Hermann Area District Hospital

Hermann Area Hospital District Employee Health Care Plan

Plan Document and Summary Plan Description
Effective: January 01, 2016
As Amended January 01, 2019

Administered By:

Contents

ESTABLISHMENT OF THE PLAN: ADOPTION OF THE PLAN DOCUMENT AND SUMMARY PLAN DESCRIPTION

THIS PLAN DOCUMENT AND SUMMARY PLAN DESCRIPTION ("Plan Document"), made by Hermann Area Hospital District (the "Company" or the "Plan Sponsor") as of January 01, 2019, hereby sets forth the provisions of the Hermann Area Hospital District Employee Health Care Plan (the "Plan"). Any wording with may be contrary to Federal Laws or Statues is hereby understood to meet the standards set forth in such. Also, any changes in Federal Laws or Statues with could affect the Plan are also automatically a part of the Plan, if required.

1.01 Effective Date
The Plan Document is effective as of the date first set forth above, and each amendment is effective as of the date set forth therein, (the "Effective Date").

1.02 Adoption of the Plan Document
The Plan Sponsor, as the settlor of the Plan, hereby adopts this Plan Document as the written description of the Plan. This Plan Document represents both the Plan Document and Summary Plan Description, which is required by the Employee Retirement Income Security Act of 1974, 29 U.S.C et seq. ("ERISA"). This Plan Documents amends and replaces any prior statement of the health care coverage contained in the Plan or any predecessor to the Plan.

IN WITNESS WHEREOF, the Plan Sponsor has caused this Plan Document to be executed.

Hermann Area Hospital District

By: _____

Name: Dan McKinney

Title: Administrator

Date: 5/1/19

INTRODUCTION AND PURPOSE; GENERAL PLAN INFORMATION

2.01 Introduction and Purpose

The Plan Sponsor has established the Plan for the benefit of eligible Employees and their eligible Dependents, in accordance with the terms and conditions described herein. Plan benefits are self-funded through a benefit fund or a trust established by the Plan Sponsor and self-funded with contributions from Participants and/or the Plan Sponsor, or are funded solely from the general assets of the Plan Sponsor. The Plan's benefits and administration expenses are paid directly from the Employer's general assets. Participants in the Plan may be required to contribute toward their benefits. Contributions received from Participants are used to cover Plan costs and are expended immediately.

The Plan Sponsor's purpose in establishing the Plan is to protect eligible Employees and their Dependents against certain health expenses and to help defray the financial effects arising from Injury or Sickness. To accomplish this purpose, the Plan Sponsor must be mindful of the need to control and minimize health care costs through innovative and efficient plan design and cost containment provisions, and of abiding by the terms of the Plan Document, to allow the Plan Sponsor to effectively assign the resources available to help Participants in the Plan to the maximum feasible extent.

The Plan Sponsor is required under ERISA to provide to Participants a Plan Document and a Summary Plan Description; a combined Plan Document and Summary Plan Description, such as this document, is an acceptable structure for ERISA compliance. The Plan Sponsor has adopted this Plan Document as the written description of the Plan to set forth the terms and provisions of the Plan that provide for the payment or reimbursement of all or a portion of certain expenses for eligible benefits. The Plan Document is maintained by **Hermann Area District Hospital** and may be reviewed at any time during normal working hours by any Participant.

2.02 General Plan Information

Name of Plan:
Hermann Area Hospital District Employee Health Care Plan

Plan Sponsor:
Hermann Area Hospital District
509 W 18th St
Hermann, MO 65041
Phone: 573-486-2191
Fax: 573-486-3743
Website: www.hadh.org

Plan Sponsor ID No. (EIN):
43-0891513

Source of Funding:
Self-Funded

Plan Status:
Non-Grandfathered

Applicable Law:
ERISA

Plan Year:
January through December

Plan Number:

501

Plan Type:
Medical
Prescription

Third Party Administrator:
Mercy Benefit Administrators
3265 S National Ste 210
Springfield, MO 65807
Phone: 877-875-7700
Fax: 417-820-3816
Email: SPRGBenefitAdmins@mercy.net

Prescription Drug Plan Administrator:
MedTrak
7101 College Blvd Ste 1000
Overland Park, KS 66210
Phone: 800-894-0794
Fax: 913-262-2025

Participating Employer(s):
Hermann Area Hospital District
PO Box 470
Hermann, MO 65041
Phone: 573-486-2191

Agent for Service of Process:
Hermann Area Hospital District
509 W 18th St
Hermann, MO 65041
Phone: 573-486-2191
Fax: 573-486-3743
Website: www.hadh.org

The Plan shall take effect for each Participating Employer on the Effective Date, unless a different date is set forth above opposite such Participating Employer's name.

2.03 Legal Entity; Service of Process
The Plan is a legal entity. Legal notice may be filed with, and legal process served upon, the Plan Administrator.

2.04 Not a Contract
This Plan Document and any amendments constitute the terms and provisions of coverage under this Plan. The Plan Document is not to be construed as a contract of any type between the Company and any Participant or to be consideration for, or an inducement or condition of, the employment of any Employee. Nothing in this Plan Document shall be deemed to give any Employee the right to be retained in the service of the Company or to interfere with the right of the Company to discharge any Employee at any time; provided, however, that the foregoing shall not be deemed to modify the provisions of any collective bargaining agreements which may be entered into by the Company with the bargaining representatives of any Employees.

2.05 Mental Health Parity
Pursuant to the Mental Health Parity Act (MHPA) of 1996 and the Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA), collectively, the mental health parity provisions in Part 7 of ERISA, this Plan applies its terms uniformly and enforces parity between covered health care benefits and covered mental health and substance disorder benefits relating to financial cost sharing restrictions and treatment duration limitations. For further details, please contact the Plan Administrator.

2.06 Applicable Law

This is a self-funded benefit plan coming within the purview of the Employee Retirement Income Security Act of 1974 (“ERISA”). The Plan is funded with Employee and/or Employer contributions. As such, when applicable, Federal law and jurisdiction preempt State law and jurisdiction.

2.07 Discretionary Authority

The Plan Administrator shall have sole, full and final discretionary authority to interpret all Plan provisions, including the right to remedy possible ambiguities, inconsistencies and/or omissions in the Plan and related documents; to make determinations in regards to issues relating to eligibility for benefits; to decide disputes that may arise relative to a Participant's rights; and to determine all questions of fact and law arising under the Plan.

DEFINITIONS

The following words and phrases shall have the following meanings when used in the Plan Document. **The following definitions are not an indication that charges for particular care, supplies or services are eligible for payment under the Plan, however they may be used to identify ineligible expenses; please refer to the appropriate sections of the Plan Document for that information.**

"Accident"
"Accident" shall mean an event which takes place without one's foresight or expectation, or a deliberate act that results in unforeseen consequences.

"Accidental Bodily Injury" or "Accidental Injury"
"Accidental Bodily Injury" or "Accidental Injury" shall mean an Injury sustained as the result of an Accident and independently of all other causes by an outside traumatic event or due to exposure to the elements.

"Actively At Work" or "Active Employment"
"Actively At Work" or "Active Employment" shall mean the Employee who has begun and is performing all the regular duties of his or her occupation at an established business location of the Participating Employer, or at another designated location to which he or she may be required to travel to perform the duties of his or her employment. An Employee shall be deemed Actively at Work if the Employee is absent from work due to a health factor. An Employee will not be considered under any circumstances Actively at Work if he or she has effectively terminated employment.

"ADA"
"ADA" shall mean the American Dental Association.

"Adverse Benefit Determination"
"Adverse Benefit Determination" shall mean any of the following:

1. A denial in benefits;
2. A reduction in benefits;
3. A rescission of coverage;
4. A termination of benefits; or
5. A failure to provide or make payment (in whole or in part) for a benefit, including any such denial, reduction, termination, or failure to provide or make payment that is based on a determination of a Claimant's eligibility to participate in the Plan.

"Affordable Care Act (ACA)"
The "Affordable Care Act (ACA)" means the health care reform law enacted in March 2010. The law was enacted in two parts: the Patient Protection and Affordable Care Act was signed into law on March 23, 2010 and was amended by the Health Care and Education Reconciliation Act on March 30, 2010. The name "Affordable Care Act" is commonly used to refer to the final, amended version of the law. In this document, the Plan uses the name Affordable Care Act (ACA) to refer to the health care reform law.

"AHA"
"AHA" shall mean the American Hospital Association.

"Allowable Expenses"
"Allowable Expenses" shall mean the Usual and Customary charge for any Medically Necessary, Reasonable, and eligible items of expense, at least a portion of which is covered under a Plan. When some Other Plan pays first in accordance with the Application to Benefit Determinations Section, this Plan's Allowable Expenses shall in no event exceed the Other Plan's Allowable Expenses. When some Other Plan provides benefits in the form of services instead of cash payments, the reasonable cash value of each service rendered, in the amount that would be payable in accordance with the terms of the Plan, shall be deemed to be the benefit. Benefits payable under any Other Plan include the benefits that would have been payable had claim been duly made therefore.

In the case of HMO (Health Maintenance Organization) plans, this Plan will not consider any charges in excess of what an HMO Provider has agreed to accept as payment in full. Also, when an HMO is primary and the Participant does not use an HMO Provider, this Plan will not consider as an Allowable Expenses any charge that would have been covered by the HMO had the Participant used the services of an HMO Provider.

"Alternate Recipient"
"Alternate Recipient" shall mean any Child of a Participant who is recognized under a Medical Child Support Order as having a right to enrollment under this Plan as the Participant's eligible Dependent. For purposes of the benefits provided under this Plan, an Alternate Recipient shall be treated as an eligible Dependent, but for purposes of the reporting and disclosure requirements under ERISA, an Alternate Recipient shall have the same status as a Participant.

"AMA"
"AMA" shall mean the American Medical Association.

"Ambulatory Surgical Center"
"Ambulatory Surgical Center" shall mean any permanent public or private State licensed and approved (whenever required by law) establishment that operates exclusively for the purpose of providing Surgical Procedures to patients not requiring hospitalization with an organized medical staff of Physicians, with continuous Physician and nursing care by Registered Nurses (R.N.s). The patient is admitted to and discharged from the facility within the same working day as the facility does not provide service or other accommodations for patients to stay overnight.

"Approved Clinical Trial"
"Approved Clinical Trial" means a phase I, II, III or IV trial that is Federally funded by specified Agencies (National Institutes of Health, CDCP, Agency for Health Care Research, Centers for Medicare and Medicaid Services ("CMS"), Dept. of Defense or Veterans Affairs, or a non-governmental entity identified by NIH guidelines) or is conducted under an Investigational new drug application reviewed by the FDA (if such application is required).

The Affordable Care Act requires that if a "qualified individual" is in an "Approved Clinical Trial," the Plan cannot deny coverage for related services ("routine patient costs").

A "qualified individual" is someone who is eligible to participate in an "Approved Clinical Trial" and either the individual's doctor has concluded that participation is appropriate or the Participant provides medical and scientific information establishing that their participation is appropriate.

"Routine patient costs" include all items and services consistent with the coverage provided in the plan that is typically covered for a qualified individual who is not enrolled in a clinical trial. Routine patient costs do not include 1) the Investigational item, device or service itself; 2) items and services that are provided solely to satisfy data collection and analysis needs and that are not used in the direct clinical management of the patient; and 3) a service that is clearly inconsistent with the widely accepted and established standards of care for a particular Diagnosis. Plans are not required to provide benefits for routine patient care services provided outside of the Plan's Network area unless out-of network benefits are otherwise provided under the Plan.

"Assignment of Benefits"
"Assignment of Benefits" shall mean an arrangement whereby the Participant, at the discretion of the Plan Administrator, assigns their right to seek and receive payment of eligible Plan benefits, less Deductibles, co-payments and the coinsurance percentage that is not paid by the Plan, in strict accordance with the terms of this Plan Document, to a Provider. If a Provider accepts said arrangement, Providers' rights to receive Plan benefits are equal to those of a Participant, and are limited by the terms of this Plan Document. A Provider that accepts this arrangement indicates acceptance of an "Assignment of Benefits" and Deductibles, co-payments and the coinsurance percentage that is the responsibility of the Participant, as consideration in full for services, supplies, and/or treatment rendered. The Plan

Administrator may revoke or disregard an Assignment of Benefits at its discretion and continue to treat the Participant as the sole beneficiary.

"Calendar Year"
"Calendar Year" shall mean the 12 month period from January 1 through December 31 of each year.

"Cardiac Care Unit"
"Cardiac Care Unit" shall mean a separate, clearly designated service area which is maintained within a Hospital and which meets all the following requirements:

1. It is solely for the care and treatment of critically ill patients who require special medical attention because of their critical condition;
2. It provides within such area special nursing care and observation of a continuous and constant nature not available in the regular rooms and wards of the Hospital;
3. It provides a concentration of special lifesaving equipment immediately available at all times for the treatment of patients confined within such area;
4. It contains at least two beds for the accommodation of critically ill patients; and
5. It provides at least one professional Registered Nurse, in continuous and constant attendance of the patient confined in such area on a 24 hour a day basis.

