer reserves the right to collect additional monies if claims are paid in excess of the Employee's and/or Dependent's paid contributions.**

**When Employee Coverage Terminates.** Employee coverage will terminate at midnight on the earliest of these dates (except in certain circumstances, a covered Employee may be eligible for COBRA continuation coverage. For a complete explanation of when COBRA continuation coverage is available, what conditions apply and how to select it, see the section entitled Continuation Coverage Rights under COBRA):

1. The date the Plan is terminated.
2. The date the covered Employee's Eligible Class is eliminated.
3. The day the covered Employee ceases to be in one of the Eligible Classes. This includes death or termination of Active Employment of the covered Employee. (See the section entitled Continuation Coverage Rights under COBRA.)
4. The date the Employee elects to terminate coverage. (Voluntary termination may or may not be allowed in certain situations according to State and Federal law.) This termination is typically not a COBRA qualifying event.
5. When applicable, the end of the period for which the Employer and/or the Employee made any required contribution for the coverage on the date contributions are normally deducted from the company payroll. If the contribution is not made within 15 days of such date, a non-payment notice is given, and if payment is not received within 15 days of the date of the notice, coverage under the plan for the participant and all covered dependents will end retroactive to the date the 1st deducted payment was missed. (If a leave of absence is a paid leave, normal contributions will continue to be payroll deducted. If the leave of absence is not a paid leave, the participant must pay the required contribution at the same time that contributions are normally taken from the company payroll.) .
6. If an Employee no longer satisfies the eligibility requirements under the Plan and fails to elect COBRA within the appropriate time period, coverage will be retroactively terminated to the date as stated in the applicable item above. If the Employer or Plan is notified during the COBRA election period, the difference in premium can be paid in order to continue coverage.
7. If an Employee commits fraud or makes an intentional misrepresentation of material fact in applying for or obtaining coverage, or obtaining benefits under the Plan, then the Employer or Plan may either void coverage for the Employee and covered Dependents for the period of time coverage was in effect, may terminate coverage as of a date to be determined at the Plan's discretion, or may immediately terminate coverage. If coverage is to be terminated or voided retroactively for fraud or misrepresentation, the Plan will provide at least 30 days' advance written notice of such action.

**Continuation During Periods of Employer-Certified Disability or Leave of Absence.** A person may remain eligible for a limited time if Active, full-time work ceases due to disability or leave of absence. The Employer will notify the Employee of any applicable increase in premium contributions. This continuance will end as follows:

**For leave of absence:** The Employee is responsible for the premium (same rate as when active) if the Employee continues coverage during the FMLA or non FMLA leave. If the Employee does not return to work at the end of the leave, COBRA may be elected. COBRA may be elected beginning with the first day of non-active employment following either of these periods if the Employee has not returned to active status. (See the COBRA Continuation Options.)

While continued, coverage will be that which was in force on the last day worked as an Active Employee. However, if benefits reduce for others in the class, they will also reduce for the continued person.

**Continuation During Family and Medical Leave.** Regardless of the established leave policies mentioned above, if the Employer meets the requirements of the law, this Plan shall at all times comply with the Family and Medical Leave Act of 1993 as promulgated in regulations issued by the Department of Labor.

**The Family and Medical Leave Act (FMLA) requires *Employers of fifty (50) or more employees* to provide up to twelve (12) or twenty-six (26) weeks of unpaid, job-protected leave to “eligible” Employees for certain family and medical reasons. Employees are eligible if they have worked for the Employer for at least one (1) year and one thousand two hundred fifty (1,250) hours over the previous twelve (12) months.**

During any leave taken under the Family and Medical Leave Act, the Employer will maintain coverage under this Plan on the same conditions as coverage would have been provided if the covered Employee had been continuously employed during the entire leave period.

If coverage terminates under this Plan during the FMLA leave, at the request of the Employee, coverage will be reinstated if the Employee returns to work in accordance with the terms of the FMLA leave. Coverage will be reinstated only if the person(s) had coverage under this Plan when the FMLA leave started, and will be reinstated to the same extent that it was in force when that coverage terminated. For example, other Waiting Periods will not be imposed unless they were in effect for the Employee and/or his or her Dependents when Plan coverage terminated.

**Rehiring a Terminated Employee.** If a terminated Employee experiences a period without any Hours of Service and resumes Hours of Service and:

1. if the Employee is rehired following a Break in Service (as defined in the Plan’s Eligibility Appendix), the Employee will be treated as a New Employee and be required to satisfy all eligibility and enrollment requirements under the Plan as stated in the “Eligibility Requirements for Employee Coverage” section.
2. if the Employee is rehired without experiencing a Break in Service, the Employee will be treated as a Continuous Employee and is eligible for coverage under the Plan upon return if they were enrolled in coverage prior to the start of the period with no Hours of Service. Such coverage will be effective the first day of the month following the date Hours of Service resumes.
3. if the Employee was continuously covered as a COBRA participant of this Plan, a new employment waiting period does not have to be satisfied and coverage will change to Active Employee status as of the first of the month following the date Hours of Service resumes.

**Employees on Military Leave.** Employees going into or returning from military service may elect to continue Plan coverage as mandated by the Uniformed Services Employment and Reemployment Rights Act (USERRA). These rights apply only to Employees and their Dependents covered under the Plan immediately before leaving for military service.

In general, the Employee must meet the same requirements for electing USERRA coverage as are required under COBRA continuation coverage. Coverage elected under these circumstances is concurrent not cumulative. The Employee may elect USERRA continuation coverage for the Employee and their Dependents. Only the Employee has election rights. Dependents do not have any independent right to elect USERRA health plan continuation.

**When Dependent Coverage Terminates.** A Dependent's coverage will terminate at midnight on the earliest of these dates (except in certain circumstances, a covered Dependent may be eligible for COBRA continuation coverage. For a complete explanation of when COBRA continuation coverage is available, what conditions apply and how to select it, see the section entitled Continuation Coverage Rights under COBRA):

* 1. The date the Plan or Dependent coverage under the Plan is terminated.
  2. The date that the Employee's coverage under the Plan terminates for any reason including death. (See the section entitled Continuation Coverage Rights under COBRA.)
  3. The date a covered Spouse loses coverage due to loss of dependency status. (See the section entitled Continuation Coverage Rights under COBRA.)
  4. On the last day of the calendar month that a Dependent child ceases to be a Dependent as defined by the Plan. (See the section entitled Continuation Coverage Rights under COBRA.)
  5. The date the Employee requests that a Dependent’s coverage be terminated (Voluntary termination may or may not be allowed in certain situations according to State and Federal law.). This termination is typically not a COBRA qualifying event.
  6. The end of the period for which the required contribution has been paid if the full premium for the next period is not paid when due. If a Dependent no longer satisfies the eligibility requirements under the Plan and fails to elect COBRA within the appropriate time period, coverage will be retroactively terminated to the date as stated in the applicable item above. If the Employer or Plan is notified during the COBRA election period, the difference in premium can be paid in order to continue coverage.
  7. If a Dependent commits fraud or makes an intentional misrepresentation of material fact in applying for or obtaining coverage, or obtaining benefits under the Plan, then the Employer or Plan may either void coverage for the Dependent for the period of time coverage was in effect, may terminate coverage as of a date to be determined at the Plan's discretion, or may immediately terminate coverage. If coverage is to be terminated or voided retroactively, the Plan will provide at least 30 days' advance written notice of such action.

**The Employee shall be responsible for notifying the Plan Administrator of new Eligible Dependents and of any changes in the eligibility status of a Dependent. (Refer to the COBRA section.) Benefits provided to an ineligible Dependent will be recouped by the Plan in accordance with its rights for reimbursement. Employee contributions paid for a period when the Employee knew or should have known the Dependent was ineligible will not be reimbursed to the Employee.**

# MEDICAL BENEFITS

Medical Benefits apply when Covered Charges are incurred by a Covered Person for care of an Injury or Sickness and while the person is covered for these benefits under the Plan.

## DEDUCTIBLE

**Deductible Amount.** This is an amount of Covered Charges for which no benefits will be paid. Before benefits can be paid in a Calendar Year a Covered Person must meet the deductible shown in the Schedule of Benefits.

This amount will accrue toward the 100% maximum out-of-pocket payment. It does not count toward the coinsurance maximum.

**Family Unit Limit.** When the maximum amount shown in the Schedule of Benefits has been incurred by members of a Family Unit toward their Calendar Year deductibles, the deductibles of all members of that Family Unit will be considered satisfied for that year.

## BENEFIT PAYMENT

Each Calendar Year, benefits will be paid for the Covered Charges of a Covered Person that are in excess of the deductible and any copayments. Payment will be made at the rate shown under reimbursement rate in the Schedule of Benefits. No benefits will be paid in excess of the Maximum Benefit Amount or any listed limit of the Plan.

## OUT-OF-POCKET LIMIT

Refer to the Schedule of Benefits for a list of charges that are included and not included in this limit. Covered Charges are payable at the percentages shown each Calendar Year until the out-of-pocket limit shown in the Schedule of Benefits is reached. Then, Covered Charges incurred by a Covered Person will be payable as shown in the Schedule of Benefits (except for the charges excluded) for the rest of the Calendar Year.

When a Family Unit reaches the out-of-pocket limit, Covered Charges for that Family Unit will be payable as shown in the Schedule of Benefits (except for the charges excluded) for the rest of the Calendar Year.

When a Covered Person elects COBRA, he/she will only receive credit for any individual deductible and coinsurance amounts applied on services incurred prior to the COBRA coverage date. Individual deductible and/or coinsurance amounts applied to claims with dates of service incurred after the COBRA coverage date will not apply toward the prior active family accumulated totals. A Family Unit for Covered Persons who elect COBRA will be the following: Employee plus Spouse; Employee plus child(ren); family; and Spouse plus children. Dependent Children who elect COBRA without a parent will be covered as separate individuals. Covered Persons in a Family Unit on COBRA will accrue their individual totals toward the Family Unit totals.

## MAXIMUM BENEFIT AMOUNT

The Maximum Benefit Amount is shown in the Schedule of Benefits. It is the total amount of benefits that will be paid under the Plan for all Covered Charges incurred by a Covered Person. The Maximum Benefit applies to the benefit options offered under the Integrity Home Care Employee Major Medical Health Care Plan, as described in this document.

## COVERED CHARGES

Covered Charges are the Usual and Customary Allowances that are incurred for the following items of service and supply. These charges are subject to the benefit limits, exclusions and other provisions of this Plan. A charge is incurred on the date that the service or supply is performed or furnished.

1. **Hospital Care.** The medical services and supplies furnished by a Hospital or Outpatient Surgical Center or a Birthing Center. Covered Charges for room and board will be payable as shown in the Schedule of Benefits. After 23 observation hours, a confinement will be considered an Inpatient confinement. Claims submitted for longer than 23 hours will be reviewed on a case-by-case basis to determine if it will be pended for a corrected Inpatient claim. The Plan may determine the Allowed Amount will be based upon the allowance for an observation stay or the allowance if it had been billed as an Inpatient claim

The Allowed Amount for room charges made by a network Hospital having only private rooms will be the network contracted rate.

If a non-network Hospital having only private rooms is utilized, the Allowed Amount for eligible room charges will be at 80% of the facility’s billed private room rate or the Usual and Customary Allowance, whichever is less. If the Hospital/Physician assigns the patient to a private room due to Medical Necessity, the Allowed Amount will be the billed room rate. The admitting Physician must provide documentation of the Medical Necessity to the Claims Supervisor prior to or along with the Hospital claim for prompt consideration of the billed charges.

Charges for an Intensive Care Unit stay are payable as described in the Schedule of Benefits.

1. **Coverage of Pregnancy.** Charges for the care and treatment of Pregnancy are covered the same as any other Sickness for a covered Employee, covered Spouse, or covered Dependent.

Under federal law, group health plans and health insurance issuers offering group health insurance coverage generally may not 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 delivery by cesarean section. However, the Plan or issuer may pay for a shorter stay if the attending provider (i.e., your Physician, nurse midwife, or physician assistant), after consultation with the mother, discharges the mother or newborn earlier.

Also, under federal law, plans and issuers may not set the level of benefits or out-of-pocket costs so that any later portion of the 48-hour (or 96-hour) stay is treated in a manner less favorable to the mother or newborn than any earlier portion of the stay.

In addition, a plan or issuer may not, under federal law, require that a *Physician or other health care provider* obtain authorization for prescribing a length of stay of up to 48 hours (or 96 hours). However, to use certain providers or facilities, or to reduce your out-of-pocket costs, you may be required to obtain precertification. The *Covered Person* is still responsible for the Precertification process. (Refer to the Cost Management Section.) The 48- or 96-hour Inpatient stay begins at the time the delivery occurs in the Hospital. For deliveries occurring outside of the Hospital, the stay begins at the time the mother and/or newborn are admitted as an Inpatient to a Hospital.

1. **Skilled Nursing Facility Care.** The room and board and nursing care furnished by a Skilled Nursing Facility will be payable if and when:
   1. the patient is confined as a bed patient in the facility; and
   2. following a period of Home Health Care that was covered by the Plan; and
   3. the attending Physician certifies that the confinement is needed for further care of the condition that caused the Hospital confinement;
   4. the attending Physician completes a treatment plan which includes a diagnosis, the proposed course of treatment and the projected date of discharge from the Skilled Nursing Facility. The care must be likely to result in a significant improvement in the Covered Person’s condition; and
   5. the degree of care must be more than can be given in the Covered Person’s home, but not so much as to require acute hospitalization.

In lieu of the above criteria, services will be covered if they are pre-certified/authorized as Medically Necessary through the Utilization Review program. Covered Charges for a Covered Person's care in these facilities are payable as described in the Schedule of Benefits.

1. **Physician Care.**

Charges for **multiple surgical procedures**, **Physician’s Assistants and Nurse Practitioners** will be a Covered Charge subject to the following provisions, except claims for certain PPO network providers will be based upon the network contracts and reduced by the PPO prior to filing the claim with the Claims Supervisor:

* 1. If Bilateral or Multiple Surgical Procedures are performed by one (1) surgeon, benefits

will be determined based on the Usual and Customary Allowance that is allowed for the primary procedures; 50% of the Usual and Customary Allowance will be allowed for each additional procedure performed through the same incision; and 70% of the Usual and Customary Allowance will be allowed for each additional procedure performed through a separate incision. Any procedure that would not be an integral part of the primary procedure or is unrelated to the diagnosis will be considered "incidental" and no benefits will be provided for such procedures;

* 1. If multiple unrelated surgical procedures are performed by two (2) or more surgeons on separate operative fields, benefits will be based on the Usual and Customary Allowance for each surgeon's primary procedure. If two (2) or more surgeons perform a procedure that is normally performed by one (1) surgeon, benefits for all surgeons will not exceed the Usual and Customary Allowance for that procedure; and
  2. If an assistant surgeon (another Physician or Certified First Assistant) is required (according to Medicare guidelines), the assistant surgeon's covered charge will not exceed 20% of the surgeon's contract rate, Usual and Customary allowance*,* or billed charges, whichever is less. If the acting assistant surgeon is a physician’s assistant or nurse practitioner, the covered charge will not exceed 15% of the surgeon’s contract rate, the network rate established in the contract, Usual and Customary allowance or billed charges, whichever is less;
  3. If a physician’s assistant or nurse practitioner bills for covered services other than as an assistant surgeon (see above), the covered charge will not exceed 75% of the M.D. or D.O.’s contract rate, Usual and Customary allowance or billed charges, whichever is less.

1. **Private Duty Nursing Care.** The private duty nursing care by a licensed nurse (R.N., L.P.N. or L.V.N.). Covered Charges for this service will be included to this extent:
   1. **Inpatient Nursing Care.** Charges are covered only when care is Medically Necessary or not Custodial in nature and the Hospital's Intensive Care Unit are filled or the Hospital has no Intensive Care Unit.
   2. **Outpatient Nursing Care**. Charges are covered only when care is Medically Necessary, not Custodial in nature and is in lieu of Inpatient acute care. Outpatient private duty nursing care must be authorized by the Utilization Review Coordinator. Services are subject to the benefits shown in the Schedule of Benefits.
2. **Home Health Care Services and Supplies.** Charges for home health care services and supplies are covered only for care and treatment of an Injury or Sickness when Hospital or Skilled Nursing Facility confinement would otherwise be required. The diagnosis, care and treatment must be certified by the attending Physician and be contained in a Home Health Care Plan.

Benefit payment for nursing, home health aide and therapy services is subject to the Home Health Care limit shown in the Schedule of Benefits. Services provided by a home health aide are covered if in conjunction with Home Health Care provided by a nurse or therapist and the services provided support skilled nursing services. The following services are considered Covered Expenses under this benefit:

* 1. Part-time or intermittent nursing care by or under the supervision of a registered nurse (RN);
  2. Part-time or intermittent home health aide services which consist primarily of caring for the patient;
  3. Physical therapy, occupational therapy and speech therapy provided by a Home Health Care Agency;
  4. Medical supplies, laboratory services, drugs and medications prescribed by a Physician.

A home health care visit will be considered a periodic visit by either a nurse or therapist, as the case may be, or four hours of home health aide services.

Expenses incurred in connection with home health care visits are covered under the Plan provided:

1. the services are pre-authorized as Medically Necessary through the Utilization Review Program,
2. the services are rendered in accordance with a treatment plan submitted by the attending physician, and
3. in-patient confinement in a Hospital or Skilled Nursing Facility would be required in absence of Home Health Care.
4. **Hospice Care Services and Supplies.** Charges for hospice care services and supplies are covered only when the attending Physician has diagnosed the Covered Person's condition as being terminal, determined that the person is not expected to live more than six months and placed the person under a Hospice Care Plan.

Covered Charges for Hospice Care Services and Supplies are payable as described in the Schedule of Benefits.

Covered Charges for in-patient Hospice Care include room and board and other services and supplies furnished for pain control and other acute and chronic symptom management.

Covered Charges for out-patient Hospice Care include charges for:

* 1. part-time or intermittent nursing care by an R.N. or L.P.N. as needed to meet the person's assessed needs;
  2. psychological and dietary counseling;
  3. consultation or case management services by a Physician;
  4. physical therapy;
  5. part-time or intermittent home health aide services; and
  6. medical supplies, drugs, and medicines prescribed by a Physician.

1. **Other Medical Services and Supplies.** These services and supplies not otherwise included in the items above are covered as follows:
   1. **Allergy Treatment.** Evaluation, diagnosis and treatment of allergies (immunotherapy).
   2. Local Medically Necessary professional ground or air **ambulance** service. A charge for this item will be a Covered Charge only if the service is to transport a person from the place where he/she is injured or stricken by disease to the nearest Hospital/Skilled Nursing Facility where necessary treatment can be provided unless the Plan Administrator finds a longer trip was Medically Necessary.

Ground ambulance is also covered in the following circumstances:

* + 1. To transport a patient from one Hospital to another nearby Hospital when the first Hospital does not have the required services and/or facilities to treat the patient;
    2. To transport a patient from Hospital to Skilled Nursing Facility when the patient cannot be safely or adequately transported in another way without endangering the individual’s health, whether or not such other transportation is actually available; or
    3. To transport a patient from Skilled Nursing Facility to Hospital for medically necessary Inpatient or Outpatient treatment when an ambulance is required to safely and adequately transport the patient.
    4. To transport a patient from a Non-Participating Provider to a Participating Network Provider.

Ambulette Service or other forms of passenger transportation that are available to the public (e.g., buses, taxis or airplanes) are not covered. (Refer to Plan Exclusions.)

Air Ambulance is a covered expense in the following circumstances:

1. When a patient requires transport to a Hospital or from one Hospital to another because the first Hospital does not have the required services and/or facilities to treatment the patient; and
2. Ground ambulance transportation is not medically appropriate because of the distance involved or because the patient has an unstable condition requiring medical supervision and rapid transport.

Except in Life-threatening emergencies, coverage of air ambulance transport requires preauthorization.

Transportation by ground or air for patient convenience or for nonclinical (social) reasons is not covered.

1. **Anesthetic**; oxygen; blood and blood derivatives that are not donated or replaced; intravenous injections and solutions. Administration of these items is included.
2. **Blood sugar kits (glucometers)** are a covered expense when Medically Necessary.
3. Radiation or **chemotherapy** and treatment with radioactive substances. The materials and services of technicians are included.
4. **Chiropractic Services** by a licensed Doctor of Chiropractic. All services (manipulations, non- manipulation office visits, evaluations, labs, x-rays, etc.) rendered by a chiropractor will be applied to the Spinal Manipulation/Chiropractic Services maximum stated in the Schedule of Benefits. General anesthesia, IV sedation and maintenance or preventive care visits are not covered. No benefits for Chiropractic Care will be paid under any other section of the Plan.
5. Initial **contact lenses or glasses** required following cataract surgery,. In this case, rose-tinting, scratch-resistant coating and the additional charge for progressive lenses are considered cosmetic and not covered. However basic tinting, frames and up to tri-focal lenses are covered. If surgery is performed on one eye and then the second eye within 2 years, only the second lenses will be covered and not a new pair of glasses. If later than that time period, a full pair of glasses will be covered. Accommodating Intra-Ocular Lenses used to replace the lens of the eye following cataract surgery are not covered under this Plan.
6. Rental of **durable medical or surgical equipment** if deemed Medically Necessary.

These items may be bought rather than rented, with the cost not to exceed the fair market value of the equipment at the time of purchase, but only if agreed to in advance by the Plan Administrator. Sales tax and shipping charges on covered equipment are covered expenses. Shipping charges solely for the patient's convenience will not be covered. DME includes, but is not limited to, crutches, trusses, catheters/ostomy supplies, self-injection supplies for diabetics, wheelchairs, Hospital beds, oxygen/administration equipment, etc.

Rental fees, but not to exceed, in aggregate, the purchase price, for Durable Medical Equipment made and used only for treatment of Injury or Illness.

Replacement of durable medical equipment will be considered a Covered Expense when Medically Necessary and appropriate and when repairs are cost prohibitive. Replacement due to improper use or care (according to the manufacturer’s guide on proper use) will not be covered. Repairs not covered under the warranty or required after the warranty expires will be covered, unless cost-prohibitive. Power-operated vehicles may be replaced no more often than every five years and if repair is cost- prohibitive or is Medically Necessary due to a change in the Covered Person’s physical condition.

1. **Educational training.** One Medically Necessary unit of educational training is allowed per Illness per lifetime, however, subject to approval by the Utilization Review Coordinator a new unit will be allowed when one of the following occurs: a change in diagnosis, prescribed treatment or prescribed supplies (i.e., non-insulin dependent to insulin dependent diabetes; self-injectable to insulin pump). A unit may be multiple visits with different specialists over multiple days.
2. **Genetic testing** is covered if it aids diagnosing of a Covered Person with functional abnormalities or who is symptomatic of an Illness which may be inheritable and the results of the test will impact the treatment being delivered.
3. Medically Necessary services for care and treatment of **jaw joint conditions, including Temporomandibular Joint disease(TMJ)**.
4. **Laboratory studies.** Covered Charges for diagnostic and preventive lab testing and services.
5. Treatment of **Mental Disorders and Substance Abuse**. Charges for care, supplies and treatment of Mental Disorders and Substance Abuse will be limited as follows: rev 021909Benefits.

Psychiatrists (M.D.), psychologists (Ph.D.), counselors (Ph.D. or L.P.C.) or Licensed Clinical Social Worker (L.C.S.W.) may bill the Plan directly. Other licensed mental health practitioners must be under the direction of these professionals.

Benefits are payable under this provision for Mental Disorders and Substance Abuse upon the diagnosis and recommendation of a Physician. Such effective treatment must meet all of the following tests.

* 1. The treatment facility, either Inpatient, Outpatient or at a Residential Treatment center, is appropriate for the diagnosis.
  2. Treatment is prescribed and supervised by a Physician within the scope of his license.
  3. Treatment includes a follow-up program, as appropriate, which is Physician directed; and
  4. Treatment includes patient attendance, as appropriate, at meetings of organizations devoted to the therapeutic treatment of the illness.

Treatment solely for detoxification or maintenance care is not considered effective treatment and is not covered under this provision. "Detoxification" means care is aimed primarily at overcoming the after-effects of a specific drinking or drug episode and "maintenance care" means providing an environment free of alcohol or drugs. Detoxification in conjunction with appropriate therapeutic treatment is covered under this provision.

1. **MDLive.** Treatment received by Physicians via MDLive.
2. **Treatment of mouth, teeth and gums.**
   1. **Care of mouth, teeth and gums**. Charges for care of the mouth, teeth, gums and alveolar processes will be Covered Charges under Medical Benefits only if that care is for the following oral surgical procedures or for diagnostic and office visit charges for evaluation of the following services (Note: Tooth extractions will only be covered as listed below. If not listed, extractions are not covered.):
      * + Excision of bony growths of the jaw and hard palate.
        + Excision or biopsy of tumors and cysts of the jaws, cheeks, lips, tongue, hard palate and floor of the mouth.
        + Incision and drainage of cellulitis.
        + Incision of sensory sinuses, salivary glands or ducts.
        + Removal of impacted teeth. No other extractions are covered. (If the Covered Person is enrolled in the Employer’s Select Supplemental Plan offering Dental Benefits, this Plan will cover extractions in lieu of coverage under that plan.)
        + Reduction of dislocations and excision of temporomandibular joints (TMJs).
        + Osteotomy (jaw surgery) which is Medically Necessary and not cosmetic in nature.
        + Removal of teeth for the medical management of a hazardous medical condition to include but not limited to the following: anticoagulation, valvular heart disease, hemophilia, preparation for cancer treatment in the neck/head region. Initial office visit and diagnostic services will be covered when connected to the services to remove the teeth. Documentation of the Illness should be submitted with the charges.
        + This Plan will cover the Usual and Customary allowance for the replacement of any teeth that were required to be removed for this treatment.
        + Hospital and anesthesia charges for pediatric or adult dental procedures that require the use of anesthesia in an Outpatient surgical facility or Hospital setting. Services must be Medically Necessary due to an underlying medical condition requiring this setting. Physician's charges for the dental procedure (unless for removal of impacted teeth as listed above) **are not** eligible under this Medical Plan. Documentation of the Medical Necessity should be submitted with the charges.
   2. **Injury to or care of mouth, teeth and gums**. Charges for repairs to the mouth, teeth, gums and alveolar processes due to an Injury will be Covered Charges under Medical Benefits only if that care is for the following oral procedures:
      * + Repair (or replacement when necessary).
        + Due to Injury to the mouth, teeth or gums;
          - Of any appliance in the mouth at the time of the Injury; or
          - Of previously repaired/replaced teeth due to the Injury.
        + Surgery needed to correct accidental Injuries to the jaws, cheeks, lips, tongue, floor and roof of the mouth.

No charge will be covered under Medical Benefits for dental and oral surgical procedures involving orthodontic care of the teeth, periodontal disease or preparing the mouth for the fitting of or continued use of dentures unless specifically addressed in the benefit. If the Covered Person chooses dental implants as the alternative treatment for the repair of the teeth, the Plan will allow the coverage up to the amount allowed for a lesser treatment, i.e., bridge. The Covered Person will be responsible for all charges above that amount.

1. **Organ transplant** limits. All Organ Transplant services, including evaluation, must be preauthorized or benefits may otherwise be reduced or denied. Therefore, the Covered Person or his/her physician must call the Utilization Review Coordinator (Refer to General Plan Information section for contact information.) when the Physician first indicates a transplant is recommended. Retransplantation procedures must also have preauthorization. Charges otherwise covered under the Plan that are incurred for the care and treatment due to an organ or tissue transplant are subject to these limits:
   1. DEFINITIONS. For purposes of this section, the following definitions apply.

**Approved Transplant:** A human organ or bone marrow transplant procedure currently performed at a Designated Transplant Facility.

**Approved Transplant Services:** Medically Necessary services and supplies which are related to an Approved Transplant procedure; are approved in writing under the Precertification and/or Preauthorization process; and include but are not limited to:

* + - * Pre-transplant patient evaluation for the Medical Necessity of the transplant.
      * Hospital charges.
      * Physician charges.
      * Tissue typing and ancillary services.
      * Organ procurement or acquisition.

**Center of Excellence:** A Designated Transplant Facility that has a Medicare- approved transplant program and is recognized by the United Network for Organ Sharing (UNOS) and the National Marrow Donor Program (NMDP) (non-profit organizations under contract with the United States Department of Health and Human Services to coordinate organ and bone marrow donation and distribution). These organizations have set standards for physical facilities, laboratory capabilities for organ and tissue matching, the recipient selection process and the availability of specialized services. The criteria used for selection of a Designated Transplant Facility are intended to ensure that approval is given only to facilities with the necessary experience and expertise to perform these complex surgeries successfully.

Medicare-approved medical centers must meet extensive criteria set out by Centers for Medicare & Medicaid Services (CMMS) [formerly Health Care Financing Administration (HCFA)] and a review board comprised of transplant surgeons, specialists, and other clinicians and scientists. A facility must have Medicare-approval status before it can receive payment for transplantation services provided to Covered Persons.

All Designated Transplant Facilities must offer comprehensive services that include experts in many medical specialties, such as radiology, infectious disease and pathology, as well as a range of allied health services that may include physical therapy, rehabilitation and social services.

**Clinical Practice Guidelines**: Reports written by experts who have carefully studied whether a treatment works and which patients are most likely to be helped by it.

**Designated Transplant Facility:** A Center of Excellence facility which has an agreement with the Plan Administrator or Claims Supervisor to render Approved Transplant Services to Covered Persons. This agreement will be made through a national organ transplant network and may not be located in the person’s geographic area. Contact the Utilization Review Coordinator for a list of facilities.

**Non-designated Transplant Facility:** A facility which does not have an agreement with the Plan Administrator or Claims Supervisor to render approved Transplant Services to Covered Persons.

**Transplant Benefit Period:** The period of time from the date the person receives prior authorization and has an initial evaluation for the transplant procedure until the earliest of:

* one year from the date the transplant procedure was performed.
* the date coverage under the Plan terminates.
* the date of the Covered Person’s death.

If, during the same admission as the initial transplant a retransplant occurs, the period of time is one year from the date of the initial transplant. If a retransplant will be done during a subsequent admission, a new Transplant Benefit Period starts from the date the person receives authorization for the retransplant.

* 1. DESIGNATED FACILITIES FOR APPROVED TRANSPLANT SERVICES

This provision only applies to transplant procedures listed in the definition of Approved Transplant.

Transplant procedures must have preauthorization. The Covered Person or his/her Physician must call the toll free number provided for this purpose. Retransplantation procedures must also have preauthorization.

If the Physician and the Plan Administrator or Claims Supervisor do not agree that the transplant procedure is Medically Necessary and appropriate, the Covered Person will be informed in writing of the right to a second opinion. A Board Certified Specialist must be utilized for this second opinion.

A person who will be undergoing a transplant procedure will be referred to a Designated Transplant Facility. This referral and authorization for services at a Designated Transplant Facility shall continue to be appropriate through the Transplant Benefit Period.

If the Covered Person is denied the procedure by the Designated Transplant Facility, he/she may be referred to a second such facility for evaluation. If the second facility determines, for any reason, that the person is not an acceptable candidate for the procedure, no benefits will be paid for any services or supplies related to that procedure. This applies regardless of whether the services or supplies are provided at a third Designated Transplant Facility or at a Non-designated Transplant Facility.

* 1. BENEFITS

Benefits for Approved Transplant Services provided during a Transplant Benefit Period will be paid as shown in the Schedule of Benefits. Benefits will be different for services provided at a Designated Transplant Facility than services provided at a Non-designated Transplant Facility. Other transplant procedures will be considered for benefit payment according to the provisions of the Plan.

Benefits will be paid for expenses incurred for Approved Transplant Services done at a Designated Transplant Facility as follows:

The transplant must be performed to replace an organ or tissue.

Benefit payments for transplant charges are included under the Organ Transplant Maximum Benefit Limit shown in the Schedule of Benefits.

Benefit payments for donor charges are subject to the separate Donor Maximum Benefit limit as shown in the Schedule of Benefits.

Donor charges:

* + - * Charges for obtaining donor organs or tissue for a covered recipient are considered Covered Charges under this Plan. The donor’s expenses will be applied toward the benefits of the covered recipient.

Donor charges include those for:

* evaluating the organ or tissue;
* removing the organ or tissue from the donor.
* transporting the organ within the United States and Canada to the place in the US where the transplant is to take place.
  + - * If the organ donor is a Covered Person and the recipient is not, then this Plan will always pay secondary to any other coverage. This Plan will cover donor charges for:
* evaluating the organ or tissue;
* removing the organ or tissue from the donor.
* No transportation charges will be considered.

For procedures done at a Non-designated Transplant Facility, the benefits listed above will be paid as shown in the Schedule of Benefits. The organ transplant limitations will apply.

* 1. EXCLUSIONS

No benefits will be paid for any service:

* + - * related to the transplantation of any non-human organ or tissue, except for heart valves.
      * for a facility or Physician outside the United States of America.
      * which are eligible to be repaid under any private or public research fund.

1. The initial purchase (of a single unit per body part), fitting, repair and replacement of **orthotic appliances** such as braces, splints or other appliances which are required for support for an injured or deformed part of the body as a result of a disabling congenital condition or an Injury or Sickness. Replacement of orthotics will not be covered unless 1) there is sufficient change in the Covered Person’s physical condition to make the original device no longer functional or 2) the device has reached its life expectancy and is no longer functioning (but no more frequently than every 3 years). . The benefit payment will be based on the cost of the treatment which provides professionally satisfactory results at the most cost-effective level. (Refer to Plan Exclusions items Foot and Hand Care and Orthotics for further information.) Preauthorization of services and/or treatment is required (Refer to Cost Management Services.).
2. **Prescription Drugs** (as defined) and supplies. Refer to the Prescription Drug Benefit section for further details on covered and excluded drugs dispensed at a pharmacy (including a facility’s pharmacy for dispensing take-home medications for use upon release from that facility). Call the pharmacy benefit manager (PBM) at the number on your ID card for complete information about covered and excluded Prescription Drugs and supplies purchased at the Pharmacy.

Prescription Drugs consumed on the premises of a Physician or facility, i.e., a Hospital, urgent care facility or Physician’s office, are covered under the Medical Benefits as stated in the Schedule of Benefits.

The following contraceptive Prescription Drugs and/or supplies through a Pharmacy or Physician’s office is covered by the Prescription Drug or Medical Benefits of this Plan: oral, injectable (i.e., Depo Provera), implantable (i.e., Norplant), topical, intravaginal (i.e., ring or diaphragm) or intrautero (i.e., IUD).

Prescription Drug use does not have unlimited coverage. As with all medical and Hospital services, Prescription Drug utilization is subject to determinations of Medical Necessity and appropriate use. Drug utilization review (DUR) may be retrospective, concurrent or prospective. Retrospective DUR generally involves claim review and may include communication by the PBM with prescribers to coordinate care and verify diagnoses and Medical Necessity. Concurrent DUR generally occurs at the point of service and may include electronic claim edits to protect patients from potential drug interactions, drug-therapy conflicts or overuse or underdose of medications. Prospective DUR may include, among other things, therapy guidelines or Physician or Pharmacy assignment in which one Physician or Pharmacy is selected to serve as the coordinator or Prescription Drug services and benefits for the eligible Covered Person.

1. **Preventive Care.** Covered Charges under Medical Benefits are payable for routine Preventive Care as described in the Schedule of Benefits.
   1. **Charges for Routine Well Adult Care**. Routine well adult care is care by a Physician that is not for an Injury or Sickness for Covered Persons age 19 and older.
   2. **Charges for Routine Well Child Care.** Routine well child care is routine care by a Physician that is not for an Injury or Sickness up to age 19.
2. The initial purchase, fitting, repair and replacement of fitted prosthetic devices which replace body parts. Replacement of prostheses will not be covered unless
   1. there is sufficient change in the Covered Person’s physical condition to make the original device no longer functional or
   2. the device has reached its life expectancy and needs to be replaced (but no more frequently than every 5 years). Replacement of the device must be pre-authorized. (Refer to Cost Management Services.). Replacement due to improper use or care (according to the manufacturer’s guide on proper use) will not be covered. Repairs not covered under the warranty or required after the warranty expires will be covered, unless cost-prohibitive. The benefit payment will be based on the cost of the treatment which provides professionally satisfactory results at the most cost-effective level. (Refer to Plan Exclusions for Prosthetic devices for further information.) Preauthorization of services and/or treatment recommended.

Two mastectomy bras are covered every six months; one prosthetic every Calendar Year. Compression stockings are covered with a prescription or Physician’s orders. The prescription must require measurement of the patient for proper fitting. Limit two (2) pair per Calendar Year.

1. **Reconstructive Surgery.** Correction of abnormal congenital conditions, repair of damage from an accident or Injury, repair following Medically Necessary surgery for an Illness and reconstructive mammoplasties will be considered Covered Charges.

The Women's Health and Cancer Rights Act of 1998 (WHCRA) states that since the Plan provides coverage for services related to mastectomies, the Plan must provide coverage for:

* 1. reconstruction of the breast on which a mastectomy has been performed,
  2. surgery and reconstruction of the other breast to produce a symmetrical appearance, and
  3. coverage of initial and replacement prostheses (two mastectomy bras are covered every six months; one prosthesis every Calendar Year) and physical complications during all stages of mastectomy, including lymphedemas, in a manner determined in consultation with the attending Physician and the patient.

1. **Spinal Manipulation/Chiropractic services** by a licensed M.D., D.O. or D.C. (Refer to the Schedule of Benefits for benefit maximum.) General anesthesia or IV sedation for the sole purpose of performing a manipulation is not covered. Also refer to Chiropractic Care in this section.
2. **Sterilization** procedures.
3. **Surgical** dressings, splints, casts, supplies and other implantable devices.
4. **Therapies:**
   1. **Cardiac rehabilitation** as deemed Medically Necessary provided services are rendered (a) under the supervision of a Physician; (b) in connection with a myocardial infarction, coronary occlusion or coronary bypass surgery; (c) initiated within 12 weeks after other treatment for the medical condition ends; and (d) in a Medical Care Facility as defined by this Plan.
   2. **Occupational therapy** by a licensed occupational therapist. Preauthorization of therapy is recommended. Therapy must be ordered by a Physician, result from an Injury or Sickness, improve a body function and treat conditions which are subject to significant improvement through short-term therapy. Covered Charges do not include recreational programs, maintenance therapy or supplies used in occupational therapy. The therapy must be expected to produce a significant improvement of the Covered Person's condition within a two (2) month period. The need for the therapy, the care and the regimen established must be documented in writing for each two (2) month period. This therapy is subject to the Reasonable and Necessary, Restorative Therapy and Maintenance provisions as found in the Defined Terms section of the Plan.
   3. **Physical therapy** by a licensed physical therapist. Preauthorization of therapy is recommended. The therapy must be in accord with a Physician's exact orders as to type, frequency and duration, to improve a body function and to treat conditions which are subject to significant improvement through short- term therapy. The therapy must be expected to produce a significant improvement of the Covered Person's condition within a two (2) month period. Accepted level of rehabilitation is when the Covered Person can perform basic Activities of Daily Living. The need for the therapy, the care and the regimen established must be documented in writing for each two (2) month period. This therapy is subject to the Reasonable and Necessary, Restorative Therapy and Maintenance provisions as found in the Defined Terms section of the Plan.
   4. **Pulmonary rehabilitation** as deemed Medically Necessary, Reasonable and Necessary, and Restorative. These services must be rendered: (a) under the supervision of a Physician; (b) for chronic pulmonary disability with reduction of exercise tolerance which restricts the abilities of the Covered Person to perform daily activities and/or work; and (c) in a Medical Care Facility as defined by this Plan. Pulmonary Function Test must show FEV1 of less than 60% predicted. Maintenance programs are not covered.
   5. **Speech therapy** by a licensed speech therapist. Preauthorization of therapy is recommended. Therapy must be ordered by a Physician and follow either:

* surgery for correction of a congenital condition of the oral cavity, throat or nasal complex; or
* an Injury or Sickness that results in loss of previously acquired speech, or normal swallowing mechanics. Maintenance programs are not covered.
  1. **Vision therapy.** Charges incurred in connection with vision therapy for rehabilitative therapy after brain injury, including stroke, that are Medically Necessary, Reasonable and Necessary, and Restorative. Maintenance programs are not covered.

1. **Weight Management/Control**. Medically necessary laparoscopic vertical sleeve gastrectomy, Roux-en-Y gastric bypass (RYGB) and Biliopancreatic diversion (BPD) with or without duodenal switch (DS) are covered when all clinical criteria described in the Bariatric Policy are met. Bariatric surgery must be performed at a facility that is designated as a Mercy approved Center. Procedures at any other facility will not be covered. Pre-operative care (e.g. nutritional counseling, weight loss program, etc.) and post-operative follow-up care must be provided by a facility that is a Mercy-approved Center or Center of Excellence.

Coverage Limitations:

1. One bariatric procedure per lifetime per member.
2. Medically necessary procedures required to treat or correct a complication that may result from the original weight loss procedure.
3. Bariatric surgery for all other indications is not covered.
4. Travel expenses related to the covered services are not covered.
5. Band adjustment procedures are limited to the first 2 years following the date of the primary bariatric procedure, per Plan policy.
6. Revision or replacement of any bariatric procedure previously covered by the Plan is not covered

**\*Prior Authorization Required for Bariatric Surgery**

You must obtain Prior Authorization before receiving bariatric surgery. Please instruct your provider to call the Prior Authorization number on Your ID card. Non-designated Center of Excellence and Out-of-network bariatric surgeries are not covered. Failure to obtain prior authorization is the member’s responsibility. Unless Mercy Care Management pre-approves these services, there will be no benefit available.

1. Coverage of **Well Newborn Nursery/Physician Care**.
   1. **Charges for Routine Nursery Care.** Routine well newborn nursery care is care while the newborn is Hospital-confined after birth and includes room, board and other normal care for which a Hospital makes a charge.

This coverage is only provided if the newborn child is an eligible Dependent and a parent

* is a Covered Person who was covered under the Plan at the time of the birth or
* enrolls himself or herself (as well as the newborn child if requested) in accordance with the Special Enrollment provisions with coverage effective as of the date of birth.