"Centers of Excellence"
"Centers of Excellence" shall mean medical care facilities that have met stringent criteria for quality care in the specialized procedures of organ transplantation. These centers have the greatest experience in performing transplant procedures and the best survival rates. The Plan Administrator shall determine what Network Centers of Excellence are to be used.

Any Participant in need of an organ transplant may contact the Third Party Administrator to initiate the pre certification process resulting in a referral to a Center of Excellence. The Third Party Administrator acts as the primary liaison with the Center of Excellence, patient and attending Physician for all transplant admission taking place at a Center of Excellence.

If a Participant chooses not to use a Center of Excellence, the payment for services will be limited to what would have been the cost at the nearest Center of Excellence.

Additional information about this option, as well as a list of Centers of Excellence, will be given to covered Employees and updated as requested.

"Child" and/or "Children"
"Child" shall mean the Employee's natural Child, or the natural Child of Employee's spouse, legally adopted Child, or any other Child for whom the Employee has been named legal guardian. For purposes of this definition, a legally adopted Child shall include a Child placed in an Employee's physical custody in anticipation of adoption. "Child" shall also mean a covered Employee's Child who is an Alternate Recipient under a Qualified Medical Child Support Order, as required by the Federal Omnibus Budget Reconciliation Act of 1993.

"CHIP"
"CHIP" refers to the Children's Health Insurance Program or any provision or section thereof, which is herein specifically referred to, as such act, provision or section may be amended from time to time.

"CHIPRA"
"CHIPRA" refers to the Children's Health Insurance Program Reauthorization Act of 2009 or any provision or section thereof, which is herein specifically referred to, as such act.

“Chiropractic Care”
“Chiropractic Care” shall mean the detection and correction, by manual or mechanical means, of the interference with nerve transmissions and expressions resulting from distortion, misalignment or dislocation of the spinal (vertebrae) column.

“Claim Determination Period”
“Claim Determination Period” shall mean each Calendar Year.

“Clean Claim”
A “Clean Claim” is one that can be processed in accordance with the terms of this document without obtaining additional information from the service Provider or a third party. It is a claim which has no defect or impropriety. A defect or impropriety shall include a lack of required sustaining documentation as set forth and in accordance with this document, or a particular circumstance requiring special treatment which prevents timely payment as set forth in this document, and only as permitted by this document, from being made. A Clean Claim does not include claims under investigation for fraud and abuse or claims under review for Medical Necessity and Reasonableness, or fees under review for Usual and Customariness, or any other matter that may prevent the charge(s) from being Covered Expenses in accordance with the terms of this document.

Filing a Clean Claim. A Provider submits a Clean Claim by providing the required data elements on the standard claims forms, along with any attachments and additional elements or revisions to data elements, attachments and additional elements, of which the Provider has knowledge. The Plan Administrator may require attachments or other information in addition to these standard forms (as noted elsewhere in this document and at other times prior to claim submittal) to ensure charges constitute Covered Expenses as defined by and in accordance with the terms of this document. The paper claim form or electronic file record must include all required data elements and must be complete, legible, and accurate. A claim will not be considered to be a Clean Claim if the Participant has failed to submit required forms or additional information to the Plan as well.

“COBRA”
“COBRA” shall mean the Consolidated Omnibus Budget Reconciliation Act of 1985, as amended.

"Cosmetic Surgery”
“Cosmetic Surgery” shall mean any expenses Incurred in connection with the care and treatment of, or operations which are performed for plastic, reconstructive, or cosmetic purposes or any other service or supply which are primarily used to improve, alter, or enhance appearance of a physical characteristic which is within the broad spectrum of normal but which may be considered displeasing or unattractive, except when required by an Injury.

“Covered Expense(s)”
“Covered Expense(s)” means a Usual and Customary fee for, and/or, a Reasonable, Medically Necessary service, treatment or supply, meant to improve a condition or Participant’s health, which is eligible for coverage under this Plan. Covered Expenses will be determined based upon all other Plan provisions.

All treatment is subject to benefit payment maximums shown in the Summary of Benefits and as determined elsewhere in this document.

“Custodial Care”
“Custodial Care” shall mean care or confinement designated principally for the assistance and maintenance of the Participant, in engaging in the activities of daily living, whether or not Totally Disabled. This care or confinement could be rendered at home or by persons without professional skills or training. This care may relieve symptoms or pain but is not reasonably expected to improve the underlying medical condition. Custodial Care includes, but is not limited to, assistance in eating, dressing, bathing and using the toilet, preparation of special diets, supervision of medication which can normally be self administered, assistance in walking or getting in and out of bed, and all domestic activities.

“Deductible”

"Deductible" shall mean the aggregate amount for certain expenses for covered services that is the responsibility of the Participant to pay for him or herself each Calendar Year before the Plan will begin its payments.

"Dentist"
"Dentist" shall mean a properly trained person holding a D.D.S. or D.M.D. degree and practicing within the scope of a license to practice dentistry within their applicable geographic venue.

"Dependent"
"Dependent" shall mean one or more of the following person(s):

1. An Employee's present spouse, evidenced by valid marriage license, not annulled or voided in any way.
2. An Employee's Child who is less than 26 years of age; or
3. An Employee's Child, regardless of age, who is mentally or physically incapable of sustaining his or her own living. Such Child must have been mentally or physically incapable of earning his or her own living prior to attaining the limiting age as stated in the numbers above. Written proof of such incapacity and dependency satisfactory to the Plan must be furnished and approved by the Plan within 31 days after the date the Child attains the limiting age as stated in the numbers above. The Plan may require, at reasonable intervals, subsequent proof satisfactory to the Plan during the next two years after such date. After such two year period, the Plan may require such proof, but not more often than once each year.
4. For purposes of this definition, "spouse" shall mean any person to whom Employee is legally married according to the laws of any State, and required to be recognized as a legal marriage by the laws of the State of Missouri.

Members of any armed force shall not be deemed to be "Dependents."

Residents of a country other than the United States shall not be deemed to be "Dependents."

To establish a Dependent relationship, the Plan reserves the right to require documentation satisfactory to the Plan Administrator.

"Diagnosis"
"Diagnosis" shall mean the act or process of identifying or determining the nature and cause of a Disease or Injury through evaluation of patient history, examination, and review of laboratory data.

"Diagnostic Service"
"Diagnostic Service" shall mean an examination, test, or procedure performed for specified symptoms to obtain information to aid in the assessment of the nature and severity of a medical condition or the identification of a Disease or Injury. The Diagnostic Service must be ordered by a Physician or other professional Provider.

"Disease"
"Disease" shall mean any disorder which does not arise out of, which is not caused or contributed to by, and which is not a consequence of, any employment or occupation for compensation or profit; however, if evidence satisfactory to the Plan is furnished showing that the individual concerned is covered as an Employee under any workers' compensation law, occupational disease law or any other legislation of similar purpose, or under the maritime doctrine of maintenance, wages, and cure, but that the disorder involved is one not covered under the applicable law or doctrine, then such disorder shall, for the purposes of the Plan, be regarded as a Sickness, Illness or Disease.

"Drug"
"Drug" shall mean an FDA approved drug or medicine that is listed with approval in the *United States Pharmacopeia*, *National Formulary* or *AMA Drug Evaluations* published by the American Medical Association (AMA), that is prescribed for human consumption, and that is required by law to bear the legend: "Caution—Federal Law prohibits dispensing without prescription," or a State restricted drug (any medicinal substance which may be dispensed only by prescription, according to State law), legally

obtained and dispensed by a licensed drug dispenser only, according to a written prescription given by a Physician and/or duly licensed Provider. "Drug" shall also mean insulin for purposes of injection.

"Durable Medical Equipment"
"Durable Medical Equipment" shall mean equipment and/or supplies ordered by a health care Provider for everyday or extended use which:

1. Can withstand repeated use;
2. Is primarily and customarily used to serve a medical purpose;
3. Generally is not useful to a person in the absence of an Illness or Injury; and
4. Is appropriate for use in the home.

"Emergency"
"Emergency" shall mean a situation or medical condition with symptoms of sufficient severity (including severe pain) that the absence of immediate medical attention and treatment would reasonably be expected to result in: (a) serious jeopardy to the health of the individual (or, with respect to a pregnant woman, the woman's unborn child); (b) serious impairment to bodily functions; or (c) serious dysfunction of any bodily organ or part. An Emergency includes, but is not limited to, severe chest pain, poisoning, unconsciousness, and hemorrhage. Other Emergencies and acute conditions may be considered on receipt of proof, satisfactory to the Plan, per the Plan Administrator's discretion, that an Emergency did exist. The Plan may, at its own discretion, request satisfactory proof that an Emergency or acute condition did exist.

"Emergency Medical Condition"
"Emergency Medical Condition" shall mean a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) so that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in a condition described in clause (i), (ii), or (iii) of section 1867(e)(1)(A) of the Social Security Act (42 U.S.C. 1395dd(e)(1)(A)). In that provision of the Social Security Act, clause (i) refers to placing the health of the individual (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy; clause (ii) refers to serious impairment to bodily functions; and clause (iii) refers to serious dysfunction of any bodily organ or part.

"Emergency Services"
"Emergency Services" shall mean, with respect to an Emergency Medical Condition:

1. A medical screening examination (as required under section 1867 of the Social Security Act, 42 U.S.C. 1395dd) that is within the capability of the emergency department of a Hospital, including ancillary services routinely available to the emergency department to evaluate such Emergency Medical Condition; and
2. Such further medical examination and treatment, to the extent they are within the capabilities of the staff and facilities available at the Hospital, as are required under section 1867 of the Social Security Act (42 U.S.C. 1395dd) to stabilize the patient.

"Employee"
"Employee" shall mean a person who is an active full time Employee of the Participating Employer, regularly scheduled to work for the Participating Employer in an Employer-Employee relationship. Such person must be scheduled to work at least 24 hours per week in order to be considered "full time."

"Employer"
"Employer" is Hermann Area District Hospital.

"ERISA"
"ERISA" shall mean the Employee Retirement Income Security Act of 1974, as amended.

"Essential Health Benefits"
"Essential Health Benefits" shall mean, under section 1302(b) of the Affordable Care Act, those health benefits to include at least the following general categories and the items and services covered within the

categories: ambulatory patient services; Emergency Services; hospitalization; maternity and newborn care ; mental health and substance abuse 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"
"Experimental" and/or "Investigational" ("Experimental") shall mean services or treatments that are not widely used or accepted by most practitioners or lack credible evidence to support positive short or long-term outcomes from those services or treatments and that are not the subject of, or in some manner related to, the conduct of an Approved Clinical Trial, as such term is defined herein; these services are not included under or as Medicare reimbursable procedures, and include services, supplies, care, procedures, treatments or courses of treatment which:

1. Do not constitute accepted medical practice under the standards of the case and by the standards of a reasonable segment of the medical community or government oversight agencies at the time rendered; or
2. Are rendered on a research basis as determined by the United States Food and Drug Administration and the AMA's Council on Medical Specialty Societies.

A drug, device, or medical treatment or procedure is Experimental:

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;
2. If reliable evidence shows that the drug, device or medical treatment or procedure is the subject of ongoing Phase I, II, or III clinical trials or under study to determine its:

    a. maximum tolerated dose;
    b. toxicity;
    c. safety;
    d. efficacy; and
    e. efficacy as compared with the standard means of treatment or Diagnosis; or

3. If reliable evidence shows that the consensus among experts regarding the drug, device, or medical treatment or procedure is that further studies or clinical trials are necessary to determine its:

    a. maximum tolerated dose;
    b. toxicity;
    c. safety;
    d. efficacy; and
    e. efficacy as compared with the standard means of treatment or Diagnosis.

Reliable evidence shall mean:

1. Only published reports and articles in the authoritative medical and scientific literature;
2. The written protocol or protocols used by the treating facility or the protocol(s) of another facility studying substantially the same drug, device, or medical treatment or procedure; or
3. The written informed consent used by the treating facility or by another facility studying substantially the same drug, device, or medical treatment or procedure.

The Plan Administrator retains maximum legal authority and discretion to determine what is Experimental.

"Family Unit"
"Family Unit" shall mean the Employee and his or her Dependents covered under the Plan.

“Final Internal Adverse Benefit Determination”
"Final Internal Adverse Benefit Determination" shall mean an Adverse Benefit Determination that has been upheld by the Plan at the conclusion of the internal claims and appeals process, or an Adverse Benefit Determination with respect to which the internal claims and appeals process has been deemed exhausted.

“FMLA”
“FMLA” shall mean the Family and Medical Leave Act of 1993, as amended.

“FMLA Leave”
“FMLA Leave” shall mean an unpaid, job protected Leave of Absence for certain specified family and medical reasons, which the Company is required to extend to an eligible Employee under the provisions of the FMLA.