Charges for covered routine nursery care will be applied toward the Plan of the newborn child. Charges for a newborn child who is injured or ill will be applied toward the Plan of the newborn.

The benefit is limited to Usual and Customary Allowances for nursery care for the newborn child while Hospital confined as a result of the child's birth.

Under federal law, group health plans and health insurance issuers offering group health insurance coverage generally may not 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 delivery by cesarean section. However, the Plan or issuer may pay for a shorter stay if the attending provider (e.g., your Physician, nurse midwife, or physician assistant), after consultation with the mother, discharges the mother or newborn earlier.

Also, under federal law, plans and issuers may not set the level of benefits or out-of- pocket costs so that any later portion of the 48-hour (or 96-hour) stay is treated in a manner less favorable to the mother or newborn than any earlier portion of the stay.

In addition, a plan or issuer may not, under federal law, require that a Physician or other health care provider obtain authorization for prescribing a length of stay of up to 48 hours (or 96 hours). However, to use certain providers or facilities, or to reduce your out-of-pocket costs, you may be required to obtain precertification. The Covered Person is still responsible for the Precertification process. (Refer to the Cost Management Section.) The 48- or 96-hour Inpatient stay begins at the time the delivery occurs in the Hospital. For deliveries occurring outside of the Hospital, the stay begins at the time the mother and/or newborn are admitted as an Inpatient to a Hospital.

* 1. **Charges for Routine Physician Care.** The benefit is limited to the Usual and Customary Allowances made by a Physician for the newborn child while Hospital confined as a result of the child's birth.

Circumcision is considered under this benefit if performed during the initial Hospital confinement. Otherwise, it will be considered an eligible expense under Physician Services (refer to Schedule of Benefits) up to the second birthday of the Dependent Child or within 2 years of legal adoption. Thereafter, it will not be considered an eligible charge unless Medically Necessary (refer to Physician Services in the Schedule of Benefits for benefits).

Charges for covered routine Physician care will be applied toward the Plan of the newborn child. Charges for a newborn child who is injured or ill will be applied toward the Plan of the newborn.

1. **X-rays,** electrocardiograms, electroencephalograms, pneumoencephalograms, basal metabolism tests, or similar well-established diagnostic tests generally approved by Physicians throughout the United States.

# COST MANAGEMENT SERVICES

**PREADMISSION CERTIFICATION (Inpatient hospitalizations)**

**AUTHORIZATION IS NOT A GUARANTEE THAT ALL CHARGES ARE COVERED.**

Preadmission Certification (also referred to as Precertification) means the review of all Hospital admissions prior to the admission date. This program is designed to help ensure that all Covered Persons receive necessary and appropriate health care while avoiding unnecessary expenses when a Hospital stay is proposed. For example, based on the information provided by the Physician, the Precertification Nurse will make an initial assessment of the condition to determine, among other things: if a second surgical opinion is required or recommended; if the admission is to a network facility; if concurrent review by Utilization Review Coordinator is to be initiated; and if Medical Case Management is applicable.

## PRECERTIFICATION PROCEDURES

The Covered Person or the Physician must call the Utilization Review Coordinator (Refer to the General Plan Information section for contact information) for precertification as follows in order to avoid assessment of the precertification penalty:

**Scheduled Inpatient hospitalization**- Precertify at the earliest time ***prior*** to the admission of a scheduled Hospital stay. When the Covered Person or Physician notifies the Utilization Review (UR) Coordinator of a scheduled hospitalization, the UR Coordinator will then determine the length of stay based upon diagnosis, appropriateness of services and the Physician's plan of treatment. The UR Coordinator also assures that reasonable alternatives to Inpatient care are considered, including Outpatient treatment and preadmission testing. Request for second surgical opinion may also be made at that time. For every approved admission, a target length of stay will be assigned by the UR Coordinator, based upon length of stay norms for the geographical region. A preadmission certification letter will be sent to notify the Covered Person, Hospital and attending Physician of the assigned length of stay.

**Unscheduled, non-emergent Inpatient hospitalization-** Precertify within 48 hours after a weekday admission or within 72 hours after an admission on a weekend or legal holiday. Unscheduled admission means an admission for treatment of an Injury or Illness that requires immediate Inpatient treatment which is Medically Necessary and cannot be reasonably provided on an Outpatient basis.

**Emergency Inpatient hospitalization**- Precertify within 48 hours after a weekday admission or within 72 hours after an admission on a weekend or legal holiday. Emergency admission means an admission for a Life-threatening medical condition or a condition for which the lack of immediate treatment would cause permanent disability.

## PRECERTIFICATION PENATIES

Failure to follow the precertification procedure as described above will reduce reimbursement received from the Plan.

If precertification is not obtained as explained in this section, a penalty may be applied. (Refer to the first page of the Schedule of Benefits for details.) Any reduced reimbursement due to failure to follow the precertification procedures will not accrue toward the 100% maximum out-of-pocket as indicated in the Schedule of Benefits.

**Exception:** A Plan may not, under federal law, require that a Physician or other health care provider obtain precertification from the Plan for prescribing a maternity length of stay of up to 48 hours for a vaginal delivery or 96 hours for a cesarean delivery. However, to use certain providers or facilities, or to reduce the out-of-pocket costs, the Covered Person is still required to obtain precertification for the Hospital stay. If the stay is not precertified, the individual is responsible for the amount indicated in Precertification Penalties above. A Covered Person will not be denied the Hospital stay granted under State or Federal law. For more information on precertification, contact the Plan Administrator or Claims Supervisor.

**EXTENDED HOSPITAL STAYS**

Once a Hospital stay begins, whether it is a non-emergency or emergency, if the stay is expected to exceed the number of days precertified, the Covered Person or the Physician must contact the Utilization Review Coordinator to request an extension of the length of stay.

**EFFECTS OF PREADMISSION CERTIFICATION ON BENEFITS**

Authorization is not a guarantee that all charges are covered.

If any part of a Hospital stay is not precertified, the penalty amount shown in the Precertification Penalties section and the Schedule of Benefits may be applied. No part of the penalty will be applied towards the deductible amount shown in the Schedule of Benefits or the maximum out-of-pocket expense limitation.

A Hospital stay is not precertified if:

1. Precertification is not obtained prior to admission;
2. The type of treatment, admitting Physician or the Hospital differs from the precertified treatment, Physician or Hospital.

**CONCURRENT REVIEW**

The purpose of concurrent review is to continually evaluate the Covered Person's progress toward the treatment goal and the patient's ability to function in a non-acute environment and to facilitate timely discharge as appropriate.

**PREAUTHORIZATION AND UTILIZATION REVIEW**

Preauthorization means the review of services prior to their being rendered to determine if the services are eligible under the Plan. If preauthorization is not obtained as described in this section, benefit reimbursement may be delayed while awaiting further information from the Physician or Covered Person. The Utilization Review Coordinator will consider the following, among other things, in making this decision: medical services, treatments and/or supplies are covered under this Plan; meet standards of care; are Medically Necessary; are ordered by a Physician; and are not Experimental/Investigational or otherwise excluded by this Plan.

**Services Subject to Preauthorization and Utilization Review:**

Authorization is not a guarantee that all charges are covered.

The Covered Person or the Physician should call the Utilization Review Coordinator for preauthorization of all services listed in Appendix A: Prior Authorization List (refer to the ID card or the last page of this book for the phone number):

## MEDICAL CASE MANAGEMENT

The purpose of Medical Case Management is to identify potentially high-dollar claims as a result of serious Illnesses, accidents or other circumstances and to coordinate the highest quality care in the most appropriate, cost-effective setting. The interest of the Covered Person is always primary in this program. The Covered Person receives the type of care required and the available benefits are used more effectively. Large Case Management is more than a cost containment provision. It requires in-depth involvement between the Case Manager, the provider and the Covered Person. The Covered Person, family and the attending Physician must be in agreement for any form of alternative medical care.

The Medical Case Management firm may recommend coverage for services or equipment that is not normally provided to the Covered Person under the Plan. In these instances, exceptions may be made by the Plan Administrator to cover these services or equipment that are recommended. The alternative benefits shall be determined on a case-by-case basis, and the Plan’s determination to provide the benefits in one instance shall not obligate the Plan to provide the same or similar alternative benefits for the same or any other Covered Person, nor shall it be deemed to waive the right of the Plan to strictly enforce the provisions of the Plan.

Services provided by Medical Case Management are:

**Continued Hospital Stay Review.** The Covered Person may be hospitalized longer than Medically Necessary. Substantial savings can be achieved by reviewing the Covered Person's condition and treatment based on established medical criteria. Inappropriate treatment may be identified and discontinued.

**Discharge Planning.** Careful advance planning can ease the Covered Person's transfer from an acute- care facility to a less costly and more suitable facility such as a nursing home, rehabilitation center or the Covered Person's own home. It ensures that the benefits or early discharge are not outweighed by the need for a return to the Hospital at a later date for corrective and more costly treatment.

**Home Health Care Coordination.** With the right home environment and some professional coordination, many services traditionally performed on an Inpatient basis may be handled in the Covered Person's home. Home health care involves coordination of required medical treatment and evaluation of the appropriate required level of care by the Medical Case Management firm. Patient/family counseling would be considered a covered expense in connection with these services, where applicable.

**The following types of claim situations may have the potential for Medical Case Management:**

1. Severe trauma (head Injuries, extensive burns, spinal cord Injuries, multiple fractures, etc.);
2. Coma (any cause);
3. Neonatal (prematurity, birth Injuries, congenital deformities, profound retardation, etc.);
4. Organ transplants; or
5. Any claim where it appears that there will be extensive Inpatient and/or Outpatient charges, particularly for a long duration.

**Note: Medical Case Management is a voluntary service. There are no reductions of benefits or penalties if the patient and family choose not to participate.**

**Each treatment plan is individually tailored to a specific patient and should not be seen as appropriate or recommended for any other patient, even one with the same diagnosis.**

## SECOND AND/OR THIRD OPINION PROGRAM

Certain surgical procedures are performed either inappropriately or unnecessarily. In some cases, surgery is only one of several treatment options. In other cases, surgery will not help the condition.

In order to prevent unnecessary or potentially harmful surgical treatments, the second and/or third opinion program fulfills the dual purpose of protecting the health of the Plan's Covered Persons and protecting the financial integrity of the Plan.

Benefits will be provided for a second (and third, if necessary) opinion consultation to determine the Medical Necessity of an elective surgical procedure. An elective surgical procedure is one that can be scheduled in advance; that is, it is not an emergency or is not Life-threatening in nature. Refer to the Schedule of Benefits. If the second opinion is requested by the Utilization Review Coordinator, they will inform you of the benefit payable for the consultation. If the second opinion is for non-surgical services, approval is required by the Utilization Review Coordinator for coverage under this benefit.

The patient may choose any board-certified specialist who is not an associate of the attending Physician and who is affiliated in the appropriate specialty.

While any surgical treatment is allowed a second opinion, the following procedures are ones for which surgery is often performed when other treatments are available.

|  |  |  |
| --- | --- | --- |
| Appendectomy | Hernia surgery | Spinal surgery |
| Cataract surgery | Hysterectomy | Surgery to knee, shoulder, elbow or toe |
| Cholecystectomy  (gall bladder removal) | Mastectomy surgery | Tonsillectomy and adenoidectomy |
| Deviated septum (nose surgery) | Prostate surgery | Tympanotomy (inner ear) |
| Hemorrhoidectomy | Salpingo-oophorectomy  (removal of tubes/ovaries) | Varicose vein ligation |

# 

# DEFINED TERMS

The following terms have special meanings and when used in this Plan will be capitalized.

**Active Employee** is an Employee who is on the regular payroll of the Employer and who has begun to perform the duties of his or her job with the Employer on a full-time basis or has been determined to be full-time based on Hours of Service during the Initial Measurement Period or Standard Measurement Period, as applicable. For this purpose, an Employee shall be deemed to be actively employed on the date his or her coverage would otherwise commence if the Employee is absent from work due to a medical condition (including both physical and mental Illnesses).

**Activities of Daily Living (ADLs)** are the things we normally do for self-care, work, homemaking and leisure. Health professionals routinely refer to the ability or inability to perform ADLs as a measurement of the functional status of a person. This measurement is useful for assessing the elderly, the mentally ill, those with chronic diseases, and others to evaluate the type of health care services needed.

*Basic ADLs are the basic activities of daily living and consist of these self-care tasks:* bathing/showering; dressing/undressing; eating; transferring from bed to chair, and back; toileting and functional mobility.

*Instrumental ADLs (IADLs) are things such as* doing light housework; preparing meals; taking medications; shopping for groceries or clothes; using the telephone; managing money; and using technology. *IADLs are not necessary for fundamental functioning, but they let an individual live independently in a community.*

Occupational therapists also evaluate IADLs when completing patient assessments. These include 11 areas of IADLs that are generally optional in nature and can be delegated to others: care of others (including selecting and supervising caregivers); care of pets; child rearing; use of communication devices; community mobility; financial management; health management and maintenance; home establishment and management; meal preparation and cleanup; Safety procedures and emergency responses; and shopping.

**Ambulette Service** is usually a van equipped with a wheelchair lift and other safety equipment. It is used in non-emergency transportation for wheelchair bound, physically challenged, or elderly patients. They are often used to transport dialysis, radiation, and chemotherapy patients to and from treatment or to transfer patients to and from Hospital, home or nursing facilities. They do not meet the definition of a professional ambulance.

**Bilateral Surgical Procedure** shall mean any surgical procedure performed on any body part or paired organ whose right and left halves are mirror images of each other or in which a median longitudinal section divides the organ into equivalent right and left halves or on any pair of limbs. Surgery on both halves or both limbs is performed during the same operative session and may involve one (1) or two (2) surgical incisions.

**Birthing Center** means any freestanding health facility, place, professional office or institution which is not a Hospital or in a Hospital, where births occur in a home-like atmosphere. This facility must be licensed and operated in accordance with the laws pertaining to Birthing Centers in the jurisdiction where the facility is located.

The Birthing Center must provide facilities for obstetrical delivery and short-term recovery after delivery; provide care under the full-time supervision of a Physician or a licensed nurse-midwife. The licensed nurse-midwife must have a written agreement with a Hospital in the same locality for immediate acceptance of patients who develop complications or require pre- or post-delivery confinement and a written collaborative agreement with an appropriately licensed Physician.

**Brand Name** means a trade name medication.

**Calendar Year** means January 1st through December 31st of the same year.

**COBRA** means the Consolidated Omnibus Budget Reconciliation Act of 1985, as amended.

**Cosmetic Surgery** means medically unnecessary surgical procedures, usually, but not limited to, plastic surgery directed toward preserving beauty or correcting scars, burns or disfigurements. Cosmetic Surgery is typically surgery that changes:

* + - 1. The texture or appearance of the skin; or
      2. The relative size or position of any body part

when such surgery is performed primarily for psychological purposes or is not needed to correct or improve a bodily function.

**Cost Containment Penalties** are structured by the Plan Administrator to encourage the Covered Person’s compliance with the policies and procedures. These policies and procedures are designed to maximize benefits and lower costs for both the member and the plan. Penalty amounts do not accrue towards the individual or family maximum out-of-pocket amounts. The following are examples of penalties that can be assessed: benefit reduction for not properly precertifying an Inpatient stay; additional deductible for emergency room or Inpatient stays; charges over the Usual and Customary Allowance or network contract allowance for out-of-network services; higher patient deductible and/or coinsurance for out-of-network services; day/visit/dollar limits for certain services; other provisions as stated in the Plan.

**Covered Charge(s)** means those Medically Necessary services or supplies that are covered under this Plan.

**Covered Person** is an Employee, Dependent or COBRA Continuant who is covered under this Plan.

**Creditable Coverage** shall have that definition contained in ERISA Section 701(c). Under this provision, Creditable Coverage generally includes periods of coverage under an individual or group health plan (including Medicare, Medicaid, governmental and church plans) that are not followed by a Significant Break in Coverage. Creditable Coverage does not include coverage for liability, dental, vision, specified disease and/or other supplemental-type benefits. The term "Significant Break in Coverage" means a period of 63 days or more without Creditable Coverage. Periods of no coverage during an HMO affiliation period or Waiting Period shall not be taken into account for purposes of determining whether a Significant Break in Coverage has occurred.

Creditable Coverage does not include coverage that was in place before a significant break of coverage of 63 days or more. With respect to the Trade Act of 2002, when determining whether a significant break in coverage has occurred, the period between the trade related coverage loss and the start of the special second COBRA election period under the Trade Act, does not count.

**Custodial Care** is care (including Room and Board needed to provide that care) that is given principally for personal hygiene or for assistance in daily activities and can, according to generally accepted medical standards, be performed by persons who have no medical training. Examples of Custodial Care are help in walking and getting out of bed; assistance in bathing, dressing, feeding; or supervision over medication which could normally be self-administered.

**Dependents** refer to the Eligibility section for details.

**Dentist** is a person who is properly trained and licensed to practice dentistry and who is practicing within the scope of such license.

**Durable Medical Equipment** means equipment which (a) can withstand repeated use, (b) is primarily and customarily used to serve a medical purpose, (c) generally is not useful to a person in the absence of an Illness or Injury and (d) is appropriate for use in the home.

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

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

Examples of these conditions are heart attacks, cardiovascular accidents, poisonings, loss of consciousness or respiration, convulsions or other such acute medical conditions. The Utilization Review Coordinator or Claims Supervisor will assess emergency treatment/admissions to a non-participating provider to determine if it meets the exception criteria. The exception criteria will be assessed on a case- by-case basis, taking into consideration such things as the individual’s medical history, current illness/injury and the circumstances (consciousness, EMT/ambulance services, etc.) surrounding the current illness/injury in relation to the accessibility/location of other participating providers.

**Emergency Services** means a medical screening examination (as required under Section 1867 of the Social Security Act (EMTALA)) within the capability of the Hospital emergency department, including routine ancillary services, to evaluate a Medical Emergency and such further medical examination and treatment as are within the capabilities of the staff and facilities of the Hospital and required under EMTALA to stabilize the patient.

**Employee** means a person who is an Active, regular Employee of the Employer, regularly scheduled to work for the Employer in an Employee/Employer relationship and meets the eligibility requirements outlined in “Eligibility Requirements for Employee Coverage” section. The following persons are specifically excluded from the Plan: persons employed as leased employees or independent contractors; persons who are classified by the Employer as temporary workers; and persons covered by a collective bargaining agreement unless the Employer and collective bargaining unit have agreed to participation under the Plan. For purposes of the foregoing, the Employer’s employment classification of an individual shall be binding and controlling for all purposes and shall apply regardless of any contrary classification of such person by any other person or entity, including without limitation, the Internal Revenue Service, the Department of Labor, or a court of competent jurisdiction.

**Employer** is Integrity Home Care + Hospice

**Enrollment Date** is the first day of coverage or, if there is a Waiting Period, the first day of the Waiting Period.

**ERISA** is the Employee Retirement Income Security Act of 1974, as amended.

**Essential Health Benefits** include, to the extent they are covered under the Plan, ambulatory patient services; emergency services; hospitalization; maternity and newborn care; behaviorial health and substance use disorder services, including behavioral health treatment; prescription drugs; rehabilitative and habilitative services and devices; laboratory services; preventive and wellness services and chronic disease management; and pediatric services, including oral and vision care.

**Experimental and/or Investigational** means services, supplies, care and treatment which does not constitute accepted medical practice properly within the range of appropriate medical practice under the standards of the case and by the standards of a reasonably substantial, qualified, responsible, relevant segment of the medical community or government oversight agencies at the time services were rendered.

The Plan Administrator must make an independent evaluation of the experimental/nonexperimental standings of specific technologies. The Plan Administrator shall be guided by a reasonable interpretation of Plan provisions. The decisions shall be made in good faith and rendered following a detailed factual background investigation of the claim and the proposed treatment. The decision of the Plan Administrator will be final and binding on the Plan. The Plan Administrator will be guided by the following principles:

1. if the drug or device 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 drug or device is furnished; or
2. if the drug, device, medical treatment or procedure, or the patient informed consent document utilized with the drug, device, treatment or procedure, 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 or approval; or
3. if Reliable Evidence shows that the drug, device, medical treatment or procedure is the subject of on-going phase I or phase II clinical trial 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. if Reliable Evidence shows that the prevailing opinion among experts regarding the drug, device, medical treatment or procedure 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.

For purposes of defining terms used here and in the Plan Exclusions section:

“Approved clinical trial” is a phase I, phase II, phase III, or phase IV clinical trial that is conducted in connection with the prevention, detection, or treatment of cancer or other life-threatening disease or condition and is federally funded through a variety of entities or departments of the federal government; is conducted in connection with an investigational new drug application reviewed by the Food and Drug Administration; or is exempt from investigational new drug application requirements.

“Life-threatening condition” is a disease or condition likely to result in death unless the disease or condition is interrupted.

“Routine patient care costs” shall include items and services typically provided under the Plan for a Covered Person not enrolled in a clinical trial. However, such items and services do not include:

1. The investigation item, device or service itself;
2. Items and services not included in the direct clinical management of the patient, but instead provided in connection with data collection and analysis; or
3. A service clearly not consistent with widely accepted and established standards of care for the particular diagnosis.

“Qualified Individual” is a Covered Person who is eligible, according to the trial protocol, to participate in an approved clinical trial for the treatment of cancer or other life-threatening disease or condition and either:

1. The referring health care professional is a Participating Provider and has concluded that the Covered Person’s participation in the clinical trial would be appropriate; or
2. The Covered Person provides medical and scientific information establishing that the Covered Person’s participation in the clinical trial would be appropriate.

Reliable Evidence shall 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 drug, service, medical treatment or procedure; or the written informed consent used by the treating facility or by another facility studying substantially the same drug, device, medical treatment or procedure.

Drugs are considered Experimental if they are not commercially available for purchase and/or they are not approved by the Food and Drug Administration for general use.

**Family Unit** is the covered Employee and the family members who are covered as Dependents under the Plan.

**Formulary** means a list of prescription medications of safe, effective therapeutic drugs specifically covered by this Plan.

**Generic** drug means a Prescription Drug which has the equivalency of the brand name drug with the same use and metabolic disintegration. This Plan will consider as a Generic drug any Food and Drug Administration approved generic pharmaceutical dispensed according to the professional standards of a licensed pharmacist and clearly designated by the pharmacist as being generic.

**Genetic Information** means information about the genetic tests of an individual or his family members, and information about the manifestations of disease or disorder in family members of the individual. A "genetic test" means an analysis of human DNA, RNA, chromosomes, proteins or metabolites, which detects genotypes, mutations or chromosomal changes. It does not mean an analysis of proteins or metabolites that is directly related to a manifested disease, disorder or pathological condition that could reasonably be detected by a health care professional with appropriate training and expertise in the field of medicine involved. Genetic information does not include information about the age or gender of an individual.

**Home Health Care Agency** is an organization that meets all of these tests: its main function is to provide Home Health Care Services and Supplies; it is federally certified as a Home Health Care Agency; and it is licensed by the state in which it is located, if licensing is required.

**Home Health Care Plan** must meet these tests: it must be a formal written plan made by the patient's attending Physician which is reviewed at least every 30 days; it must state the diagnosis; it must certify that the Home Health Care is in place of Hospital confinement; and it must specify the type and extent of Home Health Care required for the treatment of the patient.

**Home Health Care Services and Supplies** include: part-time or intermittent nursing care by or under the supervision of a registered nurse (R.N.); part-time or intermittent home health aide services provided through a Home Health Care Agency (this does not include general housekeeping services); physical, occupational and speech therapy; medical supplies; and laboratory services by or on behalf of the Hospital.

**Hospice Agency** is an organization where its main function is to provide Hospice Care Services and Supplies and it is licensed by the state in which it is located, if licensing is required.

**Hospice Care Plan** is a plan of terminal patient care that is established and conducted by a Hospice Agency and supervised by a Physician.

**Hospice Care Services and Supplies** are those provided through a Hospice Agency and under a Hospice Care Plan and include Inpatient care in a Hospice Unit or other licensed facility, home care, and family counseling during the bereavement period.

**Hospice Unit** is a facility or separate Hospital Unit, that provides treatment under a Hospice Care Plan and admits at least two unrelated persons who are expected to die within six months.

**Hospital** is an institution which is engaged primarily in providing medical care and treatment of sick and injured persons on an Inpatient basis at the patient's expense and which fully meets these tests: it is accredited as a Hospital by the Joint Commission on Accreditation of Healthcare Organizations (JCAHO) or the Healthcare Facilities Accreditation Program (If the Hospital is not accredited by one of the previous entities but has received accreditation through an entity recognized by CMS as an alternative to JCAHO, then this Plan will also recognize the facility as accredited.); it is approved by Medicare as a Hospital; it maintains diagnostic and therapeutic facilities on the premises for surgical and medical diagnosis and treatment of sick and injured persons by or under the supervision of a staff of Physicians; it continuously provides on the premises 24-hour-a-day nursing services by or under the supervision of registered nurses (R.N.s); and it is operated continuously with organized facilities for operative surgery on the premises. If the Plan has a network that credentials their providers for participation in the network, the facility will be considered eligible regardless of the accreditation or Medicare status required in this definition.

**Illness** means a bodily disorder, disease, physical sickness or Mental Disorder. Illness includes Pregnancy, childbirth, miscarriage or complications of Pregnancy.

**Incidental** means requiring unplanned treatment, care or services for a non-emergent Illness while outside the network area. For example, requiring Physician services for acute sinusitis while traveling outside the network area.

**Injury** means an accidental physical Injury to the body caused by unexpected external means.

**Inpatient Care and/or Services** is treatment including services, supplies and medicines provided and used at a Hospital under the direction of a Physician to a person who is admitted as a registered bed patient in a Hospital.

**Institution of Learning** means any accredited high school, accredited college or university, including other recognized educational institutions such as nursing schools, trade school, etc., with full-time curricula, regardless of the length of the term.

**Intensive Care Unit** is defined as a separate, clearly designated service area which is maintained within a Hospital solely for the care and treatment of patients who are critically ill. This also includes what is referred to as a "coronary care unit" or an "acute care unit." It has: facilities for special nursing care not available in regular rooms and wards of the Hospital; special life saving equipment which is immediately available at all times; at least two beds for the accommodation of the critically ill; and at least one registered nurse (R.N.) in continuous and constant attendance 24 hours a day.

**Late Enrollee** means a Plan Participant who enrolls under the Plan other than during the first 30-day period in which the individual is eligible to enroll under the Plan or during a Special Enrollment Period. (see below).

**Legal Guardian** means a person recognized by a court of law as having the duty of taking care of the person and managing the property and rights of a minor child.

**Legally Separated (Legal Separation)** means, for purposes of this Plan, a husband and wife have successfully petitioned a court to recognize their separation.

**Life Threatening** is defined as any serious illness or injury that necessitates immediate medical or surgical intervention to preclude permanent impairment of a body function or permanent damage to a body structure. Examples: burns, loss of organs, loss of limbs, blindness, heart attack, stroke and excessive uncontrolled bleeding through open wounds.

**Lifetime** is a word that appears in this Plan in reference to benefit maximums and limitations. Lifetime is understood to mean while covered under this Plan. Under no circumstances does Lifetime mean during the lifetime of the Covered Person.

**Maintenance** programs is a term used to qualify occupational, physical, speech and other rehabilitative therapy programs. These are the repetitive services required to maintain function and generally do not involve complex and sophisticated occupational/physical/speech therapy procedures; and consequently, the judgment and skill of a qualified therapist are not required for safety or effectiveness.

However, in certain instances, the specialized knowledge and judgment of a qualified physical therapist may be required to establish a maintenance program intended to prevent or minimize deterioration caused by a medical condition if the maintenance program is to be safely carried out and the treatment aims of the physician achieved. Establishing such a program is a skilled service and would be a covered expense under the Plan.

**Medical Care** shall mean professional services rendered by a Physician or Other Professional Provider for the treatment of an Illness of Injury.

**Medical Care Facility** means a Hospital, a facility that treats one or more specific ailments or any type of Skilled Nursing Facility.

**Medical Non-Emergency Care** means care which can safely and adequately be provided other than in a Hospital.

**Medically Necessary** care and treatment is recommended or approved by a Physician; is consistent with the patient's condition or accepted standards of good medical practice; is medically proven to be effective treatment of the condition; is not performed mainly for the convenience of the patient or provider of medical services; is not conducted for research purposes; and is the most appropriate level of services which can be safely provided to the patient.

All of these criteria must be met; merely because a Physician recommends or approves certain care does not mean that it is Medically Necessary.

The Plan Administrator has the discretionary authority to decide whether care or treatment is Medically Necessary.

**Medicare** is the Health Insurance For The Aged and Disabled program under Title XVIII of the Social Security Act, as amended.

**Mental Disorder** means any disease or condition, regardless of whether the cause is organic, that is classified as a Mental Disorder in the current edition of International Classification of Diseases, published by the U.S. Department of Health and Human Services or is listed in the current edition of Diagnostic and Statistical Manual of Mental Disorders, published by the American Psychiatric Association.

**Morbid Obesity/Severe Clinical Obesity** is a diagnosed condition in which the body weight exceeds the medically recommended weight by 100 or more pounds over normal weight (by insurance underwriting standards) or the body mass index (BMI) is 35 or greater for a person of the same height, age and mobility as the Covered Person.

**Multiple Surgical Procedures** (shall mean surgical procedures which are performed during the same operative session and which are not incidental or secondary to one (1) primary procedure for which the operative session is undertaken. An “incidental procedure” is a procedure which is not Medically Necessary at the time it is performed. A “secondary procedure” is a procedure which is not part of the primary procedure for which the operative session is undertaken.

**Never Events** are occurrences that should never happen; *e.g.*, surgery on the wrong body part or death due to contaminated drugs or devices. The criteria for inclusion on the Never Events list include: i) adverse consequence of care results in unintended injury or illness; ii) indicative of a problem in a health facility's safety systems; and iii) important for public credibility or public accountability. Refer to [www.cms.hhs.gov](http://www.cms.hhs.gov/) for the full listing of Never Events.

**No-fault Auto Insurance** is the basic reparations provision of a law providing for payments without determining fault in connection with automobile accidents.

**Nonresidential Treatment Facility** is a facility that can provide medical and other services for the treatment of Substance Abuse to individuals who do not require Inpatient status and are free from acute physical and mental complications. The facility must maintain an organized program of treatment that may be limited to less than 12 hours per day and not be available 7 days a week. The facility must be certified by the Department of Mental Health for treatment of Mental Disorder or Substance Abuse.

**Other Facility Provider** shall mean any of the following: Outpatient Care Facility, Substance Abuse Treatment Facility, free-standing dialysis facility, Outpatient psychiatric facility, psychiatric day treatment facility, psychiatric Hospital, Hospice, Extended Care Facility, or rehabilitation Hospital, which is licensed as such in the jurisdiction in which it is located.

**Other Professional Provider** or **Professional Provider** shall mean the following persons or practitioners, including Physicians, acting within the scope of such provider’s license which is certified and licensed in the jurisdiction in which the services are provided:

|  |  |
| --- | --- |
| Audiologist | Licensed Practical Nurse |
| Anesthetist | Vocational Nurse |
| Chiropractor | Physical Therapist |
| Dentist | Registered Nurse |
| Emergency Medical Technician | Respiratory Therapist |
| Independent Laboratory Technician | Speech – Language Pathologist |
| Pharmacist | Clinical Social Worker |
| Any other practitioner of the healing arts who is licensed and regulated by a state or  federal agency and is acting within the scope of his/her license. | |

**Outpatient Care and/or Services** is treatment including services, supplies and medicines provided and used at a Hospital under the direction of a Physician to a person not admitted as a registered bed patient; or services rendered in a Physician's office, laboratory or X-ray facility, an Outpatient Surgical Center, or the patient's home.

**Outpatient Surgical Center** is a licensed facility that is used mainly for performing Outpatient surgery, has a staff of Physicians, has continuous Physician and nursing care by registered nurses (R.N.s) and does not provide for overnight stays.

**Participating** or **Network Physician** shall mean a duly licensed Physician under contract with any of the Plan’s contracted Networks.

**Participating** or **Network Provider** shall mean any Hospital, Physician, pharmacy, Other Professional Provider, Other Facility Provider or other entity under contract with the Plan’s contracted Networks.

**Participating** (or Network) **Provider Organization (PPO)** is most commonly a network of providers who have agreed contractually to provide covered services at reduced rates to eligible members. The Covered Person retains the freedom to choose his/her own provider subject to a potential impact on his/her benefits.

**Pharmacy** means a licensed establishment where covered Prescription Drugs are filled and dispensed by a pharmacist licensed under the laws of the state where he or she practices.

**Pharmacy Benefit Manager** means a third party administrator of prescription drug programs who is primarily responsible for processing prescription drug claims. They also are responsible for developing and maintaining the formulary, contracting with pharmacies, and negotiating discounts and rebates with drug manufacturers. (Refer to the medical plan ID card for contact information.)

**Physician** means a Doctor of Medicine (M.D.), Doctor of Osteopathy (D.O.), and Doctor of Podiatry (D.P.M.).

**Plan** means Integrity Home Care Employee Major Medical Health Care Plan, which is a benefits plan for certain Employees of Integrity Home Care and is described in this document.

**Plan Participant** is any Employee or Dependent who is covered under this Plan.

**Plan Year** is the 12-month period beginning on either the effective date of the Plan or on the day following the end of the first Plan Year which is a short Plan Year.

**Pre-Admission Testing** is pre-operative or pre-procedural diagnostic screening required to determine the Covered Person’s health status prior to a scheduled medical or surgical procedure on an Inpatient or Outpatient basis.

**Pregnancy** is childbirth and conditions associated with pregnancy, including complications.

**Prescription Drug** means any of the following: a Food and Drug Administration-approved drug or medicine which, under federal law, is required to bear the legend: "Caution: federal law prohibits dispensing without prescription"; injectable insulin; hypodermic needles or syringes, but only when dispensed upon a written prescription of a licensed Physician. Such drug must be Medically Necessary in the treatment of a Sickness or Injury.

**Preventive Care** (“Well Adult” and “Well Child” care) is care by a Physician that is not for an Injury or Sickness. Preventive care includes services as defined under the Affordable Care Act. Preventive services are covered when performed for preventive screening reasons and billed under the appropriate preventive services codes. Examinations, screenings, tests, items or services are not covered under the Preventive Care benefit when such services are diagnostic, investigational or experimental, as determined by the Plan. Services for diagnostic reasons may be covered under other applicable plan benefits.

The Plan will use Reasonable medical management techniques to control costs of the Preventive Care benefit. The Plan will establish treatment, setting, frequency, and medical management standards for specific Preventive Care services, which must be satisfied in order to obtain payment under the Preventive Care benefit. Covered Charges under Medical Benefits for adults and children are payable as described in the Schedule of Benefits.

**Reasonable** means not excessive or extreme as determined by the Plan Administrator. See also Usual & Customary Allowance. If it is determined that a charge is not Reasonable, but services are still eligible, the allowance will be based upon an estimated 150% of the Medicare allowable, regardless of previously negotiated or contracted rates.

**Reasonable and Necessary** is a term used to qualify occupational, physical, speech and other rehabilitative therapy programs. To be considered Reasonable and Necessary, the following conditions must be met:

1. The services must be considered under accepted standards of medical practice to be a specific and effective treatment for the patient’s condition.
2. The services must be of such a level of complexity and sophistication or the condition of the patient must be such that the services required can be safely and effectively performed only by a qualified therapist or under his/her supervision. Services which do not require the performance or supervision of a therapist are not considered reasonable or necessary services, even if they are performed or supervised by a therapist.
3. The development, implementation, management, and evaluation of a patient care plan constitute skilled therapy services when, because of the patient’s condition, those activities require the skills of a therapist to meet the patient’s needs, promote recovery, and ensure medical safety. Where the skills of a therapist are needed to manage and periodically reevaluate the appropriateness of a maintenance program because of an identified danger to the patient, those Reasonable and necessary management and evaluation services may be covered, even if the skills of a therapist are not needed to carry out the activities performed as part of the maintenance program.
4. While a patient’s particular medical condition is a valid factor in deciding if skilled therapy services are needed, the key issue is whether the skills of a therapist are needed to treat the illness or injury, or whether the services can be carried out by non-skilled personnel.
5. There must be an expectation that the patient’s condition will improve significantly in a Reasonable (and generally predictable) period of time, or the services must be necessary for the establishment of a safe and effective maintenance program required in connection with a specific disease state.
6. The amount, frequency, and duration of the services must be Reasonable.

**Residential Treatment Facility** meets the following criteria:

1. Operates legally as a psychiatric Hospital or residential treatment facility for behaviorial health and licensed as such by the state in which the facility operates.
2. Is certified by the Department of Mental Health for treatment of Mental Disorder or Substance Abuse.
3. Is primarily engaged in providing diagnostic and therapeutic services for treatment of Mental Disorders and Substance Abuse on an Inpatient basis; maintains permanent and full-time facilities for bed care and full-time confinement of at least 15 resident patients.
4. Has a Physician in regular attendance; continuously provides 24-hour a day nursing service by a registered nurse (R.N.); has a full-time psychiatrist or psychologist on the staff.
5. Operates on a 24-hour basis, 7 days a week under an organized program.

**Restorative Therapy** is a term used in conjunction with occupational, physical, speech or other rehabilitative therapy which must, among other things, be Reasonable and Necessary to the treatment of the individual’s Illness or Injury. If an individual’s expected restoration potential would be insignificant in relation to the extent and duration of the therapy services required to achieve such potential, the therapy would not be considered Reasonable and Necessary. In addition, there must be an expectation that the patient’s condition will improve significantly in a reasonable (and generally predictable) period of time. However, if at any point in the treatment of an illness/injury it is determined that the expectations will not materialize, the services will no longer be considered Reasonable and Necessary and they would, therefore, be excluded from coverage.

**Sickness** is:

For a covered Employee and covered Spouse: Illness, disease or Pregnancy.

For a covered Dependent other than Spouse: Illness, disease or Pregnancy.

**Skilled Nursing Facility** is a facility that fully meets all of these tests:

1. It is licensed to provide professional nursing services on an Inpatient basis to persons convalescing from Injury or Sickness. The service must be rendered by a registered nurse (R.N.) or by a licensed practical nurse (L.P.N.) under the direction of a registered nurse. Services to help restore patients to self-care in essential daily living activities must be provided.
2. Its services are provided for compensation and under the full-time supervision of a Physician.
3. It provides 24 hour per day nursing services by licensed nurses, under the direction of a full-time registered nurse.
4. It maintains a complete medical record on each patient.
5. It has an effective utilization review plan.
6. It is not, other than incidentally, a place for rest, the aged, drug addicts, alcoholics, mentally disabled, Custodial or educational care or care of Mental Disorders.
7. It is approved and licensed by Medicare, the Joint Commission on Accreditation of Healthcare Organizations or the Commission on Accreditation of Rehabilitation Facilities.

This term also applies to charges incurred in a facility referring to itself as an extended care facility, convalescent nursing home, rehabilitation hospital, long-term acute care facility or any other similar nomenclature.

**Specialty Drugs** treat multi-faceted chronic diseases. They typically require unique clinical, administration, distribution and handling requirements. They are more expensive than traditional prescriptions and there are limited generics and biosimilars available. Biosimilars are a potential future opportunity that will provide therapeutic options for already approved specialty brand drugs at potentially lower costs. A list of these drugs is available by contacting the Claims Supervisor or Pharmacy Benefit Manager as stated on your health plan ID card. Only available through network specialty pharmacy or retail location.

**Spinal Manipulation/Chiropractic Care** means skeletal adjustments, manipulation or other treatment in connection with the detection and correction by manual or mechanical means of structural imbalance or subluxation in the human body. Such treatment is done by a Physician to remove nerve interference resulting from, or related to, distortion, misalignment or subluxation of, or in, the vertebral column.

**Substance Abuse** is regular excessive compulsive drinking of alcohol and/or physical habitual dependence on drugs. This does not include dependence on tobacco and ordinary caffeine containing drinks.

**Temporomandibular Joint (TMJ) Disease** is the treatment of jaw joint disorders including conditions of structures linking the jaw bone and skull and the complex of muscles, nerves and other tissues related to the temporomandibular joint. (Refer to Schedule of Benefits and Medical Benefits for what services are covered by this Plan.)

**Total Disability (Totally Disabled)** means: In the case of an Active Employee, the complete inability to perform any and every duty of his or her occupation or of a similar occupation for which the person is reasonably capable due to education and training, as a result of Injury or Sickness. Total Disability will be determined by the Employer in conjunction with the determination by the treating Physician.

In the case of a Dependent child, the complete inability as a result of Injury or Sickness to perform the normal activities of a person of like age and sex in good health.

In the case of a Dependent, the complete inability as a result of Injury or Sickness to perform the normal activities of a person of like age and sex in good health.

**Urgent Care Services** means care and treatment for an Illness, Injury or condition serious enough that a reasonable person would seek care right away, but not so severe as to require emergency room services.

**Usual and Customary Allowance** is determined by the Plan Administrator using the following information:

1. Third Party data;
2. Contracted allowables;
3. Medicare data;
4. Historical data of Claims Supervisor;
5. Geographic region of provider;
6. Cross-section of providers in geographic areas other than where the service is provided if the service is performed less frequently or is a newer service;
7. The nature and severity of the condition being treated. It will also consider medical complications or unusual circumstances that require more time, skill or experience; and/or
8. Any other available data to make the determination.
9. When the Usual and Customary Allowance cannot be determined with any of the above, the Plan Administrator or its designee has the discretionary authority to decide the Reasonable allowance for the care, treatment or service.
10. Even though the Usual and Customary Allowance or network/contracted rate can be determined, the Plan Administrator or its designee has the discretionary authority in determining if the established allowance is Reasonable.

For the purposes of this section, “Reasonable” means not excessive or extreme as determined by the Plan Administrator.

The Plan will consider the actual charge billed if it is less than the Usual and Customary Allowance.

**Utilization Review Coordinator** is the person who evaluates the appropriateness, medical need and efficiency of health care services, procedures and facilities according to established criteria or guidelines (industry, Claims Supervisor or appropriate third party) and under the provisions of this Plan. Typically, the review includes new activities or decisions based upon the analysis of a case. The Coordinator performs proactive procedures (such as discharge planning, concurrent planning, precertification), clinical case appeals, proactive processes (such as concurrent clinical reviews and peer reviews), and reviews appeals introduced by the provider, payer or Covered Person. A separate entity may provide the precertification services. (Refer to General Plan Information section and the health care plan ID card for contact information.).

**Waiting Period** is the time beginning on the first day of employment as a Non-variable Employee and ends at midnight on the 60th day (as long as remaining eligible). Similarly, for a Variable Hour, Part-time, Seasonal or Ongoing Employee with a change in employment status from non-Full-time to Full-time during the Measurement Period or Stability Period, it is the time beginning on the first day of employment as a Full-time Employee and ends at midnight on the 60th day (as long as remaining eligible). If earlier, coverage will be effective the 1st day of the Stability Period, if the Employee averaged 30 Hours of Service or more per week (130 Hours of Service or more in a Month) during the Measurement Period.

# PLAN EXCLUSIONS

**Note: All exclusions related to Prescription Drugs are shown in the Prescription Drug Plan.**

**The services, treatments, items or supplies listed in this section are not covered health services, except as may be otherwise specifically provided in the description and schedule of benefits or as otherwise approved by the Plan. The exclusions listed herein supersede and take precedence over any policy that may be in conflict with regard to the applicable product or service coverage:**

1. **Abortion.** Services, supplies, care or treatment in connection with an abortion unless the life of the mother is endangered by the continued Pregnancy.
2. **Acupuncture or acupressure.** Services, supplies, care or treatment for acupuncture or acupressure.
3. **Alcohol.** Services, supplies, care or treatment to a Covered Person for an Injury or Sickness that occurred while the Covered Person was illegally using alcohol (whether operating a motorized vehicle or another illegal situation). Expenses will be covered for Injured Covered Persons other than this Covered Person. The on-site and/or responding officer or treating facility’s notation and/or determination of inebriation (such as through a field sobriety test, observations and Blood Alcohol Content level test) will be sufficient for this exclusion. The exclusion applies regardless of whether the use of alcohol was the direct cause of the Injury. The Covered Person’s expenses for Substance Abuse treatment will be covered as specified in this Plan. This exclusion does not apply if the Injury resulted from an act of domestic violence or a medical (including both physical and behaviorial health) condition.
4. **Ambulette Service**. Ambulette Services or other forms of passenger transportation that are available to the public (e.g., buses, taxis or airplanes).
5. **Charges** for failure to keep scheduled appointments, charges for completion of claim forms or late payment charges.
6. **Complications of non-covered or not medically necessary conditions or treatments.** Care, services or treatment required as a result of a condition not covered under the Plan (i.e., is excluded) or complications from a treatment not covered under the Plan.
7. **Correctional agency or court-ordered care.** Care provided while a Covered Person is in the custody or care of a correctional agency; or when a Covered Person receives care under the authority of a court order for services rendered as a condition of parole or probation or in lieu of other correctional action.
8. **(a) Cosmetic reasons.** Examples include:

* Procedures or services that change or improve appearance without improving function
* Pharmacological regimens, nutritional procedures or treatments.
* Scar, keloid or tattoo removal or revision procedures (such as salabrasion, chemosurgery and other such skin abrasion procedures).
* Skin abrasion procedures performed as a treatment for acne.
* Liposuction
* Correction of asymmetric breasts or abnormal nipple-areolar complexes and protruding ears.
* Treatment of surgical complications that is primarily cosmetic in nature, resulting from either covered or non-covered services.
* All other Cosmetic Procedures except if Medically Necessary:
  1. To repair a functional disorder caused by a disease or an accidental injury suffered while insured by the Plan;
  2. To restore or improve function for a structurally abnormal Congenital or developmental defect or anomaly in a Covered individual under age twenty-six (26) (includes orthagnathic surgery as per policy criteria). Anomaly is defined as a marked deviation beyond the range of normal human variation
  3. For reconstructive breast surgery performed post-mastectomy

**(b)** Replacement of an existing breast implant if the earlier breast implant was performed as a Cosmetic procedure

**(c)** Physical conditional programs such as athletic training, bodybuilding, exercise, fitness, flexibility, and diversion or general motivation

**(d)** Weight loss programs whether or not they are under medical supervision except as a required prerequisite of a covered bariatric surgery

**(e)** Wigs, except for use during or following radiation or chemotherapy treatment and the hair loss is caused by such treatment

**(f)** Treatment of benign gynecomastia (abnormal breast enlargement in males)

**(g)** Surgical and non-surgical treatment of obesity, including morbid obesity, except as otherwise specified in the Medical Benefits Section of this document; dietary or nutritional supplements; behavioral or community support programs; exercise programs; medical testing, medications, and office visits associated with any weight loss program including medications for the purpose of appetite suppression, weight loss or binge eating are also excluded

**(h)** Growth hormone therapy except for growth hormone deficiencies

**(i)** Sex transformation operations

**(j)** Breast reduction surgery (reduction Mammoplasty) except for Covered individuals who meet the medical criteria established by Mercy Care Management policy

1. **Custodial care.** Services or supplies provided mainly as a rest cure, maintenance or Custodial Care.
2. **Dental Expenses.** Care, services or treatment provided for expenses incurred for dental work, unless such care is specifically covered in the Schedule of Benefits or Medical Benefits section of this Plan
3. **Dental Implants.** Dental implants, including any appliances and/or crowns and the surgical insertion or removal of implants, unless such care is specifically covered in the Schedule of Benefits or Medical Benefits section of this Plan.
4. **Educational or vocational testing.** Services for educational or vocational testing or training; non-medical self-care or self-help training; and remedial reading and special education. One Medically Necessary unit of medical educational training is allowed per Illness per lifetime.
5. **Excess charges.** The part of an expense for care and treatment of an Injury or Sickness that is in excess of the Usual and Customary Allowance.
6. **Exercise programs.** Exercise programs for treatment of any condition, except for Physician-supervised cardiac or pulmonary rehabilitation, occupational or physical therapy covered by this Plan; charges for enrollment in a health, athletic or similar club; or charges for athletic trainers.
7. **Experimental or not Medically Necessary.** Care and treatment that is either Experimental/Investigational or not Medically Necessary. This exclusion shall not apply to the extent that the charge is for a Qualified Individual who is a participant in an approved clinical trial with respect to the treatment of cancer or another life-threatening disease or condition. The Plan shall not deny, limit or impose additional conditions on Routine Patient Care Costs for items and services furnished in connection with participation in the clinical trial. However, this provision does not require the Plan to pay charges for services or supplies that are not otherwise Covered Charges (including, without limitation, charges which the Qualified Individual would not be required to pay in the absence of this coverage) or prohibit the Plan from imposing all applicable cost sharing and reasonable cost management provisions. For these purposes, a Qualified Individual is a Covered Person who is eligible to participate in an approved clinical trial according to the trial protocol with respect to the treatment of cancer or another life-threatening disease or condition, and either: (1) the referring health care professional is a Participating Provider and has concluded that the individual's participation in such trial would be appropriate; or (2) the Covered Person provides medical and scientific information establishing that the individual's participation in such trial would be appropriate. (Refer to Defined Terms “Experimental and/or Investigational” for definitions of capitalized terms.)
8. **Eye care.** Radial keratotomy or other eye surgery to correct refractive disorders. Also, routine eye examinations, including refractions, lenses for the eyes and exams for their fitting. This exclusion does not apply to aphakic patients and soft lenses or sclera shells intended for use as corneal bandages or as may be covered under the well adult or well child sections of this Plan. Accommodating Intra-Ocular Lenses used to replace the lens of the eye following cataract surgery are not covered under this Plan.
9. **Foot and Hand care.** Diagnosis and Treatment of flat feet, corns, calluses and trimming of the nails (unless needed in treatment of a metabolic or peripheral-vascular disease and authorized by the Utilization Review Coordinator). Surgical treatment of toenails is eligible if Medically Necessary. Charges for the purchase of orthotics or arch supports are not covered.
10. **Foreign travel.** Care, treatment or supplies outside of the U.S. if travel is for the sole purpose of obtaining medical services. This exclusion also applies to Prescription Drugs obtained from outside the U.S. even if travel was not required. Exception: Care, treatment or supplies related to an Emergency Medical Condition or Medically Necessary treatment of an Illness while traveling outside the U.S.
11. **Gene Manipulation Therapy.** Care, treatment or services for gene manipulation therapy that is Experimental and/or Investigational or not Medically Necessary.
12. **Genetic testing.** Genetic testing is not covered unless it is Medically Necessary and evidence-based and likely to aid in the diagnosis and/or medical management of a Covered Person with functional abnormalities, illness or who is asymptomatic of an Illness which may be inheritable and the results of the test will impact the treatment being delivered.
13. **Government coverage.** To the extent permitted by law, medical care, services and supplies which are furnished by a Hospital or facility operated by or at the direction of the United States government or any authorized agency thereof, or furnished at the expense of such government or agency, or by a Physician employed by such a Hospital or facility, unless (1) the treatment is of an emergency nature, and (2) the Covered Individual is not entitled to such treatment without charge by reason of status as a veteran or otherwise. This will also apply to services excluded under “**Correctional agency or court-ordered care**” listed above. This does not apply to Medicaid or when otherwise prohibited by law.
14. **Hair loss.** Care and treatment for hair loss. Care and treatment includes wigs(except for use during or following radiation or chemotherapy treatment and the hair loss is caused by such treatment), hair transplants or any Prescription Drug that promises hair growth, whether or not prescribed by a Physician. However, care and treatment with Prescription Drugs for conditions related to alopecia areata or scalp infection or as a result of treatment of a medical condition (i.e., chemotherapy for cancer) will have coverage under the Prescription Drug plan and may require a prior authorization.
15. **Hearing aids and exams.** Charges for services or supplies in connection with hearing aids (including external or implanted hearing aids) or exams for their fitting, except as may be covered under the well adult or well child sections of this Plan.
16. **Home modifications.** Expenses for modification of home or living quarters due to medical disabilities.
17. **Hypnosis.** Charges for hypnosis are not covered.
18. **Illegal acts** (as defined by the state statutes where the incident occurred)**.** Charges for services received as a result of Injury or Sickness caused by, or contributed to by, engaging in an illegal act or occupation; by committing or attempting to commit any crime, criminal act, assault or other felonious behavior; or by participating in a riot or public disturbance. This exclusion does not apply if the Injury resulted from an act of domestic violence or a medical (including both physical and behaviorial health) condition. Refer to the Alcohol exclusion for the separate criteria for Injuries involving alcohol.
19. **Illegal drugs or medications.** Services, supplies, care or treatment to a Covered Person for Injury or Sickness resulting from that Covered Person's voluntary taking of or being under the influence of any controlled substance, drug, hallucinogen or narcotic not administered on the advice of a Physician. Expenses will be covered for Injured Covered Persons other than the person using controlled substances and expenses will be covered for Substance Abuse treatment as specified in this Plan. This exclusion does not apply if the Injury resulted from an act of domestic violence or a medical (including both physical and behaviorial health) condition.
20. **Infertility.** Care, supplies, services and treatment for infertility, including but not limited to diagnostic services, artificial insemination, other artificial methods of conception, in vitro fertilization, sexual dysfunction or a surrogate mother (even in the absence of an infertility diagnosis and whether or not the surrogate is a Covered Person acting as a surrogate mother). If the treatment of the medical condition is Medically Necessary for an indication other than the promotion of fertility, then the services will be covered.
21. **Internet/Telephonic Services.** Services, supplies or treatment rendered through the Internet or over the telephone are not covered unless part of an established program in the Participating Provider’s contract or allowed by the fee schedule in this contract or the Pharmacy Benefit Manager’s services for this Plan.
22. **Lost, stolen or misused appliances/Durable Medical Equipment (DME).** Charges incurred to replace lost or stolen appliances/DME or to replace or repair appliances/DME due, in whole or in part, to improper use or care (according to the manufacturer’s guide on proper use).
23. **Marital or pre-marital counseling.** Care and treatment for marital or pre-marital counseling.
24. **Military-related disability or coverage.** Care in connection with a military-related disability to which the Covered Person is legally entitled and for which facilities are reasonably available, to the extent permitted by law; or coverage while engaged in service with the armed forces of any international organization, nation or state.
25. **Never Events.** Services, supplies, care or treatment as a result of a Never Events as defined by the National Quality Forum.
26. **No charge.** Care and treatment for which there would not have been a charge if no coverage had been in force.
27. **Non-compliance.** Charges in connection with treatments or medications where the Covered Person is non-compliant with prescribed treatment. If it is determined by the Claims Supervisor that a Covered Person is repeatedly non-compliant with prescribed treatment and the non-compliance has and will continue to result in additional treatment, the Claims Supervisor may, at its discretion, deny coverage of any additional treatment. The Covered Person will be notified of the effective date and condition, treatments and/or medications that have been determined to be ineligible. The Claims Supervisor will review medical records for compliance by the Covered Person to determine eligibility of additional treatment.
28. **Non-emergency Hospital admissions.** Care and treatment billed by a Hospital for services performed for a non-Emergency Medical Condition unless surgery is performed within 24 hours of admission. This preadmission (presurgical) day will not be covered if it is not approved through the precertification process for the surgery.
29. **No obligation to pay.** Charges incurred for which the Plan has no legal obligation to pay.
30. **No Physician recommendation.** Care, treatment, services or supplies not recommended and approved by a Physician; or treatment, services or supplies when the Covered Person is not under the regular care of a Physician. Regular care means ongoing medical supervision or treatment which is appropriate care for the Injury or Sickness.
31. **Not specified as covered.** Medical services, treatments and supplies which are not specified as covered under this Plan. Medical services, treatments and supplies that meet standards of care, are Medically Necessary, are ordered by a Physician, are not Experimental/ Investigational and not otherwise excluded by this Plan will be covered.
32. **Nutrition.** Including but not limited to:
33. Megavitamins in and nutrition based therapy (for any purpose).
34. Vitamins (other than those prenatal vitamins prescribed for a Covered Individual who is then pregnant).
35. Nutritional counseling and other hospital-based educational programs for either individuals or groups, except as authorized by the Plan.
36. Medical Foods and other nutritional and electrolyte supplement s taken orally or enterally regardless of the disease state, including infant formula and donor breast milk. This exclusion does not apply to the treatment of Phenylketonuria or any inherited disease of amino or organic acids, or nutritional supplements ordered by a Physician in connection with home care when the Covered Individual has an enteral feeding tube as the primary (>50%) source of nutrition.
37. Non-FDA approved, investigational or experimental medical foods or nutritional supplement s given parenterally.
38. **Obesity.** Care and treatment of obesity, weight loss or dietary control. Medically Necessary charge for health problems associated with high-risk Morbid Obesity/Severe Clinical Obesity will be covered. Refer to Weight Management in the Medical Benefits section for details.
39. **Occupational.** Care and treatment of an Injury or Sickness that is occupational (that is, arises from work for wage or profit including self-employment) for which the Covered Person is entitled to benefits under any Workers' Compensation or Occupational Disease Law, or any such similar law. If the Covered Person is entitled to these benefits but did not receive them due to a failure to follow that plan’s guidelines, this Plan will not consider those eligible charges. The Plan will not pay for any medical benefits related to a condition for which the Covered Person received a settlement for future medical benefits from a workers’ compensation carrier.
40. **Orthotics.** Except as described under Covered Charges. (Refer to Plan Exclusions items Foot and Hand Care and Orthotics for further information.)
41. **Personal comfort items.** Including but not limited to:
42. Television
43. Telephone
44. Beauty/Barber service
45. Guest service
46. Automated travel devices (motor scooters)
47. Supplies, equipment and similar incidental services and supplies for personal comfort or convenience. Examples include:
    * Air conditioners
    * Air purifiers and filters
    * Batteries and battery chargers
    * Lights/lighting
    * Dehumidifiers, humidifiers and vaporizers
    * Electrostatic machines
    * Portable room heaters
    * Grab bars, etc
    * Tanning booths
    * Exercise equipment
    * Raised or regular toilet seats or chairs
    * Whirlpools, saunas and hot tubs
48. Devices and computers to assist in communication and speech. Augmentative communication devices, including but not limited to computer assisted speech devices, speech teaching machines, telephones, TOO equipment , Braille teaching texts, computers, and telephone alert systems. Exceptions include basic, Non-digital voice systems, such as the Electro-Larynx , after post-radical neck or other invasive surgery that interferes with laryngeal function.
49. Personal hygiene items and hygienic items, including but not limited to shower chairs, commodes (unless the individual is confined to room or bed), incontinence pads, bed baths, etc.
50. Devices that are primarily non-medical in nature or used primarily for comfort, including but not limited to:
    * Bathtub seats
    * Bed boards
    * Carafes
    * Cold or heat therapy devices
    * Emesis basins
    * Elevators
    * Foam pads
    * Heating pads
    * Maternity belts
    * Overbed tables
    * Standing tables and strollers
51. Chair lifts, bath tub lifts, bed lifter, and other similar devices.
52. Exercise equipment including but not limited to parallel bars, weights, bicycles, rowing machines, and treadmills.
53. Devices and equipment that is not normally appropriate outside a Hospital or other provider setting, such as blood glucose analyzers, diathermy machines, esophageal dilators, and paraffin unit baths. Home monitoring devices and supplies are not covered, except Medically Necessary cardiac monitoring devices (such as halter monitors and event recorders), home prenatal monitoring and associated nursing support. apnea monitors, glucometers, and related supplies.
54. AED (automatic electronic defibrillator) or other external defibrillator devices (other than temporary wearable defibrillator devices as defined in Plan policy).
55. Devices used specifically for safety purposes (examples include ear molds and helmets, car seats and strollers).
56. Devices and supplements that affect performance in sports-related activities: and expenses related to physical conditioning programs such as athletic training, body building and exercise or fitness programs.
57. **Plan design excludes.** Charges excluded by the Plan design as mentioned in this document.
58. **Prosthetic devices.** Certain prosthetic devices are not covered under this Plan: electrical convenience aids, either anal or urethral; implants for cosmetic or psychological reasons, penile prostheses for non-organic impotence; dental appliance; orthodontic appliance; remote control devices; devices employing robotics; and investigation or obsolete devices and supplies. Replacement of prostheses will not be covered unless:
    1. there is sufficient change in the Covered Person’s physical condition to make the original device no longer functional or
    2. the device has reached its life expectancy and is no longer functioning(but no more frequently than every 5 years).

Replacement of the device must be preauthorized. (Refer to Cost Management Services.). Replacement due to improper use or care (according to the manufacturer’s guide on proper use) will not be covered. Repairs not covered under the warranty or required after the warranty expires will be covered, unless cost-prohibitive. The benefit payment will be based on the cost of the treatment which provides professionally satisfactory results at the most cost-effective level. (Refer to Plan Exclusions for Prosthetic devices for further information.)

1. **Psychoanalysis or counseling with relatives** (except if the counseling is with a covered parent on behalf of a covered minor child)**,** unless stated otherwise in the Medical Benefits section.
2. **Psychological reasons.** Surgery performed for psychological or emotional reasons.
3. **Relative providing services.** Professional services performed by a person who ordinarily resides in the Covered Person's home or is related to the Covered Person as a Spouse, parent, child, brother or sister, whether the relationship is by blood or exists in law.
4. **Safety devices.** Charges for safety devices such as helmets (except cranial molding helmets and medically necessary post-surgical helmets), shower chairs, restraints, telephone alert systems, safety eyeglasses and safety enclosure bed frames/canopies (i.e., Vail enclosures, Posey bed enclosures/canopy systems) which are used to prevent a patient from leaving their bed. These devices are not primarily medical in nature and are therefore considered not Medically Necessary.
5. **Self-Inflicted.** Any loss due to an intentionally self-inflicted Injury. This exclusion does not apply if the Injury resulted from an act of domestic violence or a medical (including both physical and behaviorial health) condition.
6. **Services before or after coverage.** Care, treatment or supplies for which a charge was incurred before a person was covered under this Plan or after coverage ceased under this Plan.
7. **Sex changes.** Care, services or treatment for non-congenital transsexualism, gender dysphoria or sexual reassignment or change. This exclusion includes medications, implants, hormone therapy, surgery and medical or psychiatric treatment.
8. **Sexual dysfunction.** Care, services or treatment for sexual dysfunction unrelated to organic disease.
9. **Smoking cessation.** Care and treatment for smoking cessation programs, including smoking deterrent patches, unless Medically Necessary due to a severe active lung Illness such as emphysema or asthma.
10. **Surgical sterilization reversal.** Care and treatment for reversal of surgical sterilization.
11. **Travel or accommodations.** Charges for travel or accommodations, whether or not recommended by a Physician, except for ambulance charges as defined as a Covered Charge.
12. **War.** Any loss that is due to a declared or undeclared act of war. This also applies for intentional or accidental atomic explosion or other release of nuclear energy, whether in peacetime or wartime.

# PRESCRIPTION DRUG BENEFITS

**(Dispensed at a Pharmacy)**

**Pharmacy Drug Charge**

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

## COPAYMENTS

The copayment is applied to each covered pharmacy drug or mail order drug charge and is shown in the schedule of benefits. The copayment amount is not a Covered Charge under the medical Plan. Any one pharmacy prescription is limited to a 30-day supply. Any one mail order prescription is limited to a 90-day supply.

If a drug is purchased from a non-participating pharmacy, or a participating pharmacy when the Covered Person's ID card is not used, the Covered Person should follow the guidelines for filing the claim. The amount payable will be as shown in the schedule of benefits.

## COVERED PRESCRIPTION DRUGS

1. All drugs prescribed by a Physician that require a prescription either by federal or state law.

This does include oral contraceptives purchased at the Pharmacy, but excludes any drugs stated as not covered under this Plan.

1. Insulin and other diabetic supplies when prescribed by a Physician.
2. Injectable drugs or any prescription directing administration by injection, such as Insulin, Imitrex, Lovenox, Betaseron, Copaxone, Avonex, Epogen, Neupogen or any other medication available to be filled as a self-injectable through the pharmacy. If the Plan covers oral contraceptives, Depo Provera will be considered a covered expense when purchased through the Pharmacy. This list is subject to change. For the latest information on approved drugs and to obtain approval for the purchase of the drug through the pharmacy, please contact the Pharmacy Benefit Manager as listed on the health care plan ID card.
3. All drugs required to be covered under the Affordable Care Act when purchased at a Participating Pharmacy.
4. Any drugs specifically allowed under the prescription benefits as established with the Pharmacy Benefit Manager that may be excluded under Medical Plan.

## LIMITS TO THIS BENEFIT

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

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

## EXPENSES NOT COVERED

This benefit will not cover a charge for any of the following:

1. **Administration.** Any charge for the administration of a covered Prescription Drug.
2. **Appetite suppressants.** A charge for appetite suppressants, dietary supplements or vitamin supplements, except for prenatal vitamins requiring a prescription or prescription vitamin supplements containing fluoride.
3. **Consumed on premises.** Any drug or medicine that is consumed or administered at the place where it is dispensed.
4. **Devices.** Devices of any type, even though such devices may require a prescription. These include (but are not limited to) therapeutic devices, artificial appliances, braces, support garments, or any similar device.
5. **Drugs used for cosmetic purposes.** Charges for drugs used for cosmetic purposes, such as anabolic steroids, Retin A or medications for hair growth or removal, unless prior authorized with the Utilization Review Coordinator/Claims Supervisor for treatment of an Illness or Injury.
6. **Experimental.** Experimental drugs and medicines, even though a charge is made to the Covered Person. A prior authorization is required for coverage of drugs related to a covered clinical trial for which the Covered Person is responsible for the cost of the drugs.
7. **FDA.** Any drug not approved by the Food and Drug Administration.
8. **Growth hormones.** Charges for drugs to enhance physical growth or athletic performance or appearance, unless prior authorized with the Pharmacy Benefit Manager or Utilization Review Coordinator/Claims Supervisor. (Refer to medical plan ID card for contact information.)
9. **Immunization.** Immunization agents or biological sera.
10. **Impotence.** A charge for impotence medication.
11. **Infertility.** A charge for infertility medication.
12. **Inpatient medication.** A drug or medicine that is to be taken by the Covered Person, in whole or in part, while Hospital confined. This includes being confined in any institution that has a facility for the dispensing of drugs and medicines on its premises.
13. **Investigational.** A drug or medicine labeled: "Caution - limited by federal law to investigational use".
14. **Medical exclusions.** A charge excluded under Medical Plan Exclusions unless specifically allowed under the prescription benefits as established with the Pharmacy Benefit Manager.
15. **No charge.** A charge for Prescription Drugs which may be properly received without charge under local, state or federal programs.
16. **Non-legend drugs.** Any drug for which no prescription is required by federal or state law. These are generally referred to as “over-the-counter” items.
17. **No prescription.** Any drug for which no prescription is required by federal or state law. These are generally referred to as “over-the-counter” items. This does not apply to injectable insulin. Contact the Pharmacy Benefit Manager for details. (Refer to medical plan ID card for contact information.) Certain non-prescription medications are eligible for coverage under these benefits; however, a prescription for a Physician is required.
18. **Refills.** Any refill that is requested more than one year after the prescription was written or any refill that is more than the number of refills ordered by the Physician.
19. **Smoking cessation.** A charge for Prescription Drugs, such as nicotine gum or smoking deterrent patches, for smoking cessation.

# HOW TO SUBMIT A CLAIM

**Benefits are provided in accordance with the terms and conditions of this Plan, as set forth in this Summary Plan Description .**

Charges for medical services are billed by the provider at their normal rates. This is the price an individual would be charged in absence of any contractual arrangements with the provider. When contractual arrangements exist, the claim is re-priced to the discounted rate. This repricing function may either be performed by the Claims Supervisor or a PPO Network. The billed amount less any ineligible amount (including Usual and Customary Allowance), contracted discount or negotiated discount results in the Allowed Amount under this Plan. (Refer to the Schedule of Benefits for further information.)

A "Claim" is defined as any request for a Plan benefit, made by a Covered Person or by an authorized representative of a Covered Person that is filed with the Plan in accordance with the procedures described below. There are different types of Claims that may be filed under this Plan (as defined in the Claims and Appeals Timelines section below). For purposes of the appeals procedures as outlined, a Claim also includes any appeal of the Plan’s decision to retroactively rescind your coverage due to fraud or intentional misrepresentation. For purposes of this section, a Claim does NOT include any request for eligibility to participate or to change an election under the Plan. If you have a question about eligibility or enrollment, contact the Plan Administrator.

## HOW TO FILE A CLAIM

If you visit a network provider, the provider will file the Claim on your behalf. Even though the network provider files on your behalf, you should check with the provider to ensure that the provider did, in fact, file the Claim on your behalf.

If you visit an out of network provider, you or your authorized representative must file the Claim with the Plan at the address identified on your ID Card. You must file the Claim in accordance with the procedures described below.

1. Obtain a Claim form from [www.mercyoptions.net](http://www.mercyoptions.net).
2. Complete the primary insured portion of the form. ALL QUESTIONS MUST BE ANSWERED.
3. If a claim or bill from the provider is not available with all the information requested, have the Physician complete the provider's portion of the form.
4. Attach bills or invoices from the provider for the services rendered for which you are requesting benefits under the Plan.
5. Send the above to the **address on the ID card**.

Regardless of whether a network provider, you or your authorized representative files the Claim, it is not possible to make a determination that benefits are payable unless the Claim constitutes a “Clean Claim”. A **“Clean Claim”** means a claim void of any material errors, omissions of pertinent information, coordination of benefits issues, and any liability issues, as determined by the Plan Administrator. Where not otherwise specified, this Plan follows National Correct Coding Initiative (NCCI) for coding modifiers, bundling/unbundling, and payment parameters. Other guidelines may be applicable where NCCI is silent. The Plan Administrator has full discretionary authority to select guidelines and/or vendors to assist in making determinations. The Plan reserves the right to have a Plan Participant seek a second medical opinion.

## WHEN CLAIMS SHOULD BE FILED

Claims must be filed with the Claims Supervisor within six months of the date services or treatments giving rise to the charges were provided. The following additional filing limitations apply:

1. Claims for Benefits for services or treatments for which a Claim has not previously been filed but that relate to charges for services or treatments for which a Claim has been file are still considered a new claim and must be filed in the time limit above.
2. Corrected information submitted on an initial claim determination is considered an appeal and not a newly filed claim. The filing limit will follow the appeal guidelines explained further in this section.
3. **I**f the person is not capable of submitting the claim due to Illness including mental or physical incapacity that made it unreasonably difficult to file the claim within the specified timeframe. The Claims Supervisor will determine if it was or was not reasonably possible for the claim to be submitted within the time limit above.
4. If there are complications in the filing of claims due to the person having primary insurance with another plan and this plan is the secondary plan, the filing period will be 12 months from the date of service. The Claims Supervisor will determine if it was or was not reasonably possible for the claim to be submitted within the time limit above.
5. The Plan Administrator will determine the length of time for claims to be filed following the plan’s termination date. The Employee will be notified of the filing limit so appropriate follow-up may be performed with providers regarding outstanding claims. The time period typically allowed for the filing of claims is at least 90 days from the Plan’s termination date.

*If you do not receive timely notice of the determination of your Claim (as described below), please contact the Claim Supervisor directly at the phone number listed on your ID card to verify receipt of the claim. You may also contact the provider to make sure the claim was filed correctly.*

NOTE: Benefits are based on the Plan's provisions at the time the services or treatments were provided

## NOTICE OF DETERMINATIONS AND APPEALS

Once the Claims Supervisor receives your timely and properly filed Claim, the Claims Supervisor will review your Claim to determine whether Benefits are payable in accordance with the terms of the Plan. The following describes the step by step process once the Claims Supervisor receives your Claim and your and the Plan’s rights and obligations under the Plan with respect to appeals of any denials of your Claim. In addition, you may also be eligible to request an external review of any denied Claims and Appeals. See the “External Review” section below for more details.

**Step 1: Notice is received from Claims Supervisor.**

You will typically receive a notice from the Claims Supervisor indicating the extent to which Benefits are payable under the Plan with respect to your Claim. If your Claim is denied in whole or part, the Claims Supervisor will provide a written notice of its determination to you or your authorized representative within the time frames set forth in the Claims and Appeals Timeline Chart in this section. If the Claim is an Urgent Care Claim, the Claims Supervisor may initially notify you of its determination orally. The Claims Supervisor may take an extension of time to make the determination for reasons beyond the Claims Supervisor’s control (e.g. your Claim is not a Clean Claim). If an extension is needed, the Claims Supervisor will notify you in writing (oral notice may be provided if the Claim is an Urgent Care Claim) within the time frames identified in the chart below. If the reason for the extension is that you need to provide additional information in order for the Claims Supervisor to make a determination, you will be afforded the opportunity to provide the missing information prior to the date set forth in the extension notice, which will be no less than 45 days from the date you receive the extension request. The Claims Supervisor’s time period for making a determination is suspended until the date that your provide the information or the end of the information gathering period, whichever is earlier.

The notice will contain the following information:

1. The reason(s) for the denial and the Plan provisions on which the denial is based.
2. A description of any additional information necessary for you to perfect your claim, why the information is necessary, and your time limit for submitting the information.
3. A statement indicating whether an internal rule, guideline or protocol was relied upon in making the denial and a statement that a copy of that rule, guideline or protocol will be made available upon request free of charge
4. If the denial is based on a medical necessity, experimental treatment or a similar exclusion or limit, either an explanation of the scientific or clinical judgment for the determination or a statement that such explanation will be provided free of charge upon request, and
5. If the claim was an Urgent Care Claim, a description of the expedited appeals process. The notice may be provided to you orally; however, a written or electronic notification will be sent to you no later than three days after the oral notification.
6. Information sufficient to identify the claim (including the date of service, the health care provider, and the claim amount (if applicable).
7. An explanation of how to request diagnosis and treatment codes (and their corresponding meanings).
8. The contact information for the office of health insurance consumer assistance or ombudsman to assist you with your claims, appeals and external review.
9. A statement indicating that you will have the right to file suit in federal court, as prescribed by ERISA, once you have exhausted the Plan’s internal claims and appeals procedures.

**Step 2: If you disagree with the decision and you desire additional consideration, you must file a 1st** **level Appeal with the Claims Supervisor.**

1. If you do not agree with the decision of the Claims Supervisor, or the Pharmacy Benefit Manager (PBM) in the case of prescriptions drugs filled through a Pharmacy, and you desire additional consideration, you must submit a written appeal to the Claims Supervisor within 180 days of receiving the denial from the Claims Supervisor. If the Claim is an Urgent Care Claim, you may submit your request orally by contacting the Utilization Review Coordinator as indicated on your ID card or in the General Plan Information section of this document. There is only one level of appeal for Urgent Care Claims.
2. You should submit all of the information identified in the Claims Supervisor’s denial letter as necessary to perfect your claim. In addition, you should include any additional information that you believe will support your Claim.

**Step 3: Notice of denial on the 1st Level Appeal.**

**(1)** If your 1st Level Appeal is denied in whole or part, the Claims Supervisor will notify you in writing of its determination within the period described in the Claims and Appeals Timeline Chart in this section. The notice of determination will include the same information as the denial notice referenced in Step #1 above.

**Step 4: If you disagree with the decision and you desire additional consideration, you must file a 2nd level Appeal with the Plan Administrator.**

1. If you do not agree with the Claims Supervisor’s 1st Level Appeal Determination, and you desire additional consideration, you must submit a written appeal to the Plan Administrator within 90 days of receipt of the Claims Supervisor’s 1st Appeal denial letter. There is only one level of appeal (to the Claims Supervisor) for claim involves urgent care.)
2. You should submit all of the information identified in the Claims Supervisor’s denial letter (referenced in Step #1) as necessary to perfect your claim. In addition, you should include any additional information that you believe will support your Claim.
3. The Plan Administrator will make its determination within the time frames set forth in the chart below.

**Other important information regarding your appeals**:

1. Each level of appeal will be independent from the previous level (i.e., the same person(s) or subordinates of the same person(s) involved in a prior level of appeal will not be involved in the appeal).
2. On each level of appeal, the claims reviewer will review relevant information that you submit even if it is new information. In addition, you have the right to request documents or other records relevant (as defined by ERISA) to your claim.
3. If a claim involves medical judgment, then the claims reviewer will consult with an independent health care professional during the Appeal that has expertise in the specific area involving medical judgment.
4. You may review the claim file and present evidence and testimony at each step of the appeals process.
5. You may request, free of charge, any new or additional evidence considered, relied upon, or generated by the plan in connection with your claim.
6. If at any level of appeal a decision is made based on a new or additional rationale, you will be provided with the rationale and be given a reasonable opportunity to respond before a final decision is made.
7. If you wish to submit relevant documentation to be considered in reviewing your claim for appeal, it must be submitted with your claim and/or appeal.
8. You cannot file suit in federal court until you have exhausted these appeals procedures. Except as otherwise required by applicable law you must exhaust the external review process before filing suit.
9. Please note that you must raise all issues that you wish to appeal during the Plan’s internal appeal process and during the external review. If you pursue legal action to appeal your claim, you are barred from raising any issue in your lawsuit that you did not raise during the administrative claims review process.
10. All notices from the Claims Supervisor or the Plan Administrator are deemed to be received by you within three (3) business days of the postmark date unless you provide objectively credible evidence to the contrary.

## EXTERNAL REVIEWS

If your 2nd Level Appeal was denied by the Plan Administrator in whole or part, and the Claim involved Medical Judgment, you may request an external review from an independent review organization (IRO) in accordance with the procedures described below.

You may also seek an external review by an Independent Review Organization for a denial of an Urgent Care Claim based on Medical Judgment provided that the time frames to complete an appeal of an Urgent Care Appeal will seriously jeopardize your life or health or would seriously jeopardize your ability to regain maximum function.

**How to Request an External Review**

You must file your written request for an external review with the Claims Supervisor within 4 months of the date you received the applicable denial (see above for appeals that enable you to request an external review).

Within 5 business days of receiving your request for external review, the Plan Administrator will complete a preliminary review of the request to determine whether you were covered under the Plan at the time the expense was incurred and whether you have exhausted the internal appeal process where required. Within 1 business day of making the determination, you will be notified if the external review request is approved or denied and if denied, you will be provided with (i) the reasons why the claim is initially ineligible for external review, or (ii) the information or materials needed for a complete request. In the event your request is denied due to lack of information or materials, you must perfect your claim by the later of the end of the 4-month period following the date you received the 2nd level appeal determination or 48 hours following notification that your request for external review was denied.

If initially eligible for an external review, the Plan Administrator will assign the request to an Independent Review Organization (IRO). The IRO will make a determination and provide you and the Plan with notice of its determination within 45 days of receiving the review request.

If, due to your medical condition, the timeframe for completion of the standard external review process would seriously jeopardize your life or health or your ability to regain maximum function, you may request an expedited external review. Under an expedited external review, the preliminary review will be completed immediately. If determined to be initially eligible, the Claims Supervisor will assign the request to an IRO and the IRO will complete the review as expeditiously as your medical condition requires, but in no event more than 72 hours after receiving the request.

## CLAIMS AND APPEALS TIMELINES

There are three types of health claims under this Plan and each has a specific timetable for approvals or denials. The definitions of the types of health claims are:

**Pre-Service Claim**. A claim for health care where prior approval for any part of the care is a condition to receiving the care. For example, the Plan requires that you precertify hospital admissions.

**Concurrent Care Claim**. A previously approved claim for an ongoing course of treatment to be provided for a period of time or for a number of treatments. Concurrent Care Claim also includes a retroactive rescission of coverage due to fraud or intentional misrepresentation.

**Post-Service Claim**. A claim for care that has already been received.

**Urgent Care Claim**: A Pre-Service or Concurrent Care Claim becomes an Urgent Care Claim when the normal time frame for making a determination would:

* Seriously jeopardize the life of the claimant (in the view of a prudent layperson acting on behalf of the Plan who possesses an average knowledge of health and medicine or a physician with knowledge of the claimant’s medical condition) or
* Subject the claimant to severe pain that cannot be adequately managed without treatment (in the view of a physician with knowledge of the claimant’s condition).

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| --- |
| **Claims and Appeals Timeline Chart**  **Group Health Benefit Plans** |

|  |  |  |  |
| --- | --- | --- | --- |
|  | **Initial Claims** | | |
| **Type of Claim** | **Claimant must be notified**  **of determination as soon** | **Extension period**  **allowed for** | **If additional**  **information is** |
| **as possible but no later** | **circumstances beyond** | **needed, claimant** |
| **than:** | **Claims Supervisor’s** | **must provide** |
|  | **control:** | **information within:** |
| **Pre-Service** | 15 days after Claims | One extension of 15 | At least 45 days of |
|  | Supervisor’s receipt of Claim | days. | date of extension |
|  | (Including approval of |  | notice |
|  | Benefits) |  |  |
| **Pre-Service** | 72 hours after Claims | Must provide notice | At least 48 hours. |
| **involving Urgent** | Supervisor’s receipt of Claim | within 24 hours of | Claims Supervisor |
| **Care** | (including approvals) | receiving Claim if | must notify claimant of |
|  |  | additional information is | determination within |
|  |  | needed | 48 hours of receipt of |
|  |  |  | claimant’s information. |
| **Concurrent:** | Claims Supervisor will notify | N/a | N/A |
| **To end or reduce** | claimant of the decision to |  |  |
| **treatment** | reduce or terminate benefits |  |  |
| **prematurely** | sufficiently in advance of the |  |  |
|  | end date in order to allow |  |  |
|  | the claimant to appeal |  |  |
| **Concurrent:** | Treat as any other pre or | One extension of 15 | At least 45 days after |
| **To deny your** | post service claim. | days | date of extension |
| **request to extend** |  |  | notice |
| **treatment** |  |  |  |
| **Concurrent** | 24 hours, if claimant’s | None | N/A |
| **involving Urgent** | request is made at least 24 |  |  |
| **Care** | hours before the date |  |  |
|  | treatment is scheduled to |  |  |
|  | end. Otherwise, request is |  |  |
|  | treated as “Pre-Service |  |  |
|  | Urgent Care” claim |  |  |
|  | (including approvals of |  |  |
|  | benefits) |  |  |
| **Post-Service** | 30 days after Claims | One extension of 15 | At least 45 days after |
|  | Supervisor's receipt of Claim | days | date of extension |
|  |  |  | notice |

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
|  | **1st Level Appeal** | | **2nd Level Appeal** | |
| **Type of Claim** | **Claimant must file appeal within:** | **Claimant will be notified of determination as soon as possible but no later than:** | **Claimant must file appeal within:** | **Claimant will be notified of determination as soon as possible but no later than:** |
| **Pre-Service** | 180 days upon receipt of Claims Supervisor’s notice of determination (Including approval of Benefits) | 15 days after Claim Supervisor’s receipt of appeal | 90 days following Claimant’s receipt of determination notice | 15 days after Plan Administrator’s receipt of appeal |
|  |
|  |
|  |
| **Pre-Service** | 180 days upon receipt of Claims Supervisor’s notice of determination | 72 hours after Claims Supervisor’s receipt of appeal | Not available | Not available |
| **involving Urgent** |
| **Care** |
|  |
|  |
|  |
| **Concurrent:** | 180 days upon receipt of Claims Supervisor’s notice of determination | 15 days after Claim Supervisor’s receipt of the appeal | 90 days following Claimant’s receipt of determination notice | 15 days after Plan Administrator’s receipt of appeal |
| **To end or reduce** |
| **treatment** |
| **prematurely** |
|  |
|  |
| **Concurrent:** | 180 days upon receipt of Claims Supervisor’s notice of determination | Treat as any other pre or post service claim | 90 days following Claimant’s receipt of determination notice | Treat as any other pre or post service claim |
| **To deny your** |
| **request to extend** |
| **treatment** |
| **Concurrent**  **involving Urgent**  **Care** | 180 days upon receipt of Claims Supervisor’s notice of determination | 72 hours after Claims Supervisor’s receipt of appeal | Not available | Not available |
|  |
| **Post-Service** | 180 days upon receipt of Claims Supervisor’s notice of determination | 30 days of Claims Supervisor’s receipt of appeal | 90 days following Claimant’s receipt of determination notice | 30 days after Plan Administrator’s receipt of appeal |
|  |
|  |

# COORDINATION OF BENEFITS

**Coordination of the benefit plans.** Coordination of benefits (COB) sets out rules for the order of payment of Covered Charges when two or more plans -- including Medicare -- are paying. When a Covered Person is covered by this Plan and another plan, or the Covered Person's Spouse is covered by this Plan and by another plan or the couple's Covered children are covered under two or more plans, the plans will coordinate benefits when a claim is received.