“GINA”
“GINA” shall mean the Genetic Information Nondiscrimination Act of 2008 (Public Law No. 110-233), which prohibits group health plans, issuers of individual health care policies, and employers from discriminating on the basis of genetic information.

“Habilitation/Habilitative Services”
“Habilitation Services” shall mean services designed to assist individuals in acquiring, retaining and improving the self-help, socialization and adaptive skills necessary to reside successfully in home and community based settings.

“HIPAA”
“HIPAA” shall mean the Health Insurance Portability and Accountability Act of 1996, as amended.

“Home Health Care”
“Home Health Care” shall mean the continual care and treatment of an individual if:

1. The institutionalization of the individual would otherwise have been required if Home Health Care was not provided;
2. The treatment plan covering the Home Health Care service is established and approved in writing by the attending Physician; and
3. The Home Health Care is the result of an Illness or Injury.

“Home Health Care Agency”
“Home Health Care Agency” shall mean an agency or organization which provides a program of Home Health Care and which:

1. Is a Federally certified Home Health Care Agency and approved as such under Medicare;
2. Meets the established standards and is operated pursuant to applicable laws in the jurisdiction in which it is located and, is licensed and approved by the regulatory authority having the responsibility for licensing, where licensing is required; or
3. Meets all of the following requirements:

    a. It is an agency which holds itself forth to the public as having the primary purpose of providing a Home Health Care delivery system bringing supportive services to the home;
    b. It has a full time administrator;
    c. It maintains written records of services provided to the patient;
    d. Its staff includes at least one Registered Nurse (R.N.) or it has nursing care by a Registered Nurse (R.N.) available; and
    e. Its employees are bonded and it provides malpractice insurance.

“Hospital”
“Hospital” shall mean an Institution, accredited by the Joint Commission on Accreditation of Hospitals (sponsored by the AMA and the AHA), under the supervision of a staff of Physicians that maintains diagnostic and therapeutic facilities on premises, for the provision of medical (including Surgical facilities

for all Institutions other than those specializing in the care and treatment of mentally ill patients, provided such Institution is accredited as such a facility by the Joint Commission on Accreditation of Hospitals sponsored by the AMA and the AHA), diagnosis, treatment, and care to Injured or sick persons, on an Inpatient basis, with 24 hour a day nursing service by Registered Nurses.

To be deemed a "Hospital," the facility must be duly licensed if it is not a State tax supported Institution, and must not be primarily a place for rest, the aged, and/or a nursing home, custodial, or training institution; or an Institution which is supported in whole or in part by a Federal government fund.

Institutions and/or facilities not deemed to be a "Hospital" in accordance with Medicare, shall not be deemed to be Hospitals for this Plan's purposes.

"Hospital" shall also have the same meaning, where appropriate in context, set forth in the definition of "Ambulatory Surgical Center."

"Illness"
"Illness" shall have the meaning set forth in the definition of "Disease."

"Impregnation and Infertility Treatment"
"Impregnation and Infertility Treatment" shall mean any services, supplies or Drugs related to the Diagnosis or treatment of infertility.

"Incurred"
A Covered Expense is "Incurred" on the date the service is rendered or the supply is obtained. With respect to a course of treatment or procedure which includes several steps or phases of treatment, Covered Expenses are Incurred for the various steps or phases as the services related to each step are rendered and not when services relating to the initial step or phase are rendered. More specifically, Covered Expenses for the entire procedure or course of treatment are not Incurred upon commencement of the first stage of the procedure or course of treatment.

"Injury"
"Injury" shall mean an Accidental Bodily Injury, which does not arise out of, which is not caused or contributed to by, and which is not a consequence of, any employment or occupation for compensation or profit.

"Inpatient"
"Inpatient" shall mean a Participant who receives care as a registered and assigned bed patient while confined in a Hospital, other than in its outpatient department, where a room and board is charged by the Hospital.

"Institution"
"Institution" shall mean a facility created and/or maintained for the purpose of practicing medicine and providing organized health care and treatment to individuals, operating within the scope of its license, such as a Hospital, Ambulatory Surgical Center, Psychiatric Hospital, community mental health center, residential treatment facility, psychiatric treatment facility, Substance Abuse Treatment Center, alternative birthing center, Home Health Care Agency, or any other such facility that the Plan approves.

"Intensive Care Unit"
"Intensive Care Unit" shall have the same meaning set forth in the definition of "Cardiac Care Unit."

"Late Enrollee"
"Late Enrollee" shall mean a Participant who enrolls in the Plan other than:

1. On the earliest date on which coverage can become effective for the individual under the terms of the Plan; or
2. Through special enrollment.

"Leave of Absence"

"Leave of Absence" shall mean a period of time during which the Employee must be away from his/her primary job with the Employer, while maintaining the status of Employee during said time away from work, generally requested by an Employee and having been approved by his or her Participating Employer, and as provided for in the Participating Employer's rules, policies, procedures and practices where applicable.

"Legal Separation"
"Legal Separation" shall mean a court order or judgment which allows a couple to live separate and apart, but which does not dissolve the marriage of the parties.

"Mastectomy"
"Mastectomy" shall mean the Surgery to remove all or part of breast tissue as a way to treat or prevent breast cancer.

"Maximum Amount" or "Maximum Allowable Charge"
"Maximum Amount" and/or "Maximum Allowable Charge" shall mean the benefit payable for a specific coverage item or benefit under the Plan. Maximum Allowable Charge(s) will be the lesser of:

1. The Usual and Customary amount;
2. The allowable charge specified under the terms of the Plan;
3. The Reasonable charge specified under the terms of the Plan;
4. The actual billed charges for the covered services; or
5. The Reasonable amount.

The Plan will reimburse the actual charge billed if it is less than the Usual and Customary amount. The Plan has the discretionary authority to decide if a charge is Usual and Customary and for a Medically Necessary and Reasonable service.

The **Maximum Allowable Charge** will not include any identifiable billing mistakes including, but not limited to, up-coding, duplicate charges, and charges for services not performed.

"Medical Child Support Order"
"Medical Child Support Order" shall mean any judgment, decree or order (including approval of a domestic relations settlement agreement) issued by a court of competent jurisdiction that:

1. Provides for child support with respect to a Child of a Participant or directs the Participant to provide coverage under a health benefits plan pursuant to a State domestic relations law (including a community property law); or
2. Is made pursuant to a law relating to medical child support described in §1908 of the Social Security Act (as added by Omnibus Budget Reconciliation Act of 1993 §13822) with respect to a group health plan.

"Medically Necessary"
"Medical Care Necessity", "Medically Necessary", "Medical Necessity" and similar language refers to health care services ordered by a Physician exercising prudent clinical judgment provided to a Participant for the purposes of evaluation, Diagnosis or treatment of that Participant's Sickness or Injury. Such services, to be considered Medically Necessary, must be clinically appropriate in terms of type, frequency, extent, site and duration for the Diagnosis or treatment of the Participant's Sickness or Injury. The Medically Necessary setting and level of service is that setting and level of service which, considering the Participant's medical symptoms and conditions, cannot be provided in a less intensive medical setting. Such services, to be considered Medically Necessary must be no more costly than alternative interventions, including no intervention and are at least as likely to produce equivalent therapeutic or diagnostic results as to the Diagnosis or treatment of the Participant's Sickness or Injury without adversely affecting the Participant's medical condition.

1. It must not be maintenance therapy or maintenance treatment;
2. Its purpose must be to restore health;
3. It must not be primarily custodial in nature;
4. It must not be a listed item or treatment not allowed for reimbursement by CMS (Medicare); and

5. The Plan reserves the right to incorporate CMS (Medicare) guidelines in effect on the date of treatment as additional criteria for determination of Medical Necessity and/or an Allowable Expense.

For Hospital stays, this means that acute care as an Inpatient is necessary due to the kind of services the Participant is receiving or the severity of the Participant's condition and that safe and adequate care cannot be received as an outpatient or in a less intensified medical setting. The mere fact that the service is furnished, prescribed or approved by a Physician does not mean that it is "Medically Necessary." In addition, the fact that certain services are excluded from coverage under this Plan because they are not "Medically Necessary" does not mean that any other services are deemed to be "Medically Necessary."

To be Medically Necessary, all of these criteria must be met. Merely because a Physician or Dentist recommends, approves, or orders certain care does not mean that it is Medically Necessary. The determination of whether a service, supply, or treatment is or is not Medically Necessary may include findings of the American Medical Association and the Plan Administrator's own medical advisors. The Plan Administrator has the discretionary authority to decide whether care or treatment is Medically Necessary.

"Medical Record Review"
"Medical Record Review" is the process by which the Plan, based upon a Medical Record Review and audit, determines that a different treatment or different quantity of a Drug or supply was provided which is not supported in the billing, then the Plan Administrator may determine the **Maximum Allowable Charge** according to the Medical Record Review and audit results.

"Medicare"
"Medicare" shall mean the Federal program by which health care is provided to individuals who are 65 or older, certain younger individuals with disabilities, and individuals with End-Stage Renal Disease, administered in accordance with parameters set forth by CMS and Title XVIII of the Social Security Act of 1965, as amended, by whose terms it was established.

"Mental Health Parity Act (MHPA) of 1996 and Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA), Collectively, the Mental Health Parity Provisions in Part 7 of ERISA"
"The Mental Health Parity Provisions" shall mean in the case of a group health plan (or health insurance coverage offered in connection with such a plan) that provides both medical and surgical benefits and mental health or substance use disorder benefits, such plan or coverage shall ensure that:

1. The financial requirements applicable to such mental health or substance use disorder benefits are no more restrictive than the predominant financial requirements applied to substantially all medical and surgical benefits covered by the Plan (or coverage) and that there are no separate cost sharing requirements that are applicable only with respect to mental health or substance use disorder benefits. If these benefits are covered by the group health plan (or health insurance coverage is offered in connection with such a plan); and
2. The treatment limitations applicable to such mental health or substance use disorder benefits are no more restrictive than the predominant treatment limitations applied to substantially all medical and surgical benefits covered by the Plan (or coverage), and that there are no separate treatment limitations that are applicable only with respect to mental health or substance use disorder benefits. If these benefits are covered by the group health plan (or health insurance coverage offered in connection with such a plan).

"Mental or Nervous Disorder"
"Mental or Nervous Disorder" shall mean any Disease or condition, regardless of whether the cause is organic, that is classified as a Mental or Nervous Disorder in the current edition of International Classification of Diseases, published by the U.S. Department of Health and Human Services, is listed in the current edition of Diagnostic and Statistical Manual of Mental Disorders, published by the American Psychiatric Association or other relevant State guideline or applicable sources.

"National Medical Support Notice" or "NMSN"
"National Medical Support Notice" or "NMSN" shall mean a notice that contains the following information:

1. The name of an issuing State child support enforcement agency; Name and mailing address (if any) of an Employee who is a Participant under the Plan;
2. The name and mailing address (if any) of the Employee who is a Participant under the Plan or eligible for enrollment;
3. The name and mailing address of each of the Alternate Recipients (i.e., the Child or Children of the Participant) or the name and address of a State or local official may be substituted for the mailing address of the Alternate Recipients(s)); and
4. Identity of an underlying child support order.

Network"
"Network" shall mean the facilities, providers and suppliers who have by contract via a medical Provider Network agreed to allow the Plan access to discounted fees for service(s) provided to Participants, and by whose terms they have agreed to accept Assignment of Benefits and the discounted fees thereby paid to them by the Plan as payment in full for Covered Expenses. The applicable Provider Network will be identified on the Participant's identification card.

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

"Nurse"
"Nurse" shall mean an individual who has received specialized nursing training and is authorized to use the designation Registered Nurse (R.N.), Licensed Vocational Nurse (L.V.N.) or Licensed Practical Nurse (L.P.N.), and who is duly licensed by the State or regulatory agency responsible for such license in the State in which the individual performs the nursing services.

"Open Enrollment Period"
"Open Enrollment Period" shall mean the month of December in each Calendar Year.

"Other Plan"
"Other Plan" shall include, but is not limited to:

1. Any primary payer besides the Plan;
2. Any other group health plan;
3. Any other coverage or policy covering the Participant;
4. Any first party insurance through medical payment coverage, personal injury protection, no-fault coverage, uninsured or underinsured motorist coverage;
5. Any policy of insurance from any insurance company or guarantor of a responsible party;
6. Any policy of insurance from any insurance company or guarantor of a third party;
7. Workers' compensation or other liability insurance company; or
8. Any other source, including but not limited to crime victim restitution funds, any medical, disability or other benefit payments, and school insurance coverage.

"Participant"
"Participant" shall mean any Employee or Dependent who is eligible for benefits under the Plan.

"Patient Protection and Affordable Care Act (PPACA)"
The "Patient Protection and Affordable Care Act (PPACA)" means the health care reform law enacted in March 2010, Public Law 111-148; PPACA, together with the Health Care and Education Reconciliation Act, is commonly referred to as Affordable Care Act (ACA). (See "Affordable Care Act").