The plan that pays first according to the COB rules (Refer to Benefit Plan Payment Order that follows) will pay as if there were no other plans involved. As a subsequent plan, this Plan will consider the allowable amount to be the lesser of:

1. what this Plan would have allowed as the primary plan; or
2. the lesser amount allowed by any preceding plan(s).

The Total payment by this Plan may be reduced so as not to exceed 100% of this total allowable amount when added to any preceding plan’s reimbursement and any responsibility of the Covered Person. Should the reimbursement(s) by any preceding plan(s) exceed this total allowable, no payment will be made by this Plan.

If the primary or any other preceding plan denies a claim due to the Covered Person or provider’s failure to respond to a request for more information, this Plan will not consider the charges as eligible.

If the primary or any other preceding plan denies a claim for lack of Medical Necessity, this Plan will not consider the charges as eligible. The appeals procedures under the prior plan(s) must be exhausted and the results provided to this Plan before charges will be reviewed for consideration under this Plan’s benefits.

**Benefit plan.** This provision will coordinate the medical benefits of a benefit plan. The term benefit plan means this Plan or any one of the following plans:

1. Group or group-type plans, including franchise or blanket benefit plans.
2. Blue Cross and Blue Shield group plans.
3. Group practice and other group prepayment plans.
4. Federal government plans or programs. This includes, but is not limited to, Medicare and Tricare.
5. Other plans required or provided by law. This does not include Medicaid or any benefit plan like it that, by its terms, does not allow coordination.
6. No Fault Auto Insurance, by whatever name it is called, when not prohibited by law.

**Allowable Charge.** To be considered a Covered Charge under this Plan, treatment, services and/or supplies must meet all of the following criteria: **(1)** Medically Necessary; **(2)** Ordered by an appropriate Physician; **(3)** Not excluded under the Plan; and **(4)** Meets the standards of care for the diagnosis.

**Automobile limitations.** When medical payments are available under vehicle insurance which insures the Covered Person, the Plan shall pay excess benefits only, without reimbursement for vehicle plan deductibles. (For purposes of this section, "available" means that the insured has personal injury coverage under his/her personal automobile insurance, and applies whether the coverage is provided directly or indirectly (i.e., under a spouse's or parent's auto policy). This Plan is secondary even if no claim is filed with the auto carrier. Accident claims filed with this Plan will not be considered pending receipt of the auto policy information. If the information is not provided within the requested period, the claim(s) will be denied. (Refer to the Claims Procedure section.)

This Plan shall always be considered the secondary carrier regardless of the individual's election under PIP (personal injury protection) coverage with the auto carrier (only available in some states).

**Benefit plan payment order.** When two or more plans provide benefits for the same Allowable Charge, benefit payment will follow these rules:

1. Plans that do not have a coordination provision, or one like it, will pay first. Plans with such a provision will be considered after those without one.
2. Plans with a coordination provision will pay their benefits up to the Allowable Charge:
   1. The benefits of the plan which covers the person directly (that is, as an employee, member or subscriber) ("Plan A") are determined before those of the plan which covers the person as a dependent ("Plan B").
   2. The benefits of a benefit plan which covers a person as an Employee who is neither laid off nor retired are determined before those of a benefit plan which covers that person as a laid-off or Retired Employee. The benefits of a benefit plan which covers a person as a Dependent of an Employee who is neither laid off nor retired are determined before those of a benefit plan which covers a person as a Dependent of a laid off or Retired Employee. If the other benefit plan does not have this rule, and if, as a result, the plans do not agree on the order of benefits, this rule does not apply.
   3. The benefits of a benefit plan which covers a person as an Employee who is neither laid off nor retired or a Dependent of an Employee who is neither laid off nor retired are determined before those of a plan which covers the person as a COBRA beneficiary.
   4. When a child is covered as a Dependent and the parents are married (whether or not living together) or are living together (whether or not they have ever been married), these rules will apply:
      1. The benefits of the benefit plan of the parent whose birthday falls earlier in a year are determined before those of the benefit plan of the parent whose birthday falls later in that year;
      2. If both parents have the same birthday, the benefits of the benefit plan which has covered the parent for the longer time are determined before those of the benefit plan which covers the other parent.
   5. When a child's parents are divorced or Legally Separated, these rules will apply:
      1. This rule applies when the parent with custody of the child has not remarried.

The benefit plan of the parent with custody will be considered before the benefit plan of the parent without custody.

* + 1. This rule applies when the parent with custody of the child has remarried. The benefit plan of the parent with custody will be considered first. The benefit plan of the stepparent that covers the child as a Dependent will be considered next. The benefit plan of the parent without custody will be considered last.
    2. This rule will be in place of items (i) and (ii) above when it applies. A court decree may state which parent is financially responsible for medical and dental benefits of the child. In this case, the benefit plan of that parent will be considered before other plans that cover the child as a Dependent.
    3. If the specific terms of the court decree state that the parents shall share joint custody, without stating that one of the parents is responsible for the health care expenses of the child, the plans covering the child shall follow the order of benefit determination rules outlined above when a child is covered as a Dependent and the parents are not separated or divorced.
    4. If there is no court decree allocating responsibility for child’s health care expenses or health coverage or for parents who were never married to each other and not living together, the rules apply as follows as long as paternity has been established:
    - The Plan of the Custodial Parent;
    - The Plan of the spouse of the Custodial Parent;
    - The Plan of the non-custodial parent; and then
    - The Plan of the spouse of the non-custodial parent.

If a court decree states that one of the parents is responsible for the Dependent Child’s health care expenses or health insurance coverage, that Plan is primary. This rule applies to Claim Determination Periods or Plan Years commencing after the Plan is given notice of the court decree.

If a court decree states that both parents are responsible for the Dependent Child’s health care expense or health insurance coverage, the provisions of subparagraph (d) of this section shall determine the order of benefits.

For the purposes of this section:

* **Custodial Parent** means the parent awarded custody by a court decree; or in the absence of a court decree, is the parent with whom the child resides more than one-half of the Calendar Year excluding any temporary visitation.
* **Claim Determination Period** means a Calendar Year. Claim Determination Period does not include any part of the Calendar Year during which a claimant has no coverage under this Plan, or before the date this COB provision or a similar provision takes effect.
  1. If there is still a conflict after these rules (a) – (e) have been applied, the benefit plan which has covered the Covered Person for the longer time will be considered first. When there is a conflict in coordination of benefit rules, the Plan will never pay more than 50% of Allowable Charges when paying secondary.
  2. This Plan will follow the adopted NAIC rules for how to coordinate benefits when a Dependent Child is covered under their own or their spouse’s insurance plan and either or both of his/her parents.

1. Medicare will pay primary, secondary or last to the extent stated in federal law. When Medicare is to be the primary payer, this Plan will base its payment upon the benefit determination by Medicare under Parts A, B and D or this Plan, if the benefit would be less. This Plan will always follow the standard Medicare Secondary Payer rules as may be revised from time to time.
2. If a Plan Participant is under a disability extension from a previous benefit plan, that benefit plan will pay first and this Plan will pay second.
3. The Plan will pay primary to Tricare and a State child health plan to the extent required by federal law.

**Claims determination period.** Benefits will be coordinated on a Calendar Year basis. This is called the claims determination period.

**Right to receive or release necessary information.** To make this provision work, this Plan may give or obtain needed information from another insurer or any other organization or person. This information may be given or obtained without the consent of or notice to any other person. A Covered Person will give this Plan the information it asks for about other plans and their payment of Allowable Charges.

**Facility of payment.** This Plan may repay other plans for benefits paid that the Plan Administrator determines it should have paid. That repayment will count as a valid payment under this Plan.

**Right of recovery.** This Plan may pay benefits that should be paid by another benefit plan. In this case this Plan may recover the amount paid from the other benefit plan or the Covered Person. That repayment will count as a valid payment under the other benefit plan.

Further, this Plan may pay benefits that are later found to be greater than the Allowable Charge. In this case, this Plan may recover the amount of the overpayment from the source to which it was paid.

**Exception to Medicaid.** In accordance with ERISA, the Plan shall not take into consideration the fact that an individual is eligible for or is provided medical assistance through Medicaid when enrolling an individual in the Plan or making a determination about the payments for benefits received by a Covered Person under the Plan.

THIRD PARTY RECOVERY PROVISION

## RIGHT OF SUBROGATION AND REFUND

**When this provision applies.** The Covered Person may incur medical or dental charges due to Injuries which may be caused by the act or omission of a Third Party or a Third Party may be responsible for payment. In such circumstances, the Covered Person may have a claim against that Third Party, or insurer, for payment of the medical or dental charges. Accepting benefits under this Plan for those incurred medical or dental expenses automatically assigns to the Plan any rights the Covered Person may have to Recover payments from any Third Party or insurer. This Subrogation right allows the Plan to pursue any claim which the Covered Person has against any Third Party, or insurer, whether or not the Covered Person chooses to pursue that claim. The Plan may make a claim directly against the Third Party or insurer, but in any event, the Plan has a Lien on any amount Recovered by the Covered Person whether or not designated as payment for medical expenses. This Lien shall remain in effect until the Plan is repaid in full.

While the Covered Person may receive payment of such claims pursuant to the terms of the Plan, the Covered Person shall be required to refund to the Plan all medical or dental expenses paid if the Covered Person Recovers from any other party.

The payment for benefits received by a Covered Person under the Plan shall be made in accordance with the assignment of rights by or on behalf of the Covered Person as required by Medicaid.

In any case in which the Plan has a legal liability to make payments for benefits received by a Covered Person, to the extent that payment has been made through Medicaid, the payment for benefits under the Plan shall be made in accordance with any state law that has provided that the state has acquired the rights of the Covered Person to the payments of those benefits.

**Payment Prior to Determination of Responsibility of a Third Party**

The Plan does not cover nor is it liable for any expenses for services or supplies incurred by a Covered Person for which a third party is required to pay because of the negligence or other tortuous or wrongful act of that third party.

However, subject to the terms and conditions of this Section, the Plan may advance payment after receipt of a properly executed reimbursement agreement and consent to lien, and pay claims in accordance with the Plan of Benefits, until it is determined whether or not a third party is required to pay for those services or supplies.

By accepting an advance of benefits paid by the Plan the Covered Person jointly and severally agrees that:

1. the Plan has a priority lien against the proceeds of any such settlement, judgment, arbitration, or recovery to assure that reimbursement is promptly made; and
2. the Plan will be subrogated to every Covered Person’s right of recovery from that third party or that third party’s insurer to the extent of the Plan’s advances any benefit payments; and
3. the Covered Person(s) will, jointly and severally, reimburse the Plan out of any and all amounts paid or payable to any or all of them by any third party or that third party’s insurer to the extent of the entire amount advanced for related claims to the accident or injury by the Plan.

The Plan’s reimbursement and/or subrogation rights will include all claims, demands, actions and rights of recovery of all Covered Persons against any third party or insurer, including any Workers’ Compensation insurer or governmental agency, and will apply to the extent of any and all advance payments made or to be made by the Plan. This means that the Covered Person recognizes the Plan’s rights to 100%, first dollar priority over any and all Recoveries and/or funds paid by a Third Party to a Covered Person relative to the Injury or Sickness, whether by judgment, settlement, arbitration award or otherwise and shall not be limited by any other characterization of the nature or purpose of the amounts recovered or by the identity of the party from which recovery is obtained. This priority is over any claims, including medical, non- medical or dental charges, attorney fees, or other costs and expenses associated with the enforcement of the Plan’s rights under this Right of Recovery/Subrogation benefit.

The Plan shall be Subrogated, and shall be entitled to Reimbursement, for any payment by a Third Party to a Covered Person for future medical expenses paid pursuant to a judgment, settlement or contract on the following bases:

1. If any amount is awarded by means of a verdict after a full and complete trial and the judgment or verdict form itemizes by separate finding or special amount awarded for future medical expenses, such amount shall be binding on the Plan and the Covered Person as the amount of future medical expenses to which the Plan is subrogated and entitled to reimbursement.
2. If there exists any contract or policy of insurance by which future medical expenses are paid (other than a policy or contract of health care, hospitalization or disability insurance issued to and in the name of such Covered Person), the Plan shall be subrogated to and entitled to reimbursement and deemed secondary or excess insurance to such contract or policy and amounts paid thereby.
3. If any amount is paid to a Covered Person by means of a settlement or general judgment or verdict which does not itemize components of damage, the Plan Administrator and the Covered Person shall agree on the amount which is attributable to future medical and dental expenses. In the event that the Plan Administrator and the Covered Person cannot agree on the amount attributable to future medical expenses, the Plan Administrator, in its sole and absolute discretion, shall determine the amount attributable to future medical expenses

If any amount awarded under subsection (1), the total amount of future medical expenses to which the Plan is Subrogated and entitled to reimbursement shall be reduced by and, in determining the amount to which the Plan is Subrogated and entitled to reimbursement under subsection (3), consideration may be given to:

* 1. the amount of proportionate or comparative fault assessed against the Covered Person which reduces the amount of total future medical expenses which are paid by the other;
  2. the amount not collectible.

In addition, in determining the amount of future medical expenses paid under subsection (3) above, consideration shall be given to the percentage of total future medical expenses paid by the one who is jointly liable with another, the other remaining liable, any discount for present value of future expenses and any discount for possibilities of incurring the claimed future medical expenses.

When any amount is paid or payable pursuant to Subsections (1), (2) or (3) above, the Covered Person shall pay all medical expenses incurred in the future for treatment of the injuries sustained for which the payments under (1), (2) or (3) were made or agreed to be made, and the Plan shall have no responsibility or liability to pay any such future medical expenses, nor shall the amount of any such payment be considered to represent a Covered Expense incurred under this Plan for purposes of satisfying any of the provisions of this Plan with respect to the Deductible or co-payment requirements, until the amount under subsection (1), (2) or (3) is fully used.

The Plan may, at its discretion, start any legal action or administrative proceeding it deems necessary to protect its right to recover any amount it advanced in accordance with the Plan of Benefits, and may try or settle any such action or proceeding in the name of and with the full cooperation of the Covered Persons.

However, in doing so, the Plan will not represent, or provide legal representation for, any covered individual with respect to that Covered Person’s damages to the extent those damages exceed any advance on account of the Plan of Benefits.

The Plan may, at its discretion, intervene in any claim, legal action, or administrative proceeding started by any Covered Person against any third party or that third party’s insurer on account of any alleged negligent, intentional or otherwise wrongful action that may have caused or contributed to the Covered Person’s injury or illness that resulted in the advance by the Plan.

**Reimbursement and/or Subrogation Agreement**

The Covered Person (or his/her representative in the case of minor child(ren) or an incapacitated Covered Person), recognizes that compliance with this section of the Plan is a condition of participating in and having payments made under this Plan, and that as such the Covered Person agrees to the provisions of this section.

The Plan’s standard administrative procedure will be to ascertain the nature of any injury to determine whether a third party could be held liable. Claims will not be paid until this determination is made. If it is determined that the claim may be the result of a third party’s negligence, the Plan will not process any claims without a properly signed Reimbursement Agreement and Consent to Lien.

Every Covered Person on whose behalf an advance may be payable must execute and deliver any and all agreements, instruments and papers requested by or on behalf of the Plan (including but not limited to the reimbursement agreement and consent to lien), and must do whatever is necessary to protect the Plan in obtaining reimbursement and/or subrogation rights. As a condition precedent to the advance payment of related claims by the Plan, all Covered Persons will, upon written request, execute a Reimbursement Agreement or Consent to Lien in a form provided by or on behalf of the Plan.

If any Covered Person does not execute any such Reimbursement Agreement or Consent to Lien for any reason, it will not waive, compromise, diminish, release, or otherwise prejudice any of the Plan reimbursement and/or subrogation rights if the Plan, at its discretion, makes an advance and inadvertently pays benefits in the absence of a reimbursement and/or subrogation agreement.

**Cooperation with the Plan by All Covered Persons**

By accepting an advance for related claim payment, every Covered Person agrees to do nothing that will waive, compromise, diminish, release or otherwise prejudice the Plan’s Reimbursement and/or Subrogation rights.

By accepting an advance payment for related claims to an injury, every Covered Person agrees to notify and consult with the Plan Administrator or its designee before:

1. starting any legal action or administrative proceeding against a third party based on any alleged negligent, intentional or otherwise wrongful action that may have caused or contributed to the Covered Person’s injury that resulted in the Plan advance payment of claims; or
2. entering into any settlement agreement with that third party or that third party’s insurer that may be related to any actions by that third party that may have caused or contributed to the Covered Person’s injury that resulted in the Plan’s advance for claims related to such injury.

By accepting an advance in claim payments, every Covered Person agrees to keep the Plan Administrator and Claims Supervisor informed of all material developments with respect to all such claims, actions or proceedings.

**All Recovered Proceeds Are to Be Applied to Reimbursement of the Plan.** The Covered Person agrees to automatically assign his/her rights against any Third Party or insurer when this provision applies. Accepting benefits under this Plan for those incurred medical or dental expenses automatically assigns to the Plan any and all rights the Covered Person may have to recover payments from any Responsible Third Party. Further, accepting benefits under this Plan for those incurred medical or dental expenses automatically assigns to the Plan the Covered’ Person’s Third Party Claims.

By accepting an advance payment of claims for an injury, every Covered Person agrees to reimburse Plan for all such advances by applying **any and all** amounts paid or payable to them by any third party or that third party’s insurer by way of settlement or in satisfaction of any judgment or agreement, regardless of whether those proceeds are characterized in the settlement or judgment as being paid on account of the medical expenses for which any advance has been made by the Plan. In such event the Plan must be fully reimbursed within 31 days, or the claimant will have additional liability for interest and all costs of collection, including reasonable attorney’s fees.

If the Covered Person fails to take action against a responsible Third Party to recover damages within one

1. year or within thirty (30) days of a request by the Plan, the Plan shall be deemed to have acquired, by assignment or Subrogation, a portion of the Covered Person’s claim equal to its prior payments. The Plan may thereafter commence proceedings directly against any responsible Third Party. The Plan shall not be deemed to waive its rights to commence action against a Third Party if it fails to act after the expiration of one (1) year, nor shall the Plan’s failure to act be deemed a waiver or discharge of the Lien described in this section.

The Plan reserves the right to be reimbursed for its court costs and attorneys’ fees if the Plan needs to file suit in order to Recover payment for medical or dental expenses from the Covered Person.

Also, The Plan’s right to Subrogation and reimbursement still applies if the Recovery received by the Covered Person is less than the claimed damage, and as a result, the claimant is not made whole.

If any Covered Person fails to reimburse the Plan as required by this section, the Plan may deny payment of claims and treat prior paid claims (related to the accident/injury) as overpayments recoverable by offset against any and all future claims for benefits that may become payable on behalf of all Covered Persons within the injured Covered Person’s immediate family to the amount not reimbursed.

Once the claim is settled, the Plan will not pay future benefits for claims related to that Injury or accident unless it is determined by the Plan Administrator or Claims Supervisor that the original settlement was reasonable and the subsequent claims were not recognized in the settlement.

The Plan shall have no obligation whatsoever to pay medical or dental benefits incurred by a Covered Person if a Covered Person refuses to cooperate with the Plan’s Reimbursement and/or Subrogation rights or refuses to execute and deliver such papers as the Plan may require in furtherance of its Reimbursement and Subrogation rights.

**No Fault Insurance Coverage**

If you are required to have No-Fault insurance coverage, the automobile No-Fault Insurance carrier will initially be liable for lost wages, medical, surgical, hospital, and related charges and expenses up to the greater of:

the maximum amount of basic reparation benefit required by applicable law: or the maximum amount of the applicable No-Fault Insurance coverage in effect.

The Plan will, thereafter, consider any excess charges and expenses under the applicable provisions of the respective Plan in which you are provided health coverage. Before related claims will be paid through this Plan, the Covered Person or his dependent will be required to sign a Reimbursement Agreement.

If the Participant or his dependent fails to secure No-Fault Insurance as required by state law, the Participant or dependent is considered as being self-insured and must pay the amount of the basic medical reparation expenses for himself and/or his dependents arising out of the accident.

**Refund of Overpayment of Benefits - Right of Recovery**

If the Plan pays benefits for expenses incurred on account of you or your Eligible Dependent, you or any other person or organization that was paid must make a refund to the Plan if:

* 1. all or some of the expenses were not paid, or did not legally have to be paid by you or your Eligible Dependents.
  2. all or some of the payment made by the Plan exceeds the benefits under the Plan.
  3. all or some of the expenses were recovered from or paid by a source other than this Plan including another Plan to which this Plan has secondary liability under the Coordination of Benefits provisions.

This may include payments made as a result of claims against a third party for negligence, wrongful acts or omissions. The refund shall equal the amount the Plan paid in excess of the amount it should have paid under the Plan. In the case of recovery from or payment by a source other than this Plan, the refund equals the amount of the recovery or payment up to the amount the Plan paid.

If you or any person or organization that was paid does not promptly refund the full amount, the Plan may reduce the amount of any future benefits that are payable under the Plan. The reductions will equal the amount of the required refund. The Plan may have other rights in addition to the right to reduce future benefits.

## RIGHT OF RECOVERY

**Recovery from another plan under which the Covered Person is covered.** This right of Subrogation and reimbursement also applies apply when a Covered Person Recovers under an uninsured or underinsured motorist plan (which will be treated as Third Party coverage when reimbursement or Subrogation is in order), homeowner’s plan, renter’s plan, medical malpractice plan or any liability or insurance plan.

If the Covered Person’s total Recovery from all sources does not adequately reimburse him for his expenses and injuries, the Plan Administrator, in its sole and absolute discretion, may accept a lesser amount in full satisfaction of its rights. The Plan Administrator shall have sole authority to determine whether a Covered Person has been adequately reimbursed and whether to accept a lesser amount.

**Waiver of Subrogation Rights.** The Plan Administrator, in its sole and absolute discretion, may agree to waive the Plan’s Subrogation rights. Such waiver shall not automatically occur in any matter. Waivers of the Subrogation and reimbursement interest of the Plan may be granted when the expected administrative costs exceed the expected reimbursement or savings to the Plan. Waivers of Subrogation and reimbursement interests will generally not be granted if the past medical expenses are greater than $500 or if the total judgment or settlement exceeds $5,000.

**Conflict Within the Plan.** If any portion of this Section on Subrogation and reimbursement is deemed to conflict with any other provision of the Plan on coordination of benefits of primary-secondary insurance coverage, the other portion of the Plan shall control and the provisions of this section shall supplement such other provisions to the extent that they are not inconsistent.

**Rights of Plan Administrator.** The Plan Administrator has a right to request reports on any and all approved settlements.

**Conditions Precedent to Coverage.** The Plan shall have no obligation whatsoever to pay medical or dental benefits to a Covered Person if a Covered Person refuses to cooperate with the Plan's reimbursement and Subrogation rights or refuses to execute and deliver such papers as the Plan may require in furtherance of its reimbursement and Subrogation rights. Further, in the event the Covered Person is a minor, the Plan shall have no obligation to pay any medical or dental benefits incurred on account of Injury or Sickness caused by a responsible Third Party until after the Covered Person or his authorized legal representative obtains valid court recognition and approval of the Plan's 100%, first dollar reimbursement and Subrogation rights on all Recoveries, as well as approval for the execution of any papers necessary for the enforcement thereof, as described herein.

**Defined terms:**

"Covered Person" means anyone covered under the Plan, including minor dependents.

“Lien” is a right created by law to obtain Reimbursement from monies paid by a Third Party in compensation for a loss. This means the Plan retains the right to repayment for the value of all benefits provided by the Plan that are associated with the Injury or Illness for which the Third Party is or may be responsible, plus the costs to perfect the Lien. To prevent a double Recovery on the payment of medical expenses, a Lien is created in favor of this Plan in providing payment of medical expenses for the injured Covered Person.

"Recover," "Recovered," "Recovery" or "Recoveries" means all monies paid to the Covered Person by way of judgment, settlement, or otherwise to compensate for all losses caused by the Injury or Sickness, whether or not said losses reflect medical or dental charges covered by the Plan. "Recoveries" further includes, but is not limited to, recoveries for medical or dental expenses, attorneys' fees, costs and expenses, pain and suffering, loss of consortium, wrongful death, lost wages and any other recovery of any form of damages or compensation whatsoever.

"Refund" means repayment to the Plan for medical or dental benefits that it has paid toward care and treatment of the Injury or Sickness.

"Reimbursement" means that the Plan has a right to be paid a Recovery received by the participant or to the extent not contrary to law, to offset all or any part of the Plan's Recovery against any amount the Plan or the Employer owes to the Covered Person or owes as benefits for the Covered Person.

"Subrogation" means the right of the Plan to be substituted in place of any Covered Person with respect to that Covered Person’s lawful claim, demand, or right of action against a third party who may have wrongfully caused the Covered Person’s injury or illness that resulted in a payment of benefits by the Plan.

"Third Party" means any Third Party including another person or a business entity.

# CONTINUATION COVERAGE RIGHTS UNDER COBRA

Under federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA), certain Employees and their families covered under The Larson Group/Larson Farm & Lawn Employee Health Care Plan (the Plan) will be entitled to the opportunity to elect a temporary extension of health coverage (called "COBRA continuation coverage") where coverage under the Plan would otherwise end. This notice is intended to inform Plan Participants and beneficiaries, in summary fashion, of their rights and obligations under the continuation coverage provisions of COBRA, as amended and reflected in final and proposed regulations published by the Department of the Treasury. This notice is intended to reflect the law and does not grant or take away any rights under the law.

Complete instructions on COBRA, as well as election forms and other information, will be provided by the COBRA Administrator to Plan Participants who become Qualified Beneficiaries under COBRA. (Refer to General Plan Information section for contact information.)

**What is COBRA continuation coverage?** COBRA continuation coverage is the temporary extension of group health plan coverage that must be offered to certain Plan Participants and their eligible family members (called "Qualified Beneficiaries") at group rates. The right to COBRA continuation coverage is triggered by the occurrence of a life event that results in the loss of coverage under the terms of the Plan (the "Qualifying Event"). The coverage must be identical to the Plan coverage that the Qualified Beneficiary had immediately before the Qualifying Event, or if the coverage has been changed, the coverage must be identical to the coverage provided to similarly situated active employees who have not experienced a Qualifying Event (in other words, similarly situated non-COBRA beneficiaries).

**Who can become a Qualified Beneficiary?** In general, a Qualified Beneficiary can be:

1. Any individual who, on the day before a Qualifying Event, is covered under a Plan by virtue of being on that day either a covered Employee, the Spouse of a covered Employee, or a Dependent child of a covered Employee. If, however, an individual who otherwise qualifies as a Qualified Beneficiary is denied or not offered coverage under the Plan under circumstances in which the denial or failure to offer constitutes a violation of applicable law, then the individual will be considered to have had the Plan coverage and will be considered a Qualified Beneficiary if that individual experiences a Qualifying Event.
2. Any child who is born to or placed for adoption with a covered Employee during a period of COBRA continuation coverage, and any individual who is covered by the Plan as an alternate recipient under a qualified medical support order. If, however, an individual who otherwise qualifies as a Qualified Beneficiary is denied or not offered coverage under the Plan under circumstances in which the denial or failure to offer constitutes a violation of applicable law, then the individual will be considered to have had the Plan coverage and will be considered a Qualified Beneficiary if that individual experiences a Qualifying Event.

The term "covered Employee" includes any individual who is provided coverage under the Plan due to his or her performance of services for the employer sponsoring the Plan (e.g., common-law employees (full or part-time), self-employed individuals, independent contractor, or corporate director). However, this provision does not establish eligibility of these individuals. Eligibility for Plan Coverage shall be determined in accordance with Plan Eligibility provisions.

An individual is not a Qualified Beneficiary if the individual's status as a covered Employee is attributable to a period in which the individual was a nonresident alien who received from the individual's Employer no earned income that constituted income from sources within the United States. If, on account of the preceding reason, an individual is not a Qualified Beneficiary, then a Spouse or Dependent child of the individual will also not be considered a Qualified Beneficiary by virtue of the relationship to the individual. A domestic partner is not a Qualified Beneficiary.

Each Qualified Beneficiary (including a child who is born to or placed for adoption with a covered Employee during a period of COBRA continuation coverage) must be offered the opportunity to make an independent election to receive COBRA continuation coverage.

**What is a Qualifying Event?** A Qualifying Event is any of the following if the Plan provided that the Plan participant would lose coverage (i.e.: cease to be covered under the same terms and conditions as in effect immediately before the Qualifying Event) in the absence of COBRA continuation coverage:

1. The death of a covered Employee.
2. The termination (other than by reason of the Employee's gross misconduct), or reduction of hours, of a covered Employee's employment.
3. The divorce or legal separation of a covered Employee from the Employee's Spouse. If the Employee reduces or eliminates the Employee's Spouse's Plan coverage in anticipation of a divorce or legal separation, and a divorce or legal separation later occurs, then the divorce or legal separation may be considered a Qualifying Event even though the Spouse's coverage was reduced or eliminated before the divorce or legal separation.
4. A covered Employee's enrollment in any part of the Medicare program.
5. A Dependent child's ceasing to satisfy the Plan's requirements for a Dependent child (for example, attainment of the maximum age for dependency under the Plan).

If the Qualifying Event causes the covered Employee, or the covered Spouse or a Dependent child of the covered Employee, to cease to be covered under the Plan under the same terms and conditions as in effect immediately before the Qualifying Event, the persons losing such coverage become Qualified Beneficiaries under COBRA if all the other conditions of COBRA are also met. For example, any increase in contribution that must be paid by a covered Employee, or the Spouse, or a Dependent child of the covered Employee, for coverage under the Plan that results from the occurrence of one of the events listed above is a loss of coverage.

The taking of leave under the Family and Medical Leave Act of 1993 ("FMLA") does not constitute a Qualifying Event. A Qualifying Event will occur, however, if an Employee does not return to employment at the end of the FMLA leave and all other COBRA continuation coverage conditions are present. If a Qualifying Event occurs, it occurs on the last day of FMLA leave and the applicable maximum coverage period is measured from this date (unless coverage is lost at a later date and the Plan provides for the extension of the required periods, in which case the maximum coverage date is measured from the date when the coverage is lost.) Note that the covered Employee and family members will be entitled to COBRA continuation coverage even if they failed to pay the employee portion of premiums for coverage under the Plan during the FMLA leave.

**What factors should be considered when determining to elect COBRA continuation coverage?** You should take into account that a failure to continue your group health coverage will affect your rights under federal law. First, you can lose the right to avoid having pre-existing condition exclusions applied by other group health plans if there is more than a 63-day gap in health coverage and election of COBRA continuation coverage may help you avoid such a gap. Second, if you do not elect COBRA continuation coverage and pay the appropriate premiums for the maximum time available to you, you will lose the right to convert to an individual health insurance policy, which does not impose such pre-existing condition exclusions. Finally, you should take into account that you have special enrollment rights under federal law (HIPAA). You have the right to request special enrollment in another group health plan for which you are otherwise eligible (such as a plan sponsored by your Spouse's employer) within 30 days after Plan coverage ends due to a Qualifying Event listed above. You will also have the same special right at the end of COBRA continuation coverage if you get COBRA continuation coverage for the maximum time available to you.

**What is the procedure for obtaining COBRA continuation coverage?** The Plan has conditioned the availability of COBRA continuation coverage upon the timely election of such coverage. An election is timely if it is made during the election period.

**What is the election period and how long must it last?** The election period is the time period within which the Qualified Beneficiary must elect COBRA continuation coverage under the Plan. The election period must begin no later than the date the Qualified Beneficiary would lose coverage on account of the Qualifying Event and ends 60 days after the later of the date the Qualified Beneficiary would lose coverage on account of the Qualifying Event or the date notice is provided to the Qualified Beneficiary of her or his right to elect COBRA continuation coverage. If coverage is not elected within the 60 day period, all rights to elect COBRA continuation coverage are forfeited.

Note: If a covered employee who has been terminated or experienced a reduction of hours qualifies for a trade readjustment allowance or alternative trade adjustment assistance under a federal law called the Trade Act of 2002, and the employee and his or her covered dependents have not elected COBRA coverage within the normal election period, a second opportunity to elect COBRA coverage will be made available for themselves and certain family members, but only within a limited period of 60 days or less and only during the six months immediately after their group health plan coverage ended. Any person who qualifies or thinks that he and/or his family members may qualify for assistance under this special provision should contact the Plan Administrator for further information.

The Trade Act of 2002 also created a tax credit for certain TAA-eligible individuals and for certain retired employees who are receiving pension payments from the Pension Benefit Guaranty Corporation (PBGC) (eligible individuals). Under the new tax provisions, eligible individuals can either take a tax credit or get advance payment of 65% of premiums paid for qualified health insurance, including continuation coverage. Recent changes in the law increased this assistance temporarily to 80%, and temporarily extended the period of COBRA continuation coverage for eligible individuals. If you have questions about these new tax provisions, you may call the Health Coverage Tax Credit Consumer Contact Center toll-free at 1-866-628- 4282. TTD/TTY callers may call toll-free at 1-866-626-4282. More information about the Trade Act is also available at [www.doleta.gov/tradeact.](http://www.doleta.gov/tradeact)

**Is a covered Employee or Qualified Beneficiary responsible for informing the Plan Administrator of the occurrence of a Qualifying Event?** The Plan will offer COBRA continuation coverage to Qualified Beneficiaries only after the Plan Administrator or its designee has been timely notified that a Qualifying Event has occurred. The employer (if the employer is not the Plan Administrator) will notify the Plan Administrator of the Qualifying Event within 30 days following the date coverage ends when the Qualifying Event is:

1. the end of employment or reduction of hours of employment,
2. death of the employee,
3. commencement of a proceeding in bankruptcy with respect to the employer, or
4. enrollment of the employee in any part of Medicare.

**IMPORTANT:**

**For the other Qualifying Events (divorce or legal separation of the employee and spouse or a dependent child's losing eligibility for coverage as a dependent child), you or someone on your behalf must notify the Plan Administrator or its designee in writing within 60 days after the Qualifying Event occurs, using the procedures specified below. If these procedures are not followed or if the notice is not provided in writing to the Plan Administrator or its designee during the 60-day notice period, any spouse or dependent child who loses coverage will not be offered the option to elect continuation coverage. You must send this notice to the Plan Sponsor.**

**NOTICE PROCEDURES:**

Any notice that you provide must be ***in writing***. Oral notice, including notice by telephone, is not acceptable. You must mail, fax or hand-deliver your notice to the Plan Administrator.

If mailed, your notice must be postmarked no later than the last day of the required notice period. Any notice you provide must state:

* the **name of the plan or plans** under which you lost or are losing coverage,
* the **name and address of the employee** covered under the plan,
* the **name(s) and address(es) of the Qualified Beneficiary(ies)**, and
* the **Qualifying Event** and the **date** it happened.

If the Qualifying Event is a **divorce or legal separation**, your notice must include **a copy of the divorce decree or the legal separation agreement**.

Be aware that there are other notice requirements in other contexts, for example, in order to qualify for a disability extension.

Once the Plan Administrator or its designee receives *timely notice* that a Qualifying Event has occurred, COBRA continuation coverage will be offered to each of the qualified beneficiaries. Each Qualified Beneficiary will have an independent right to elect COBRA continuation coverage. Covered employees may elect COBRA continuation coverage for their spouses, and parents may elect COBRA continuation coverage on behalf of their children. For each Qualified Beneficiary who elects COBRA continuation coverage, COBRA continuation coverage will begin on the date that plan coverage would otherwise have been lost. If you or your spouse or dependent children do not elect continuation coverage within the 60- day election period described above, the right to elect continuation coverage will be lost.

**Is a waiver before the end of the election period effective to end a Qualified Beneficiary's election rights?** If, during the election period, a Qualified Beneficiary waives COBRA continuation coverage, the waiver can be revoked at any time before the end of the election period. Revocation of the waiver is an election of COBRA continuation coverage. However, if a waiver is later revoked, coverage need not be provided retroactively (that is, from the date of the loss of coverage until the waiver is revoked). Waivers and revocations of waivers are considered made on the date they are sent to the Plan Administrator or its designee, as applicable.

**Is COBRA coverage available if a Qualified Beneficiary has other group health plan coverage or Medicare?** Qualified beneficiaries who are entitled to elect COBRA continuation coverage may do so even if they are covered under another group health plan or are entitled to Medicare benefits on or before the date on which COBRA is elected. However, a Qualified Beneficiary's COBRA coverage will terminate automatically if, after electing COBRA, he or she becomes entitled to Medicare or becomes covered under other group health plan coverage (but only after any applicable preexisting condition exclusions of that other plan have been exhausted or satisfied).

**When may a Qualified Beneficiary's COBRA continuation coverage be terminated?** During the election period, a Qualified Beneficiary may waive COBRA continuation coverage. Except for an interruption of coverage in connection with a waiver, COBRA continuation coverage that has been elected for a Qualified Beneficiary must extend for at least the period beginning on the date of the Qualifying Event and ending not before the earliest of the following dates:

1. The last day of the applicable maximum coverage period.
2. The first day for which Timely Payment is not made to the Plan with respect to the Qualified Beneficiary.
3. The date upon which the Employer ceases to provide any group health plan (including a successor plan) to any employee.
4. The date, after the date of the election, that the Qualified Beneficiary first becomes covered under any other Plan that does not contain any exclusion or limitation with respect to any pre-existing condition, other than such an exclusion or limitation that does not apply to, or is satisfied by, the Qualified Beneficiary.
5. The date, after the date of the election, that the Qualified Beneficiary first enrolls in the Medicare program (either part A or part B, whichever occurs earlier).
6. In the case of a Qualified Beneficiary entitled to a disability extension, the later of:
   1. (i) 29 months after the date of the Qualifying Event, or (ii) the first day of the month that is more than 30 days after the date of a final determination under Title II or XVI of the Social Security Act that the disabled Qualified Beneficiary whose disability resulted in the Qualified Beneficiary's entitlement to the disability extension is no longer disabled, whichever is earlier; or
   2. the end of the maximum coverage period that applies to the Qualified Beneficiary without regard to the disability extension.

The Plan can terminate for cause the coverage of a Qualified Beneficiary on the same basis that the Plan terminates for cause the coverage of similarly situated non-COBRA beneficiaries, for example, for the submission of a fraudulent claim.

In the case of an individual who is not a Qualified Beneficiary and who is receiving coverage under the Plan solely because of the individual's relationship to a Qualified Beneficiary, if the Plan's obligation to make COBRA continuation coverage available to the Qualified Beneficiary ceases, the Plan is not obligated to make coverage available to the individual who is not a Qualified Beneficiary.

**What are the maximum coverage periods for COBRA continuation coverage?** The maximum coverage periods are based on the type of the Qualifying Event and the status of the Qualified Beneficiary, as shown below:

1. In the case of a Qualifying Event that is a termination of employment or reduction of hours of employment, the maximum coverage period ends 18 months after the Qualifying Event if there is not a disability extension and 29 months after the Qualifying Event if there is a disability extension.
2. In the case of a covered Employee's enrollment in the Medicare program before experiencing a Qualifying Event that is a termination of employment or reduction of hours of employment, the maximum coverage period for Qualified Beneficiaries other than the covered Employee ends on the later of:
   1. 36 months after the date the covered Employee becomes enrolled in the Medicare program; or
   2. 18 months (or 29 months, if there is a disability extension) after the date of the covered Employee's termination of employment or reduction of hours of employment.
3. In the case of a Qualified Beneficiary who is a child born to or placed for adoption with a covered Employee during a period of COBRA continuation coverage, the maximum coverage period is the maximum coverage period applicable to the Qualifying Event giving rise to the period of COBRA continuation coverage during which the child was born or placed for adoption.
4. In the case of any other Qualifying Event than that described above, the maximum coverage period ends 36 months after the Qualifying Event.

**Under what circumstances can the maximum coverage period be expanded?** If a Qualifying Event that gives rise to an 18-month or 29-month maximum coverage period is followed, within that 18- or 29-month period, by a second Qualifying Event that gives rise to a 36-months maximum coverage period, the original period is expanded to 36 months, but only for individuals who are Qualified Beneficiaries at the time of and with respect to both Qualifying Events. In no circumstance can the COBRA maximum coverage period be expanded to more than 36 months after the date of the first Qualifying Event. The Plan Administrator must be notified of the second Qualifying Event within 60 days of the second Qualifying Event. This notice must be sent to the COBRA Administrator in accordance with the procedures above.

**How does a Qualified Beneficiary become entitled to a disability extension?** A disability extension will be granted if an individual (whether or not the covered Employee) who is a Qualified Beneficiary in connection with the Qualifying Event that is a termination or reduction of hours of a covered Employee's employment, is determined under Title II or XVI of the Social Security Act to have been disabled at any time during the first 60 days of COBRA continuation coverage. To qualify for the disability extension, the Qualified Beneficiary must also provide the Plan Administrator with notice of the disability determination on a date that is both within 60 days after the date of the determination and before the end of the original 18-month maximum coverage. This notice should be sent to the COBRA Administrator in accordance with the procedures above.

**Does the Plan require payment for COBRA continuation coverage?** For any period of COBRA continuation coverage under the Plan, qualified beneficiaries who elect COBRA continuation coverage must pay for COBRA continuation coverage. Qualified beneficiaries will pay up to 102% of the applicable premium and up to 150% of the applicable premium for any expanded period of COBRA continuation coverage covering a disabled Qualified Beneficiary due to a disability extension. The Plan will terminate a Qualified Beneficiary's COBRA continuation coverage as of the first day of any period for which timely payment is not made.