"Physician"
"Physician" shall mean a Doctor of Medicine (M.D.), Doctor of Osteopathy (D.O.), Doctor of Dental Surgery (D.D.S.), Doctor of Podiatry (D.P.M.), Doctor of Chiropractic (D.C.), Psychologist (Ph.D.), Audiologist, Certified Nurse Anesthetist, Licensed Professional Counselor, Licensed Professional

Physical Therapist, Master of Social Work (M.S.W.), Occupational Therapist, Physiotherapist, Speech Language Pathologist, psychiatrist, midwife, and any other practitioner of the healing arts who is licensed and regulated by a State or Federal agency, acting within the scope of that license.

"Plan Year"
"Plan Year" shall mean a period commencing on the Effective Date or any anniversary of the adoption of this Plan and continuing until the next succeeding anniversary.

"Pre-admission Tests"
"Pre-Admission Tests" shall mean those medical tests and Diagnostic Services completed prior to a scheduled procedure, including Surgery, or scheduled admissions to the Hospital or Inpatient health care facility provided that:

1. The Participant obtains a written order form the Physician;
2. The tests are approved by both the Hospital and the Physician;
3. The tests are performed on an outpatient basis prior to Hospital admission; and
4. The tests are performed at the Hospital into which confinement is scheduled, or at a qualified facility designated by the Physician who will perform the procedure or Surgery.

"Pregnancy"
"Pregnancy" shall mean a physical state whereby a woman presently bears a child or children in the womb, prior to but likely to result in childbirth, miscarriage and/or non-elective abortion. Pregnancy is considered a Sickness for the purpose of determining benefits under this Plan.

"Preventive Care"
"Preventive Care" shall mean certain Preventive Care services.

This Plan intends to comply with the Affordable Care Act's (ACA) requirement to offer in-Network coverage for certain preventive services without cost-sharing. To comply with the ACA, and in accordance with the recommendations and guidelines, the Plan will provide in-Network coverage for:

1. Evidence-based items or services rated A or B in the United States Preventive Services Task Force recommendations;
2. Recommendations of the Advisory Committee on Immunization Practices adopted by the Director of the Centers for Disease Control and Prevention;
3. Comprehensive guidelines for infants, children, and adolescents supported by the Health Resources and Services Administration (HRSA); and
4. Comprehensive guidelines for women supported by the Health Resources and Services Administration (HRSA).

Copies of the recommendations and guidelines may be found here: http://www.uspreventiveservicestaskforce.org or at https://www.healthcare.gov/preventive-care-benefits/. For more information, you may contact the Plan Administrator / Employer.

"Prior Plan"
"Prior Plan" shall mean the coverage provided on a group or group type basis by the group insurance policy, benefit plan or service plan that was terminated on the day before the Effective Date of the Plan and replaced by the Plan.

"Prior to Effective Date" or "After Termination Date"
"Prior to Effective Date" or "After Termination Date" are dates occurring before a Participant gains eligibility from the Plan, or dates occurring after a Participant loses eligibility from the Plan, as well as charges Incurred Prior to the Effective Date of coverage under the Plan or after coverage is terminated, unless Extension of Benefits applies.

"Privacy Standards"
"Privacy Standards" shall mean the standards of the privacy of individually identifiable health information, as pursuant to HIPAA.

"Provider"
"Provider" shall mean an entity whose primary responsibility is related to the supply of medical care. Each Provider must be licensed, registered, or certified by the appropriate State agency where the medical care is performed, as required by that State's law where applicable. Where there is no applicable State agency, licensure, or regulation, the Provider must be registered or certified by the appropriate professional body. The Plan Administrator may determine that an entity is not a "Provider" as defined herein if that entity is not deemed to be a "Provider" by CMS for purposes arising from payment and/or enrollment with Medicare; however, the Plan Administrator is not so bound by CMS' determination of an entity's status as a Provider.

"Psychiatric Hospital"
"Psychiatric Hospital" shall mean an Institution, appropriately licensed as a Psychiatric Hospital, established for the primary purpose of providing diagnostic and therapeutic psychiatric services for the treatment of mentally ill persons either by, or under the supervision of, a Physician. As such, to be deemed a "Psychiatric Hospital," the Institution must ensure every patient is under the care of a Physician and their staffing pattern must ensure the availability of a Registered Nurse 24 hours each day. Should the Institution fail to maintain clinical medical records on all patients permitting the determination of the degree and intensity of treatment to be provided, that Institution will not be deemed to be a "Psychiatric Hospital."

To be deemed a "Psychiatric Hospital," the Institution must be duly licensed and must not be primarily a place for rest, the aged, and/or a nursing home, custodial, or training institution.

"Qualified Medical Child Support Order" or "QMCSO"
"Qualified Medical Child Support Order" or "QMCSO" shall mean a Medical Child Support Order, in accordance with applicable law, and which creates or recognizes the existence of an Alternate Recipient's right to, or assigns to an Alternate Recipient the right to, receive benefits for which a Participant or eligible Dependent is entitled under this Plan. A QMSCO must contain the content described herein, under the applicable Section titled "Qualified Medical Child Support Orders."

"Reasonable"
"Reasonable" and/or "Reasonableness" shall mean in the Plan Administrator's discretion, services or supplies, or fees for services or supplies, which are necessary for the care and treatment of Illness or Injury not caused by the treating Provider's error or mistake. Determination that fee(s) or services are Reasonable will be made by the Plan Administrator, taking into consideration unusual circumstances or complications requiring additional time, skill and experience in connection with a particular service or supply; industry standards and practices as they relate to similar scenarios; and the cause of Injury or Illness necessitating the service(s) and/or charge(s).

This determination will consider, but will not be limited to evidence-based guidelines, and the findings and assessments of the following entities: (a) The National Medical Associations, Societies, and organizations; (b) CMS and (c) The Food and Drug Administration.

To be Reasonable, service(s) and/or fee(s) must also be in compliance with generally accepted billing practices for unbundling or multiple procedures. The Plan Administrator retains discretionary authority to determine whether service(s) and/or fee(s) are Reasonable based upon information presented to the Plan Administrator.

The Plan Administrator reserves for itself and parties acting on its behalf the right to review charges processed and/or paid by the Plan, to identify charge(s) and/or service(s) that are not Reasonable and therefore not eligible for payment by the Plan.

"Rehabilitation Hospital"
"Rehabilitation Hospital" shall mean an appropriately licensed Institution, which is established in accordance with all relevant Federal, State and other applicable laws, to provide therapeutic and restorative services to individuals seeking to maintain, reestablish, or improve motor-skills and other functioning deemed Medically Necessary for daily living, that have been lost or impaired due to Sickness

and/or Injury. To be deemed a "Rehabilitation Hospital," the Institution must be legally constituted, operated, and accredited for its stated purpose by either the Joint Commission on Accreditation of Hospitals or the Commission on Accreditation for Rehabilitation Facilities, as well as approved for its stated purpose by CMS for Medicare purposes.

To be deemed a "Rehabilitation Hospital," the Institution must be duly licensed and must not be primarily a place for rest, the aged, and/or a nursing home, custodial, or training institution.

"Room and Board"
"Room and Board" shall mean a Hospital's charge for:

1. Room and complete linen service;
2. Dietary service including all meals, special diets, therapeutic diets, required nourishment's, dietary supplements and dietary consultation;
3. All general nursing services including but not limited to coordinating the delivery of care, supervising the performance of other staff members who have delegated member care and member education; and
4. Other conditions of occupancy which are Medically Necessary.

"Security Standards"
"Security Standards" shall mean the final rule implementing HIPAA's Security Standards for the Protection of Electronic PHI, as amended.

"Service Waiting Period"
"Service Waiting Period" shall mean an interval of time that must pass before an Employee or Dependent is eligible to enroll under the terms of the Plan. The Employee must be a continuously Active Employee of the Employer during this interval of time.

"Sickness"
"Sickness" shall have the meaning set forth in the definition of "Disease."

"Substance Abuse"
"Substance Abuse" shall mean any use of alcohol, any drug (whether obtained legally or illegally), any narcotic, or any hallucinogenic or other illegal substance, which produces a pattern of pathological use, causing impairment in social or occupational functioning, or which produces physiological dependency evidenced by physical tolerance or withdrawal. It is the excessive use of a substance, especially alcohol or a drug. The Diagnostic and Statistical Manual of Mental Disorders (DSM) definition of "Substance Use Disorder" is applied as follows:

1. A maladaptive pattern of substance use leading to clinically significant impairment or distress, as manifested by one or more, of the following, occurring within a twelve month period:

    a. Recurrent substance use resulting in a failure to fulfill major role obligations at work, school or home (e.g., repeated absences or poor work performance related to substance use; substance-related absences, suspensions or expulsions from school; neglect of children or household);
    b. Recurrent substance use in situations in which it is physically hazardous (e.g., driving an automobile or operating a machine when impaired by substance use);
    c. Craving or a strong desire or urge to use a substance; or
    d. Continued substance use despite having persistent or recurrent social or interpersonal problems caused or exacerbated by the effects of the substance (e.g., arguments with spouse about consequences of intoxication, physical fights);

2. The symptoms have never met the criteria for Substance Dependence for this class of substance.

"Substance Abuse Treatment Center"
"Substance Abuse Treatment Center" shall mean an Institution whose facility is licensed, certified or approved as a Substance Abuse treatment center by a Federal, State, or other agency having legal

authority to so license; which is affiliated with a Hospital and whose primary purpose is providing diagnostic and therapeutic services for treatment of Substance Abuse. To be deemed a "Substance Abuse Treatment Center," the Institution must have a contractual agreement with the affiliated Hospital by which a system for patient referral is established, and implement treatment by means of a written treatment plan approved and monitored by a Physician. Where applicable, the "Substance Abuse Treatment Center" must also be appropriately accredited by the Joint Commission on Accreditation of Hospitals.

"Substance Dependence"
"Substance Dependence" shall mean substance use history which includes the following: (1) Substance Abuse (see above); (2) continuation of use despite related problems; (3) development of tolerance (more of the drug is needed to achieve the same effect); and (4) withdrawal symptoms.

"Surgery"
"Surgery" shall in the Plan Administrator's discretion mean the treatment of Injuries or disorders of the body by incision or manipulation, especially with instruments designed specifically for that purpose, and the performance of generally accepted operative and cutting procedures, performed within the scope of the Provider's license.

"Surgical Procedure"
"Surgical Procedure" shall have the same meaning set forth in the definition of "Surgery."

"Third Party Administrator"
"Third Party Administrator" shall mean the claims administrator which provides customer service and claims payment services only and does not assume any financial risk or obligation with respect to those claims.

"Total Disability"
"Total Disability" shall mean an individual is determined as being disabled for Social Security purposes and provides such evidence to the Plan of the determination as the Plan Administrator may, in its sole discretion, require.

"Totally Disabled"
"Totally Disabled" shall have the same meaning set forth in the definition of "Total Disability."

"Uniformed Services"
"Uniformed Services" shall mean the Armed Forces, the Army National Guard and the Air National Guard, when engaged in active duty for training, inactive duty training, or full time National Guard duty, the commissioned corps of the Public Health Service, and any other category of persons designated by the President of the United States in time of war or Emergency.

"USERRA"
"USERRA" shall mean the Uniformed Services Employment and Reemployment Rights Act of 1994 ("USERRA").

"Usual and Customary"
"Usual and Customary" shall mean, except as otherwise required under state or Federal regulations, the maximum amount the plan is obligated to pay for services provided by a non-primary PPO provider will be the lesser of the provider's billed charges for covered services and an amount determined by one or more of the following, which we may sometimes modify to maintain the reasonableness of the Allowed Amount:

- Using current publicly-available data reflecting fees typically reimbursed to providers for the same or similar professional services, adjusted for geographical differences where applicable.
- Using current publicly-available data reflecting the costs for facilities providing the same or similar services, adjusted for geographical differences where applicable, plus a margin factor.
- Using amounts calculated based on what Medicare would reimburse for the services billed.
- Using the rates negotiated with the provider for all services provided under a non-primary network contract or claim-specific agreement.

All other defined terms in this Plan Document shall have the meanings specified in the Plan Document where they appear.

ELIGIBILITY FOR COVERAGE

4.01 Eligibility for Individual Coverage

Employees classified as Medical Doctors, Nurse Practitioners, Physician Assistants, and Licensed Clinical Social Workers will become eligible for coverage under this plan with respect to himself or herself on the first day of the first full month after the employee has begun to work for his or her Partcipating Employer. All other Employees will become eligible for coverage under this Plan with respect to himself or herself on the first day of the month following completion of a Service Waiting Period of 60 days, provided the Employee has begun work for his or her Participating Employer. If the Employee is unable to begin work as scheduled, then his or her coverage will become effective on such later date when the Employee begins work. Each Employee who was covered under the Prior Plan, if any, will be eligible on the Effective Date of this Plan. Any Service Waiting Period or portion thereof satisfied under the Prior Plan, if any, will be applied toward satisfaction of the Service Waiting Period of this Plan. If employment is terminated and the Employee returns to Active Employment within three months from the date of termination, the Service Waiting Period will be waived and coverage will take effect on the first day the Employee returns to Active Employment.