**Must the Plan allow payment for COBRA continuation coverage to be made in monthly installments?** Yes. The Plan is also permitted to allow for payment at other intervals.

**What is Timely Payment for payment for COBRA continuation coverage?** Timely Payment means a payment made no later than 30 days after the first day of the coverage period. Payment that is made to the Plan by a later date is also considered Timely Payment if either under the terms of the Plan, covered employees or Qualified Beneficiaries are allowed until that later date to pay for their coverage for the period or under the terms of an arrangement between the Employer and the entity that provides Plan benefits on the Employer's behalf, the Employer is allowed until that later date to pay for coverage of similarly situated non-COBRA beneficiaries for the period.

Notwithstanding the above paragraph, the Plan does not require payment for any period of COBRA continuation coverage for a Qualified Beneficiary earlier than 45 days after the date on which the election of COBRA continuation coverage is made for that Qualified Beneficiary. Payment is considered made on the date on which it is postmarked to the Plan.

If Timely Payment is made to the Plan in an amount that is not significantly less than the amount the Plan requires to be paid for a period of coverage, then the amount paid will be deemed to satisfy the Plan's

requirement for the amount to be paid, unless the Plan notifies the Qualified Beneficiary of the amount of the deficiency and grants a reasonable period of time for payment of the deficiency to be made. A "reasonable period of time" is 30 days after the notice is provided. A shortfall in a Timely Payment is not significant if it is no greater than the lesser of $50 or 10% of the required amount.

**IF YOU HAVE QUESTIONS**

If you have questions about your COBRA continuation coverage, you should contact the COBRA Administrator. For more information about your rights under ERISA, including COBRA, the Health Insurance Portability and Accountability Act (HIPAA), and other laws affecting group health plans, contact the nearest Regional or District Office of the U.S. Department of Labor's Employee Benefits Security Administration (EBSA). Addresses and phone numbers of Regional and District EBSA Offices are available through EBSA's website at [www.dol.gov/ebsa.](http://www.dol.gov/ebsa)

**KEEP YOUR PLAN ADMINISTRATOR INFORMED OF ADDRESS CHANGES**

In order to protect your family's rights, you should keep the Plan Administrator informed of any changes in the addresses of family members. You should also keep a copy, for your records, of any notices you send to the Plan Administrator.

# RESPONSIBILITIES FOR PLAN ADMINISTRATION

**PLAN ADMINISTRATOR.** Integrity Home Care Employee Major Medical Health Care Plan is the benefit plan of Integrity Home Care, the Plan Administrator, also called the Plan Sponsor. It is to be administered by the Plan Administrator in accordance with the provisions of ERISA. An individual or committee may be appointed by Integrity Home Care to be Plan Administrator and serve at the convenience of the Employer. If the Plan Administrator or a committee member resigns, dies or is otherwise removed from the position, Integrity Home Care shall appoint a new Plan Administrator as soon as reasonably possible.

The Plan Administrator shall administer this Plan in accordance with its terms and establish its policies, interpretations, practices, and procedures. It is the express intent of this Plan that the Plan Administrator shall have maximum legal discretionary authority to construe and interpret the terms and provisions of the Plan, to make determinations regarding issues which relate to eligibility for benefits, to decide disputes which may arise relative to a Plan Participant's rights, and to decide questions of Plan interpretation and those of fact relating to the Plan. The decisions of the Plan Administrator will be final and binding on all interested parties.

Service of legal process may be made upon the Plan Administrator.

**DUTIES OF THE PLAN ADMINISTRATOR.**

1. To administer the Plan in accordance with its terms.
2. To interpret the Plan, including the right to remedy possible ambiguities, inconsistencies or omissions.
3. To decide disputes which may arise relative to a Plan Participant's rights.
4. To prescribe procedures for filing a claim for benefits and to review claim denials.
5. To keep and maintain the Plan documents and all other records pertaining to the Plan.
6. To appoint a Claims Supervisor to pay claims.
7. To perform all necessary reporting as required by ERISA.
8. To establish and communicate procedures to determine whether a medical child support order is qualified under ERISA Sec. 609.
9. To delegate to any person or entity such powers, duties and responsibilities as it deems appropriate.
10. To maintain the Plan in accordance with all applicable State and Federal laws. If this Plan has not been amended according to a required change, the administration of the Plan will comply with the change until such time that the Plan is amended.

**PLAN ADMINISTRATOR COMPENSATION.** The Plan Administrator serves **without** compensation; however, all expenses for plan administration, including compensation for hired services, will be paid by the Plan.

**FIDUCIARY.** A fiduciary exercises discretionary authority or control over management of the Plan or the disposition of its assets, renders investment advice to the Plan or has discretionary authority or responsibility in the administration of the Plan.

**FIDUCIARY DUTIES.** A fiduciary must carry out his or her duties and responsibilities for the purpose of providing benefits to the Employees and their Dependent(s), and defraying reasonable expenses of administering the Plan. These are duties which must be carried out:

1. with care, skill, prudence and diligence under the given circumstances that a prudent person, acting in a like capacity and familiar with such matters, would use in a similar situation;
2. by diversifying the investments of the Plan so as to minimize the risk of large losses, unless under the circumstances it is clearly prudent not to do so; and
3. in accordance with the Plan documents to the extent that they agree with ERISA.

**THE NAMED FIDUCIARY.** A "named fiduciary" is the one named in the Plan. A named fiduciary can appoint others to carry out fiduciary responsibilities (other than as a trustee) under the Plan. These other persons become fiduciaries themselves and are responsible for their acts under the Plan. To the extent

that the named fiduciary allocates its responsibility to other persons, the named fiduciary shall not be liable for any act or omission of such person unless either:

1. the named fiduciary has violated its stated duties under ERISA in appointing the fiduciary, establishing the procedures to appoint the fiduciary or continuing either the appointment or the procedures; or
2. the named fiduciary breached its fiduciary responsibility under Section 405(a) of ERISA.

**CLAIMS SUPERVISOR IS NOT A FIDUCIARY.** A Claims Supervisor is **not** a fiduciary under the Plan by virtue of paying claims in accordance with the Plan's rules as established by the Plan Administrator.

**DELAY OF DUTIES OF PLAN ADMINISTRATOR OR CLAIMS SUPERVISOR DUE TO FORCE**

**MAJEURE.** Force Majeure is a circumstance not within a person’s control, including but not limited to: fire, flood, war, civil disturbance/riot, court order, strike, partial or complete destruction of facilities, etc. No suit or action in law or equity may be taken against them on account of any of these events. The Plan Administrator and Claims Supervisor will have no liability or obligation if their respective services are delayed or not provided; or if medical care is delayed, not provided, or covered as non-network care due to Force Majeure. The Plan Administrator and Claims Supervisor will, however, make a good-faith effort to provide services during and subsequent to any of these events.

**COMPLIANCE WITH HIPAA PRIVACY STANDARDS.** Certain members of the Employer's workforce perform services in connection with administration of the Plan. In order to perform these services, it is necessary for these employees from time to time to have access to Protected Health Information (as defined below).

Under the Standards for Privacy of Individually Identifiable Health Information (45 CFR Part 164, the "Privacy Standards"), these employees are permitted to have such access subject to the following:

1. **General.** The Plan shall not disclose Protected Health Information to any member of the Employer's workforce unless each of the conditions set out in this HIPAA Privacy section is met. "Protected Health Information" shall have the same definition as set out in the Privacy Standards but generally shall mean individually identifiable health information about the past, present or future physical or behaviorial health or condition of an individual, including information about treatment or payment for treatment.
2. **Permitted Uses and Disclosures.** Protected Health Information disclosed to members of the Employer's workforce shall be used or disclosed by them only for purposes of Plan administrative functions. The Plan's administrative functions shall include all Plan payment and health care operations. The terms "payment" and "health care operations" shall have the same definitions as set out in the Privacy Standards, but the term "payment" generally shall mean activities taken with respect to payment of premiums or contributions, or to determine or fulfill Plan responsibilities with respect to coverage, provision of benefits, or reimbursement for health care. "Health care operations" generally shall mean activities on behalf of the Plan that are related to quality assessment; evaluation, training or accreditation of health care providers; underwriting, premium rating and other functions related to obtaining or renewing an insurance contract, including stop-loss insurance; medical review; legal services or auditing functions; or business planning, management and general administrative activities. Genetic information will not be used or disclosed for underwriting purposes.
3. **Authorized Employees.** The Plan shall disclose Protected Health Information only to members of the Employer's workforce who are designated and are authorized to receive such Protected Health Information, and only to the extent and in the minimum amount necessary for these persons to perform duties with respect to the Plan. For purposes of this HIPAA Privacy section, "members of the Employer's workforce" shall refer to all employees and other persons under the control of the Employer.
   1. **Updates Required.** The Employer shall amend the Plan promptly with respect to any changes in the members of its workforce who are authorized to receive Protected Health Information.
   2. **Use and Disclosure Restricted.** An authorized member of the Employer's workforce who receives Protected Health Information shall use or disclose the Protected Health Information only to the extent necessary to perform his or her duties with respect to the Plan.
   3. **Resolution of Issues of Noncompliance.** In the event that any member of the Employer's workforce uses or discloses Protected Health Information other than as permitted by the Privacy Standards, the incident shall be reported to the privacy official. The privacy official shall take appropriate action, including:
      1. Investigation of the incident to determine whether the breach occurred inadvertently, through negligence, or deliberately; whether there is a pattern of breaches; and the degree of harm caused by the breach;
      2. Applying appropriate sanctions against the persons causing the breach, which, depending upon the nature of the breach, may include, oral or written reprimand, additional training, or termination of employment;
      3. Mitigating any harm caused by the breach, to the extent practicable; and
      4. Documentation of the incident and all actions taken to resolve the issue and mitigate any damages.
4. **Certification of Employer.** The Employer must provide certification to the Plan that it agrees to:
   1. Not use or further disclose the Protected Health Information other than as permitted or required by the Plan documents or as required by law;
   2. Ensure that any agent or subcontractor, to whom it provides Protected Health Information received from the Plan, agrees to the same restrictions and conditions that apply to the Employer with respect to such information;
   3. Not use or disclose Protected Health Information for employment-related actions and decisions or in connection with any other benefit or employee benefit plan of the Employer;
   4. Report to the Plan any use or disclosure of the Protected Health Information of which it becomes aware that is inconsistent with the uses or disclosures hereunder or required by law;
   5. Make available Protected Health Information to individual Plan members in accordance with Section 164.524 of the Privacy Standards;
   6. Make available Protected Health Information for amendment by individual Plan members and incorporate any amendments to Protected Health Information in accordance with Section 164.526 of the Privacy Standards;
   7. Make available the Protected Health Information required to provide any accounting of disclosures to individual Plan members in accordance with Section 164.528 of the Privacy Standards;
   8. Make its internal practices, books and records relating to the use and disclosure of Protected Health Information received from the Plan available to the Department of Health and Human Services for purposes of determining compliance by the Plan with the Privacy Standards;
   9. If feasible, return or destroy all Protected Health Information received from the Plan that the Employer still maintains in any form, and retain no copies of such information when no longer needed for the purpose of which disclosure was made, except that, if such return or destruction is not feasible, limit further uses and disclosures to those purposes that make the return or destruction of the information unfeasible; and
   10. Ensure the adequate separation between the Plan and member of the Employer's workforce, as required by Section 164.504(f)(2)(iii) of the Privacy Standards.

The following members of Integrity Home Care's workforce are designated as authorized to receive Protected Health Information from Integrity Home Care Employee Major Medical Health Care Plan ("the Plan") in order to perform their duties with respect to the Plan: Privacy Officer and others as authorized by the Employer.

**COMPLIANCE WITH HIPAA ELECTRONIC SECURITY STANDARDS.** Under the Security Standards for the Protection of Electronic Protected Health Information (45 CFR Part 164.300 et. seq., the "Security Standards"), the Employer agrees to the following:

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

**FUNDING THE PLAN AND PAYMENT OF BENEFITS**

The cost of the Plan is funded as follows:

**For Employee and Dependent Coverage:** Funding is derived from the funds of the Employer and contributions made by the covered Employees.

The level of any Employee contributions will be set by the Plan Administrator. These Employee contributions will be used in funding the cost of the Plan as soon as practicable after they have been received from the Employee or withheld from the Employee's pay through payroll deduction.

Benefits are paid directly from the Plan through the Claims Supervisor.

**Assignment and Non-Alienation of Benefits:** Amounts payable at any time may be used to make direct payments to health care providers. Except as applicable law may otherwise require, no benefit, right or interest of any member hereunder shall at any time be used or be subject in any manner to alienation by anticipation, sale, transfer, assignment, bankruptcy, pledge, attachment, charge or encumbrance of any kind. Any attempt to alienate, sell, transfer, assign, pledge, attach, charge or otherwise encumber any such amount, whether presently or hereafter payable, shall be void. The Plan shall not be liable for or subject to the debts or liabilities of any person entitled to any amount payable under the Plan, or any part thereof.

**Assignment** means, for purposes of this Plan, that the Plan may pay any benefits due under this Plan directly to the Provider. The rights of a participant and the benefits to which he is entitled or for which he applies under the Plan are not assignable, except for assignment of payments directly to a provider, or in accordance with the subrogation provisions of the Plan. The Plan has full discretionary authority to accept or reject an assignment. The provisions of this Plan shall supersede any and all other assignment or alienation provisions, under whatever terms that may be used, that a member may make with a provider of health care services. Moreover, this Plan has priority lien against any and all proceeds that may be due the plan.

**THE TRUST AGREEMENT**

If this Plan is established under a Trust agreement, that agreement is made a part of the Plan. A copy of the appropriate agreement is available for examination by Employees and their Dependent(s) at the office of the Plan Administrator during normal business hours. Also, upon written request, the following items will be furnished to an Employee or Dependent:

1. A copy of the Trust agreement.
2. A complete list of employers and employee organizations sponsoring the Plan. Service of legal process may be made upon a Plan trustee or Plan Administrator.

**PLAN IS NOT AN EMPLOYMENT CONTRACT**

The Plan is not to be construed as a contract for or of employment.

**CLERICAL ERROR**

The Plan Administrator will have final determination of benefits if there are typographical or grammatical errors that appear in this document. Any clerical error by the Plan Administrator or an agent of the Plan Administrator in keeping pertinent records or a delay in making any changes will not invalidate coverage otherwise validly in force or continue coverage validly terminated. An equitable adjustment of contributions will be made when the error or delay is discovered.

If an overpayment occurs in a Plan reimbursement amount, the Plan retains a contractual right to the overpayment. The person or institution receiving the overpayment will be required to return the incorrect amount of money. In the case of a Plan Participant, the amount of overpayment may be deducted from future benefits payable.

**PHYSICAL EXAM**

The Plan has the right and opportunity to examine any Covered Person with respect to a claim for benefits that is pending under the Plan when and as often as it may reasonably require. The provider will be of the Plan’s choosing and at the Plan’s expense. A Covered Person is required by the Plan to submit to such examination as a condition of coverage. This may be required to assist the Plan Administrator/Claims Supervisor in determination of non-covered services (i.e., malpractice claim, suspected felony, or other non-covered service).

**AMENDING AND TERMINATING THE PLAN**

If the Plan is terminated, the rights of the Plan Participants are limited to expenses incurred before termination.

The Employer reserves the right, at any time, to amend, suspend or terminate the Plan in whole or in part. This includes amending the benefits under the Plan or the Trust agreement (if any).

**MATERIAL MODIFICATIONS**

Material Modifications to the Plan will be provided to all Covered Persons within sixty (60) days preceding the effective date of the change.

**CERTAIN PLAN PARTICIPANTS RIGHTS UNDER ERISA**

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

**Receive Information About Your Plan and Benefits:**

Examine, without charge, at the Plan Administrator's office, all documents governing the Plan, including insurance contracts and collective bargaining agreements, and a copy of the latest annual report (form 5500 series) filed by the Plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Employee Benefits Security Administration (formerly known as Pension and Welfare Benefits Administration).

Obtain, upon written request to the Plan Administrator, copies of Plan documents and other Plan information. The Plan Administrator may make a reasonable charge for the copies.

**Continue Group Health Plan Coverage:**

Continue health care coverage for a Plan Participant, Spouse, or other dependents if there is a loss of coverage under the Plan as a result of a Qualifying Event. Employees or dependents may have to pay for such coverage.

Review this summary plan description and the documents governing the Plan or the rules governing COBRA continuation coverage rights.

**Enforce Your Rights:**

If a Plan Participant's claim for a benefit is denied or ignored, in whole or in part, the participant has a right to know why this was done, to obtain copies of documents relating to the decision without charge, and to appeal any denial, all within certain time schedules.

Under ERISA, there are steps a Plan Participant can take to enforce the above rights. For instance, if a Plan Participant requests a copy of Plan documents or the latest annual report from the Plan and does not receive them within 30 days, he or she may file suit in a federal court. In such a case, the court may require the Plan Administrator to provide the materials and to pay the Plan Participant up to $110 a day until he or she receives the materials, unless the materials were not sent because of reasons beyond the control of the Plan Administrator. If the Plan Participant has a claim for benefits which is denied or ignored, in whole or in part, the participant may file suit in state or federal court.

In addition, if a Plan Participant disagrees with the Plan's decision or lack thereof concerning the qualified status of a domestic relations order or a medical child support order, he or she may file suit in federal court if resolution of the dispute is not otherwise resolved.

**Note:** As per this Plan’s provisions, the right to file suit in state or federal court may be initiated only following exhaustion of the grievance and appeals processes as outlined in this Plan document. In addition, you will lose your right to file suit should you fail to follow this Plan’s grievance and appeals processes as outlined in this Plan document.

**Prudent Actions by Plan Fiduciaries:**

In addition to creating rights for Plan Participants, ERISA imposes obligations upon the individuals who are responsible for the operation of this Plan. The individuals who operate the Plan, called "fiduciaries" of the Plan, have a duty to do so prudently and in the interest of the Plan Participants and their beneficiaries. No one, including the Employer or any other person, may fire a Plan Participant or otherwise discriminate against a Plan Participant in any way to prevent the Plan Participant from obtaining benefits under the Plan or from exercising his or her rights under ERISA.

If it should happen that the Plan fiduciaries misuse the Plan's money, or if a Plan Participant is discriminated against for asserting his or her rights, he or she may seek assistance from the U.S. Department of Labor, or may file suit in a federal court. The court will decide who should pay court costs and legal fees. If the Plan Participant is successful, the court may order the person sued to pay these costs and fees. If the Plan Participant loses, the court may order him or her to pay these costs and fees, for example, if it finds the claim or suit to be frivolous.

**Assistance with Your Questions:**

If the Plan Participant has any questions about the Plan, he or she should contact the Plan Administrator. If the Plan Participant has any questions about this statement or his or her rights under ERISA, including COBRA or the Health Insurance Portability and Accountability Act (HIPAA), and other laws affecting group health plans, that Plan Participant should contact either the nearest Regional or District Office of the U.S. Department of Labor's Employee Benefits Security Administration (EBSA) or visit the EBSA website at [www.dol.gov/ebsa.](http://www.dol.gov/ebsa) (Addresses and phone numbers of Regional and District EBSA Offices are available through EBSA's website.)

# GENERAL PLAN INFORMATION

**TYPE OF ADMINISTRATION**

The Plan is a self-funded group health Plan and the administration is provided through a Third Party Claims Supervisor. The funding for the benefits is derived from the funds of the Employer and contributions made by covered Employees. The Employer may insure claims for specific and/or aggregate “Stop-Loss” claim reimbursement through a re-insurance contract.

**PLAN NAME:** Integrity Home Care Employee Major Medical Health Care Plan

**PLAN NUMBER:** 501

**GROUP NUMBER:** IHC

**TAX ID NUMBER:** 43-1875357

**PLAN EFFECTIVE DATE:** September 1, 2003. Herein revised and restated January 1, 2018.

**PLAN YEAR ENDS:** December 31st

**EMPLOYER INFORMATION**

Integrity Home Care

2960 North Eastgate

Springfield, Missouri 65803

(417) 889-9773

**PLAN ADMINISTRATOR**

Co-Owner

Integrity Home Care

2960 North Eastgate

Springfield, Missouri 65803

(417) 889-9773

**NAMED FIDUCIARY**

Co-Owner

Integrity Home Care

2960 North Eastgate

Springfield, Missouri 65803

**AGENT FOR SERVICE OF LEGAL PROCESS**

Co-Owner

Integrity Home Care

2960 North Eastgate

Springfield, Missouri 65803

**CLAIMS SUPERVISOR**

Mercy Benefit Administrators

3265 S National Ave

Springfield, Missouri 65807

**UTILIZATION REVIEW COORDINATOR**

Mercy Care Management

4520 S National Ave

Springfield, Missouri 65810

**TRUSTEE(S)**

Co-Owner

2960 North Eastgate

Springfield, Missouri 65803

BY THIS AGREEMENT, Integrity Home Care Employee Major Medical Health Care Plan is hereby adopted as shown.

IN WITNESS WHEREOF, this instrument is executed for Integrity Home Care on or as of the day and year first below written.

By: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Plan Administrator

Integrity Home Care

Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Witness: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

# ELIGIBILITY APPENDIX

INTEGRITY HOME CARE

Integrity Home Care Employee Major Medical Health Care Plan

Integrity Home Care will utilize the Look Back Measurement Period Method to determine the Full-time status of Ongoing Employees and New Variable Hour, Part-time or Seasonal Employees for purpose of Plan eligibility under the Employer Shared Responsibility provisions of the Affordable Care Act. Full-Time Employee status will be based on the average Hours of Service during a Standard Measurement Period (Ongoing Employees) or an Initial Measurement Period (New Variable Hour, Part-time or Seasonal Employees). Employee eligibility (or lack thereof) for coverage under the Plan will extend through the Ongoing Employee Stability Period or New Employee Stability Periods established by the Plan, as applicable. Set forth below is a detailed description of the Look Back Measurement Period Method.

**Measurement Periods**

All Integrity Home Care Employees will fall under one of two Measurement Period options - the Standard Measurement Period for Ongoing Employees and Initial Measurement Periods for New Variable Hour, Part-time or Seasonal Employees. All Employee categories are treated the same for purpose of the Look Back Measurement Period Method, including hourly and non-hourly. For the first year of applicability of the Standard Measurement Period, Integrity Home Care will use the Transitional Relief for 2015 (detailed below).

**Ongoing Employees**

For Ongoing Employees, a 12 Calendar Month Standard Measurement Period will be utilized to determine which Employees are eligible for coverage beginning at each plan year anniversary of January 1. If, during the Standard Measurement Period, an Employee is determined to have worked, on average 30 or more Hours of Service per week (130 Hours of Service or more in a Month) [or 20 or more Hours of Service over 13 weeks for the Select Supplemental Plan] they will be offered coverage for the 12 Calendar Month Ongoing Employee Stability Period beginning on the plan year anniversary.

An Ongoing Employee Administrative Period, never to exceed 90 calendar days, will follow the Standard Measurement Period. During this Ongoing Employee Administrative Period, the Plan will make eligibility determinations for the Ongoing Employee Stability Period. If an Employee is determined to be eligible for coverage for the Ongoing Employee Stability Period, they will be eligible for the entire 12 Calendar Month duration as long as they remain in a class eligible for coverage and do not experience a Break in Service. If an Employee is not determined to be eligible for coverage for the Ongoing Employee Stability Period, they will be ineligible for the entire 12 Calendar Month duration. The timing of the Standard Measurement Period and associated Ongoing Employee Administrative Period and Ongoing Employee Stability Period will be static from year to year.

The following will apply for ongoing employees:

|  |  |
| --- | --- |
| Standard Measurement Period | 11/01-10/31 (12 Calendar Months) |
| Ongoing Employee Administrative Period | 11/01-12/31 (2 Calendar Months) |
| Ongoing Employee Stabilization Period | 01/01-12/31 (12 Calendar Months) |

**New Variable Hour Employee, Part-time Employee or Seasonal Employee**

A New Variable Hour, Part-time or Seasonal Employees will complete a 12 Calendar Month Initial Measurement Period to determine eligibility for coverage. The 12 Calendar Month Initial Measurement Period will begin on the first day of the Calendar Month following date of hire (if date of hire is the first day of the Calendar Month, the Initial Measurement Period will begin on the date of hire). During the Initial Measurement Period, if an Employee is determined to have worked, on average 30 or more Hours of Service per week (130 Hours of Service or more in a Month) [or 20 or more Hours of Service over 13 weeks for the Select Supplemental Plan] they will be offered coverage for a subsequent 12 Calendar Month New Employee Stability Period.

A New Employee Administrative Period, never to exceed 90 days or extend beyond the last day of the Calendar Month that begins on or after an Employee's anniversary date, will follow the Initial Measurement Period. During this New Employee Administrative Period, the Plan will make an eligibility determination for the New Employee Stability Period. If an Employee is determined to be eligible for coverage during a New Employee Stability Period, they will be eligible for the entire 12 Calendar Month duration as long as they remain in a class eligible for coverage and do not experience a Break in Service. If an Employee is determined to be ineligible for coverage during a New Employee Stability Period, they will be ineligible for the entire 12 Calendar Month New Employee Stability Period. The timing of the Initial Measurement Period, New Employee Administrative Period and New Employee Stability Period will vary from Employee to Employee, but Initial Measurement Periods will always commence on one of 12 monthly periods.

For purposes of determining whether an employee is a New Variable Hour, Part-time or Seasonal Employee, the Employer will not take into account the likelihood that the Employee may terminate employment with the Employer (including any member of the Employer) before the end of the Initial Measurement Period.

|  |  |
| --- | --- |
| Standard Measurement Period | 12 Calendar Months |
| New Employee Administrative Period | 1 Partial Month, if any plus 1 Calendar Month |
| New Employee Stabilization Period | 12 Calendar Months |

**New Variable Hour Employee, Part-time Employee or Seasonal Employee experiencing a Change in Employment Status during the Initial Measurement Period**

If a Variable, Part-time or Seasonal Employee experiences a change in employment status before the end of the Initial Measurement Period such that the Employee, if hired into that new position, would reasonably be expected to be employed on average at least 30 Hours of Service per week (130 Hours of Service in a Month), [or 20 or more Hours of Service over 13 weeks for the Select Supplemental Plan] they will be offered coverage following completion of the waiting period applicable to New Non-variable Hour Employees or, if earlier, the first day of the New Employee Stability Period, if the Employee averaged 30 Hours of Service or more per week (130 Hours of Service or more in a Month) [or 20 or more Hours of Service over 13 weeks for the Select Supplemental Plan] during the Initial Measurement Period.

**Tracking Hours of Service**

Each Employee's Hours of Service will be determined in a manner consistent with Internal Revenue Code Section 4980H and the regulations issued thereunder.

**Break in Service Rules**

If an Employee experiences a Break in Service during a Measurement Period or Stability Period, they will be treated as a New Employee upon the date that the Employee resumes Hours of Service for the Employer.

Alternatively, an Employee who does not experience a Break in Service, but does have a period during which they are not credited with any Hours of Service, will be considered a Continuous Employee. The Continuous Employee will resume their associated Measurement Period and Stability Period upon resuming Hours of Service for the Employer. They will be credited no Hours of Service for the time missed during the Measurement Period. If they were enrolled in coverage prior to the start of the period with no Hours of Service, the Continuous Employee's coverage will be effective the first day of the month following the date Hours of Service resume.

**Special Unpaid Leave of Absence Rules**

If the Employee takes a Special Unpaid Leave of Absence during which no Hours of Service are credited to the Employee, and the Employee resumes service as a Continuous Employee, special treatment is required for purposes of the Measurement Period.

The Employer will disregard the period that such Employee was on a Special Unpaid Leave when calculating the Hours of Service for the Employee during the applicable Measurement Period (i.e., the Measurement Period for such an Employee will be reduced by the period the Employee is on a Special Unpaid Leave).

**Defined terms**

**Break in Service**- a period of at least 13 consecutive weeks during which the Employee has no Hours of Services, as defined herein. Using the rule of parity, a Break in Service may also include a period with no credited Hours of Service (of less than 13 weeks) that is at least four consecutive weeks in duration and is longer than the Employee's period of employment immediately preceding that period with no credited Hours of Service (determined after application of the procedures applicable to Special Unpaid Leaves of Absence prescribed herein).

**Calendar Month**- one of the 12 months named in the calendar (i.e. January, February, etc.).

**Continuous Employee**- an employee who has a period during which they are credited with no Hours or Service, but the period is not sufficient enough in length to be considered a Break in Service.

**Full time Employee**- an Employee is considered to be Full-Time if he or she works an average of at least 30 Hours of Service per week with an Employer (130 Hours of Service in a Month) [or 20 or more Hours of Service over 13 weeks for the Select Supplemental Plan] and is on the regular payroll of the Employer for that work.

**Hours of Service**- each hour for which the Employee is paid or entitled to payment for performance of services for the Employer AND any hour for which the Employee is paid or entitled to payment by the Employer for a period of time during which no duties are performed due to any of the following (i.e., paid leave): vacation; holiday; illness or incapacity to the extent such coverage is provided by the Employer; layoff; jury duty; military duty or leave of absence.

**Initial Measurement Period**- for a New Variable Hour, Part-time or Seasonal Employee, the 12 Calendar Month period beginning on the first day of the Calendar Month following date of hire (if date of hire is the first day of the Calendar Month, the Initial Measurement Period will begin on date of hire). Average Hours of Service are tracked during this period to determine eligibility for coverage during the subsequent New Employee Stability Period.

**Measurement Period**- the Initial Measurement Period or the Standard Measurement Period, as applicable.

**Month**- the period that begins on any date following the first day of a calendar month and that ends on the immediately preceding date in the immediately following calendar month (for example, from February 2 to March 1 or from December 15 to January 14).

**New Employee**- an employee who has been employed by an applicable large employer for less than one complete Standard Measurement Period.

**New Employee Administrative Period**- the partial month, if any, preceding the Initial Measurement Period and the two Calendar Months following the Initial Measurement Period. During this time, the Employer will determine if the New Employee qualifies as a Full-time Employee for purpose of eligibility for coverage during the subsequent New Employee Stability Period.

**New Employee Stability Period**- 12 Calendar Months following the Initial Measurement Period and New Employee Administrative Period. If determined Full-time during the Initial Measurement Period, coverage will be offered for the duration of this period, barring a Break in Service. If determined not to be Full-time, coverage will not be offered for the duration of this period.

**Non-variable Hour Employee**- a New Employee for whom it can be determined on the start date that the Employee is reasonably expected to work, on average, 30 Hours of Service or more per week (130 Hours of Service per Month) [or 20 or more Hours of Service over 13 weeks for the Select Supplemental Plan] during each Month of employment during the Initial Measurement Period. The determination whether an employee is non-variable or not is based on the facts and circumstances that exist at the time of employment. An inclusive list of factors that may be used for this determination are: whether the Employee is replacing an Employee who is or was full-time; the extent to which Hours of Service for Ongoing Employees in comparable positions vary above or •below the 30 Hours of Service threshold during recent Measurement Periods; or whether the job was advertised as full-time or not.

**Ongoing Employee**- an employee who has been employed by an applicable large employer for at least one complete Standard Measurement Period.

**Ongoing Employee Administrative Period**- the two Calendar Months following the Standard Measurement Period. During this time, the Employer will determine which Ongoing Employees qualify as Full-time Employees for purpose of eligibility for coverage during the subsequent Ongoing Employee Stability Period.

**Ongoing Employee Stability Period**- 12 Calendar Months following the Standard Measurement Period and Ongoing Employee Administrative Period. If an Ongoing Employee is determined to be Full-time during the Standard Measurement Period, coverage will be offered for the duration of this period, barring a Break in Service. If determined not to be Full-time, coverage will not be offered for the duration of this period.

**Part-time Employee**- a New Employee who the applicable large employer member reasonably expects to be employed on average less than 30 Hours of Service per week. Whether an Employer's determination that a New Employee is a Part-time Employee is reasonable is based on the facts and circumstances at the Employee's start date.

**Seasonal Employee**- a New Employee who is hired into a position for which the customary employment is 6 months or less (although it can be longer under unusual circumstances) and the period of employment customarily begins during the same time of year each year.

**Special Unpaid Leave of Absence**- any of the following types of unpaid leaves of absence that do not constitute a Break in Service: leave protected by the Family and Medical Leave Act, leave protected by the Uniformed Services Employment and Reemployment Rights Act (USERRA) or Jury Duty.

**Stability Period**- the New Employee Stability Period or the Ongoing Employee Stability Period, as applicable. Standard Measurement Period- for Ongoing Employees, the 12 Calendar Month period from November 1 - October 31. Average Hours of Service are tracked during this period to determine eligibility for coverage during the subsequent Ongoing Employee Stability Period.

**Variable Hour Employee**- a New Employee who, based on the facts and circumstances at the Employee's start date, the applicable large employer member cannot reasonably determine whether the employee is expected to be employed on average at least 30 Hours of Service per week because the Employee's hours are variable or otherwise uncertain.

# PRIOR AUTHORIZATION APPENDIX

**Mercy Care Management**

**Prior Authorization Guide with procedure code**

**Effective January 1, 2018**

* Medical Observation admits greater than 23 hours
* Surgical Observation admits where the procedure requires Prior Authorization, or greater than 23 hours
* All Inpatient Hospital, Behavioral Health, Chemical Dependency, Skilled Nursing, Long-term Acute care and Rehabilitation admissions require Prior Referral/Authorization
* Emergency Admissions (Requires Plan notification within 24 hours)
* Maternity admissions require Prior Referral/Authorization under the following circumstances:
  + Newborn stays beyond mother’s discharge

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| --- | --- |
| Maternity | |
| CPT/HCPCS Code | Description |
| 59400-59414 | 59400 - Routine obstetric care including antepartum care, vaginal delivery (with or without episiotomy, and/or forceps) and postpartum care;  59409 – Vaginal delivery only (with or without episiotomy and/or forceps);  59410 – Vaginal Delivery only (with or without episiotomy and/or forcepts); including postpartum care;  59412 – External cephalic version, with or without tocolysis;  59414 – Delivery of placenta (separate procedure) |
| 59510-59515 | 59510 – Routine obstetric care including antepartum care, cesarean delivery, and postpartum care;  59514 – Cesarean delivery only;  59515 – Cesarean delivery only; including postpartum care |
| 59610-59614 | |  | | --- | | 59610 – Routine obstetric care including antepartum care, vaginal delivery (with or without episiotomy, and/or forceps) and postpartum care, after previous cesarean delivery;  59612 – Vaginal delivery only, after previous cesarean delivery (with or without episiotomy and/or forceps);  59614 – Vaginal delivery only, after previous cesarean delivery (with or without episiotomy and/or forceps); including postpartum care | |
| 59618-59622 | 59618 – Routine obstetric care including antepartum care, cesarean delivery, and postpartum care, following attempted vaginal delivery after previous cesarean delivery;  59620 – Cesarean delivery only, folling attempted vaginal delivery after previous cesarean delivery;  59622 – Cesarean delivery only, following attempted vaginal delivery after previous cesarean delivery; including postpartum care |

* Mental health services
* Neuropsychological testing
* Nutritional Support (enteral and parenteral feeding)
* Home Health including private duty nursing, Home Physical Therapy, Occupational Therapy and Speech Therapy
* Hospice
* Durable Medical Equipment (DME) over $1,000.00 single line item purchase price, or cumulative rental of a single item (does not include oxygen and oxygen equipment). In addition the following items, including but not limited to:
  + PAP units (not supplies) E0601; E0701
  + Home ventilators (Invasive and non-invasive)
  + TENS units (not supplies)
  + Bone growth stimulators
  + Neuromuscular stimulators
  + Hospital beds, including, but not limited to, rocking beds, cribs, mattresses
  + Wheelchairs- Wheelchairs; motorized or powered, ultra lightweight wheelchairs, power seating systems and accessories
  + All custom made items
  + Insulin pumps (not supplies) External continuous insulin infusion pump
  + Continuous Glucose Monitors
* Orthotics over $1000, all foot orthotics and any custom orthotic
* Non emergent ambulance transfers
* Air and water ambulances
* Phototherapy
* Clinical trials
* Transplants
  + Human Organ and Bone Marrow/Stem Cell Transplants
  + All Inpatient admits for the following:
    - Heart transplant
    - Liver transplant
    - Lung or double lung transplant
    - Simultaneous Pancreas./Kidney
    - Pancreas transplant
    - Kidney transplant
    - Small bowel transplant
    - Multi-visceral transplant
    - Stem cell/Bone Marrow transplant (with or without myeloablative therapy)
  + All Outpatient services for the following:
    - Stem Cell/Bone Marrow transplant (with or without myeloablative therapy)
    - Donor Leukocyte Infusion
* Prosthetics:
  + > $1000
  + Electronic, Myoelectric, Microprocessor Controlled or externally powered and selected other prosthetics
  + Cochlear implants and auditory brainstem implants
* Oscillatory devices for airway Clearance including High Frequency Chest Compression and Intrapulmonary Percussive Ventilation
* Functional Electrical Stimulation (FES); Threshold Electrical Stimulation (TES)
* Transtympanic Micropressure for the Treatment of Ménière’s Disease
* Standing Frames
* Pneumatic pressure devices
* Orthotic devices
* Augmentative and Alternative Communication (AAC) Devices/Speech Generating Devices (SGD Cooling Devices and Combined Cooling/Heating Devices
* Wearable Cardiac Defibrillator
* Accidental dental services
* All CPT codes ending in “99”
* All CPT codes ending in “T”
* Genetic testing

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| --- | --- |
| Integumentary System | |
| CPT/HCPCS Code | Description |
| 11920-11922 | 11920 - Tattooing, intradermal introduction of insoluble opaque pigments to correct color defects of skin, including micropigmentation; 6.0 sq cm or less;  11921 - Tattooing, intradermal introduction of insoluble opaque pigments to correct color defects of skin, including micropigmentation; 6.1 to 20.0 sq cm  11922 - Tattooing, intradermal introduction of insoluble opaque pigments to correct color defects of skin, including micropigmentation; each additional 20.0 sq cm, or part thereof; |
| 11960 | Insertion of tissue expander(s) for other than breast, including subsequent expansion |
| 11970 | Replacement of tissue expander with permanent prosthesis |
| 11971 | Removal of tissue expander(s) without insertion of prosthesis |
| 11976 | Removal, implantable contraceptive capsules |
| 11981-11982 | 11981 - Insertion, non-biodegradable drug delivery implant;  11982 - Removal, non-biodegradable drug delivery implant |
| 15822-15823 | 15822 - Blepharoplasty, upper eyelid;  15823 – Blepharoplasty, upper eyelid; with excessive skin weighting down lid |
| 15830, 15847 | 15830 - Excision, excessive skin and subcutaneous tissue (includes lipectomy); abdomen, infraumbilical panniculectomy  15847 – Excision, excessive skin and subcutaneous tissue (includes lipectomy), abdomen (eg, abdominoplasty) (includes umbilical transposition and fascial plication) (List separately in addition to code for primary procedure) |
| 15840-15845 | 15840 - Graft for facial nerve paralysis; free fascia graft (including obtaining fascia);  15841 – Graft for facial nerve paralysis; free muscle graft (including obtaining graft);  15842 - Graft for facial nerve paralysis;free muscle flap by microsurgical technique; 15845 - Graft for facial nerve paralysis; regional muscle transfer regional muscle transfer |
| 19300 | Mastectomy for gynecomastia |
| 19316 | Mastopexy |
| 19318 | Reduction mammaplasty |
| 19324-19325 | 19324 - Mammaplasty, augmentation; without prosthetic implant;  19325 - Mammaplasty, augmentation; with prosthetic implant |
| 19328 | Removal of intact mammary implant |
| 19330 | Removal of mammary implant material |
| 19340-19342 | 19340 - Immediate insertion of breast prosthesis following mastopexy, mastectomy, or in reconstruction  19342 - Delayed insertion of breast prosthesis following mastopexy, mastectomy or in reconstruction |
| 19350 | Nipple/areola reconstruction |
| 19357-19369 | 19357 - Breast reconstruction, immediate or delayed, with tissue expander, including subsequent expansion;  19361 – Breast reconstruction with latissimus dorsi flap, without prosthetic implant;  19364 - Breast reconstruction with free flap;  19366 - Breast reconstruction with other technique;  19367 – Breast reconstruction with transverse rectus abdominis myocutaneous flap (TRAM), single pedicle, including closure of donor site;  19368 - Breast reconstruction with transverse rectus abdominis myocutaneous flap (TRAM), single pedicle, including closure of donor site; with microvascular anastomosis (supercharging);  19369 - Breast reconstruction with transverse rectus abdominis myocutaneous flap (TRAM), double pedicle, including closure of donor site |
| 19380,19396 | 19380 - Revision of reconstructed breast; preparation of moulage for custom breast implant;  19396 - Preparation of moulage for custom breast implant |
| 64804  J0585  97033 | 64804 - Sympathectomy, cervicothoracic;  J0585 - Injection, onabotulinumtoxina, 1 unit;  97033 **-**Application of a modality to 1 or more areas; iontophoresis, each 15 minutes |