4.02 Eligibility Dates for Dependent Coverage

Each Employee will become eligible for coverage under this Plan for his or her Dependents on the latest of the following dates:

1. His or her date of eligibility for coverage for himself or herself under the Plan;
2. The date coverage for his or her Dependents first becomes available under any amendment to the Plan, if such coverage was not provided under the Plan on the Effective Date of the Plan; and
3. The first date upon which he or she acquires a Dependent.

In no event will any Dependent Child be covered as a Dependent of more than one Employee who is covered under the Plan.

Any reference in this Plan to an Employee's Dependent being covered means that such Employee is covered for Dependent Coverage.

4.03 Effective Dates of Coverage; Conditions

The coverage for which an individual is eligible under this Plan will become effective on the date specified below, subject to the conditions of this section.

1. Enrollment Form. Employee(s) may seek to obtain coverage for themselves and/or Dependents via a form furnished by the Plan Administrator, in a manner that is satisfactory to the Plan Administrator, and within 31 days following the applicable date of eligibility. If coverage is available and appropriate, coverage will become effective after review of the form, and upon the subsequent date such Employee or Dependents are eligible.

2. Coverage as Both Employee and Dependent. A Participant that may enroll in this Plan as an Employee or a Dependent may enroll as either an Employee or Dependent, but not both.

3. Newly Acquired Dependents. If while an Employee is enrolled for coverage, that Employee acquires a Dependent, coverage for the newly acquired Dependent shall be effective on the date the Dependent becomes eligible only if coverage is secured by the Employee. A written application must be made to the Plan within 31 days of the date of the newly acquired Dependent's eligibility, and any required contributions are also to be made if enrollment is otherwise approved by the Plan Administrator.

4. Requirement for Employee Coverage. Coverage for Dependents shall only be available to Dependents of Employees eligible for coverage for him or herself.

5. Dependents of Multiple Employees. If a Dependent may be deemed to be a Dependent of more than one Covered Employee, such Dependent shall be deemed to be a Dependent of one such Employee only.

6. Medicaid Coverage. An individual's eligibility for any State Medicaid benefits will not be taken into account by the Plan in determining that individual's eligibility under the Plan.

7. FMLA Leave. Regardless of any requirements set forth in the Plan, the Plan shall at all times comply with FMLA.

NOTE: It is the responsibility of the enrolled Employee to notify his/her Employer of any changes in the Dependent's status.

4.04 Special and Open Enrollment

Federal law requires and the Plan provides so-called "Special Enrollment Periods," during which Employees may enroll in the Plan, even if they declined to enroll during an initial or subsequent eligibility period. The Special Enrollment rules are described in more detail within this Article.

4.04A Loss of Other Coverage

This Plan will permit an eligible Employee or Dependent (including his or her spouse) who is eligible, but not enrolled, to enroll for coverage under the terms of the Plan if each of the following conditions are met:

1. The eligible Employee or Dependent was covered under another group health plan or had other health insurance coverage at the time coverage under this Plan was offered;
2. The eligible Employee stated in writing at the time this Plan was offered, that the reason for declining enrollment was due to the eligible Employee having coverage under another group health plan or due to the Employee having other health insurance coverage;
3. The eligible Employee or Dependent lost other coverage pursuant to one of the following events:

    a. The eligible Employee or Dependent was under COBRA and the COBRA coverage was exhausted;
    b. The eligible Employee or Dependent was not under COBRA and the other coverage was terminated as a result of loss of eligibility (including as a result of Legal Separation, divorce, loss of Dependent status, death, termination of employment, or reduction in the number of hours worked);
    c. The eligible Employee or Dependent moved out of an HMO service area with no other option available;
    d. The Plan is no longer offering benefits to a class of similarly situated individuals;
    e. The benefit package option is no longer being offered and no substitute is available; or
    f. The Employer contributions were terminated; and

4. Under the terms of this Plan, the eligible Employee requests enrollment into this Plan not later than 30 days after an event, as described in item 3 above.

Special enrollment rights will not be available to an Employee or Dependent if:

1. 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 Other Plan).

For an eligible Employee or Dependent(s) who has met the conditions specified above, this Plan will be effective at 12:01 A.M. on the first day of the first calendar month beginning after the date the written request for enrollment is received by the Plan and the request is made within 30 days from loss of coverage. For example, if the Employee loses his or her other health coverage on April 22, he or she must notify the Plan Administrator and apply for coverage by close of business on May 22.

4.04B New Dependent

An Employee or Dependent who is eligible, but not enrolled in this Plan, may be eligible to enroll during a special enrollment period if an Employee acquires a new Dependent as a result of marriage, birth, adoption, placement for adoption, or judgment of guardianship. To be eligible for this special enrollment, the Employee must apply in writing no later than 30 days after he or she acquires the new Dependent. For example, if the Employee or Employee's spouse gives birth to a baby on June 22, he or she must notify the Plan Administrator and apply for coverage by close of business on July 22. The following conditions apply to any eligible Employee and Dependents:

An Employee or Dependent who is eligible, but not enrolled in this Plan, may enroll during a special enrollment period if:

1. The eligible Employee is a covered Employee under the terms of this Plan but elected not to enroll during a previous enrollment period; and
2. An individual has become a Dependent of the eligible Employee through marriage, birth, adoption, or placement for adoption.

If the conditions for special enrollment are satisfied, the coverage of the Dependent and/or Employee enrolled during the Special Enrollment Period will be effective at 12:01 A.M.:

1. In the case of marriage, on the date of the marriage;
2. In the case of a Dependent's birth, as of the date of birth; or
3. In the case of a Dependent's adoption or placement for adoption, the date of the adoption or placement for adoption.

4.04C Additional Special Enrollment Rights

Employees and Dependents who are eligible but not enrolled are entitled to enroll under the following circumstances:

1. The Employee's or Dependent's Medicaid or State Child Health Insurance Plan (i.e. CHIP) coverage has terminated as a result of loss of eligibility and the Employee requests coverage under the Plan within 60 days after the termination; or
2. The Employee or Dependent become eligible for a contribution / premium assistance subsidy under Medicaid or a State Child Health Insurance Plan (i.e. CHIP), and the Employee requests coverage under the Plan within 60 days after eligibility is determined.

4.04D Open Enrollment

Prior to the start of a Plan Year, this Plan has an Open Enrollment Period. Eligible Participants who are not covered under this Plan may enroll for coverage during Open Enrollment Periods. Employees who are enrolled will be given an opportunity to change their coverage effective the first day of the upcoming Plan Year. Coverage for Participants enrolling during an Open Enrollment Period will become effective on January 1st, unless the Employee has not satisfied the Service Waiting Period, in which event coverage for the Employee and his or her Dependents will become effective on the day following completion of the Service Waiting Period.

The terms of the Open Enrollment Period, including duration of the election period, shall be determined by the Plan Administrator and communicated prior to the start of an Open Enrollment Period.

"Open Enrollment Period" shall mean the month of December in each Calendar Year.

4.04E Effective Date of Coverage; Conditions

All conditions for effectiveness of coverage under the Plan, which are set forth in the section entitled "Effective Dates of Coverage; Conditions," will apply to Participants enrolling during a special or Open Enrollment Period. Coverage for Participants enrolling during a special enrollment period will become effective on the first day due to loss of coverage or marriage, and on the date of birth, adoption or placement for adoption in the case of such events.

4.05 Qualified Medical Child Support Orders

This Plan will provide for immediate enrollment and benefits to the Child(ren) of a Participant who are the subject of a Qualified Medical Child Support Order (QMCSO), regardless of whether the Child(ren) reside with the Participant, provided the Child or Children are not already enrolled as an eligible Dependent as described in this Plan. If a QMCSO is issued, then the Child(ren) shall become Alternate Recipient(s) of the benefits under this Plan, subject to the same limitations, restrictions, provisions and procedures as any other Participant. The Plan Administrator will determine if the order properly meets the standards described herein. A properly completed National Medical Support Notice (NMSN) will be treated as a QMCSO and will have the same force and effect.

"Alternate Recipient" shall mean any Child of a Participant who is recognized under a Medical Child Support Order as having a right to enrollment under this Plan as the Participant's eligible Dependent. For purposes of the benefits provided under this Plan, an Alternate Recipient shall be treated as an eligible Dependent, but for purposes of the reporting and disclosure requirements under ERISA, an Alternate Recipient shall have the same status as a Participant.

"Medical Child Support Order" shall mean any judgment, decree or order (including approval of a domestic relations settlement agreement) issued by a court of competent jurisdiction that:

1. Provides for child support with respect to a Participant's Child or directs the Participant to provide coverage under a health benefits plan pursuant to a State domestic relations law (including a community property law); or
2. Is made pursuant to a law relating to medical child support described in §1908 of the Social Security Act (as added by Omnibus Budget Reconciliation Act of 1993 §13822) with respect to a group health plan.

"National Medical Support Notice" or "NMSN" shall mean a notice that contains the following information:

1. The name of an issuing State child support enforcement agency;
2. The name and mailing address (if any) of the Employee who is a Participant under the Plan or eligible for enrollment;
3. The name and mailing address of each of the Alternate Recipients (i.e., the Child or Children of the Participant) or the name and address of a State or local official may be substituted for the mailing address of the Alternate Recipients(s)); and
4. Identity of an underlying child support order.

"Qualified Medical Child Support Order" or "QMCSO" shall mean a Medical Child Support Order, in accordance with applicable law, and which creates or recognizes the existence of an Alternate Recipient's right to, or assigns to an Alternate Recipient the right to, receive benefits for which a Participant or eligible Dependent is entitled under this Plan.

To be considered a Qualified Medical Child Support Order, the medical child support order must contain the following information:

1. The name and last known mailing address (if any) of the Participant and the name and mailing address of each such Alternate Recipient covered by the order;
2. A reasonable description of the type of coverage to be provided by this Plan to each Alternate Recipient, or the manner in which such type of coverage is to be determined;
3. The period of coverage to which the order applies; and
4. The name of this Plan.

A National Medical Support Notice shall be deemed a QMCSO if it:

1. Contains the information set forth above in the definition of "National Medical Support Notice";
2. Identifies either the specific type of coverage or all available group health coverage. If the Employer receives an NMSN that does not designate either specific type(s) of coverage or all available coverage, the Employer and the Plan Administrator will assume that all are designated;
3. Informs the Plan Administrator that, if a group health plan has multiple options and the Participant is not enrolled, the issuing agency will make a selection after the NMSN is qualified, and, if the agency does not respond within 20 days, the Child will be enrolled under the Plan's default option (if any); and

4. Specifies that the period of coverage may end for the Alternate Recipient(s) only when similarly situated dependents are no longer eligible for coverage under the terms of the Plan, or upon the occurrence of certain specified events.

An NMSN need not be recognized as a QMSCO if it requires the Plan to provide any type or form of benefit, or any option, not otherwise provided to the Participants and eligible Participants without regard to the provisions herein, except to the extent necessary to meet the requirements of a State law relating to Medical Child Support Orders, as described in Social Security Act §1908 (as added by Omnibus Budget Reconciliation Act of 1993 §13822).

In the instance of any Medical Child Support Order received by this Plan, the Plan Administrator shall, as soon as administratively possible:

1. In writing, notify the Participant and each Alternate Recipient covered by such Order (at the address included in the Order) of the receipt of such Order and the Plan's procedures for determining whether the Order qualifies as a QMCSO; and
2. Make an administrative determination if the order is a QMCSO and notify the Participant and each affected Alternate Recipient of such determination.

In the instance of any National Medical Support Notice received by this Plan, the Plan Administrator shall:

1. Notify the State agency issuing the notice with respect to the Child whether coverage of the Child is available under the terms of the Plan and, if so:

    a. Whether the Child is covered under the Plan; and
    b. Either the effective date of the coverage or, if necessary, any steps to be taken by the custodial parent or by the official of a State or political subdivision to effectuate the coverage; and

2. Provide to the custodial parent (or any State official serving in a substitute capacity) a description of the coverage available and any forms or documents necessary to effectuate such coverage.

As required by Federal law, the Plan Administrator shall:

1. Establish reasonable procedures to determine whether Medical Child Support Order or National Medical Support Notice are Qualified Medical Child Support Orders; and
2. To administer the provision of benefits under such qualified orders.
3. Such procedures shall:

    a. Be in writing;
    b. Provide for the notification of each person specified in a Medical Child Support Order as eligible to receive benefits under the plan (at the address included in the Medical Child Support Order) of such procedures promptly upon receipt by the plan of the Medical Child Support Order; and
    c. Permit an Alternate Recipient to designate a representative for receipt of copies of notices that are sent to the Alternate Recipient with respect to a Medical Child Support Order.

4.06 Late Enrollee

"Late Enrollee" shall mean a Participant who enrolls in the Plan other than:

1. On the earliest date on which coverage can become effective for the individual under the terms of the Plan; or
2. Through special enrollment.

4.07 Acquired Companies

Eligible Employees of an acquired company who are Actively at Work and were covered under the Prior Plan of the acquired company will be eligible for the benefits under this Plan on the date of

acquisition. Any waiting period previously satisfied under the prior health plan will be applied toward satisfaction of the Service Waiting Period of this Plan. In the event that an acquired company did not have a health plan, all eligible Employees will be eligible on the date of the acquisition.

4.08 Genetic Information Nondiscrimination Act ("GINA")

"GINA" prohibits group health plans, issuers of individual health care policies, and employers from discriminating on the basis of genetic information.

The term "genetic information" means, with respect to any individual, information about:

1. Such individual's genetic tests;
2. The genetic tests of family members of such individual; and
3. The manifestation of a Disease or disorder in family members of such individual.

The term "genetic information" includes participating in clinical research involving genetic services. Genetic tests would include analysis of human DNA, RNA, chromosomes, proteins, or metabolite that detect genotypes, mutations, or chromosomal changes. Genetic information is a form of Protected Health Information (PHI) as defined by and in accordance with the Health Insurance Portability and Accountability Act of 1996 (HIPAA), and is subject to applicable Privacy and Security Standards.

Family members as it relates to GINA include dependents, plus all relatives to the fourth degree, without regard to whether they are related by blood, marriage, or adoption. Underwriting as it relates to GINA includes any rules for determining eligibility, computing premiums or contributions, and applying pre-existing condition limitations. Offering reduced premiums or other rewards for providing genetic information would be impermissible underwriting.

GINA will not prohibit a health care Provider who is treating an individual from requesting that the patient undergo genetic testing. The rules permit the Plan to obtain genetic test results and use them to make claims payment determinations when it is necessary to do so to determine whether the treatment provided to the patient was medically advisable and/or necessary.

The Plan may request, but not require, genetic testing in certain very limited circumstances involving research, so long as the results are not used for underwriting, and then only with written notice to the individual that participation is voluntary and will not affect eligibility for benefits, premiums or contributions. In addition, the Plan will notify and describe its activity to the Health and Human Services secretary of its activities falling within this exception.

While the Plan may collect genetic information after initial enrollment, it may not do so in connection with any annual renewal process where the collection of information affects subsequent enrollment. The Plan will not adjust premiums or increase group contributions based upon genetic information, request or require genetic testing or collect genetic information either prior to or in connection with enrollment or for underwriting purposes.

TERMINATION OF COVERAGE

5.01 Termination Dates of Individual Coverage

The coverage of any Employee for himself or herself under this Plan will terminate on the earliest to occur of the following dates:

1. The last day of the month following termination of the Plan;
2. The last day of the month in, or with respect to which, he or she requests that such coverage be terminated, on the condition that such request is made on or before such date, unless prohibited by law (i.e., when election changes cannot be made due to IRC section 125 "change in status" guidelines);
3. The last day of the month for which the Employee has made a contribution, in the event of his or her failure to make, when due, any contribution for coverage for himself or herself to which he or she has agreed in writing;
4. The last day of the month in which he or she no longer eligible for such coverage under the Plan;
5. The last day of the month in which the termination of employment occurs; or
6. The last day of the month during which there has been a submission of a fraudulent claim or any fraudulent information to the Plan (including enrollment information), by and/or on behalf of an Employee or his or her Dependent, or upon the Employee or his or her Dependent gaining knowledge of the submission, as determined by the Plan Administrator in its discretion, consistent with applicable laws and/or rules regarding such rescission.

5.02 Termination Dates of Dependent Coverage

The coverage for any Dependents of any Employee who are covered under the Plan will terminate on the earliest to occur of the following dates:

1. The date upon which the Plan is terminated;
2. Upon the discontinuance of coverage for Dependents under the Plan;
3. The date of termination of the Employee's coverage for himself or herself under the Plan;
4. The date of the expiration of the last period for which the Employee has made a contribution, in the event of his or her failure to make, when due, any contribution for coverage for Dependents to which he or she has agreed in writing;
5. In the case of a Child age 26 or older for whom coverage is being continued due to mental or physical inability to earn his or her own living, the earliest to occur of:

    a. Cessation of such disability or inability;
    b. Failure to provide any required proof of continuous disability or inability or to submit to any required examination; or
    c. Upon the Child's no longer being dependent on the Employee for his or her support;

6. The day immediately preceding the date such person is no longer a Dependent spouse, as defined herein, except as may be provided for in other areas of this section;
7. The last day of the month in which such person ceases to be a Dependent Child, as defined herein, except as may be provided for in other areas of this section or within this document;
8. For a Dependent Child whose coverage is required pursuant to a QMCSO, the last day of the calendar month as of which coverage is no longer required under the terms of the order or this Plan; or
9. Immediately upon submission of a fraudulent claim or any fraudulent information to the Plan (including enrollment information), by and/or on behalf of an Employee or his or her Dependent, or upon the Employee or his or her Dependent gaining knowledge of the submission, as determined by the Plan Administrator in its discretion, consistent with applicable laws and/or rules regarding such rescission.

CONTINUATION OF COVERAGE

6.01 Continuation During Family and Medical Leave Act (FMLA) Leave
The Plan shall at all times comply with FMLA. It is the intention of the Plan Administrator to provide these benefits only to the extent required by applicable law and not to grant greater rights than those so required. During a FMLA Leave, coverage will be maintained in accordance with the same Plan conditions as coverage would otherwise be provided if the covered Employee had been a continuously active employee during the entire leave period. If Plan coverage lapses during the FMLA Leave, coverage will be reinstated for the person(s) who had coverage under the Plan when the FMLA Leave began, upon the Employee's return to work at the conclusion of the FMLA Leave.

6.01A Family and Medical Leave Act of 1993 (FMLA)
This applies to Employers with 50 or more Employees within 75 miles for at least 20 workweeks in the current or preceding Calendar Year. The following are some definitions identified by the FMLA:

Covered Service Member
"Covered Service Member" shall mean current service members and covered veterans who are undergoing medical treatment, recuperation, or therapy due to a serious Injury or Illness, rather than just current service members. A covered veteran is an individual who was discharged or released under conditions other than dishonorable at any time during the five-year period prior to when the eligible Employee takes FMLA Leave to care for the covered veteran.

Eligible Employee
"Eligible Employee" shall mean an individual who has been employed by Hermann Area District Hospital for at least 12 months, has performed at least 1,250 hours of service during the previous 12 month period, and has worked at a location where at least 50 Employees are employed by the Employer within 75 miles.

Family Member
"Family Member" shall mean the (a) Employee's biological, step, or foster parent or (b) a natural, adopted, foster, or stepchild, or a legal ward under 18 years of age, or 18 years and older and incapable of self-care because of a mental or physical disability or (c) spouse.

Serious Illness or Injury (of a service member or covered veteran)
"Serious Illness or Injury" shall mean an Illness or Injury Incurred in the line of duty that may render the service member medically unfit to perform his or her military duties. A serious Injury or Illness for a current service member includes an Injury or Illness that existed before the beginning of the service member's active duty and was aggravated by service in the line of duty on active duty in the armed forces. A serious Injury or Illness for a covered veteran means an Injury or Illness that was Incurred or aggravated by the service member in the line of duty on active duty in the armed forces and manifested itself before or after the service member became a veteran.

These definitions are listed as a guide and the actual wording of the FMLA, as amended, shall supersede these definitions.

6.01B Basic Leave Entitlement
FMLA requires covered Employers to provide up to 12 weeks of unpaid, job-protected leave to eligible Employees for the following reasons:

1. For incapacity due to Pregnancy, prenatal medical care or Child birth;
2. To care for the Employee's Child after birth, or placement for adoption or foster care;
3. To care for the Employee's spouse, son, daughter or parent, who has a serious health condition; or
4. For a serious health condition that makes the Employee unable to perform the Employee's job.

6.01C Military Family Leave Entitlements

Eligible Employees whose spouse, son, daughter or parent is on covered active duty or call to covered active duty status may use their 12 week leave entitlement to address certain qualifying exigencies. Qualifying exigencies may include attending certain military events, arranging for alternative childcare, addressing certain financial and legal arrangements, attending certain counseling sessions, and attending post-deployment reintegration briefings.

FMLA also includes a special leave entitlement that permits eligible Employees to take up to 26 weeks of leave to care for a covered service member during a single 12 month period. A covered service member is:

(1) a current member of the Armed Forces, including a member of the National Guard or Reserves, who is undergoing medical treatment, recuperation or therapy, is otherwise in outpatient status, or is otherwise on the temporary disability retired list, for a serious Injury or Illness*; or (2) a veteran who was discharged or released under conditions other than dishonorable at any time during the five-year period prior to the first date the eligible Employee takes FMLA Leave to care for the covered veteran, and who is undergoing medical treatment, recuperation, or therapy for a serious Injury or Illness.*

***The FMLA definitions of "serious Injury or Illness" for current service members and veterans are distinct from the FMLA definition of "serious health condition".**

6.01D Benefits and Protections

During FMLA Leave, the Employer must maintain the Employee's health coverage under any "group health plan" on the same terms as if the Employee had continued to work. Upon return from FMLA Leave, most Employees must be restored to their original or equivalent positions with equivalent pay, benefits, and other employment terms.

Use of FMLA Leave cannot result in the loss of any employment benefit that accrued prior to the start of an Employee's leave.

6.01E Eligibility Requirements

Employees are eligible if they have worked for a covered Employer for at least 12 months, have 1,250 hours of service in the previous 12 months*, and if at least 50 Employees are employed by the Employer within 75 miles.

***Special hours of service eligibility requirements apply to airline flight crew Employees.**

6.01F Definition of Serious Health Condition

A serious health condition is an Illness, Injury, impairment, or physical or mental condition that involves either an overnight stay in a medical care facility, or continuing treatment by a health care Provider for a condition that either prevents the Employee from performing the functions of the Employee's job, or prevents the qualified family member from participating in school or other daily activities.

Subject to certain conditions, the continuing treatment requirement may be met by a period of incapacity of more than three consecutive calendar days combined with at least two visits to a health care Provider or one visit and a regimen of continuing treatment, or incapacity due to Pregnancy, or incapacity due to a chronic condition. Other conditions may meet the definition of continuing treatment.

6.01G Use of Leave

An Employee does not need to use this leave entitlement in one block. Leave can be taken intermittently or on a reduced leave schedule when Medically Necessary. Employees must make reasonable efforts to schedule leave for planned medical treatment so as not to unduly disrupt the Employer's operations. Leave due to qualifying exigencies may also be taken on an intermittent basis.

6.01H Substitution of Paid Leave for Unpaid Leave

Employees may choose or Employers may require use of accrued paid leave while taking FMLA Leave. In order to use paid leave for FMLA Leave, Employees must comply with the Employer's normal paid leave policies.

6.01I Employee Responsibilities
Employees must provide 30 days' advance notice of the need to take FMLA Leave when the need is foreseeable. When 30 days notice is not possible, the Employee must provide notice as soon as practicable and generally must comply with an Employer's normal call-in procedures.

Employees must provide sufficient information for the Employer to determine if the leave may qualify for FMLA protection and the anticipated timing and duration of the leave. Sufficient information may include that the Employee is unable to perform job functions, the family member is unable to perform daily activities, the need for hospitalization or continuing treatment by a health care Provider, or circumstances supporting the need for military family leave. Employees also must inform the Employer if the requested leave is for a reason for which FMLA Leave was previously taken or certified. Employees also may be required to provide a certification and periodic recertification supporting the need for leave.

6.01J Employer Responsibilities
Covered Employers must inform Employees requesting leave whether they are eligible under FMLA. If they are, the notice must specify any additional information required as well as the Employees' rights and responsibilities. If they are not eligible, the Employer must provide a reason for the ineligibility.

Covered Employers must inform Employees if leave will be designated as FMLA-protected and the amount of leave counted against the Employee's leave entitlement. If the Employer determines that the leave is not FMLA-protected, the Employer must notify the Employee.

6.01K Unlawful Acts by Employers
FMLA makes it unlawful for any Employer to:

1. Interfere with, restrain, or deny the exercise of any right provided under FMLA; and
2. Discharge or discriminate against any person for opposing any practice made unlawful by FMLA or for involvement in any proceeding under or relating to FMLA.

6.01L Enforcement
An Employee may file a complaint with the U.S. Department of Labor or may bring a private lawsuit against an Employer.

FMLA does not affect any Federal or State law prohibiting discrimination, or supersede any State or local law or collective bargaining agreement which provides greater family or medical leave rights.

FMLA section 109 (29 U.S.C. § 2619) requires FMLA covered Employers to post the text of this notice. Regulation 29 C.F.R. § 825.300(a) may require additional disclosures.