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| --- | --- |
| Musculoskeletal System | |
| CPT/HCPCS Code | Description |
| 20974-20975 | 20974 - Electrical stimulation to aid bone healing; noninvasive (nonoperative);  20975 - Electrical stimulation to aid bone healing; invasive (operative) |
| 20979 | Low intensity ultrasound stimulation to aid bone healing, noninvasive (nonoperative) |
| 20999 | Unlisted procedure, musculoskeletal system, general |
| 21010 | Arthrotomy, temporomandibular joint |
| 21050-21060 | 21050 - Condylectomy, temporomandibular joint (separate procedure);  21060 - Meniscectomy, partial or complete, temporomandibular joint (separate procedure) |
| 21070 | Coronoidectomy (separate procedure) |
| 21076-21088 | 21076 - Impression and custom preparation; surgical obturator prosthesis;  21077- Impression and custom preparation; orbital prosthesis;  21079 - Impression and custom preparation; interim obturator prosthesis;  21080 - Impression and custom preparation; definitive obturator prosthesis;  21081 - Impression and custom preparation; mandibular resection prosthesis;  21082 - Impression and custom preparation; palatal augmentation prosthesis;  21083 - Impression and custom preparation; palatal lift prosthesis;  21084 - Impression and custom preparation; speech aid prosthesis;  21085 - Impression and custom preparation; oral surgical splint;  21086 - Impression and custom preparation; auricular prosthesis;  21087 - Impression and custom preparation; nasal prosthesis;  21088 - Impression and custom preparation; facial prosthesis |
| 21089 | Unlisted maxillofacial prosthetic procedure |
| 21100 | Application of halo type appliance for maxillofacial fixation, includes removal (separate procedure) |
| 21110 | Application of interdental fixation device for conditions other than fracture or dislocation, includes removal |
| 21116 | Injection procedure for temporomandibular joint arthrography |
| 21120-21123 | 21120 - Genioplasty; augmentation (autograft, allograft, prosthetic material);  21121 - Genioplasty; sliding osteotomy, single piece;  21122 **-**Genioplasty; sliding osteotomies, 2 or more osteotomies (eg, wedge excision or bone wedge reversal for asymmetrical chin);  21123 **-**Genioplasty; sliding, augmentation with interpositional bone grafts (includes obtaining autografts) |
| 21125-21127 | 21125 – Augmentation, mandibular body or angle; prosthetic material;,  21127 -Augmentation, mandibular body or angle; with bone graft, onlay or interpositional (includes obtaining autograft) |
| 21137-21139 | 21137 - Reduction forehead; contouring only;  21138 - Reduction forehead; contouring and application of prosthetic material or bone graft (includes obtaining autograft);  21139 - Reduction forehead; contouring and setback of anterior frontal sinus wall |
| 21141-21160 | 21141 - Reconstruction midface, LeFort I; single piece, segment movement in any direction (e.g., for Long Face Syndrome), without bone graft 21142 - Reconstruction midface, LeFort I; 2 pieces, segment movement in any direction, without bone graft;  21143 - Reconstruction midface, LeFort I; 3 or more pieces, segment movement in any direction, without bone graft;  21145 - Reconstruction midface, LeFort I; single piece, segment movement in any direction, requiring bone grafts (includes obtaining autografts);  21146 - Reconstruction midface, LeFort I; 2 pieces, segment movement in any direction, requiring bone grafts (includes obtaining autografts) (e.g., ungrafted unilateral alveolar cleft);  21147 - Reconstruction midface, LeFort I; 3 or more pieces, segment movement in any direction, requiring bone grafts (includes obtaining autografts) (e.g., ungrafted bilateral alveolar cleft or multiple osteotomies);  21150 - Reconstruction midface, LeFort II; anterior intrusion (e.g., Treacher-Collins Syndrome);  21151 - Reconstruction midface, LeFort II; any direction, requiring bone grafts (includes obtaining autografts);  21154 - Reconstruction midface, LeFort III (extracranial), any type, requiring bone grafts (includes obtaining autografts); without LeFort I;  21155 - Reconstruction midface, LeFort III (extracranial), any type, requiring bone grafts (includes obtaining autografts); with LeFort I;  21159 - Reconstruction midface, LeFort III (extra and intracranial) with forehead advancement (e.g., mono bloc), requiring bone grafts (includes obtaining autografts); without LeFort I;  21160 - Reconstruction midface, LeFort III (extra and intracranial) with forehead advancement (e.g., mono bloc), requiring bone grafts (includes obtaining autografts); with LeFort I; |
| 21172-21196 | 21175 - Reconstruction, bifrontal, superior-lateral orbital rims and lower forehead, advancement or alteration (e.g., plagiocephaly, trigonocephaly, brachycephaly), with or without grafts (includes obtaining autografts) 21179 - Reconstruction, entire or majority of forehead and/or supraorbital rims; with grafts (allograft or prosthetic material);  21180 - Reconstruction, entire or majority of forehead and/or supraorbital rims; with autograft (includes obtaining grafts);  21181 - Reconstruction by contouring of benign tumor of cranial bones (e.g., fibrous dysplasia), extracranial;  21182 - Reconstruction of orbital walls, rims, forehead, nasoethmoid complex following intra- and extracranial excision of benign tumor of cranial bone (e.g., fibrous dysplasia), with multiple autografts (includes obtaining grafts); total area of bone grafting less than 40 sq cm;  21183 - Reconstruction of orbital walls, rims, forehead, nasoethmoid complex following intra- and extracranial excision of benign tumor of cranial bone (e.g., fibrous dysplasia), with multiple autografts (includes obtaining grafts); total area of bone grafting greater than 40 sq cm but less than 80 sq cm;  21184 - Reconstruction of orbital walls, rims, forehead, nasoethmoid complex following intra- and extracranial excision of benign tumor of cranial bone (e.g., fibrous dysplasia), with multiple autografts (includes obtaining grafts); total area of bone grafting greater than 80 sq cm;  21188 - Reconstruction midface, osteotomies (other than LeFort type) and bone grafts (includes obtaining autografts);  21193 - Reconstruction of mandibular rami, horizontal, vertical, C, or L osteotomy; without bone graft;  21194 - Reconstruction of mandibular rami, horizontal, vertical, C, or L osteotomy; with bone graft (includes obtaining graft);  21195 - Reconstruction of mandibular rami and/or body, sagittal split; without internal rigid fixation;  21196 - Reconstruction of mandibular rami and/or body, sagittal split; with internal rigid fixation |
| 21198-21199 | 21198 - Osteotomy, mandible, segmental;  21199 - Osteotomy, mandible, segmental; with genioglossus advancement |
| 21206-21208 | 21206 - Osteotomy, maxilla, segmental (e.g., Wassmund or Schuchard)  21208 - Osteoplasty, facial bones; augmentation (autograft, allograft, or prosthetic implant) |
| 21210-21234 | 21210 - Graft bone; nasal, maxillary or malar areas (includes obtaining graft);  21215 - Graft, bone; mandible (includes obtaining graft);  21230 - Graft; rib cartilage, autogenous, to face, chin, nose or ear (includes obtaining graft);  21235 - Graft; ear cartilage, autogenous, to nose or ear (includes obtaining graft) |
| 21240-21243 | 21240 - Arthroplasty, temporomandibular joint, with or without autograft (includes obtaining graft);  21242 - Arthroplasty, temporomandibular joint, with allograft;  21243 - Arthroplasty, temporomandibular joint, with prosthetic joint replacement |
| 21244-21249 | 21244 - Reconstruction of mandible, extraoral, with transosteal bone plate (e.g., mandibular staple bone plate);  21245 - Reconstruction of mandible or maxilla, subperiosteal implant; partial;  21246 - Reconstruction of mandible or maxilla, subperiosteal implant; complete;  21247 - Reconstruction of mandibular condyle with bone and cartilage autografts (includes obtaining grafts) (e.g., for hemifacial microsomia);  21248 - Reconstruction of mandible or maxilla, endosteal implant (e.g., blade, cylinder); partial;  21249 - Reconstruction of mandible or maxilla, endosteal implant (e.g., blade, cylinder); complete |
| 21255 | Reconstruction of zygomatic arch and glenoid fossa with bone and cartilage (includes obtaining autografts) |
| 21256-21268 | 21256 - Reconstruction of orbit with osteotomies (extracranial) and with bone grafts (includes obtaining autografts) (e.g., micro-ophthalmia);  21260 - Periorbital osteotomies for orbital hypertelorism, with bone grafts; extracranial approach;  21261 - Periorbital osteotomies for orbital hypertelorism, with bone grafts; combined intra- and extracranial approach;  21263 - Periorbital osteotomies for orbital hypertelorism, with bone grafts; with forehead advancement;  21267 - Orbital repositioning, periorbital osteotomies, unilateral, with bone grafts; extracranial approach;  21268 - Orbital repositioning, periorbital osteotomies, unilateral, with bone grafts; combined intra- and extracranial approach |
| 21270 | Malar augmentation, prosthetic material |
| 21275 | Secondary revision of orbitocraniofacial reconstruction |
| 21299 | Unlisted craniofacial and maxillofacial procedure |
| 21740-21743 | 21740 - Reconstructive repair of pectus excavatum or carinatum; open;  21742 - Reconstructive repair of pectus excavatum or carinatum; minimally invasive approach (Nuss procedure), without thoracoscopy;  21743 - Reconstructive repair of pectus excavatum or carinatum; minimally invasive approach (Nuss procedure), with thoracoscopy |
| 22100-22116 | 22100 - Partial excision of posterior vertebral component (e.g., spinous process, lamina or facet) for intrinsic bony lesion, single vertebral segment; cervical;  22101 - Partial excision of posterior vertebral component (e.g., spinous process, lamina or facet) for intrinsic bony lesion, single vertebral segment; thoracic;  22102 - Partial excision of posterior vertebral component (e.g., spinous process, lamina or facet) for intrinsic bony lesion, single vertebral segment; lumbar  22103 - Partial excision of posterior vertebral component (e.g., spinous process, lamina or facet) for intrinsic bony lesion, single vertebral segment; each additional segment (List separately in addition to code for primary procedure);  22110 - Partial excision of vertebral body, for intrinsic bony lesion, without decompression of spinal cord or nerve root(s), single vertebral segment; cervical;  22112 - Partial excision of vertebral body, for intrinsic bony lesion, without decompression of spinal cord or nerve root(s), single vertebral segment; thoracic;  22114 - Partial excision of vertebral body, for intrinsic bony lesion, without decompression of spinal cord or nerve root(s), single vertebral segment; lumbar;  22116 - Partial excision of vertebral body, for intrinsic bony lesion, without decompression of spinal cord or nerve root(s), single vertebral segment; each additional vertebral segment (List separately in addition to code for primary procedure) |
| 22206-22226 | 22206 - Osteotomy of spine, posterior or posterolateral approach, 3 columns, 1 vertebral segment (e.g., pedicle/vertebral body subtraction); thoracic;  22207 - Osteotomy of spine, posterior or posterolateral approach, 3 columns, 1 vertebral segment (e.g., pedicle/vertebral body subtraction); lumbar;  22208 - Osteotomy of spine, posterior or posterolateral approach, 3 columns, 1 vertebral segment (e.g., pedicle/vertebral body subtraction); each additional vertebral segment (List separately in addition to code for primary procedure);  22210 - Osteotomy of spine, posterior or posterolateral approach, 1 vertebral segment; cervical;  22212 - Osteotomy of spine, posterior or posterolateral approach, 1 vertebral segment; thoracic;  22214 - Osteotomy of spine, posterior or posterolateral approach, 1 vertebral segment; lumbar;  22216 - Osteotomy of spine, posterior or posterolateral approach, 1 vertebral segment; each additional vertebral segment (List separately in addition to primary procedure);  22220 - Osteotomy of spine, including discectomy, anterior approach, single vertebral segment; cervical;  22222 - Osteotomy of spine, including discectomy, anterior approach, single vertebral segment; thoracic;  22224 - Osteotomy of spine, including discectomy, anterior approach, single vertebral segment; lumbar;  22226 - Osteotomy of spine, including discectomy, anterior approach, single vertebral segment; each additional vertebral segment (List separately in addition to code for primary procedure) |
| 22520-22525  (Codes deleted 1.1.2015 See codes 22510 – 22515) | 22510 - Percutaneous vertebroplasty (bone biopsy included when performed), 1 vertebral body, unilateral or bilateral injection, inclusive of all imaging guidance; cervicothoracic;  22511 - Percutaneous vertebroplasty (bone biopsy included when performed), 1 vertebral body, unilateral or bilateral injection, inclusive of all imaging guidance; lumbosacral  22512 - Percutaneous vertebroplasty (bone biopsy included when performed), 1 vertebral body, unilateral or bilateral injection, inclusive of all imaging guidance; each additional cervicothoracic or lumbosacral vertebral body (List separately in addition to code for primary procedure);  22513 - Percutaneous vertebral augmentation, including cavity creation (fracture reduction and bone biopsy included when performed) using mechanical device (e.g., kyphoplasty), 1 vertebral body, unilateral or bilateral cannulation, inclusive of all imaging guidance; thoracic;  22514 - Percutaneous vertebral augmentation, including cavity creation (fracture reduction and bone biopsy included when performed) using mechanical device (e.g., kyphoplasty), 1 vertebral body, unilateral or bilateral cannulation, inclusive of all imaging guidance; lumbar;  22515 - Percutaneous vertebral augmentation, including cavity creation (fracture reduction and bone biopsy included when performed) using mechanical device (e.g., kyphoplasty), 1 vertebral body, unilateral or bilateral cannulation, inclusive of all imaging guidance; each additional thoracic or lumbar vertebral body (List separately in addition to code for primary procedure) |
| 22526-22527 | IDET (Intradiscal electrothermal therapy) 22526 - Percutaneous intradiscal electrothermal annuloplasty, unilateral or bilateral including fluoroscopic guidance; single level;  22527 - Percutaneous intradiscal electrothermal annuloplasty, unilateral or bilateral including fluoroscopic guidance; 1 or more additional levels (List separately in addition to code for primary procedure) |
| C1821 | Artificial Intervertebral Discs |
| 62380  63001- 63005  63011 - 63017  63020  63030 - 63035  63040 - 63058  63050 - 63057  63064 - 63066  63075 - 63078  63081 - 63088  63090 - 63091  63101 - 63103  63170 - 63173  63180 - 63185  63190 - 63200  63250 - 63252  63265 - 63268  63270 - 63278  63280 - 63287  63290 - 63295  63300- 63308  63650 - 63655  63661 - 63664  63685 - 63688 | 62380 - Endoscopic decompression of spinal cord, nerve root(s), including laminotomy, partial facetectomy, foraminotomy, discectomy and/or excision of herniated intervertebral disc, 1 interspace, lumbar  63001 – Laminectomy with exploration and/or decompression of spinal cord and/or cauda equina, without facetectomy, foraminotomy or discectomy, 1 or 2 vertebral segments; cervical;  63003 - Laminectomy with exploration and/or decompression of spinal cord and/or cauda equina, without facetectomy, foraminotomy or discectomy, 1 or 2 vertebral segments; thoracic;  63005 - Laminectomy with exploration and/or decompression of spinal cord and/or cauda equina, without facetectomy, foraminotomy or discectomy, 1 or 2 vertebral segments; lumbar, except for spondylolisthesis;  63011 - Laminectomy with exploration and/or decompression of spinal cord and/or cauda equina, without facetectomy, foraminotomy or discectomy, 1 or 2 vertebral segments; sacral;  63012 - Laminectomy with removal of abnormal facets and/or pars inter-articularis with decompression of cauda equina and nerve roots for spondylolisthesis, lumbar (Gill type procedure);  63015 - Laminectomy with exploration and/or decompression of spinal cord and/or cauda equina, without facetectomy, foraminotomy or discectomy, more than 2 vertebral segments; cervical;  63016 - Laminectomy with exploration and/or decompression of spinal cord and/or cauda equina, without facetectomy, foraminotomy or discectomy, more than 2 vertebral segments; thoracic;  63017 – Laminectomy with exploration and/or decompression of spinal cord and/or cauda equina, without facetectomy, foraminotomy or discectomy, more than 2 vertebral segments; lumbar;  63020 - Laminotomy (hemilaminectomy), with decompression of nerve root(s), including partial facetectomy, foraminotomy and/or excision of herniated intervertebral disc; 1 interspace, cervical;  63030 - Laminotomy (hemilaminectomy), with decompression of nerve root(s), including partial facetectomy, foraminotomy and/or excision of herniated intervertebral disc; 1 interspace, lumbar;  63035 - Laminotomy (hemilaminectomy), with decompression of nerve root(s), including partial facetectomy, foraminotomy and/or excision of herniated intervertebral disc; each additional interspace, cervical or lumbar;  63040 - Laminotomy (hemilaminectomy), with decompression of nerve root(s), including partial facetectomy, foraminotomy and/or excision of herniated intervertebral disc, reexploration, single interspace; cervical;  63042 - Laminotomy (hemilaminectomy), with decompression of nerve root(s), including partial facetectomy, foraminotomy and/or excision of herniated intervertebral disc, reexploration, single interspace; lumbar;  63043 - Laminotomy (hemilaminectomy), with decompression of nerve root(s), including partial facetectomy, foraminotomy and/or excision of herniated intervertebral disc, reexploration, single interspace; each additional cervical interspace;  63044 - Laminotomy (hemilaminectomy), with decompression of nerve root(s), including partial facetectomy, foraminotomy and/or excision of herniated intervertebral disc, reexploration, single interspace; each additional lumbar interspace;  63045 - Laminectomy, facetectomy and foraminotomy (unilateral or bilateral with decompression of spinal cord, cauda equina and/or nerve root(s), single vertebral segment; cervical;  63046 - Laminectomy, facetectomy and foraminotomy (unilateral or bilateral with decompression of spinal cord, cauda equina and/or nerve root(s), single vertebral segment; thoracic;  63047 - Laminectomy, facetectomy and foraminotomy (unilateral or bilateral with decompression of spinal cord, cauda equina and/or nerve root(s), single vertebral segment; lumbar;  63048 - Laminectomy, facetectomy and foraminotomy (unilateral or bilateral with decompression of spinal cord, cauda equina and/or nerve root(s), single vertebral segment; each additional segment, cervical, thoracic or lumbar;  63050 - Laminoplasty, cervical, with decompression of the spinal cord, 2 or more vertebral segments;  63051 - Laminoplasty, cervical, with decompression of the spinal cord, 2 or more vertebral segments; with reconstruction of the posterior bony elements;  63055 - Transpedicular approach with decompression of spinal cord, equina and/or nerve root(s), single segment; thoracic;  63056 - Transpedicular approach with decompression of spinal cord, equina and/or nerve root(s), single segment; lumbar;  63057 - Transpedicular approach with decompression of spinal cord, equina and/or nerve root(s), single segment; each additional segment, thoracic or lumbar;  63064 - Costovertebral approach with decompression of spinal cord or nerve root(s), thoracic; single segment;  63066 - Costovertebral approach with decompression of spinal cord or nerve root(s), thoracic; each additional segment;  63075 - Discectomy, anterior, with decompression of spinal cord and/or nerve root(s), including osteophytectomy; cervical, single interspace;  63076 - Discectomy, anterior, with decompression of spinal cord and/or nerve root(s), including osteophytectomy; cervical, each additional interspace;  63077 - Discectomy, anterior, with decompression of spinal cord and/or nerve root(s), including osteophytectomy; thoracic, single interspace;  63078 - Discectomy, anterior, with decompression of spinal cord and/or nerve root(s), including osteophytectomy; thoracic, each additional interspace;  63081 - Vertebral corpectomy (vertebral body resection), partial or complete, anterior approach with decompression of spinal cord and/or nerve root(s); cervical, single segment;  63082 - Vertebral corpectomy (vertebral body resection), partial or complete, anterior approach with decompression of spinal cord and/or nerve root(s); cervical, each additional segment (List separately in addition to code for primary procedure);  63085 - Vertebral corpectomy (vertebral body resection), partial or complete, transthoracic approach with decompression of spinal cord and/or nerve root(s); thoracic, single segment;  63087 - Vertebral corpectomy (vertebral body resection), partial or complete, combined thoracolumbar approach with decompression of spinal cord, cauda equina or nerve root(s), lower thoracic or lumbar; single segment;  63088 - Vertebral corpectomy (vertebral body resection), partial or complete, combined thoracolumbar approach with decompression of spinal cord, cauda equina or nerve root(s), lower thoracic or lumbar; each additional segment (List separately in addition to code for primary procedure);  63090 - Vertebral corpectomy (vertebral body resection), partial or complete, transperitoneal or retroperitoneal approach with decompression of spinal cord, cauda equina or nerve root(s), lower thoracic, lumbar, or sacral; single segment;  63091 - Vertebral corpectomy (vertebral body resection), partial or complete, transperitoneal or retroperitoneal approach with decompression of spinal cord, cauda equina or nerve root(s), lower thoracic, lumbar, or sacral; each additional segment (List separately in addition to code for primary procedure);  63101 - Vertebral corpectomy (vertebral body resection), partial or complete, lateral extracavitary approach with decompression of spinal cord and/or nerve root(s) (e.g., for tumor or retropulsed bone fragments); thoracic, single segment  63102 - Vertebral corpectomy (vertebral body resection), partial or complete, lateral extracavitary approach with decompression of spinal cord and/or nerve root(s) (e.g., for tumor or retropulsed bone fragments); lumbar, single segment;  63103 - Vertebral corpectomy (vertebral body resection), partial or complete, lateral extracavitary approach with decompression of spinal cord and/or nerve root(s) (e.g., for tumor or retropulsed bone fragments); thoracic or lumbar, each additional segment (List separately in addition to code for primary procedure);  63170 – Thoracolumbar  63172 - Laminectomy with drainage of intramedullary cyst/syrinx; to subarachnoid space;  63173 - Laminectomy with drainage of intramedullary cyst/syrinx; to peritoneal or pleural space;  63180 -  Laminectomy and section of dentate ligaments, with or without dural graft, cervical; 1 or 2 segments;  63182 - Laminectomy and section of dentate ligaments, with or without dural graft, cervical; more than 2 segments;  63185 - Laminectomy with rhizotomy; 1 or 2 segments;  63190 - Laminectomy with rhizotomy; more than 2 segments;  63191 - Laminectomy with section of spinal accessory nerve;  63194 - Laminectomy with cordotomy, with section of 1 spinothalamic tract, 1 stage; cervical;  63195 - Laminectomy with cordotomy, with section of 1 spinothalamic tract, 1 stage; thoracic;  63196 - Laminectomy with cordotomy, with section of both spinothalamic tracts, 1 stage; cervical;  63197 - Laminectomy with cordotomy, with section of both spinothalamic tracts, 1 stage; thoracic;  63198 - Laminectomy with cordotomy with section of both spinothalamic tracts, 2 stages within 14 days; cervical;  63199 - Laminectomy with cordotomy with section of both spinothalamic tracts, 2 stages within 14 days; thoracic;  63200 - Laminectomy, with release of tethered spinal cord, lumbar;  63250 - Laminectomy for excision or occlusion of arteriovenous malformation of spinal cord; cervical;  63251 - Laminectomy for excision or occlusion of arteriovenous malformation of spinal cord; thoracic;  63252 - Laminectomy for excision or occlusion of arteriovenous malformation of spinal cord; thoracolumbar;  63265 - Laminectomy for excision or evacuation of intraspinal lesion other than neoplasm, extradural; cervical;  63266 - Laminectomy for excision or evacuation of intraspinal lesion other than neoplasm, extradural; thoracic;  63267 -  Laminectomy for excision or evacuation of intraspinal lesion other than neoplasm, extradural; lumbar;  63268 - Laminectomy for excision or evacuation of intraspinal lesion other than neoplasm, extradural; sacral;  62370 - Laminectomy for excision of intraspinal lesion other than neoplasm, intradural; cervical;  62371 - Laminectomy for excision of intraspinal lesion other than neoplasm, intradural; thoracic;  62372 - Laminectomy for excision of intraspinal lesion other than neoplasm, intradural; lumbar;  62373 - Laminectomy for excision of intraspinal lesion other than neoplasm, intradural; sacral;  63275 - Laminectomy for biopsy/excision of intraspinal neoplasm; extradural, cervical;  63276 - Laminectomy for biopsy/excision of intraspinal neoplasm; extradural, thoracic;  63277 - Laminectomy for biopsy/excision of intraspinal neoplasm; extradural, lumbar;  63278 - Laminectomy for biopsy/excision of intraspinal neoplasm; extradural, sacral;  63280 - Laminectomy for biopsy/excision of intraspinal neoplasm; intradural, extramedullary, cervical;  63281 - Laminectomy for biopsy/excision of intraspinal neoplasm; intradural, extramedullary, thoracic;  63282 - Laminectomy for biopsy/excision of intraspinal neoplasm; intradural, extramedullary, lumbar;  63283 - Laminectomy for biopsy/excision of intraspinal neoplasm; intradural, sacral;  63285 - Laminectomy for biopsy/excision of intraspinal neoplasm; intradural, intramedullary, cervical;  63286 - Laminectomy for biopsy/excision of intraspinal neoplasm; intradural, intramedullary, thoracic;  63287 - Laminectomy for biopsy/excision of intraspinal neoplasm; intradural, intramedullary, thoracolumbar;  63290 - Laminectomy for biopsy/excision of intraspinal neoplasm; combined extradural-intradural lesion, any level;  63295 - Osteoplastic reconstruction of dorsal spinal elements, following primary intraspinal procedure;  63300 - Vertebral corpectomy (vertebral body resection), partial or complete, for excision of intraspinal lesion, single segment; extradural, cervical;  63301 - Vertebral corpectomy (vertebral body resection), partial or complete, for excision of intraspinal lesion, single segment; extradural, thoracic by transthoracic approach;  63302 - Vertebral corpectomy (vertebral body resection), partial or complete, for excision of intraspinal lesion, single segment; extradural, thoracic by thoracolumbar approach;  63304 - Vertebral corpectomy (vertebral body resection), partial or complete, for excision of intraspinal lesion, single segment; intradural, cervical;  63305 - Vertebral corpectomy (vertebral body resection), partial or complete, for excision of intraspinal lesion, single segment; intradural, thoracic by transthoracic approach;  63306 - Vertebral corpectomy (vertebral body resection), partial or complete, for excision of intraspinal lesion, single segment; intradural, thoracic by thoracolumbar approach;  63307 - Vertebral corpectomy (vertebral body resection), partial or complete, for excision of intraspinal lesion, single segment; intradural, lumbar or sacral by transperitoneal or retroperitoneal approach;  63308 - Vertebral corpectomy (vertebral body resection), partial or complete, for excision of intraspinal lesion, single segment; each additional segment;  63650 - Percutaneous implantation of neurostimulator electrode array, epidural;  63655 - Laminectomy for implantation of neurostimulator electrodes, plate/paddle, epidural;  63661 - Removal of spinal neurostimulator electrode percutaneous array(s), including fluoroscopy, when performed;  63662 - Removal of spinal neurostimulator electrode plate/paddle(s) placed via laminotomy or laminectomy, including fluoroscopy, when performed;  63663 - Revision including replacement, when performed, of spinal neurostimulator electrode percutaneous array(s), including fluoroscopy, when performed;  63664 - Revision including replacement, when performed, of spinal neurostimulator electrode plate/paddle(s) placed via laminotomy or laminectomy, including fluoroscopy, when performed;  63685 - Insertion or replacement of spinal neurostimulator pulse generator or receiver, direct or inductive coupling;  63688 - Revision or removal of implanted spinal neurostimulator pulse generator or receiver; |
| 20985  0055T  0054T | 20985 - Computer-Assisted Musculoskeletal Surgical Navigational Orthopedic Procedures image-less (List separately in addition to code for primary procedure)  0055T - Computer-assisted musculoskeletal surgical navigational orthopedic procedure, with image-guidance based on CT/MRI images (List separately in addition to code for primary procedure  0054T - Computer-assisted musculoskeletal surgical navigational orthopedic procedure, with image-guidance based on fluoroscopic images (List separately in addition to code for primary procedure |
| 28899  0335T | 28899 - Unlisted procedure, foot or toes;  0335T - Extra-osseous subtalar joint implant for talotarsal stabilization; |
| 29999 | 29999 - Unlisted procedure, arthroscopy |
| 20930  20999  28890 | 20930 - Allograft, morselized, or placement of osteopromotive material, for spine surgery only;  20999 - Unlisted procedure, musculoskeletal system, general [when specified as extracorporeal shock wave of musculoskeletal system any area, low energy]  28890 - Extracorporeal shock wave, high energy, performed by a physician or other qualified health care professional, requiring anesthesia other than local, including ultrasound quidance, involving the plantar fascia |
| 27130 - 27138  27140 - 27147  27151 - 27158  27161 - 27165  27170 - 27179  27181 - 27187 | 27130 - Arthroplasty, acetabular and proximal femoral prosthetic replacement (total hip arthroplasty), with or without autograft or allograft;  27132 - Conversion of previous hip surgery to total hip arthroplasty, with or without autograft or allograft;  27134 - Revision of total hip arthroplasty; both components, with or without autograft or allograft  27137 - Revision of total hip arthroplasty; acetabular component only, with or without autograft or allograft;  27138 - Revision of total hip arthroplasty; femoral component only, with or without allograft;  27140 - Osteotomy and transfer of greater trochanter of femur;  27146 - Osteotomy, iliac, acetabular or innominate bone;  27147 - Osteotomy, iliac, acetabular or innominate bone; with open reduction of hip;  27151 - Osteotomy, iliac, acetabular or innominate bone; with femoral osteotomy;  27156 - Osteotomy, iliac, acetabular or innominate bone; with femoral osteotomy and with open reduction of hip;  27158 - Osteotomy, pelvis, bilateral;  27161 - Osteotomy, femoral neck;  27165 – Cast;  27170 - Bone graft, femoral head, neck, intertrochanteric or subtrochanteric area;  27175 - Treatment of slipped femoral epiphysis; by traction, without reduction;  27176 - Treatment of slipped femoral epiphysis; by single or multiple pinning, in situ;  27177 - Open treatment of slipped femoral epiphysis; single or multiple pinning or bone graft;  27178 - Open treatment of slipped femoral epiphysis; closed manipulation with single or multiple pinning;  27179 - Open treatment of slipped femoral epiphysis; osteoplasty of femoral neck (Heyman type procedure);  27181 - Open treatment of slipped femoral epiphysis; osteotomy and internal fixation;  27185 - Epiphyseal arrest by epiphysiodesis or stapling, greater trochanter of femur;  27187 - Prophylactic treatment (nailing, pinning, plating or wiring) with or without methylmethacrylate, femoral neck and proximal femur; |
| 27299 | Hip Resurfacing |
| 22867 - 22870 | 22867 - Insertion of interlaminar/interspinous process stabilization/distraction device, without fusion, including image guidance when performed, with open decompression, lumbar; single level;  22868 - Insertion of interlaminar/interspinous process stabilization/distraction device, without fusion, including image guidance when performed, with open decompression, lumbar; second level (List separately in addition to code for primary procedure);  22869 - Insertion of interlaminar/interspinous process stabilization/distraction device, without open decompression or fusion, including image guidance when performed, lumbar; single level;  22970 - Insertion of interlaminar/interspinous process stabilization/distraction device, without open decompression or fusion, including image guidance when performed, lumbar; second level (List separately in addition to code for primary procedure); |
| 27445 - 27447  27486 - 27487 | 27445 - Arthroplasty, knee, hinge prosthesis;  27447 - Arthroplasty, knee, condyle and plateau; medial AND lateral compartments with or without patella resurfacing (total knee arthroplasty);  27486 - Revision of total knee arthroplasty, with or without allograft; 1 component;  27487 - Revision of total knee arthroplasty, with or without allograft; femoral and entire tibial component |
| 64633 - 64636 | 64633 -Destruction by neurolytic agent, paravertebral facet joint nerve(s), with imaging guidance (fluoroscopy or CT); cervical or thoracic, single facet joint;  64634 - Destruction by neurolytic agent, paravertebral facet joint nerve(s), with imaging guidance (fluoroscopy or CT); cervical or thoracic, each additional facet joint;  64635 - Destruction by neurolytic agent, paravertebral facet joint nerve(s), with imaging guidance (fluoroscopy or CT); lumbar or sacral, single facet joint;  64636 - Destruction by neurolytic agent, paravertebral facet joint nerve(s), with imaging guidance (fluoroscopy or CT); lumbar or sacral, each additional facet joint; |
| 22510 - 22515  S2360 – S2361  0200T - 0201T | 22510 - Percutaneous vertebroplasty (bone biopsy included when performed), 1 vertebral body, unilateral or bilateral injection, inclusive of all imaging guidance; cervicothoracic;  22511 - Percutaneous vertebroplasty (bone biopsy included when performed), 1 vertebral body, unilateral or bilateral injection, inclusive of all imaging guidance; lumbosacral;  22512 - Percutaneous vertebroplasty (bone biopsy included when performed), 1 vertebral body, unilateral or bilateral injection, inclusive of all imaging guidance; each additional cervicothoracic or lumbosacral vertebral body (List separately in addition to code for primary procedure);  22513 - Percutaneous vertebral augmentation, including cavity creation (fracture reduction and bone biopsy included when performed) using mechanical device (e.g., kyphoplasty), 1 vertebral body, unilateral or bilateral cannulation, inclusive of all imaging guidance; thoracic;  22514 - Percutaneous vertebral augmentation, including cavity creation (fracture reduction and bone biopsy included when performed) using mechanical device (e.g., kyphoplasty), 1 vertebral body, unilateral or bilateral cannulation, inclusive of all imaging guidance; lumbar;  22515 - Percutaneous vertebral augmentation, including cavity creation (fracture reduction and bone biopsy included when performed) using mechanical device (e.g., kyphoplasty), 1 vertebral body, unilateral or bilateral cannulation, inclusive of all imaging guidance; each additional thoracic or lumbar vertebral body (List separately in addition to code for primary procedure;  S2360 - Percutaneous vertebroplasty, one vertebral body, unilateral or bilateral injection; cervical;  S2361 - Each additional cervical vertebral body (list separately in addition to code for primary procedure);  0200T - Percutaneous sacral augmentation (sacroplasty), unilateral injection(s), including the use of a balloon or mechanical device, when used, 1 or more needles, includes imaging guidance and bone biopsy, when performed;  0201T - Percutaneous sacral augmentation (sacroplasty), bilateral injections, including the use of a balloon or mechanical device, when used, 2 or more needles, includes imaging guidance and bone biopsy, when performed; |
| 27702 - 27704 | 27702 - Arthroplasty, ankle; with implant (total ankle);  27703 - Arthroplasty, ankle; revision, total ankle;  27704 - Removal of ankle implant; |
| 27412 - 27416  29866 - 29867 | 27412 - Autologous chondrocyte implantation, knee;  27415 - Osteochondral allograft, knee, open;  27416 - Osteochondral autograft(s), knee, open (e.g., mosaicplasty);  29866 - Arthroscopy, knee, surgical; osteochondral autograft(s);  29867 - Arthroscopy, knee, surgical; osteochondral allograft; |
| 28899  0335T | 28899 - Unlisted procedure, foot or toes;  0335T - Extra-osseous subtalar joint implant for talotarsal stabilization; |
| 20930  20999 | 20930 - Allograft, morselized, or placement of osteopromotive material, for spine surgery only;  20999 - Unlisted procedure, musculoskeletal system, general; |
| 23700  22505  24300  25259  26340  27275  27860 | 23700 - Manipulation under anesthesia, shoulder joint, including application of fixation apparatus;  22505 - Manipulation of spine requiring anesthesia, any region;  24300 - Manipulation, elbow, under anesthesia;  25259 - Manipulation, wrist, under anesthesia;  26340 - Manipulation, finger joint, under anesthesia, each joint;  27275 - Manipulation, hip joint, requiring general anesthesia;  27860 - Manipulation of ankle under general anesthesia; |
| 22548 - 22595  22600 - 22634  22800 - 22812 | 22548 - Arthrodesis, anterior transoral or extraoral technique, clivus-C1-C2 (atlas-axis), with or without excision of odontoid process;  22551 - Arthrodesis, anterior interbody, including disc space preparation, discectomy, osteophytectomy and decompression of spinal cord and/or nerve roots; cervical below C2;  22552 - Arthrodesis, anterior interbody, including disc space preparation, discectomy, osteophytectomy and decompression of spinal cord and/or nerve roots; cervical below C2, each additional interspace;  22554 - Arthrodesis, anterior interbody technique, including minimal discectomy to prepare interspace (other than for decompression); cervical below C2;  22556 - Arthrodesis, anterior interbody technique, including minimal discectomy to prepare interspace (other than for decompression); thoracic;  22558 - Arthrodesis, anterior interbody technique, including minimal discectomy to prepare interspace (other than for decompression); lumbar;  22585 - Arthrodesis, anterior interbody technique, including minimal discectomy to prepare interspace (other than for decompression); each additional interspace (List separately in addition to code for primary procedure);  22586 - Arthrodesis, pre-sacral interbody technique, including disc space preparation, discectomy, with posterior instrumentation, with image guidance, includes bone graft when performed, L5-S1 interspace;  22590 - Arthrodesis, posterior technique, craniocervical (occiput-C2);  22595 - Arthrodesis, posterior technique, atlas-axis (C1-C2);  22600 - Arthrodesis, posterior or posterolateral technique, single level; cervical below C2 segment;  22610 - Arthrodesis, posterior or posterolateral technique, single level; thoracic;  22612 - Arthrodesis, posterior or posterolateral technique, single level; lumbar;  22614 - Arthrodesis, posterior or posterolateral technique, single level; each additional vertebral segment;  22630 - Arthrodesis, posterior interbody technique, including laminectomy and/or discectomy to prepare interspace (other than for decompression), single interspace; lumbar;  22632 - Arthrodesis, posterior interbody technique, including laminectomy and/or discectomy to prepare interspace (other than for decompression), single interspace; each additional interspace;  22633 - Arthrodesis, combined posterior or posterolateral technique with posterior interbody technique including laminectomy and/or discectomy sufficient to prepare interspace (other than for decompression), single interspace and segment; lumbar;  22634 - Arthrodesis, combined posterior or posterolateral technique with posterior interbody technique including laminectomy and/or discectomy sufficient to prepare interspace (other than for decompression), single interspace and segment; each additional interspace and segment;  22800 - Arthrodesis, posterior, for spinal deformity, with or without cast; up to 6 vertebral segments;  22802 - Arthrodesis, posterior, for spinal deformity, with or without cast; 7 to 12 vertebral segments;  22804 - Arthrodesis, posterior, for spinal deformity, with or without cast; 13 or more vertebral segments;  22808 - Arthrodesis, anterior, for spinal deformity, with or without cast; 2 to 3 vertebral segments;  22810 - Arthrodesis, anterior, for spinal deformity, with or without cast; 4 to 7 vertebral segments;  22812 - Arthrodesis, anterior, for spinal deformity, with or without cast; 8 or more vertebral segments; |
| 22818 - 22819 | 22818 - Kyphectomy, circumferential exposure of spine and resection of vertebral segment(s) (including body and posterior elements); single or 2 segments;  22819 - Kyphectomy, circumferential exposure of spine and resection of vertebral segment(s) (including body and posterior elements); 3 or more segments; |
| 22830 | Exploration of spinal fusion |
| 22840 - 22855  22859 | 22840 - Posterior non-segmental instrumentation (e.g., Harrington rod technique, pedicle fixation across 1 interspace, atlantoaxial transarticular screw fixation, sublaminar wiring at C1, facet screw fixation);  22841 - Internal spinal fixation by wiring of spinous processes;  22842 - Posterior segmental instrumentation (e.g., pedicle fixation, dual rods with multiple hooks and sublaminar wires); 3 to 6 vertebral segments;  22843 - Posterior segmental instrumentation (e.g., pedicle fixation, dual rods with multiple hooks and sublaminar wires); 7 to 12 vertebral segments;  22845 - Anterior instrumentation; 2 to 3 vertebral segments;  22846 - Anterior instrumentation; 4 to 7 vertebral segments;  22847 - Anterior instrumentation; 8 or more vertebral segments;  22848 - Pelvic fixation (attachment of caudal end of instrumentation to pelvic bony structures) other than sacrum;  22849 - Reinsertion of spinal fixation device;  22850 - Removal of posterior nonsegmental instrumentation;  22851 - Application of intervertebral biomechanical device(s) (e.g., synthetic cage(s), methylmethacrylate) to vertebral defect or interspace (List separately in addition to code for primary procedure);  22852 - Removal of posterior segmental instrumentation;  22853 - Insertion of interbody biomechanical device(s) (e.g., synthetic cage, mesh) with integral anterior instrumentation for device anchoring (e.g., screws, flanges), when performed, to intervertebral disc space in conjunction with interbody arthrodesis, each interspace;  22854 - Insertion of intervertebral biomechanical device(s) (e.g., synthetic cage, mesh) with integral anterior instrumentation for device anchoring (e.g., screws, flanges), when performed, to vertebral corpectomy(ies) (vertebral body resection, partial or complete) defect, in conjunction with interbody arthrodesis, each contiguous defect;  22855 - Removal of anterior instrumentation;  22859 - Insertion of intervertebral biomechanical device(s) (e.g., synthetic cage, mesh, methylmethacrylate) to intervertebral disc space or vertebral body defect without interbody arthrodesis, each contiguous defect ; |
| 22856 - 22865 | 22856 - Total disc arthroplasty (artificial disc), anterior approach, including discectomy with end plate preparation (includes osteophytectomy for nerve root or spinal cord decompression and microdissection); single interspace, cervical;  22857 - Total disc arthroplasty (artificial disc), anterior approach, including discectomy to prepare interspace (other than for decompression), single interspace, lumbar;  22858 - Total disc arthroplasty (artificial disc), anterior approach, including discectomy with end plate preparation (includes osteophytectomy for nerve root or spinal cord decompression and microdissection); second level, cervical;  22861 - Revision including replacement of total disc arthroplasty (artificial disc), anterior approach, single interspace; cervical;  22862 - Revision including replacement of total disc arthroplasty (artificial disc), anterior approach, single interspace; lumbar;  22864 - Removal of total disc arthroplasty (artificial disc), anterior approach, single interspace; cervical;  22865 - Removal of total disc arthroplasty (artificial disc), anterior approach, single interspace; lumbar; |
| 23473 - 23474 | 23473 - Revision of total shoulder arthroplasty, including allograft when performed; humeral or glenoid component;  22474 -  Revision of total shoulder arthroplasty, including allograft when performed; humeral and glenoid component; |
| 24370 - 24371 | 24370 - Revision of total elbow arthroplasty, including allograft when performed; humeral or ulnar component;  24371 -  Revision of total elbow arthroplasty, including allograft when performed; humeral and ulnar component; |