For additional information:
1-866-4US-WAGE (1-866-487-9243) TTY: 1-877-889-5627
WWW.WAGEHOUR.DOL.GOV
U.S. Department of Labor Wage and Hour Division
WHD Publication 1420 · Revised February 2013

6.02 Continuation During USERRA
Participants who are absent from employment because they are in the Uniformed Services may elect to continue their coverage under this Plan for up to 24 months. To continue coverage, Participants must comply with the terms of the Plan, including election during the Plan's annual enrollment period, and pay their contributions, if any. In addition, USERRA also requires that, regardless of whether a Participant elected to continue his or her coverage under the Plan, his or her coverage and his or her Dependents' coverage be reinstated immediately upon his or her return to employment, so long as he or she meets certain requirements contained in USERRA. Participants should contact their participating Employer for information concerning their eligibility for USERRA and any requirements of the Plan.

Participants may have other options available when group health coverage is lost. For example, a Participant may be eligible to buy an individual plan through the Health Insurance Marketplace. By enrolling in coverage through the Marketplace, the Participant may qualify for lower costs on his or her

monthly premiums and lower out-of-pocket costs. Additionally, the Participant may qualify for a 30-day special enrollment period for another group health plan for which the Participant is eligible (such as a spouse's plan), even if that plan generally doesn't accept late enrollees.

6.03 Continuation During Periods of Employer-Certified Disability, Leave of Absence
A person may remain eligible for a limited time if Active, full-time work ceases due to disability or approved leave of absence. In the case of an approved leave of absence, your coverage may continue up to the date your leave of absence terminates, or the subscriber no longer meets the rules that are set by the group for coverage under this health plan.

6.04 Continuation During COBRA – Introduction
The right to this form of continued coverage was created by a Federal law, under the Consolidated Omnibus Budget Reconciliation Act of 1985, as amended ("COBRA"). COBRA Continuation Coverage can become available to Participants when they otherwise would lose their group health coverage. It also can become available to other members of the Participants family who are covered under the Plan when they otherwise would lose their group health coverage. Under the Plan, Qualified Beneficiaries that elect COBRA Continuation Coverage must pay the entire cost of the coverage, including a reasonable administration fee. There are several ways coverage will terminate, including the failure of the Participant or their covered Dependents to make timely payment of contributions or premiums. For additional information, Participants should contact the Participating Employer to determine if COBRA applies to him or her and/or his or her covered Dependents.

Participants may have other options available when group health coverage is lost. For example, a Participant may be eligible to buy an individual plan through the Health Insurance Marketplace. By enrolling in coverage through the Marketplace, the Participant may qualify for lower costs on his or her monthly premiums and lower out-of-pocket costs. Additionally, the Participant may qualify for a 30-day special enrollment period for another group health plan for which the Participant is eligible (such as a spouse's plan), even if that plan generally doesn't accept late enrollees.

6.04A COBRA Continuation Coverage
"COBRA Continuation Coverage" is a continuation of Plan coverage when coverage would otherwise end because of a life event known as a "Qualifying Event." COBRA (and the description of COBRA Continuation Coverage contained in this Plan) does not apply to the following benefits (if available as part of the Employer's plan): life insurance, accidental death and dismemberment benefits and weekly income or long term disability benefits. The aforementioned benefits are not considered for continuation under COBRA. The Plan provides no greater COBRA rights than what COBRA requires – nothing in this Plan is intended to expand the Participant's rights beyond COBRA's requirements.

6.04B Qualifying Events
Specific Qualifying Events are listed below. After a Qualifying Event, COBRA Continuation Coverage must be offered to each person who is a "Qualified Beneficiary." A Qualified Beneficiary is someone who is or was covered by the Plan, and has lost or will lose coverage under the Plan due to the occurrence of a Qualifying Event. The Employee and/or Employee's Dependents could therefore become Qualified Beneficiaries if applicable coverage under the Plan is lost because of the Qualifying Event.

An Employee, who is properly enrolled in this Plan and is a covered Employee, will become a Qualified Beneficiary if he or she loses his or her coverage under the Plan because either one of the following Qualifying Events happens:

1. The hours of employment are reduced; or
2. The employment ends for any reason other than gross misconduct.

The spouse of a covered Employee will become a Qualified Beneficiary if he or she loses his or her coverage under the Plan because any of the following Qualifying Events happens:

1. The spouse dies;
2. The spouse's hours of employment are reduced;
3. The spouse's employment ends for any reason other than his or her gross misconduct;

4. The spouse becomes entitled to Medicare benefits (under Part A, Part B, or both); or
5. The spouse becomes divorced or legally separated from his or her spouse.

Dependent Children will become Qualified Beneficiaries if they lose coverage under the Plan because any of the following Qualifying Events happens:

1. The parent-covered Employee dies;
2. The parent-covered Employee's hours of employment are reduced;
3. The parent-covered Employee's employment ends for any reason other than his or her gross misconduct;
4. The parent-covered Employee becomes entitled to Medicare benefits (Part A, Part B, or both);
5. The parents become divorced or or legally separated; or
6. The Child stops being eligible for coverage under the Plan as a Dependent Child.

6.04C Employer Notice of Qualifying Events

When the Qualifying Event is the end of employment (for reasons other than gross misconduct), reduction of hours of employment, death of the covered Employee, or the covered Employee's becoming entitled to Medicare benefits (under Part A, Part B, or both), the Employer must notify the COBRA Administrator of the Qualifying Event.

6.04D Employee Notice of Qualifying Events

In certain circumstances, the covered Employee or Qualified Beneficiary, in order to protect his or her rights under COBRA, is required to provide notification to the COBRA Administrator in writing, either by U.S. First Class Mail or hand delivery. These circumstances are:

1. **Notice of Divorce or Separation**: Notice of the occurrence of a Qualifying Event that is a divorce or Legal Separation of a covered Employee (or former Employee) from his or her spouse;
2. **Notice of Child's Loss of Dependent Status**: Notice of the occurrence of a Qualifying Event that is an individual's ceasing to be eligible as a Dependent Child under the terms of the Plan;
3. **Notice of a Second Qualifying Event**: Notice of the occurrence of a second Qualifying Event after a Qualified Beneficiary has become entitled to COBRA Continuation Coverage with a maximum duration of 18 (or 29) months;
4. **Notice Regarding Disability**: Notice that a Qualified Beneficiary entitled to receive COBRA Continuation Coverage with a maximum duration of 18 months has been determined by the Social Security Administration ("SSA") to be disabled at any time during the first 60 days of COBRA Continuation Coverage; and
5. **Notice Regarding End of Disability**: Notice that a Qualified Beneficiary, with respect to whom a notice described above in #4 has been provided, has subsequently been determined by the SSA to no longer be disabled.

As indicated above, Notification of a Qualifying Event must be made in writing. Notice must be made by submitting the "Notice of Qualifying Event" form and mailing it by U.S. First Class Mail or hand delivery to the COBRA Administrator. This form is available, without charge, from the COBRA Administrator.

Notification must include an adequate description of the Qualifying Event or disability determination. Please see the remainder of this Article for additional information.

Notification must be received by the COBRA Administrator is:

Mercy Benefit Administrators
3265 S National Ste 210
Springfield, MO 65807
Phone: 877-875-7700
Fax: 417-820-3816
Email/Website: SPRGBenefitAdmins@mercy.net

A form of notice is available, free of charge, from the COBRA Administrator and must be used when providing the notice.

6.04E Deadline for providing the notice

For Qualifying Events described above, notice must be furnished within 60 days of the latest occurring event set forth below:

1. The date upon which the Qualifying Event occurs;
2. The date upon which the Qualified Beneficiary loses (or would lose) Plan coverage due to a Qualifying Event; or
3. The date upon which the Qualified Beneficiary is notified via the Plan's SPD or general notice, and/or becomes aware of their status as a Qualified Beneficiary and/or the occurrence of a Qualifying Event; as well as their subsequent responsibility to comply with the Plan's procedure(s) for providing notice to the COBRA Administrator regarding said status.

As described above, if an Employee or Qualified Beneficiary is determined to be disabled under the Social Security Act, the notice must be delivered no more than 60 days after the latest of:

1. The date of the disability determination by the SSA;
2. The date on which a Qualifying Event occurs;
3. The date on which the Qualified Beneficiary loses (or would lose) coverage under the Plan as a result of the Qualifying Event; or
4. The date on which the Qualified Beneficiary is informed, through the furnishing of the Plan's SPD or the general notice, of both the responsibility to provide the notice and the Plan's procedures for providing such notice to the COBRA Administrator.

In any event, this notice must be provided within the first 18 months of COBRA Continuation Coverage.

For a change in disability status described above, the notice must be furnished by the date that is 30 days after the later of:

1. The date of the final determination by the SSA that the Qualified Beneficiary is no longer disabled; or
2. The date on which the Qualified Beneficiary is informed, through the furnishing of the Plan's SPD or the general notice, of both the responsibility to provide the notice and the Plan's procedures for providing such notice to the COBRA Administrator.

The notice must be postmarked (if mailed), or received by the COBRA Administrator (if hand delivered), by the deadline set forth above. If the notice is late, the opportunity to elect or extend COBRA Continuation Coverage is lost, and if the person is electing COBRA Continuation Coverage, his or her coverage under the Plan will terminate on the last date for which he or she is eligible under the terms of the Plan, or if the person is extending COBRA Continuation Coverage, such Coverage will end on the last day of the initial 18-month COBRA coverage period.

6.04F Who Can Provide the Notice

Any individual who is the covered Employee (or former Employee) with respect to a Qualifying Event, or any representative acting on behalf of the covered Employee (or former Employee) or Qualified Beneficiary, may provide the notice. Notice by one individual shall satisfy any responsibility to provide notice on behalf of all related Qualified Beneficiaries with respect to the Qualifying Event.

6.04G Required Contents of the Notice

After receiving a notice of a Qualifying Event, the Plan must provide the Qualified Beneficiary with an election notice, which describes their rights to COBRA Continuation Coverage and how to make such an election. The notice must contain the following information:

1. Name and address of the covered Employee or former Employee;
2. Name of the Plan and the name, address, and telephone number of the Plan's COBRA administrator;

3. Identification of the Qualifying Event and its date (the initial Qualifying Event and its date if the Qualifying Participant is already receiving COBRA Continuation Coverage and wishes to extend the maximum coverage period);
4. A description of the Qualifying Event (for example, divorce, Legal Separation cessation of Dependent status, entitlement to Medicare by the covered Employee or former Employee, death of the covered Employee or former Employee, disability of a Qualified Beneficiary or loss of disability status);

    a. In the case of a Qualifying Event that is divorce or Legal Separation name(s) and address(es) of spouse and Dependent Child(ren) covered under the Plan, date of divorce or Legal Separation and a copy of the decree of divorce or Legal Separation;
    b. In the case of a Qualifying Event that is Medicare entitlement of the covered Employee or former Employee, date of entitlement, and name(s) and address(es) of spouse and Dependent Child(ren) covered under the Plan;
    c. In the case of a Qualifying Event that is a Dependent Child's cessation of Dependent status under the Plan, name and address of the Child, reason the Child ceased to be an eligible Dependent (for example, attained limiting age, lost student status or other);
    d. In the case of a Qualifying Event that is the death of the covered Employee or former Employee, the date of death, and name(s) and address(es) of spouse and Dependent Child(ren) covered under the Plan;
    e. In the case of a Qualifying Event that is disability of a Qualified Beneficiary, name and address of the disabled Qualified Beneficiary, name(s) and address(es) of other family members covered under the Plan, the date the disability began, the date of the SSA's determination, and a copy of the SSA's determination;
    f. In the case of a Qualifying Event that is loss of disability status, name and address of the Qualified Beneficiary who is no longer disabled, name(s) and address(es) of other family members covered under the Plan, the date the disability ended and the date of the SSA's determination;

5. Identification of the Qualified Beneficiaries (by name or by status);
6. An explanation of the Qualified Beneficiaries' right to elect continuation coverage;
7. The date coverage will terminate (or has terminated) if continuation coverage is not elected;
8. How to elect continuation coverage;
9. What will happen if continuation coverage isn't elected or is waived;
10. What continuation coverage is available, for how long, and (if it is for less than 36 months), how it can be extended for disability or second qualifying events;
11. How continuation coverage might terminate early;
12. Premium payment requirements, including due dates and grace periods;
13. A statement of the importance of keeping the Plan Administrator informed of the addresses of Qualified Beneficiaries;
14. A statement that the election notice does not fully describe COBRA or the plan and that more information is available from the Plan Administrator and in the SPD; and
15. A certification that the information is true and correct, a signature and date.

If a copy of the decree of divorce or Legal Separation or the SSA's determination cannot be provided by the deadline for providing the notice, complete and provide the notice, as instructed, by the deadline and submit the copy of the decree of divorce or Legal Separation or the SSA's determination within 30 days after the deadline. The notice will be timely if done so. However, no COBRA Continuation Coverage, or extension of such Coverage, will be available until the copy of the decree of divorce or Legal Separation or the SSA's determination is provided.