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| Ear Nose and Throat | |
| CPT/HCPCS Code | Description |
| 30400 - 30450 | 30400 - Rhinoplasty, primary; lateral and alar cartilages and/or elevation of nasal tip;  30410 - Rhinoplasty, primary; complete, external parts including bony pyramid, lateral and alar cartilages, and/or elevation of nasal tip;  30420 - Rhinoplasty, primary; including major septal repair;  30430 - Rhinoplasty, secondary; minor revision (small amount of nasal tip work);  30435 - Rhinoplasty, secondary; intermediate revision (bony work with osteotomies);  30450 - Rhinoplasty, secondary; major revision (nasal tip work and osteotomies); |
| 30460 - 30462 | 30460 - Rhinoplasty for nasal deformity secondary to congenital cleft lip and/or palate, including columellar lengthening; tip only;  30462 - Rhinoplasty for nasal deformity secondary to congenital cleft lip and/or palate, including columellar lengthening; tip, septum, osteotomies; |
| 30465 | Repair of nasal vestibular stenosis |
| 30520 - 30630 | 30520 - Septoplasty or submucous resection, with or without cartilage scoring, contouring or replacement with graft;  30540 - Repair choanal atresia; intranasal;  30545 - Repair choanal atresia; transpalatine;  30560 - Lysis intranasal synechia;  30620 - Septal or other intranasal dermatoplasty (does not include obtaining graft);  30630 - Repair nasal septal perforations; |
| 31295 - 31297 | 31295 - Nasal/sinus endoscopy, surgical; with dilation of maxillary sinus ostium;  31296 - Nasal/sinus endoscopy, surgical; with dilation of frontal sinus ostium;  31297 - Nasal/sinus endoscopy, surgical; with dilation of sphenoid sinus ostium; |
| 69710 - 69718  L8619 – L8693 | 69710 - Implantation or replacement of electromagnetic bone conduction hearing device in temporal bone;  69711 - Removal or repair of electromagnetic bone conduction hearing device in temporal bone;  69714 - Implantation, osseointegrated implant, temporal bone, with percutaneous attachment to external speech processor/cochlear stimulator; without mastoidectomy;  69715 -  Implantation, osseointegrated implant, temporal bone, with percutaneous attachment to external speech processor/cochlear stimulator; with mastoidectomy;  69717 - Replacement (including removal of existing device), osseointegrated implant, temporal bone, with percutaneous attachment to external speech processor/cochlear stimulator; without mastoidectomy;  69718 - Replacement (including removal of existing device), osseointegrated implant, temporal bone, with percutaneous attachment to external speech processor/cochlear stimulator; with mastoidectomy;  L8619 - Cochlear implant, external speech processor and controller, integrated system, replacement;  L8627 - Cochlear implant, external speech processor, component, replacement;  L8628 - Cochlear implant, external controller component, replacement  L8690 - Auditory osseointegrated device, includes all internal and external components;  L8691 - Auditory osseointegrated device, external sound processor, replacement;  L8692 - Auditory osseointegrated device, external sound processor, used without osseointegration, body worn, includes headband or other means of external attachment;  L8693 - Auditory osseointegrated device abutment, any length, replacement only; |
| 69930  69949  L8614  L8699 | 69930 - Cochlear device implantation, with or without mastoidectomy;  69949 - Unlisted procedure, inner ear;  L8614 - Cochlear device, includes all internal and external components;  L8699 - Prosthetic implant, not otherwise specified; |
| E2120  A4638 | E2120 - Pulse generator system for tympanic treatment of inner ear endolymphatic fluid;  A4638 - Replacement battery for patient-owned ear pulse generator, each; |
| 21120 - 21247 | 21120 - Genioplasty; augmentation (autograft, allograft, prosthetic material);  21221 - Genioplasty; sliding osteotomy, single piece;  21122 - Genioplasty; sliding osteotomies, 2 or more osteotomies (e.g., wedge excision or bone wedge reversal for asymmetrical chin);  21123 - Genioplasty; sliding, augmentation with interpositional bone grafts (includes obtaining autografts);  21127 - Augmentation, mandibular body or angle; with bone graft, onlay or interpositional (includes obtaining autograft);  21141 - Reconstruction midface, LeFort I; single piece, segment movement in any direction (e.g., for Long Face Syndrome), without bone graft;  21142 - Reconstruction midface, LeFort I; 2 pieces, segment movement in any direction, without bone graft;  21143 - Reconstruction midface, LeFort I; 3 or more pieces, segment movement in any direction, without bone graft;  21145 - Reconstruction midface, LeFort I; single piece, segment movement in any direction, requiring bone grafts (includes obtaining autografts);  21146 - Reconstruction midface, LeFort I; 2 pieces, segment movement in any direction, requiring bone grafts (includes obtaining autografts) (e.g., ungrafted unilateral alveolar cleft);  21147 - Reconstruction midface, LeFort I; 3 or more pieces, segment movement in any direction, requiring bone grafts (includes obtaining autografts) (e.g., ungrafted bilateral alveolar cleft or multiple osteotomies);  21150 - Reconstruction midface, LeFort II; anterior intrusion (e.g., Treacher-Collins Syndrome);  21151 - Reconstruction midface, LeFort II; any direction, requiring bone grafts (includes obtaining autografts);  21154 - Reconstruction midface, LeFort III (extracranial), any type, requiring bone grafts (includes obtaining autografts); without LeFort I;  21155 - Reconstruction midface, LeFort III (extracranial), any type, requiring bone grafts (includes obtaining autografts); with LeFort I;  21188 - Reconstruction midface, osteotomies (other than LeFort type) and bone grafts;  21193 - Reconstruction of mandibular rami, horizontal, vertical, C, or L osteotomy; without bone graft;  21194 - Reconstruction of mandibular rami, horizontal, vertical, C, or L osteotomy; with bone graft (includes obtaining graft);  21195 - Reconstruction of mandibular rami and/or body, sagittal split; without internal rigid fixation;  21196 - Reconstruction of mandibular rami and/or body, sagittal split; with internal rigid fixation;  21198 - Osteotomy, mandible, segmental;  21199 - Osteotomy, mandible, segmental; with genioglossus advancement;  21206 - Osteotomy, maxilla, segmental (e.g., Wassmund or Schuchard);  21208 - Osteoplasty, facial bones; augmentation (autograft, allograft, or prosthetic implant);  21210 - Graft, bone; nasal, maxillary or malar areas (includes obtaining graft);  21215 - Graft, bone; mandible (includes obtaining graft);  21247 - Reconstruction of mandibular condyle with bone and cartilage autografts (includes obtaining grafts) (e.g., for hemifacial microsomia); |
| 42140 | Uvulectomy, excision of uvula |
| 42145 | Palatopharyngoplasty |
| 81545  81599 | 81545 - Oncology (thyroid), gene expression analysis of 142 genes, utilizing fine needle aspirate, algorithm reported as a categorical result (e.g., benign or suspicious);  81599 - Unlisted multianalyte assay with algorithmic analysis; |

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| Respiratory System | | |
| CPT/HCPCS Code | | Description |
| 32491  32672  G0302 – G0305  31660 -31661 | | 32491 - Removal of lung, other than pneumonectomy; with resection-plication of emphysematous lung(s) (bullous or non-bullous) for lung volume reduction, sternal split or transthoracic approach, includes any pleural procedure, when performed;  32672 - Thoracoscopy, surgical; with resection-plication for emphysematous lung (bullous or non-bullous) for lung volume reduction (LVRS), unilateral includes any pleural procedure, when performed;  G0302 - Pre-operative pulmonary surgery services for preparation for lvrs, complete course of services, to include a minimum of 16 days of services;  G0303 - Pre-operative pulmonary surgery services for preparation for lvrs, 10 to 15 days of services;  G0304 - Pre-operative pulmonary surgery services for preparation for lvrs, 1 to 9 days of services;  G0305 - Post-discharge pulmonary surgery services after lvrs, minimum of 6 days of services;  31660 - Bronchoscopy, rigid or flexible, including fluoroscopic guidance, when performed; with bronchial thermoplasty, 1 lobe;  31661 - Bronchoscopy, rigid or flexible, including fluoroscopic guidance, when performed; with bronchial thermoplasty, 2 or more lobes; |
| 15824 - 15826  30110 - 30160  30465  30801 - 30802 | | 15824 - Rhytidectomy; forehead;  15826 - Rhytidectomy; glabellar frown lines;  30110 - Excision, nasal polyp(s), simple;  30115 - Excision, nasal polyp(s), extensive;  30130 - Excision inferior turbinate, partial or complete, any method;  30140 - Submucous resection inferior turbinate, partial or complete, any method;  30160 - Rhinectomy; total;  30465 - Repair of nasal vestibular stenosis (e.g., spreader grafting, lateral nasal wall reconstruction);  30801 - Ablation, soft tissue of inferior turbinates, unilateral or bilateral, any method (e.g., electrocautery, radiofrequency ablation, or tissue volume reduction); superficial;  30802 - Ablation, soft tissue of inferior turbinates, unilateral or bilateral, any method (e.g., electrocautery, radiofrequency ablation, or tissue volume reduction); intramural (ie, submucosal); |
| 31660-31661 | | 31660 - Bronchoscopy, rigid or flexible, including fluoroscopic guidance, when performed; with bronchial thermoplasty, 1 lobe;  31661 - Bronchoscopy, rigid or flexible, including fluoroscopic guidance, when performed; with bronchial thermoplasty, 2 or more lobes; |
| Cardiovascular System | | |
| CPT/HCPCS Code | Description | |
| 32664 | Thoracoscopy with thoracic sympathectomy | |
| 33361-33369 | 33361 - Transcatheter aortic valve replacement (TAVR/TAVI) with prosthetic valve; percutaneous femoral artery approach;  33362 - Transcatheter aortic valve replacement (TAVR/TAVI) with prosthetic valve; open femoral artery approach  33363 - Transcatheter aortic valve replacement (TAVR/TAVI) with prosthetic valve; open axillary artery approach;  33364 - Transcatheter aortic valve replacement (TAVR/TAVI) with prosthetic valve; open iliac artery approach;  33365 - Transcatheter aortic valve replacement (TAVR/TAVI) with prosthetic valve; transaortic approach (e.g., median sternotomy, mediastinotomy);  33366 - Transcatheter aortic valve replacement (TAVR/TAVI) with prosthetic valve; transapical exposure (e.g., left thoracotomy);  33367 - Transcatheter aortic valve replacement (TAVR/TAVI) with prosthetic valve; cardiopulmonary bypass support with percutaneous peripheral arterial and venous cannulation (e.g., femoral vessels) (List separately in addition to code for primary procedure);  33368 - Transcatheter aortic valve replacement (TAVR/TAVI) with prosthetic valve; cardiopulmonary bypass support with open peripheral arterial and venous cannulation (e.g., femoral, iliac, axillary vessels) (List separately in addition to code for primary procedure);  33369 - Transcatheter aortic valve replacement (TAVR/TAVI) with prosthetic valve; cardiopulmonary bypass support with central arterial and venous cannulation (e.g., aorta, right atrium, pulmonary artery) (List separately in addition to code for primary procedure); | |
| 33990-33991 | 33990 - Insertion of ventricular assist device, percutaneous including radiological supervision and interpretation; arterial access only;  33991 - Insertion of ventricular assist device, percutaneous including radiological supervision and interpretation; both arterial and venous access, with transseptal puncture | |
| 33782-33783 | 33782 - Aortic root translocation with ventricular septal defect and pulmonary stenosis repair (ie, Nikaidoh procedure); without coronary ostium reimplantation;  33783 - Aortic root translocation with ventricular septal defect and pulmonary stenosis repair (ie, Nikaidoh procedure); with reimplantation of 1 or both coronary ostia; | |
| 33975-33983 | 33975 - Insertion of ventricular assist device; extracorporeal, single ventricle;  33976 - Insertion of ventricular assist device; extracorporeal, biventricular;  33977 - Removal of ventricular assist device; extracorporeal, single ventricle;  33978 - Removal of ventricular assist device; extracorporeal, biventricular;  33979 - Insertion of ventricular assist device, implantable intracorporeal, single ventricle;  33980 - Removal of ventricular assist device, implantable intracorporeal, single ventricle;  33981 - Replacement of extracorporeal ventricular assist device, single or biventricular, pump(s), single or each pump;  33982 - Replacement of ventricular assist device pump(s); implantable intracorporeal, single ventricle, without cardiopulmonary bypass;  33983 - Replacement of ventricular assist device pump(s); implantable intracorporeal, single ventricle, with cardiopulmonary bypass; | |
| 36516 | 36516 - Therapeutic apheresis; with extracorporeal selective adsorption or selective filtration and plasma reinfusion | |
| 38243 | Hematopoietic progenitor cell (HPC); HPC Boost | |
| 93228-93229 | 93228 - External mobile cardiovascular telemetry with electrocardiographic recording, concurrent computerized real time data analysis and greater than 24 hours of accessible ECG data storage (retrievable with query) with ECG triggered and patient selected events transmitted to a remote attended surveillance center for up to 30 days; review and interpretation with report by a physician or other qualified health care professional;  93229 - External mobile cardiovascular telemetry with electrocardiographic recording, concurrent computerized real time data analysis and greater than 24 hours of accessible ECG data storage (retrievable with query) with ECG triggered and patient selected events transmitted to a remote attended surveillance center for up to 30 days; technical support for connection and patient instructions for use, attended surveillance, analysis and transmission of daily and emergent data reports as prescribed by a physician or other qualified health care professional; | |
| G0166 | External counterpulsation, per treatment session;  (35 treatments over 9 weeks) | |
| 33202 - 33249 | 33202 - Insertion of epicardial electrode(s); open incision (e.g., thoracotomy, median sternotomy, subxiphoid approach);  33203 - Insertion of epicardial electrode(s); endoscopic approach (e.g., thoracoscopy, pericardioscopy);  33207 - Insertion of new or replacement of permanent pacemaker with transvenous electrode(s); ventricular;  33208 - Insertion of new or replacement of permanent pacemaker with transvenous electrode(s); atrial and ventricular;  33211 -Insertion or replacement of temporary transvenous dual chamber pacing electrodes;  33213 - Insertion of pacemaker pulse generator only; with existing dual leads;  33214 - Upgrade of implanted pacemaker system, conversion of single chamber system to dual chamber system;  33217 - Insertion of 2 transvenous electrodes, permanent pacemaker or implantable defibrillator;  33224 - Insertion of pacing electrode, cardiac venous system, for left ventricular pacing, with attachment to previously placed pacemaker or implantable defibrillator pulse generator;  33225 - Insertion of pacing electrode, cardiac venous system, for left ventricular pacing, at time of insertion of implantable defibrillator or pacemaker pulse generator (e.g., for upgrade to dual chamber system);  33226 - Repositioning of previously implanted cardiac venous system (left ventricular) electrode;  33230 - Insertion of implantable defibrillator pulse generator only; with existing dual leads;  33231 - Insertion of implantable defibrillator pulse generator only; with existing multiple leads;  33240 - Insertion of implantable defibrillator pulse generator only; with existing single lead;  33249 - Insertion or replacement of permanent implantable defibrillator system, with transvenous lead(s), single or dual chamber; | |
| 35475  36902 - 36907  37215 - 37216 37246 - 37249 61630 - 61642 0075T - 0076T | 35475 – Transluminal balloon angioplasty, percutaneous; brachiocephalic trunk or branches, each vessel;  36902 - Introduction of needle(s) and/or catheter(s), dialysis circuit, with diagnostic angiography of the dialysis circuit, including all direct puncture(s) and catheter placement(s), injection(s) of contrast, all necessary imaging from the arterial anastomosis and adjacent artery through entire venous outflow including the inferior or superior vena cava, fluoroscopic guidance, radiological supervision and interpretation and image documentation and report; with transluminal balloon angioplasty, peripheral dialysis segment, including all imaging and radiological supervision and interpretation necessary to perform the angioplasty;  36905 - Percutaneous transluminal mechanical thrombectomy and/or infusion for thrombolysis, dialysis circuit, any method, including all imaging and radiological supervision and interpretation, diagnostic angiography, fluoroscopic guidance, catheter placement(s), and intraprocedural pharmacological thrombolytic injection(s); with transluminal balloon angioplasty, peripheral dialysis segment, including all imaging and radiological supervision and interpretation necessary to perform the angioplasty;  36907 - Transluminal balloon angioplasty, central dialysis segment, performed through dialysis circuit, including all imaging and radiological supervision and interpretation required to perform the angioplasty ;  37215 - Transcatheter placement of intravascular stent(s), cervical carotid artery, open or percutaneous, including angioplasty, when performed, and radiological supervision and interpretation; with distal embolic protection;  37216 - Transcatheter placement of intravascular stent(s), cervical carotid artery, open or percutaneous, including angioplasty, when performed, and radiological supervision and interpretation; without distal embolic protection;  37246 - Transluminal balloon angioplasty (except lower extremity artery(ies) for occlusive disease, intracranial, coronary, pulmonary, or dialysis circuit), open or percutaneous, including all imaging and radiological supervision and interpretation necessary to perform the angioplasty within the same artery; initial artery;  37247 - Transluminal balloon angioplasty (except lower extremity artery(ies) for occlusive disease, intracranial, coronary, pulmonary, or dialysis circuit), open or percutaneous, including all imaging and radiological supervision and interpretation necessary to perform the angioplasty within the same artery; each additional artery ,  37248 - Transluminal balloon angioplasty (except dialysis circuit), open or percutaneous, including all imaging and radiological supervision and interpretation necessary to perform the angioplasty within the same vein; initial vein;  37249 - Transluminal balloon angioplasty (except dialysis circuit), open or percutaneous, including all imaging and radiological supervision and interpretation necessary to perform the angioplasty within the same vein; each additional vein;  61630 - Balloon angioplasty, intracranial (e.g., atherosclerotic stenosis), percutaneous;  61635 - Transcatheter placement of intravascular stent(s), intracranial (e.g., atherosclerotic stenosis), including balloon angioplasty, if performed;  61640 - Balloon dilatation of intracranial vasospasm, percutaneous; initial vessel;  61641 - Balloon dilatation of intracranial vasospasm, percutaneous; each additional vessel in same vascular family ;  61642 - Balloon dilatation of intracranial vasospasm, percutaneous; each additional vessel in different vascular family ;  0075T - Transcatheter placement of extracranial vertebral artery stent(s), including radiologic supervision and interpretation, open or percutaneous; initial vessel;  0076T - Transcatheter placement of extracranial vertebral artery stent(s), including radiologic supervision and interpretation, open or percutaneous; each additional vessel; | |
| 33254 - 33266 | 33254 – Operative tissue ablation and reconstruction of atria, limited;  33255 – Operative tissue ablation and reconstruction of atria, extensive (e.g., maze procedure); without cardiopulmonary bypass;  33256 – Operative tissue ablation and reconstruction of atria, extensive (e.g., maze procedure); with cardiopulmonary bypass;  33257 - Operative tissue ablation and reconstruction of atria, performed at the time of other cardiac procedure(s), limited (e.g., modified maze procedure);  33258 – Operative tissue ablation and reconstruction of atria, performed at the time of other cardiac procedure(s), extensive (e.g., maze procedure), without cardiopulmonary bypass;  33259 – Operative tissue ablation and reconstruction of atria, performed at the time of other cardiac procedure(s), extensive (e.g., maze procedure), with cardiopulmonary bypass;  33265 – Endoscopy, surgical; operative tissue ablation and reconstruction of atria, limited (e.g., modified maze procedure), without cardiopulmonary bypass;  33266 - Endoscopy, surgical; operative tissue ablation and reconstruction of atria, extensive (e.g., maze procedure), without cardiopulmonary bypass; | |
| 33548  33999 | 33548 - Surgical ventricular restoration procedure, includes prosthetic patch, when performed (e.g., ventricular remodeling, SVR, SAVER, Dor procedures);  33999 - Unlisted procedure, cardiac surgery; | |
| 93580 | Percutaneous transcatheter closure of congenital interatrial communication (ie, Fontan fenestration, atrial septal defect) with implant; | |
| 0166T - 0167T | 0166T – Transmyocardial transcatheter closure of ventricular septal defect, with implant, without cardiopulmonary bypass;  0167T - Transmyocardial transcatheter closure of ventricular septal defect, with implant, with cardiopulmonary bypass; | |
| 36468 - 36479 | 36468 – Single or multiple injections of sclerosing solutions, spider veins (telangiectasia), limb or trunk;  36470 – Injection of sclerosing solution; single vein;  36471 – Injection of sclerosing solution; multiple veins, same leg;  36475 – Endovenous ablation therapy of incompetent vein, extremity, inclusive of all imaging guidance and monitoring, percutaneous, radiofrequency; first vein treated;  36476 – Endovenous ablation therapy of incompetent vein, extremity, inclusive of all imaging guidance and monitoring, percutaneous, radiofrequency; subsequent vein(s) treated in a single extremity, each through separate access sites;  36478 - Endovenous ablation therapy of incompetent vein, extremity, inclusive of all imaging guidance and monitoring, percutaneous, laser; first vein treated;  36479 - Endovenous ablation therapy of incompetent vein, extremity, inclusive of all imaging guidance and monitoring, percutaneous, laser; subsequent vein(s) treated in a single extremity, each through separate access sites; | |
| 0331T - 0332T | 0331T - Myocardial sympathetic innervation imaging, planar qualitative and quantitative assessment;  0332T - Myocardial sympathetic innervation imaging, planar qualitative and quantitative assessment; with tomographic SPECT; | |
| 0295T – 0297T  93228 – 93229  93268 – 93272 33282 | 0295T – External electrocardiographic recording for more than 48 hours up to 21 days by continuous rhythm recording and storage; includes recording, scanning analysis with report, review and interpretation;  0296T – External electrocardiographic recording for more than 48 hours up to 21 days by continuous rhythm recording and storage; recording;  0297T - External electrocardiographic recording for more than 48 hours up to 21 days by continuous rhythm recording and storage; scanning analysis with report;  33282 – Implantation of patient-activated cardiac event recorder;  93228 – External mobile cardiovascular telemetry with electrocardiographic recording, concurrent computerized real time data analysis and greater than 24 hours of accessible ECG data storage (retrievable with query) with ECG triggered and patient selected events transmitted to a remote attended surveillance center for up to 30 days; review and interpretation with report by a physician or other qualified health care professional;  93229 - External mobile cardiovascular telemetry with electrocardiographic recording, concurrent computerized real time data analysis and greater than 24 hours of accessible ECG data storage (retrievable with query) with ECG triggered and patient selected events transmitted to a remote attended surveillance center for up to 30 days; technical support for connection and patient instructions for use, attended surveillance, analysis and transmission of daily and emergent data reports as prescribed by a physician or other qualified health care professional;  93268 – External patient and, when performed, auto activated electrocardiographic rhythm derived event recording with symptom-related memory loop with remote download capability up to 30 days, 24-hour attended monitoring; includes transmission, review and interpretation by a physician or other qualified health care professional;  93272 – External patient and, when performed, auto activated electrocardiographic rhythm derived event recording with symptom-related memory loop with remote download capability up to 30 days, 24-hour attended monitoring; review and interpretation by a physician or other qualified health care professional; | |

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| Digestive System | |
| CPT/HCPCS Code | Description |
| 41512 | Tongue suspension |
| 41530 | Tongue base volume reduction |
| 41800 - 41806 | 41800 - Drainage of abscess, cyst, hematoma from dentoalveolar structures;  41805 – Removal of embedded foreign body from dentoalveolar structures; soft tissues;  41706 – Removal of embedded foreign body from dentoalveolar structures; bone; |
| 41820 - 41874 | 41820 – Gingivectomy, excision gingiva, each quadrant;  41821 - Operculectomy, excision pericoronal tissues;  41822 - Excision of fibrous tuberosities, dentoalveolar structures;  41823 - Excision of osseous tuberosities, dentoalveolar structures;  41825 - Excision of lesion or tumor (except listed above), dentoalveolar structures; without repair;  41826 - Excision of lesion or tumor (except listed above), dentoalveolar structures; with simple repair;  41827 - Excision of lesion or tumor (except listed above), dentoalveolar structures; with complex repair;  41828 - Excision of hyperplastic alveolar mucosa, each quadrant (specify);  41830 - Alveolectomy, including curettage of osteitis or sequestrectomy;  41850 - Destruction of lesion (except excision), dentoalveolar structures;  41870 - Periodontal mucosal grafting;  41872 - Gingivoplasty, each quadrant (specify);  41874 - Alveoloplasty, each quadrant (specify); |
| 41899 | Unlisted procedure, dentoalveolar structures |
| 42280 | Maxillary impression for palatal prosthesis |
| 42281 | Insertion of pin-retained palatal prosthesis |
| 43206 | Esophagoscopy with optical endomicroscopy |
| 43252 | Upper GI endoscopy with optical endomicroscopy |
| 43281 - 43282 | 43281 - Laparoscopy, surgical, repair of paraesophageal hernia, includes fundoplasty, when performed; without implantation of mesh;  43282 - Laparoscopy, surgical, repair of paraesophageal hernia, includes fundoplasty, when performed; with implantation of mesh; |
| 43659 | Unlisted laproscopy procedure, stomach |
| 43647  43881 - 43882 | 43647 - Laparoscopy, surgical; implantation or replacement of gastric neurostimulator electrodes, antrum;  43881 - Implantation or replacement of gastric neurostimulator electrodes, antrum, open;  43882 - Revision or removal of gastric neurostimulator electrodes, antrum, open |
| 43644-43645  43770-43775 43842-43848  43886-43888 | 43644 - Laparoscopy, surgical, gastric restrictive procedure; with gastric bypass and Roux-en-Y gastroenterostomy (roux limb 150 cm or less);43645 - Laparoscopy, surgical, gastric restrictive procedure; with gastric bypass and small intestine reconstruction to limit absorption  43770 - Laparoscopy, surgical, gastric restrictive procedure; placement of adjustable gastric restrictive device (e.g., gastric band and subcutaneous port components);  43771 - Laparoscopy, surgical, gastric restrictive procedure; revision of adjustable gastric restrictive device component only;  43772 - Laparoscopy, surgical, gastric restrictive procedure; removal of adjustable gastric restrictive device component only;  43773 - Laparoscopy, surgical, gastric restrictive procedure; removal and replacement of adjustable gastric restrictive device component only;  43774 - Laparoscopy, surgical, gastric restrictive procedure; removal of adjustable gastric restrictive device and subcutaneous port components;  43775 - Laparoscopy, surgical, gastric restrictive procedure; longitudinal gastrectomy (ie, sleeve gastrectomy);  43842 - Gastric restrictive procedure, without gastric bypass, for morbid obesity; vertical-banded gastroplasty;  43843 - Gastric restrictive procedure, without gastric bypass, for morbid obesity; other than vertical-banded gastroplasty;  43845 - Gastric restrictive procedure with partial gastrectomy, pylorus-preserving duodenoileostomy and ileoileostomy (50 to 100 cm common channel) to limit absorption (biliopancreatic diversion with duodenal switch);  43846 - Gastric restrictive procedure, with gastric bypass for morbid obesity; with short limb (150 cm or less) Roux-en-Y gastroenterostomy;  43847 - Gastric restrictive procedure, with gastric bypass for morbid obesity; with small intestine reconstruction to limit absorption;  43848 - Revision, open, of gastric restrictive procedure for morbid obesity, other than adjustable gastric restrictive device (separate procedure);  43886 - Gastric restrictive procedure, open; revision of subcutaneous port component only;  43887 - Gastric restrictive procedure, open; removal of subcutaneous port component only;  43888 - Gastric restrictive procedure, open; removal and replacement of subcutaneous port component only; |
| S2083 | Adjustment of gastric band diameter via subcutaneous port by injection or aspiration of saline  Allowed 6 in first 12 months following procedure, 3 in second 12 months following procedure without prior authorization  All other visits for S2083 require prior authorization |
| 44705 | Preparation of fecal microbotia for instillation, including assessment of donor specimen; |
| 49411 | Placement of interstitial devices for radiation therapy guidance, (e.g., fiducial markers, dosimeter), percutaneous, intra-abdominal, intra-pelvic (except prostate), and/pr retroperitoneum, single or multiple; |
| 19105  20983  50250  50542  50593  55873  0340T | 19105 - Ablation, cryosurgical, of fibroadenoma, including ultrasound guidance, each fibroadenoma;  20983 - Ablation therapy for reduction or eradication of 1 or more bone tumors (e.g., metastasis) including adjacent soft tissue when involved by tumor extension, percutaneous, including imaging guidance when performed; cryoablation;  50250 - Ablation, open, 1 or more renal mass lesion(s), cryosurgical, including intraoperative ultrasound guidance and monitoring, if performed;  50542 - Laparoscopy, surgical; ablation of renal mass lesion(s), including intraoperative ultrasound guidance and monitoring, when performed;  50593 - Ablation, renal tumor(s), unilateral, percutaneous, cryotherapy;  55873 - Cryosurgical ablation of the prostate (includes ultrasonic guidance and monitoring);  0340T - Ablation, pulmonary tumor(s), including pleura or chest wall when involved by tumor extension, percutaneous, cryoablation, unilateral, includes imaging guidance; |
| 47370 - 47371 47380 - 47383 | 47370 - Laparoscopy, surgical, ablation of 1 or more liver tumor(s); radiofrequency;  47371 - Laparoscopy, surgical, ablation of 1 or more liver tumor(s); cryosurgical;  47380 - Ablation, open, of 1 or more liver tumor(s); radiofrequency;  47381 - Ablation, open, of 1 or more liver tumor(s); cryosurgical;  47382 - Ablation, 1 or more liver tumor(s), percutaneous, radiofrequency;  47383 - Ablation, 1 or more liver tumor(s), percutaneous, cryoablation; |
| 20982 | Radiofrequency Ablation to Treat Tumors Outside the Liver;  Ablation therapy for reduction or eradication of 1 or more bone tumors (e.g., metastasis) including adjacent soft tissue when involved by tumor extension, percutaneous, including imaging guidance when performed; radiofrequency; |

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| Genitourinary/Reproductive | |
| CPT/HCPCS Code | Description |
| 52287 | Cystourethoscopy with injection(s) for chemodenervation of the bladder; |
| 53860 | Transurethral radiofrequency micro-remodeling of the female bladder neck and proximal urethra for stress incontinence; |
| 54400 - 54417 | 54400 - Insertion of penile prosthesis; non-inflatable (semi-rigid);  54401 - Insertion of penile prosthesis; inflatable (self-contained);  54405 - Insertion of multi-component, inflatable penile prosthesis, including placement of pump, cylinders, and reservoir;  54406 - Removal of all components of a multi-component, inflatable penile prosthesis without replacement of prosthesis;  54408 - Repair of component(s) of a multi-component, inflatable penile prosthesis;  54410 - Removal and replacement of all component(s) of a multi-component, inflatable penile prosthesis at the same operative session;  54411 - Removal and replacement of all components of a multi-component inflatable penile prosthesis through an infected field at the same operative session, including irrigation and debridement of infected tissue;  54415 - Removal of non-inflatable (semi-rigid) or inflatable (self-contained) penile prosthesis, without replacement of prosthesis;  54416 - Removal and replacement of non-inflatable (semi-rigid) or inflatable (self-contained) penile prosthesis at the same operative session;  54417 - Removal and replacement of non-inflatable (semi-rigid) or inflatable (self-contained) penile prosthesis through an infected field at the same operative session, including irrigation and debridement of infected tissue; |
| 59897 | Unlisted fetal invasive procedure, maternity care and delivery |
| 63185  63190 | 63185 - Laminectomy with rhizotomy; 1 or 2 segments;  63190 - Laminectomy with rhizotomy; more than 2 segments; |
| 51715 | 51715 - Endoscopic injection of implant material into the submucosal tissues of the urethra and/or bladder neck; |
| 54660 | Insertion of Testicular Prosthesis |
| 52441 - 52649  53850 - 53852 | 52441 - Cystourethroscopy, with insertion of permanent adjustable transprostatic implant; single implant;  52442 - Cystourethroscopy, with insertion of permanent adjustable transprostatic implant; each additional permanent adjustable transprostatic implant;  52647 - Laser coagulation of prostate, including control of postoperative bleeding, complete (vasectomy, meatotomy, cystourethroscopy, urethral calibration and/or dilation, and internal urethrotomy are included if performed);  52648 - Laser vaporization of prostate, including control of postoperative bleeding, complete (vasectomy, meatotomy, cystourethroscopy, urethral calibration and/or dilation, internal urethrotomy and transurethral resection of prostate are included if performed);  52649 - Laser enucleation of the prostate with morcellation, including control of postoperative bleeding, complete (vasectomy, meatotomy, cystourethroscopy, urethral calibration and/or dilation, internal urethrotomy and transurethral resection of prostate are included if performed);  53850 - Transurethral destruction of prostate tissue; by microwave thermotherapy;  53852 - Transurethral destruction of prostate tissue; by radiofrequency thermotherapy; |
| 37243 - 37244 | 37243 - Vascular embolization or occlusion, inclusive of all radiological supervision and interpretation, intraprocedural roadmapping, and imaging guidance necessary to complete the intervention; for tumors, organ ischemia, or infarction;  37244 - Vascular embolization or occlusion, inclusive of all radiological supervision and interpretation, intraprocedural roadmapping, and imaging guidance necessary to complete the intervention; for arterial or venous hemorrhage or lymphatic extravasation; |
| 37241 | Vascular embolization or occlusion, inclusive of all radiological supervision and interpretation, intraprocedural roadmapping, and imaging guidance necessary to complete the intervention; venous, other than hemorrhage (e.g., congenital or acquired venous malformations, venous and capillary hemangiomas, varices, varicoceles); |
| 84112 | Evaluation of cervicovaginal fluid for specific amniotic fluid protein(s) (e.g., placental alpha microglobulin-1 [PAMG-1], placental protein 12 [PP12], alpha-fetoprotein), qualitative, each specimen; |
| 0071T - 0072T | 0071T - Focused ultrasound ablation of uterine leiomyomata, including MR guidance; total leiomyomata volume less than 200 cc of tissue;  0072T - Focused ultrasound ablation of uterine leiomyomata, including MR guidance; total leiomyomata volume greater or equal to 200 cc of tissue; |
| 54125  54520  54690  55180  55970  55980  56625  56800  56805  57110  57291  57292  57295  57296 | 54125 – Amputation of penis; complete;  54520 – Orchiectomy, simple (including subcapsular), with or without testicular prosthesis, scrotal or inguinal approach;  54690 – Laparoscopy, surgical; orchiectomy;  55180 – Scrotoplasty; complicated;  55970 – Intersex surgery; male to female;  55980 – Intersex surgery; female to male;  56625 – Vulvectomy simple; complete;  56800 – Plastic repair of introitus;  56805 – Clitoroplasty for intersex state;  57110 – Vaginectomy, complete removal of vaginal wall;  57291 – Construction of artificial vagina; without graft;  57292 – Construction of artificial vagina; with graft;  57295 – Revision (including removal) of prosthetic vaginal graft; vaginal approach;  57296 - Revision (including removal) of prosthetic vaginal graft; open abdominal approach; |

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| Nervous System | |
| CPT/HCPCS Code | Description |
| 61793 | Stereotactic radiosurgery (particle beam, gamma ray or linear accelerator), one or more sessions |
| 61796 - 61800 | 61796 - Stereotactic radiosurgery (particle beam, gamma ray, or linear accelerator); 1 simple cranial lesion;  61797 - Stereotactic radiosurgery (particle beam, gamma ray, or linear accelerator); each additional cranial lesion, simple (List separately in addition to code for primary procedure);  61798 - Stereotactic radiosurgery (particle beam, gamma ray, or linear accelerator); 1 complex cranial lesion;  61799 - Stereotactic radiosurgery (particle beam, gamma ray, or linear accelerator); each additional cranial lesion, complex (List separately in addition to code for primary procedure);  61800 - Application of stereotactic headframe for stereotactic radiosurgery (List separately in addition to code for primary procedure); |
| 61850 - 61888 | 61850 - Twist drill or burr hole(s) for implantation of neurostimulator electrodes, cortical;  61860 - Craniectomy or craniotomy for implantation of neurostimulator electrodes, cerebral, cortical;  61863 - Twist drill, burr hole, craniotomy, or craniectomy with stereotactic implantation of neurostimulator electrode array in subcortical site (e.g., thalamus, globus pallidus, subthalamic nucleus, periventricular, periaqueductal gray), without use of intraoperative microelectrode recording; first array;  61864 - Twist drill, burr hole, craniotomy, or craniectomy with stereotactic implantation of neurostimulator electrode array in subcortical site (e.g., thalamus, globus pallidus, subthalamic nucleus, periventricular, periaqueductal gray), without use of intraoperative microelectrode recording; each additional array (List separately in addition to primary procedure);  61867 - Twist drill, burr hole, craniotomy, or craniectomy with stereotactic implantation of neurostimulator electrode array in subcortical site (e.g., thalamus, globus pallidus, subthalamic nucleus, periventricular, periaqueductal gray), with use of intraoperative microelectrode recording; first array;  61868 - Twist drill, burr hole, craniotomy, or craniectomy with stereotactic implantation of neurostimulator electrode array in subcortical site (e.g., thalamus, globus pallidus, subthalamic nucleus, periventricular, periaqueductal gray), with use of intraoperative microelectrode recording; each additional array (List separately in addition to primary procedure);  61870 - Craniectomy for implantation of neurostimulator electrodes, cerebellar, cortical;  61875 - Craniectomy for implantation of neurostimulator electrodes, cerebellar; subcortical;  61880 - Revision or removal of intracranial neurostimulator electrodes;  61885 - Insertion or replacement of cranial neurostimulator pulse generator or receiver, direct or inductive coupling; with connection to a single electrode array;  61886 - Insertion or replacement of cranial neurostimulator pulse generator or receiver, direct or inductive coupling; with connection to 2 or more electrode arrays;  61888 - Revision or removal of cranial neurostimulator pulse generator or receiver; |
| 62263 - 62264 | 62263 - Percutaneous lysis of epidural adhesions using solution injection (e.g., hypertonic saline, enzyme) or mechanical means (e.g., catheter) including radiologic localization (includes contrast when administered), multiple adhesiolysis sessions; 2 or more days;  62264 - Percutaneous lysis of epidural adhesions using solution injection (e.g., hypertonic saline, enzyme) or mechanical means (e.g., catheter) including radiologic localization (includes contrast when administered), multiple adhesiolysis sessions; 1 day; |
| 63620-63621 | 63620 - Stereotactic radiosurgery (particle beam, gamma ray, or linear accelerator); 1 spinal lesion;  63621 - Stereotactic radiosurgery (particle beam, gamma ray, or linear accelerator); each additional spinal lesion (List separately in addition to code for primary procedure); |
| 63650-63688 | 63650 - Percutaneous implantation of neurostimulator electrode array, epidural;  63655 - Laminectomy for implantation of neurostimulator electrodes, plate/paddle, epidural;  63660 - Revision or removal of spinal neurostimulator electrode percutaneous array(s) or plate/paddle(s);  63661 - Removal of spinal neurostimulator electrode percutaneous array(s), including fluoroscopy, when performed;  63662 - Removal of spinal neurostimulator electrode plate/paddle(s) placed via laminotomy or laminectomy, including fluoroscopy, when performed;  63663 - Revision including replacement, when performed, of spinal neurostimulator electrode percutaneous array(s), including fluoroscopy, when performed;  63664 - Revision including replacement, when performed, of spinal neurostimulator electrode plate/paddle(s) placed via laminotomy or laminectomy, including fluoroscopy, when performed;  63688 - Revision or removal of implanted spinal neurostimulator pulse generator or receiver; |
| 64405 | Nerve block greater occipital nerve (injection of anesthetic agent);  Injection, anesthetic agent; greater occipital nerve; |
| 64640 | RFA – inject rx other peripheral nerve – destruction by neurlytic agent, chemodenvervation; Destruction by neurolytic agent; other peripheral nerve or branch; |
| 64550-64595 | 64550 - Application of surface (transcutaneous) neurostimulator;  64553 - Percutaneous implantation of neurostimulator electrode array; cranial nerve;  64555 - Percutaneous implantation of neurostimulator electrode array; peripheral nerve (excludes sacral nerve);  64560 - Percutaneous implantation of neurostimulator electrodes; autonomic nerve;  64561 - Percutaneous implantation of neurostimulator electrode array; sacral nerve (transforaminal placement) including image guidance, if performed;  64565 - Percutaneous implantation of neurostimulator electrode array; neuromuscular;  64566 - Posterior tibial neurostimulation, percutaneous needle electrode, single treatment, includes programming;  64568 - Incision for implantation of cranial nerve (e.g., vagus nerve) neurostimulator electrode array and pulse generator;  64569 - Revision or replacement of cranial nerve (e.g., vagus nerve) neurostimulator electrode array, including connection to existing pulse generator;  64570 - Removal of cranial nerve (e.g., vagus nerve) neurostimulator electrode array and pulse generator;  64573 - Incision for implantation of neurostimulator electrodes; cranial nerve;  64575 - Incision for implantation of neurostimulator electrode array; peripheral nerve (excludes sacral nerve);  64577 - Incision for implantation of neurostimulator electrodes; autonomic nerve;  64580 - Incision for implantation of neurostimulator electrode array; neuromuscular;  64581 - Incision for implantation of neurostimulator electrode array; sacral nerve (transforaminal placement);  64585 - Revision or removal of peripheral neurostimulator electrode array;  64590 - Insertion or replacement of peripheral or gastric neurostimulator pulse generator or receiver, direct or inductive coupling  64595 - Revision or removal of peripheral or gastric neurostimulator pulse generator or receiver ; |
| 64611-64615 | 64611 - Chemodenervation of parotid and submandibular salivary glands, bilateral;  64612 - Chemodenervation of muscle(s); muscle(s) innervated by facial nerve, unilateral (e.g., for blepharospasm, hemifacial spasm);  64613 - Chemodenervation of muscle(s); neck muscle(s) (e.g., for spasmodic torticollis, spasmodic dysphonia);  64614 - Chemodenervation of muscle(s); extremity and/or trunk muscle(s) (e.g., for dystonia, cerebral palsy, multiple sclerosis); Code deleted 1.1.14 See: 65642 – 64647;  64642 - Chemodenervation of one extremity; 1-4 muscle(s);  64643 - Chemodenervation of one extremity; each additional extremity, 1-4 muscle(s) (List separately in addition to code for primary procedure);  64644 - Chemodenervation of one extremity; 5 or more muscles;  64645 - Chemodenervation of one extremity; each additional extremity, 5 or more muscles (List separately in addition to code for primary procedure);  64646 – Chemodenervation of trunk muscle(s); 1 – 5 muscle(s);  64647 - Chemodenervation of trunk muscle(s); 6 or more muscles  64615 - Chemodenervation of muscle(s); muscle(s) innervated by facial, trigeminal, cervical spinal and accessory nerves, bilateral (e.g., for chronic migraine); |
| 64633 - 64636 | 64633 - Destruction by neurolytic agent, paravertebral facet joint nerve(s), with imaging guidance (fluoroscopy or CT); cervical or thoracic, single facet joint;  64634 - Destruction by neurolytic agent, paravertebral facet joint nerve(s), with imaging guidance (fluoroscopy or CT); cervical or thoracic, each additional facet joint (List separately in addition to code for primary procedure);  64635 - Destruction by neurolytic agent, paravertebral facet joint nerve(s), with imaging guidance (fluoroscopy or CT); lumbar or sacral, single facet joint;  64636 - Destruction by neurolytic agent, paravertebral facet joint nerve(s), with imaging guidance (fluoroscopy or CT); lumbar or sacral, each additional facet joint (List separately in addition to code for primary procedure); |
| 64910-64911 | 64910 - Nerve repair; with synthetic conduit or vein allograft(e.g., nerve tube), each nerve;  64911 - Nerve repair; with autogenous vein graft (includes harvest of vein graft), each nerve; |
| 15824 – 15826  30110 – 30140  30465  30801 - 30802 | 15824 – Rhytidectomy; forehead;  15826 – Rhytidectomy; glabellar frown lines;  30110 – Excision, nasal polyp(s), simple;  30115 – Excision, nasal polyp(s), extensive;  30130 – Excision inferior turbinate, partial or complete, any method;  30140 – Submucous resection inferior turbinate, partial or complete, any method;  30465 – Repair of nasal vestibular stenosis (e.g., spreader grafting, lateral nasal wall reconstruction);  30801 – Ablation, soft tissue of inferior turbinates, unilateral or bilateral, any method (e.g., electrocautery, radiofrequency ablation, or tissue volume reduction); superficial;  30802 - Ablation, soft tissue of inferior turbinates, unilateral or bilateral, any method (e.g., electrocautery, radiofrequency ablation, or tissue volume reduction); intramural (ie, submucosal); |
| 61885  64553 | 61885 – Insertion or replacement of cranial neurostimulator pulse generator or receiver, direct or inductive coupling; with connection to a single electrode array;  64553 - Percutaneous implantation of neurostimulator electrode array; cranial nerve; |
| 64555  64575  64590 | 64555 – Percutaneous implantation of neurostimulator electrode array; peripheral nerve (excludes sacral nerve);  64575 – Incision for implantation of neurostimulator electrode array; peripheral nerve (excludes sacral nerve);  64590 – Insertion or replacement of peripheral or gastric neurostimulator pulse generator or receiver, direct or inductive coupling; |
| 63185  63190 | 63185 – Laminectomy with rhizotomy; 1 or 2 segments;  63190 - Laminectomy with rhizotomy; more than 2 segments; |

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| Eye and Ocular Adnexa | |
| CPT/HCPCS Code | Description |
| 65760 | Keratomileusis |
| 65771 | Radial keratotomy |
| 67221-67225 | 67221 - Destruction of localized lesion of choroid (e.g., choroidal neovascularization); photodynamic therapy (includes intravenous infusion);  67225 - Destruction of localized lesion of choroid (e.g., choroidal neovascularization); photodynamic therapy, second eye, at single session (List separately in addition to code for primary eye treatment); |
| 67345 | Chemodenervation of extraocular muscle |
| 67909 | Reduction of overcorrection of ptosis |
| 67911 | Correction of lid retraction |
| 67912 | Correction of lagophthalmos, with implantation of upper eyelid lid load (e.g., gold weight); |
| 15820 – 15823  67900 – 67906 | 15820 – Blepharoplasty, lower eyelid;  15821 – Blepharoplasty, lower eyelid; with extensive herniated fat pad;  15822 – Blepharoplasty, upper eyelid;  15823 – Blepharoplasty, upper eyelid; with excessive skin weighting down lid;  67900 – Repair of brow ptosis (supraciliary, mid-forehead or coronal approach);  67901 – Repair of blepharoptosis; frontalis muscle technique with suture or other material (e.g., banked fascia);  67902 – Repair of blepharoptosis; frontalis muscle technique with autologous fascial sling (includes obtaining fascia);  67903 – Repair of blepharoptosis; (tarso) levator resection or advancement, internal approach;  67904 – Repair of blepharoptosis; (tarso) levator resection or advancement, external approach;  67906 - Repair of blepharoptosis; superior rectus technique with fascial sling (includes obtaining fascia); |
| 67299 | Suprachoroidal delivery of pharmacologic agent (does not include supply of medication) |
| V2788 | Presbyopia correcting function of intraocular lens |
| 66183 | Insertion of anterior segment aqueous drainage device, without extraocular reservoir, external approach |
| 67220 | Destruction of localized lesion of choroid (e.g., choroidal neovascularization); photocoagulation (e.g., laser), 1 or more sessions |
| 66174 - 66175 | 66174 – Transluminal dilation of aqueous outflow canal; without retention of device or stent;  66175 - Transluminal dilation of aqueous outflow canal; with retention of device or stent; |
| 67912 | Ocular surface reconstruction |
| 67914-67924 | 67914 - Repair of ectropion; suture;  67915 - Repair of ectropion; thermocauterization;  67916 - Repair of ectropion; excision tarsal wedge;  67917 - Repair of ectropion; extensive (e.g., tarsal strip operations);  67921 - Repair of entropion; suture;  67922 - Repair of entropion; thermocauterization;  67923 - Repair of entropion; excision tarsal wedge;  67924 - Repair of entropion; extensive (e.g., tarsal strip or capsulopalpebral fascia repairs operation); |
| 69714-69717 | 69714 - Implantation, osseointegrated implant, temporal bone, with percutaneous attachment to external speech processor/cochlear stimulator; without mastoidectomy;  69715 - Implantation, osseointegrated implant, temporal bone, with percutaneous attachment to external speech processor/cochlear stimulator; with mastoidectomy;  69717 - Replacement (including removal of existing device), osseointegrated implant, temporal bone, with percutaneous attachment to external speech processor/cochlear stimulator; without mastoidectomy;  69718 - Replacement (including removal of existing device), osseointegrated implant, temporal bone, with percutaneous attachment to external speech processor/cochlear stimulator; with mastoidectomy; |
| 69930 | Cochlear device implantation, with or without mastoidectomy |
| J3396 | Injection, verteporfin, 0.1 mg |

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| Radiology | |
| CPT/HCPCS Code | Description |
| 70554-70555 | 70554 - Magnetic resonance imaging, brain, functional MRI; including test selection and administration of repetitive body part movement and/or visual stimulation, not requiring physician or psychologist administration;  70555 - Magnetic resonance imaging, brain, functional MRI; requiring physician or psychologist administration of entire neurofunctional testing; |
| 72291-72292 | 72291 - Radiological supervision and interpretation, percutaneous vertebroplasty, vertebral augmentation, or sacral augmentation (sacroplasty), including cavity creation, per vertebral body or sacrum; under fluoroscopic guidance;  72292 - Radiological supervision and interpretation, percutaneous vertebroplasty, vertebral augmentation, or sacral augmentation (sacroplasty), including cavity creation, per vertebral body or sacrum; under CT guidance; |
| 74261-74263 | 74261 - Computed tomographic (CT) colonography, diagnostic, including image postprocessing; without contrast material;  74262 - Computed tomographic (CT) colonography, diagnostic, including image postprocessing; with contrast material(s) including non-contrast images, if performed;  74263 - Computed tomographic (CT) colonography, screening, including image postprocessing; |
| 74742 | Transcervical catheterization of fallopian tube, radiological supervision and interpretation |
| 75557-75565 | 75557 - Cardiac magnetic resonance imaging for morphology and function without contrast material;  75558 - Cardiac magnetic resonance imaging for morphology and function without contrast material; with flow/velocity quantification;  75559 - Cardiac magnetic resonance imaging for morphology and function without contrast material; with stress imaging;  75560 - Cardiac magnetic resonance imaging for morphology and function without contrast material; with flow/velocity quantification and stress;  75561 - Cardiac magnetic resonance imaging for morphology and function without contrast material(s), followed by contrast material(s) and further sequences;  75562 - Cardiac magnetic resonance imaging for morphology and function without contrast material(s), followed by contrast material(s) and further sequences; with flow/velocity quantification;  75563 - Cardiac magnetic resonance imaging for morphology and function without contrast material(s), followed by contrast material(s) and further sequences; with stress imaging;  75564 - Cardiac magnetic resonance imaging for morphology and function without contrast material(s), followed by contrast material(s) and further sequences; with flow/velocity quantification and stress;  75565 - Cardiac magnetic resonance imaging for velocity flow mapping (List separately in addition to code for primary procedure); |
| 75571-75574 | 75571 - Computed tomography, heart, without contrast material, with quantitative evaluation of coronary calcium;  75572 - Computed tomography, heart, with contrast material, for evaluation of cardiac structure and morphology (including 3D image postprocessing, assessment of cardiac function, and evaluation of venous structures, if performed);  75573 - Computed tomography, heart, with contrast material, for evaluation of cardiac structure and morphology in the setting of congenital heart disease (including 3D image postprocessing, assessment of LV cardiac function, RV structure and function and evaluation of venous structures, if performed);  75574 - Computed tomographic angiography, heart, coronary arteries and bypass grafts (when present), with contrast material, including 3D image postprocessing (including evaluation of cardiac structure and morphology, assessment of cardiac function, and evaluation of venous structures, if performed) |
| 76390 | Magnetic resonance spectroscopy |
| 76498 | Unlisted magnetic resonance procedure (e.g., diagnostic, interventional) |
| 76977  78350  77078-77083 | 76977 - Ultrasound bone density measurement and interpretation, peripheral site(s), any method;  78350 - Bone density (bone mineral content) study, 1 or more sites; single photon absorptiometry;  77078 - Computed tomography, bone mineral density study, 1 or more sites; axial skeleton (e.g., hips, pelvis, spine);  77079 - Computed tomography, bone mineral density study, 1 or more sites; appendicular skeleton (peripheral) (e.g., radius, wrist, heel);  77080 - Dual-energy X-ray absorptiometry (DXA), bone density study, 1 or more sites; axial skeleton (e.g., hips, pelvis, spine);  77081 - Dual-energy X-ray absorptiometry (DXA), bone density study, 1 or more sites; appendicular skeleton (peripheral) (e.g., radius, wrist, heel);  77082 - Dual-energy X-ray absorptiometry (DXA), bone density study, 1 or more sites; vertebral fracture assessment (Code deleted 1.1.15; See 77086);  77083 - Radiographic absorptiometry (e.g., photodensitometry, radiogrammetry), 1 or more sites (Code deleted 1.1.12);  Bone density testing when performed on a woman < 65 yrs age or a man <70 yrs age, or when more than once every 2 years |
| 61793  77371-77373 G0339-G0340 | 61793 - Stereotactic radiosurgery (particle beam, gamma ray or linear accelerator), one or more sessions;  77371 - Radiation treatment delivery, stereotactic radiosurgery (SRS), complete course of treatment of cranial lesion(s) consisting of 1 session; multi-source Cobalt 60 based;  77372 - Radiation treatment delivery, stereotactic radiosurgery (SRS), complete course of treatment of cranial lesion(s) consisting of 1 session; linear accelerator based;  77373 - Stereotactic body radiation therapy, treatment delivery, per fraction to 1 or more lesions, including image guidance, entire course not to exceed 5 fractions  G0339 - Image-guided robotic linear accelerator-based stereotactic radiosurgery, complete course of therapy in one session or first session of fractionated treatment;  G0340 - Image-guided robotic linear accelerator-based stereotactic radiosurgery, delivery including collimator changes and custom plugging, fractionated treatment, all lesions, per session, second through fifth sessions, maximum five sessions per course of treatment |
| 61796 - 61800, 63620 - 63621  77520 - 77525 | 61796 – Stereotactic radiosurgery (particle beam, gamma ray, or linear accelerator); 1 simple cranial lesion;  61797 – Stereotactic radiosurgery (particle beam, gamma ray, or linear accelerator); each additional cranial lesion, simple;  61798 – Stereotactic radiosurgery (particle beam, gamma ray, or linear accelerator); 1 complex cranial lesion;  61799 – Stereotactic radiosurgery (particle beam, gamma ray, or linear accelerator); each additional cranial lesion, complex ;  61800 – Application of stereotactic headframe for stereotactic radiosurgery;  63620 – Stereotactic radiosurgery (particle beam, gamma ray, or linear accelerator); 1 spinal lesion;  63621 - Stereotactic radiosurgery (particle beam, gamma ray, or linear accelerator); each additional spinal lesion;  77520 – Proton treatment delivery; simple, without compensation;  77522 – Proton treatment delivery; simple, with compensation;  77523 – Proton treatment delivery; intermediate;  77525 - Proton treatment delivery; complex; |
| 77058 - 77059 | 77058 - Magnetic resonance imaging, breast, without and/or with contrast material(s); unilateral;  77059 - Magnetic resonance imaging, breast, without and/or with contrast material(s); bilateral |
| 78459 | Myocardial imaging, positron emission tomography (PET), metabolic evaluation |
| 78491-78492 | 78491 - Myocardial imaging, positron emission tomography (PET), perfusion; single study at rest or stress;  78492 - Myocardial imaging, positron emission tomography (PET), perfusion; multiple studies at rest and/or stress; |
| 78608-78609 | 78608 - Brain imaging, positron emission tomography (PET); metabolic evaluation;  78609 - Brain imaging, positron emission tomography (PET); perfusion evaluation; |
| 78811 -78816 | 78811 - Positron emission tomography (PET) imaging; limited area (e.g., chest, head/neck);  78812 - Positron emission tomography (PET) imaging; skull base to mid-thigh;  78813 - Positron emission tomography (PET) imaging; whole body;  78814 - Positron emission tomography (PET) with concurrently acquired computed tomography (CT) for attenuation correction and anatomical localization imaging; limited area (e.g., chest, head/neck);  78815 - Positron emission tomography (PET) with concurrently acquired computed tomography (CT) for attenuation correction and anatomical localization imaging; skull base to mid-thigh;  78816 - Positron emission tomography (PET) with concurrently acquired computed tomography (CT) for attenuation correction and anatomical localization imaging; whole body;; |
| G0219  G0235  G0252 | G0219 - Pet imaging whole body; melanoma for non-covered indications;  G0235 - Pet imaging, any site, not otherwise specified;  G0252 - Pet imaging, full and partial-ring pet scanners only, for initial diagnosis of breast cancer and/or surgical planning for breast cancer (e.g. initial staging of axillary lymph nodes); |
| 74261 - 74263 | 74621 – Computed tomographic (CT) colonography, diagnostic, including image postprocessing; without contrast material;  74622 – Computed tomographic (CT) colonography, diagnostic, including image postprocessing; with contrast material(s) including non-contrast images, if performed;  74623 - Computed tomographic (CT) colonography, screening, including image postprocessing; |
| G0297 | Low dose ct scan (ldct) for lung cancer screening |
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|  | Medicine |
| CPT/HCPCS Code | Description |
| 90378 | Respiratory syncytial virus, monoclonal antibody, recombinant, for intramuscular use, 50 mg, each |
| 90875-90876 | 90875 - Individual psychophysiological therapy incorporating biofeedback training by any modality (face-to-face with the patient), with psychotherapy (e.g., insight oriented, behavior modifying or supportive psychotherapy); 30 minutes;  90876 - Individual psychophysiological therapy incorporating biofeedback training by any modality (face-to-face with the patient), with psychotherapy (e.g., insight oriented, behavior modifying or supportive psychotherapy); 45 minutes |
| 90901-90911 | 90901 - Biofeedback training by any modality;  90911 - Biofeedback training, perineal muscles, anorectal or urethral sphincter, including EMG and/or manometry |
| 91110-91112 | 91110 - Gastrointestinal tract imaging, intraluminal (e.g., capsule endoscopy), esophagus through ileum, with interpretation and report;  91111 - Gastrointestinal tract imaging, intraluminal (e.g., capsule endoscopy), esophagus with interpretation and report;  91112 - Gastrointestinal transit and pressure measurement, stomach through colon, wireless capsule, with interpretation and report |
| 93228-93229 | 93228 - External mobile cardiovascular telemetry with electrocardiographic recording, concurrent computerized real time data analysis and greater than 24 hours of accessible ECG data storage (retrievable with query) with ECG triggered and patient selected events transmitted to a remote attended surveillance center for up to 30 days; review and interpretation with report by a physician or other qualified health care professional;  93229 - External mobile cardiovascular telemetry with electrocardiographic recording, concurrent computerized real time data analysis and greater than 24 hours of accessible ECG data storage (retrievable with query) with ECG triggered and patient selected events transmitted to a remote attended surveillance center for up to 30 days; technical support for connection and patient instructions for use, attended surveillance, analysis and transmission of daily and emergent data reports as prescribed by a physician or other qualified health care professional; |
| 96020 | Neurofunctional testing selection and administration during noninvasive imaging functional brain mapping, with test administered entirely by a physician or other qualified health care professional (ie, psychologist), with review of test results and report |
| 96118-96120 | 96118 - Neuropsychological testing (e.g., Halstead-Reitan Neuropsychological Battery, Wechsler Memory Scales and Wisconsin Card Sorting Test), per hour of the psychologist's or physician's time, both face-to-face time administering tests to the patient and time interpreting these test results and preparing the report;  96119 - Neuropsychological testing (e.g., Halstead-Reitan Neuropsychological Battery, Wechsler Memory Scales and Wisconsin Card Sorting Test), with qualified health care professional interpretation and report, administered by technician, per hour of technician time, face-to-face;  96120 - Neuropsychological testing (e.g., Wisconsin Card Sorting Test), administered by a computer, with qualified health care professional interpretation and report; |
| 96900 | Actinotherapy (ultraviolet light) |
| 96902 | Microscopic examination of hairs plucked or clipped by the examiner (excluding hair collected by the patient) to determine telogen and anagen counts, or structural hair shaft abnormality |
| 96910-96913 | 96910 - Photochemotherapy; tar and ultraviolet B (Goeckerman treatment) or petrolatum and ultraviolet B;  96912 - Photochemotherapy; psoralens and ultraviolet A (PUVA);  96913 - Photochemotherapy (Goeckerman and/or PUVA) for severe photoresponsive dermatoses requiring at least 4-8 hours of care under direct supervision of the physician (includes application of medication and dressings) |
| 97532 | Development of cognitive skills to improve attention, memory, problem solving (includes compensatory training), direct (one-on-one) patient contact, each 15 minutes |
| 97533 | Sensory integrative techniques to enhance sensory processing and promote adaptive responses to environmental demands, direct (one-on-one) patient contact, each 15 minutes |
| 97537 | Community/work reintegration training (e.g., shopping, transportation, money management, avocational activities and/or work environment/modification analysis, work task analysis, use of assistive technology device/adaptive equipment), direct one-on-one contact, each 15 minutes |
| 97545-97546 | 97545 - Work hardening/conditioning; initial 2 hours;  97546 - Work hardening/conditioning; each additional hour (List separately in addition to code for primary procedure) |
| 97605-97606 | 97605 - Negative pressure wound therapy (e.g., vacuum assisted drainage collection), utilizing durable medical equipment (DME), including topical application(s), wound assessment, and instruction(s) for ongoing care, per session; total wound(s) surface area less than or equal to 50 square centimeters;  97606 - Negative pressure wound therapy (e.g., vacuum assisted drainage collection), utilizing durable medical equipment (DME), including topical application(s), wound assessment, and instruction(s) for ongoing care, per session; total wound(s) surface area greater than 50 square centimeters |
| 97750 | Physical performance test or measurement (e.g., musculoskeletal, functional capacity), with written report, each 15 minutes |
| 99183 | Physician or other qualified health care professional attendance and supervision of hyperbaric oxygen therapy, per session |
| J0585-J0588 | J0585 - Injection, onabotulinumtoxina, 1 unit;  J0586 - Injection, abobotulinumtoxina, 5 units;  J0587 - Injection, rimabotulinumtoxinb, 100 units;  J0588 - Injection, incobotulinumtoxin a, 1 unit |
| J1745 | Injection, infliximab, excludes biosimilar, 10 mg |
|  | Additional Medications are listed on additional attachment. |

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| Plastic/Reconstructive surgery | |
| CPT/HCPCS Code | Description |
| 15820 – 15823  67900 - 67906 | 15820 – Blepharoplasty, lower eyelid;  15821 – Blepharoplasty, lower eyelid; with extensive herniated fat pad;  15822 – Blepharoplasty, upper eyelid;  15823 – Blepharoplasty, upper eyelid; with excessive skin weighting down lid;  67900 – Repair of brow ptosis (supraciliary, mid-forehead or coronal approach);  67901 – Repair of blepharoptosis; frontalis muscle technique with suture or other material (e.g., banked fascia);  67902 – Repair of blepharoptosis; frontalis muscle technique with autologous fascial sling (includes obtaining fascia);  67903 – Repair of blepharoptosis; (tarso) levator resection or advancement, internal approach;  67904 – Repair of blepharoptosis; (tarso) levator resection or advancement, external approach;  67906 - Repair of blepharoptosis; superior rectus technique with fascial sling (includes obtaining fascia); |
| 19318 | Reduction Mammaplasty |
| 11920 - 11922 19316  19324 - 19325  19340 - 19342  19350 - 19357 19361 - 19369  19380 - 19396 | 11920 - Tattooing, intradermal introduction of insoluble opaque pigments to correct color defects of skin, including micropigmentation; 6.0 sq cm or less;  11921 - Tattooing, intradermal introduction of insoluble opaque pigments to correct color defects of skin, including micropigmentation; 6.1 to 20.0 sq cm  11922 - Tattooing, intradermal introduction of insoluble opaque pigments to correct color defects of skin, including micropigmentation; each additional 20.0 sq cm, or part thereof;  19316 – Mastopexy;  19324 - Mammaplasty, augmentation; without prosthetic implant;  19325 - Mammaplasty, augmentation; with prosthetic implant;  19340 – Immediate insertion of breast prosthesis following mastopexy, mastectomy or in reconstruction;  19342 - Delayed insertion of breast prosthesis following mastopexy, mastectomy or in reconstruction;  19350 – Nipple/areola reconstruction;  19357 – Breast reconstruction, immediate or delayed, with tissue expander, including subsequent expansion;  19361 – Breast reconstruction with latissimus dorsi flap, without prosthetic implant;  19364 – Breast reconstruction with free flap;  19366 – Breast reconstruction with other technique;  19367 – Breast reconstruction with transverse rectus abdominis myocutaneous flap (TRAM), single pedicle, including closure of donor site;  19368 – Breast reconstruction with transverse rectus abdominis myocutaneous flap (TRAM), single pedicle, including closure of donor site; with microvascular anastomosis (supercharging);  19369 – Breast reconstruction with transverse rectus abdominis myocutaneous flap (TRAM), double pedicle, including closure of donor site;  19380 – Revision of reconstructed breast;  19396 - Preparation of moulage for custom breast implant; |
| 21120 - 21123 | 21120 – Genioplasty; augmentation (autograft, allograft, prosthetic material);  21121 – Genioplasty; sliding osteotomy, single piece;  21122 – Genioplasty; sliding osteotomies, 2 or more osteotomies (e.g., wedge excision or bone wedge reversal for asymmetrical chin);  21123 – Genioplasty; sliding, augmentation with interpositional bone grafts (includes obtaining autografts |
| 15819  15824 – 15829  15838  15840 – 15841  21083 – 21087  21120 – 21188  21208 – 21210  21230 – 21235  21244 – 21256  21270  30120  30400 – 30450  64716  64732 – 64742  64864 – 64870  69090  69300  69955 | 15819 –  Cervicoplasty;  15824 – Rhytidectomy; forehead;  15825 – Rhytidectomy; neck with platysmal tightening (platysmal flap, P-flap);  15826 – Rhytidectomy; glabellar frown lines;  15828 – Rhytidectomy; cheek, chin, and neck;  15829 – Rhytidectomy; superficial musculoaponeurotic system (SMAS) flap;  15838 – Excision, excessive skin and subcutaneous tissue (includes lipectomy); submental fat pad;  15840 – Graft for facial nerve paralysis; free fascia graft (including obtaining fascia);  15841 – Graft for facial nerve paralysis; free muscle graft (including obtaining graft);  21083 – Impression and custom preparation; palatal lift prosthesis;  21087 – Impression and custom preparation; nasal prosthesis;  21120 – Genioplasty; augmentation (autograft, allograft, prosthetic material);  21121 – Genioplasty; sliding osteotomy, single piece;  21122 – Genioplasty; sliding osteotomies, 2 or more osteotomies (e.g., wedge excision or bone wedge reversal for asymmetrical chin);  21123 – Genioplasty; sliding, augmentation with interpositional bone grafts (includes obtaining autografts);  21125 – Augmentation, mandibular body or angle; prosthetic material;  21127 – Augmentation, mandibular body or angle; with bone graft, onlay or interpositional (includes obtaining autograft);  21137 – Reduction forehead; contouring only;  21138 – Reduction forehead; contouring and application of prosthetic material or bone graft (includes obtaining autograft);  21139 – Reduction forehead; contouring and setback of anterior frontal sinus wall;  21141 – Reconstruction midface, LeFort I; single piece, segment movement in any direction (e.g., for Long Face Syndrome), without bone graft;  21142 – Reconstruction midface, LeFort I; 2 pieces, segment movement in any direction, without bone graft;  21143 – Reconstruction midface, LeFort I; 3 or more pieces, segment movement in any direction, without bone graft;  21145 – Reconstruction midface, LeFort I; single piece, segment movement in any direction, requiring bone grafts (includes obtaining autografts);  21146 - Reconstruction midface, LeFort I; 2 pieces, segment movement in any direction, requiring bone grafts (includes obtaining autografts) (e.g., ungrafted unilateral alveolar cleft);  21147 – Reconstruction midface, LeFort I; 3 or more pieces, segment movement in any direction, requiring bone grafts (includes obtaining autografts) (e.g., ungrafted bilateral alveolar cleft or multiple osteotomies);  21150 – Reconstruction midface, LeFort II; anterior intrusion (e.g., Treacher-Collins Syndrome);  21151 – Reconstruction midface, LeFort II; any direction, requiring bone grafts (includes obtaining autografts);  21154 – Reconstruction midface, LeFort III (extracranial), any type, requiring bone grafts (includes obtaining autografts); without LeFort I;  21155 – Reconstruction midface, LeFort III (extracranial), any type, requiring bone grafts (includes obtaining autografts); with LeFort I;  21159 – Reconstruction midface, LeFort III (extra and intracranial) with forehead advancement (e.g., mono bloc), requiring bone grafts (includes obtaining autografts); without LeFort I;  21160 – Reconstruction midface, LeFort III (extra and intracranial) with forehead advancement (e.g., mono bloc), requiring bone grafts (includes obtaining autografts); with LeFort I;  21172 – Reconstruction superior-lateral orbital rim and lower forehead, advancement or alteration, with or without grafts (includes obtaining autografts);  21175 – Reconstruction, bifrontal, superior-lateral orbital rims and lower forehead, advancement or alteration (e.g., plagiocephaly, trigonocephaly, brachycephaly), with or without grafts (includes obtaining autografts);  21179 – Reconstruction, entire or majority of forehead and/or supraorbital rims; with grafts (allograft or prosthetic material);  21180 – Reconstruction, entire or majority of forehead and/or supraorbital rims; with autograft (includes obtaining grafts);  21188 – Reconstruction midface, osteotomies (other than LeFort type) and bone grafts (includes obtaining autografts);  21208 – Osteoplasty, facial bones; augmentation (autograft, allograft, or prosthetic implant);  21209 – Osteoplasty, facial bones; reduction;  21210 – Graft, bone; nasal, maxillary or malar areas (includes obtaining graft);  21230 – Graft; rib cartilage, autogenous, to face, chin, nose or ear (includes obtaining graft);  21235 – Graft; ear cartilage, autogenous, to nose or ear (includes obtaining graft);  21244 – Reconstruction of mandible, extraoral, with transosteal bone plate (e.g., mandibular staple bone plate);  21245 – Reconstruction of mandible or maxilla, subperiosteal implant; partial;  21246 – Reconstruction of mandible or maxilla, subperiosteal implant; complete;  21248 – Reconstruction of mandible or maxilla, endosteal implant (e.g., blade, cylinder); partial;  21249 - Reconstruction of mandible or maxilla, endosteal implant (e.g., blade, cylinder); complete;  21255 – Reconstruction of zygomatic arch and glenoid fossa with bone and cartilage (includes obtaining autografts);  21256 – Reconstruction of orbit with osteotomies (extracranial) and with bone grafts;  21270 – Malar augmentation, prosthetic material;  30120 – Excision or surgical planing of skin of nose for rhinophyma;  30400 – Rhinoplasty, primary; lateral and alar cartilages and/or elevation of nasal tip;  30410 – Rhinoplasty, primary; complete, external parts including bony pyramid, lateral and alar cartilages, and/or elevation of nasal tip;  30420 – Rhinoplasty, primary; including major septal repair;  30430 – Rhinoplasty, secondary; minor revision (small amount of nasal tip work);  30435 – Rhinoplasty, secondary; intermediate revision (bony work with osteotomies);  30450 – Rhinoplasty, secondary; major revision (nasal tip work and osteotomies);  64716 – Neuroplasty and/or transposition; cranial nerve;  64732 – Transection or avulsion of; supraorbital nerve;  64734 – Transection or avulsion of; infraorbital nerve;  64736 – Transection or avulsion of; mental nerve;  64738 – Transection or avulsion of; inferior alveolar nerve by osteotomy;  64740 – Transection or avulsion of; lingual nerve;  64742 – Transection or avulsion of; facial nerve, differential or complete;  64864 – Suture of facial nerve; extracranial;  64865 – Suture of facial nerve; infratemporal, with or without grafting;  64866 – Anastomosis; facial-spinal accessory;  64868 – Anastomosis; facial-hypoglossal;  64870 – Anastomosis; facial-phrenic;  69090 – Ear piercing;  69300 – Otoplasty, protruding ear, with or without size reduction;  69955 - Total facial nerve decompression and/or repair; |
| 15832 – 15839  15876 – 15979  21742 – 21743  54360  54440  56805 – 56810  57291 - 57292 | 15832 – Excision, excessive skin and subcutaneous tissue (includes lipectomy); thigh;  15833 – Excision, excessive skin and subcutaneous tissue (includes lipectomy); leg;  15834 – Excision, excessive skin and subcutaneous tissue (includes lipectomy); hip;  15835 – Excision, excessive skin and subcutaneous tissue (includes lipectomy); buttock;  15836 – Excision, excessive skin and subcutaneous tissue (includes lipectomy); arm;  15837 – Excision, excessive skin and subcutaneous tissue (includes lipectomy); forearm or hand;  15839 – Excision, excessive skin and subcutaneous tissue (includes lipectomy); other area;  15876 – Suction assisted lipectomy; head and neck;  15877 – Suction assisted lipectomy; trunk;  15878 – Suction assisted lipectomy; upper extremity;  15979 – Suction assisted lipectomy; lower extremity;  21742 – Reconstructive repair of pectus excavatum or carinatum; minimally invasive approach (Nuss procedure), without thoracoscopy;  21743 – Reconstructive repair of pectus excavatum or carinatum; minimally invasive approach (Nuss procedure), with thoracoscopy;  54360 – Plastic operation on penis to correct angulation;  54440 – Plastic operation of penis for injury;  56800 – Plastic repair of introitus;  56805 – Clitoroplasty for intersex state;  56810 – Perineoplasty, repair of perineum, nonobstetrical ;  57291 – Construction of artificial vagina; without graft;  57292 - Construction of artificial vagina; with graft; |
| 11921 – 11922  11950 – 11954  15775 – 15793  17380  36469 | 11921 – Tattooing, intradermal introduction of insoluble opaque pigments to correct color defects of skin, including micropigmentation; 6.1 to 20.0 sq cm;  11922 – Tattooing, intradermal introduction of insoluble opaque pigments to correct color defects of skin, including micropigmentation; each additional 20.0 sq cm, or part thereof;  11950 – Subcutaneous injection of filling material (e.g., collagen); 1cc or less;  11951 – Subcutaneous injection of filling material (e.g., collagen); 1.1 to 5.0 cc;  11952 – Subcutaneous injection of filling material (e.g., collagen); 5.1 to 10.0 cc;  11954 – Subcutaneous injection of filling material (e.g., collagen); over 10.0 cc;  15775 – Punch graft for hair transplant; 1 to 15 punch grafts;  15776 - Punch graft for hair transplant; more than 15 punch grafts  15780 – Dermabrasion; total face (e.g., for acne scarring, fine wrinkling, rhytids, general keratosis);  15781 – Dermabrasion; segmental, face;  15782 – Dermabrasion; regional, other than face;  15783 – Dermabrasion; superficial, any site (e.g., tattoo removal);  15786 – Abrasion; single lesion (e.g., keratosis, scar);  15787 – Abrasion; each additional 4 lesions or less ;  15788 – Chemical peel, facial; epidermal;  15789 – Chemical peel, facial; dermal;  15792 – Chemical peel, nonfacial; epidermal;  15793 – Chemical peel, nonfacial; dermal;  17380 – Electrolysis epilation, each 30 minutes;  36469 – Single or multiple injections of sclerosing solutions, spider veins (telangiectasia); face; |
| 15775 - 15776  17380 | 15775 – Punch graft for hair transplant; 1 to 15 punch grafts;  15776 - Punch graft for hair transplant; more than 15 punch grafts;  17380 - Electrolysis epilation, each 30 minutes; |
| 51715 | Endoscopic injection of implant material into the submucosal tissues of the urethra and/or bladder neck |
| 19300  15877 | 19300 - Mastectomy for gynecomastia;  15877 - Suction assisted lipectomy; trunk; |
| 15830  15847 | 15830 – Excision, excessive skin and subcutaneous tissue (includes lipectomy); abdomen, infraumbilical panniculectomy;  15847 - Excision, excessive skin and subcutaneous tissue (includes lipectomy), abdomen (e.g., abdominoplasty) (includes umbilical transposition and fascial plication) (List separately in addition to code for primary procedure); |
| 15830  15847  22999 | 15830 – Excision, excessive skin and subcutaneous tissue (includes lipectomy); abdomen, infraumbilical panniculectomy;  15847 - Excision, excessive skin and subcutaneous tissue (includes lipectomy), abdomen (e.g., abdominoplasty) (includes umbilical transposition and fascial plication) (List separately in addition to code for primary procedure);  22999 - Unlisted procedure, abdomen, musculoskeletal system; |
| 30400  30410  30420  30430  30450 | 30400 – Rhinoplasty, primary; lateral and alar cartilages and/or elevation of nasal tip;  30410 – Rhinoplasty, primary; complete, external parts including bony pyramid, lateral and alar cartilages, and/or elevation of nasal tip;  30420 - Rhinoplasty, primary; including major septal repair;  30430 – Rhinoplasty, secondary; minor revision (small amount of nasal tip work);  30450 - Rhinoplasty, secondary; major revision (nasal tip work and osteotomies); |

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| Cosmetic: Not Covered | |
| CPT/HCPCS Code | Description |
| 11950-11954 | 11950 - Subcutaneous injection of filling material (e.g., collagen); 1 cc or less;  11951 - Subcutaneous injection of filling material (e.g., collagen); 1.1 to 5.0 cc;  11952 - Subcutaneous injection of filling material (e.g., collagen); 5.1 to 10.0 cc;  11954 - Subcutaneous injection of filling material (e.g., collagen); over 10.0 cc; |
| 15775-15776 | 15775 - Punch graft for hair transplant; 1 to 15 punch grafts;  15776 - Punch graft for hair transplant; more than 15 punch grafts; |
| 15780-15793 | 15780 - Dermabrasion; total face (e.g., for acne scarring, fine wrinkling, rhytids, general keratosis);  15781 - Dermabrasion; segmental, face;  15782 - Dermabrasion; regional, other than face;  15783 - Dermabrasion; superficial, any site (e.g., tattoo removal);  15786 - Abrasion; single lesion (e.g., keratosis, scar);  15787 - Abrasion; each additional 4 lesions or less (List separately in addition to code for primary procedure);  15788 - Chemical peel, facial; epidermal; 15789 - Chemical peel, facial; dermal;  15792 - Chemical peel, nonfacial; epidermal;  15793 - Chemical peel, nonfacial; dermal; |
| 15819 | Cervicoplasty |
| 15820-15821 | 15820 - Blepharoplasty, lower eyelid;  15821 - Blepharoplasty, lower eyelid; with extensive herniated fat; pad |
| 15824-15829 | 15824 - Rhytidectomy; forehead;  15825 - Rhytidectomy; neck with platysmal tightening (platysmal flap, P-flap);  15826 - Rhytidectomy; glabellar frown lines;  15828 - Rhytidectomy; cheek, chin, and neck;  15829 - Rhytidectomy; superficial musculoaponeurotic system (SMAS) flap |
| 15830-15839 | 15830 - Excision, excessive skin and subcutaneous tissue (includes lipectomy); abdomen, infraumbilical panniculectomy;  15832 - Excision, excessive skin and subcutaneous tissue (includes lipectomy); thigh;  15833 - Excision, excessive skin and subcutaneous tissue (includes lipectomy); leg;  15834 - Excision, excessive skin and subcutaneous tissue (includes lipectomy); hip;  15835 - Excision, excessive skin and subcutaneous tissue (includes lipectomy); buttock;  15836 - Excision, excessive skin and subcutaneous tissue (includes lipectomy); arm;  15837 - Excision, excessive skin and subcutaneous tissue (includes lipectomy); forearm or hand;  15838 - Excision, excessive skin and subcutaneous tissue (includes lipectomy); submental fat pad;  15839 - Excision, excessive skin and subcutaneous tissue (includes lipectomy); other area |
| 15876-15879 | 15876 - Suction assisted lipectomy; head and neck;  15877 - Suction assisted lipectomy; trunk;  15878 - Suction assisted lipectomy; upper extremity;  15879 - Suction assisted lipectomy; lower extremity |
| 17380 | Electrolysis epilation, each 30 minutes |
| 19316 | Mastopexy |
| 19355 | Correction of inverted nipples |
| 21209 | Osteoplasty, facial bones; reduction |
| 21280-21282 | 21280 - Medial canthopexy (separate procedure);  21282 - Lateral canthopexy |
| 21295-21296 | 21295 - Reduction of masseter muscle and bone (e.g., for treatment of benign masseteric hypertrophy); extraoral approach;  21296 - Reduction of masseter muscle and bone (e.g., for treatment of benign masseteric hypertrophy); intraoral approach |
| 30120 | Excision or surgical planing of skin of nose for rhinophyma |
| 36468-36471 | 36468 - Single or multiple injections of sclerosing solutions, spider veins (telangiectasia), limb or trunk;  36469 - Single or multiple injections of sclerosing solutions, spider veins (telangiectasia); face;  36470 - Injection of sclerosing solution; single vein;  36471 - Injection of sclerosing solution; multiple veins, same leg |
| 67715 | Canthotomy |
| 67900-67911 | 67900 - Repair of brow ptosis (supraciliary, mid-forehead or coronal approach);  67901 - Repair of blepharoptosis; frontalis muscle technique with suture or other material (e.g., banked fascia);  67902 - Repair of blepharoptosis; frontalis muscle technique with autologous fascial sling (includes obtaining fascia);  67903 - Repair of blepharoptosis; (tarso) levator resection or advancement, internal approach;  67904 - Repair of blepharoptosis; (tarso) levator resection or advancement, external approach;  67906 - Repair of blepharoptosis; superior rectus technique with fascial sling (includes obtaining fascia);  67908 - Repair of blepharoptosis; conjunctivo-tarso-Muller's muscle-levator resection (e.g., Fasanella-Servat type);  67909 - Reduction of overcorrection of ptosis;  67911 - Correction of lid retraction |
| 67950 | Canthoplasty, (reconstruction of canthus) |
| 69090 | Ear piercing |
| 69300 | Otoplasty, protruding ear, with or without size reduction |

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| Infertility: Not Covered | |
| CPT/HCPCS Code | Description |
| 55400 | Vasovasostomy Vasovasorrhaphy |

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| Dental: Not Covered | |
| CPT/HCPCS Code | Description |
| 40840 | Vestibuloplasty; Anterior |
| 40842 | Vestibuloplasty; posterior, unilateral |
| 40843 | Vestibuloplasty; posterior, bilateral |
| 40844 | Vestibuloplasty; entire arch |
| 40845 | Vestibuloplasty; complex (including ridge extension, muscle repositioning) |

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| Unlisted not ending in “99” | |
| CPT/HCPCS Code | Description |
| 88749 | Unlisted In vivo lab service |
| 89398 | Unlisted reproductive medicine lab procedure |

This list excludes xxxxT (Category III Codes). If a Category III code is available for a given service or procedure, use the Category III code instead of a Category I Unlisted code. If billing with a temporary code, include supporting documentation with the claim.

Behavioral Health/Substance Abuse (MHSA)

Professionals are available 24 hours a day 7 days a week.

Specially trained professionals will handle referrals and coordinate care for mental health and substance abuse:

ABA (Applied Behavioral Analysis)

All facility based care

Inpatient admissions

Intensive outpatient therapy

Partial Hospitalization

Residential Care

Electric Convulsive Therapy (ECT)

Transcranial Magnetic Stimulation

Intensive In-home Behavioral Health Services

Alcohol and/or drug testing (collection and handling only-specimens other than blood)

Non-medical Family planning education

Psychometric testing

Psychoanalysis

Narcosynthesis

Psychologist Testing by a computer with interpretation

Mental Health services by a non-physician

Behavioral Health Day treatment

Theraputic behavioral services

\*Speciality Drug precert list under separate attachment