If the notice does not contain all of the required information, the COBRA Administrator may request additional information. If the individual fails to provide such information within the time period specified by the COBRA Administrator in the request, the COBRA Administrator may reject the notice if it does not contain enough information for the COBRA Administrator to identify the plan, the covered Employee (or former Employee), the Qualified Beneficiaries, the Qualifying Event or disability, and the date on which the Qualifying Event, if any, occurred.

6.04H Electing COBRA Continuation Coverage

Complete instructions on how to elect COBRA Continuation Coverage will be provided by the COBRA Administrator within 14 days of receiving the notice of the Qualifying Event. The individual then has 60 days in which to elect COBRA Continuation Coverage. The 60 day period is measured from the later of the date coverage terminates and the date of the notice containing the instructions. If COBRA Continuation Coverage is not elected in that 60 day period, then the right to elect it ceases.

Each Qualified Beneficiary will have an independent right to elect COBRA Continuation Coverage. Covered Employees may elect COBRA Continuation Coverage on behalf of all other Qualified Beneficiaries, including their spouses, and parents or a legal guardian may elect COBRA Continuation Coverage on behalf of their Children.

In the event that the COBRA Administrator determines that the individual is not entitled to COBRA Continuation Coverage, the COBRA Administrator will provide to the individual an explanation as to why he or she is not entitled to COBRA Continuation Coverage.

6.04I Duration of COBRA Continuation Coverage

The maximum time period shown below shall dictate for how long COBRA Continuation Coverage will be available. The maximum time period for coverage is based on the type of the Qualifying Event and the status of the Qualified Beneficiary. Multiple Qualifying Events that may be combined under COBRA will not ordinarily continue coverage for more than 36 months beyond the date of the original Qualifying Event. When the Qualifying Event is "entitlement to Medicare," the 36 month continuation period is measured from the date of the original Qualifying Event. For all other Qualifying Events, the continuation period is measured from the date of the Qualifying Event, not the date of loss of coverage.

When the Qualifying Event is the death of the covered Employee (or former Employee), the covered Employee's (or former Employee's) becoming entitled to Medicare benefits (under Part A, Part B, or both), a divorce or Legal Separation, or a Dependent Child's losing eligibility as a Dependent Child, COBRA Continuation Coverage lasts for up to a total of 36 months.

When the Qualifying Event is the end of employment or reduction of the covered Employee's hours of employment, and the covered Employee became entitled to Medicare benefits less than 18 months before the Qualifying Event, COBRA Continuation Coverage for Qualified Beneficiaries other than the covered Employee lasts until 36 months after the date of Medicare entitlement. For example, if a covered Employee becomes entitled to Medicare eight months before the date on which his or her employment terminates, COBRA Continuation Coverage for his or her spouse and Children can last up to thirty-six months after the date of Medicare entitlement, which is equal to twenty-eight months after the date of the Qualifying Event (thirty-six months minus eight months).

Otherwise, when the Qualifying Event is the end of employment (for reasons other than gross misconduct) or reduction of the covered Employee's hours of employment, COBRA Continuation Coverage generally lasts for only up to a total of 18 months. There are two ways in which this eighteen month period of COBRA Continuation Coverage can be extended.

6.04J Disability Extension of COBRA Continuation Coverage

Disability can extend the 18 month period of continuation coverage for a Qualifying Event that is a termination of employment or reduction of hours, if an Employee or anyone in an Employee's family covered under the Plan is determined by the Social Security Administration ("SSA") to be disabled, and the Employee notifies the COBRA Administrator. The Employee and his or her Dependents may thereby be entitled to an additional 11 months of COBRA Continuation Coverage, for a total of 29 months, if the disability started at some time before the 60th day of COBRA Continuation Coverage and lasts at least until the end of the 18 month period of COBRA Continuation Coverage. The Plan can charge 150% of the premium cost for the extended period of coverage.

6.04K Second Qualifying Event Extension of COBRA Continuation Coverage

If an Employee's family experiences another Qualifying Event while receiving 18 months of COBRA Continuation Coverage, Dependents may receive up to 18 additional months of COBRA Continuation

Coverage, for a maximum of 36 months, if notice of the second Qualifying Event is provided to the Plan Administrator or COBRA Administrator in accordance with the procedures set forth herein. This extension may be applicable to the Employee's death, Medicare Parts A and/or B eligibility, divorce or Legal Separation, or a loss of Dependent status under the terms of the Plan if the event would have also caused the spouse or Dependent Child to lose coverage under the Plan regardless of whether the first Qualifying Event had occurred.

6.04L Shorter Duration of COBRA Continuation Coverage

COBRA establishes required periods of coverage for continuation health benefits. A plan, however, may provide longer periods of coverage beyond those required by COBRA. COBRA Qualified Beneficiaries generally are eligible for group coverage during a maximum of 18 months after Qualifying Events arising due to employment termination or reduction of hours of work. Certain Qualifying Events, or a second Qualifying Events during the initial period of coverage, may permit a Qualified Beneficiary to receive a maximum of 36 months of coverage.

It is not necessary that COBRA Continuation Coverage be in effect for the maximum period of time, as set forth herein. COBRA Continuation Coverage may conclude prior to the latest possible date if the Employer ceases to provide a group health plan to any Employee; the Qualified Beneficiary fails to make timely payment of any required contributions or premium; the Qualified Beneficiary gains coverage under another group health plan (as an Employee or otherwise) or becomes entitled to either Medicare Part A or Part B (whichever comes first) ; and/or any other event occurs which enables the Plan Administrator to terminate coverage without offering COBRA Continuation Coverage (such as the commission of fraud by the Qualified Beneficiary and/or their Dependent).

6.04M Contribution and/or Premium Requirements

The cost of the elected COBRA Continuation Coverage must be paid within 45 days of its election. Payments will then be subsequently due on the first day of each month. COBRA Continuation Coverage will be canceled and will not be reinstated if any payment is made late; however, the Plan Administrator may allow for a 30 day grace period during which a late payment may still be made without the loss of COBRA Continuation Coverage.

6.05 Additional Information

Please contact the COBRA Administrator with any questions about the Plan and COBRA Continuation Coverage at the following:

Mercy Benefit Administrators
3265 S National Ste 210
Springfield, MO 65807
Phone: 877-875-7700
Fax: 417-820-3816
Email/Website: SPRGBenefitAdmins@mercy.net

Questions concerning the Plan or COBRA continuation coverage rights should be addressed to the contact or contacts identified below. For more information about a Participant's rights under the Employee Retirement Income Security Act (ERISA), including COBRA, the Affordable Care Act, 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) or visit www.dol.gov/ebsa. (Addresses and phone numbers of Regional and District EBSA Offices are available through EBSA's website.) For more information about the Marketplace, visit www.HealthCare.gov.

6.06 Current Addresses

Important information is distributed by mail. In order to protect the rights of the Employee's family, the Employee should keep the COBRA Administrator (who has been previously identified in this Article) informed of any changes in the addresses of family members.

LIMITATIONS AND EXCLUSIONS

Coverage is not available from the Plan for charges arising from care, supplies, treatment, and/or services:

1. Alternative Treatments

i. Acupressure
ii. Acupuncture or Auriculotherapy, unless otherwise covered by the Plan.
iii. Aromatherapy.
iv. Hypnotism.
v. Massage Therapy.
vi. Rolfing.
vii. Herbal remedies.
viii. Ayurvedic therapies.
ix. Reflexology.
x. Biofeedback and neurofeedback therapy.
xi. Other forms of alternative treatment as defined by the Office of Alternative Medicine of the National Institutes of Health.

2. Chiropractic

i. Services beyond the scope of the Chiropractor's license to practice chiropractic care.
ii. Preventive care services.
iii. Services for examination and/or treatment of strictly non-neuromusculoskeletal disorders.
iv. Rental or purchase of air conditioners, air purifiers, therapeutic mattresses, orthotics, prosthetics, herbal and dietary services, Durable Medical Equipment, supplies, or any other similar devices, appliances, or equipment whether or not their use or installation is for the purpose of providing therapy or easy access.
v. Services that are not considered Medically Necessary and/or clinically appropriate.

3. Comfort or Convenience

i. Television.
ii. Telephone.
iii. Beauty/Barber service.
iv. Guest service.
v. Automated travel devices (motor scooters).
vi. Supplies, equipment and similar incidental services and supplies for personal comfort or convenience. Examples include:
    a. Air conditioners
    b. Air purifiers and filters
    c. Bath chairs
    d. Batteries and battery chargers
    e. Dehumidifiers, Humidifiers and Vaporizors
    f. Electrostatic machines
    g. Lights/lighting
    h. Portable room heaters, grab bars, etc.
    i. Tanning booths
    j. Exercise equipment
    k. Raised or regular toilet seats
    l. Whirlpools, saunas, and hot tubs

vii. 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, TDD 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.

viii. 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.

ix. Devices that are primarily non-medical in nature or used primarily for comfort, including but not limited to:
    a. Bathtub Seats
    b. Bed boards
    c. Beds other than standard
    d. Carafes
    e. Cold or heat therapy devices
    f. Emesis basins
    g. Elevators
    h. Foam pads
    i. Heating pads
    j. Maternity belts
    k. Overbed tables
    l. Single hospital beds
    m. Standing tables and strollers

x. Chair lifts, bathtub lifts, bed lifter, and other similar devices.

xi. Exercise equipment including but not limited to parallel bars, weights, bicycles, rowing machines, and treadmills.

xii. 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.

xiii. Home monitoring devices and supplies are not covered, except Medically Necessary cardiac monitoring devices (such as holter monitors and event recorders), home prenatal monitoring and associated nursing support, apnea monitors, glucometers, and related supplies.

xiv. Devices used specifically for safety purposes (examples include ear molds and helmets, car seats and strollers).

xv. 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.

4. Dental

i. Dental care.

ii. Preventive care, diagnosis, treatment of or related to the teeth, jawbones or gums, whether the services are considered to be medical or dental in nature. Examples include all of the following:
    a. Extraction, restoration and replacement of teeth;
    b. Medical or surgical treatments of dental conditions;
    c. Services to improve dental clinical outcomes;
    d. Services for overbite or underbite;
    e. Services related to surgery for cutting through the lower or upper jaw bone;
    f. Maxillary and mandibulary osteotomies
    g. Orthognathic surgery

iii. Dental Implants and associated oral surgery and supplies, even if associated with Accidental Dental Services. This includes but is not limited to any enabling procedures for Implants, as well as placement, maintenance, restoration, and removal of dental Implants. Any prosthetic superstructure fabricated upon a dental Implant is also excluded.

iv. Dental braces and occlusal splints.

v. Dental X-rays, supplies and appliances and all associated expenses, including hospitalizations and anesthesia. The only exceptions to this are for any of the following:
    a. Transplant preparation;
    b. Initiation of immunosuppressives;
    c. The direct treatment of acute traumatic Injury;
    d. The direct treatment of cancer (i.e., Injury to teeth as a direct effect of cancer treatment);
    e. Cleft palate.

vi. Treatment of congenitally missing, malpositioned, or super numerary teeth, even if part of a Congenital Anomaly, except with respect to newborns
vii. Orthodontic services.
viii. Upper and lower jawbone surgery except as required for direct treatment of acute traumatic Injury or cancer.

5. Drugs

Prescription drug products for outpatient use that are filled by a prescription order or refill.

i. Non-injectable medications given in a Physician's office except as required in an Emergency.
ii. Over the counter drugs and treatments.
iii. Charges for supplies for use beyond the first twenty-four (24) hours following discharge from the Hospital as an Inpatient or following the provision of Emergency Care, including any Prescription Drugs intended primarily for home use.

6. Experimental, Investigational or Unproven Services

Experimental, Investigational or Unproven Services are excluded except for routine patient care cost including drugs or devices Incurred as a result of phase I, II, III or IV of clinical trials undertaken for the purpose of the prevention, early detection or treatment of cancer. The fact that an Experimental, Investigational or Unproven Service, treatment, device or pharmacological regimen is the only available treatment for a particular condition will not result in Benefits if the procedure is considered to be Experimental, Investigational or Unproven in the treatment of that particular condition.

7. Foot Care

i. Routine foot care (including the cutting or removal of corns and calluses).
ii. Nail trimming, cutting, or debriding, unless the charges are for the removal of a nail or root in connection with the treatment of a metabolic or peripheral-vascular disease or infection.
iii. Hygienic and preventive maintenance foot care. Examples include the following:
    a. Cleaning and soaking the feet;
    b. Applying skin creams in order to maintain skin tone;
    c. Other services that are performed when there is not a localized Sickness, Injury or symptom involving the foot.
iv. Treatment of flat feet, painful feet, fallen arches, metatarsalgia, plantar fasciitis, neuromas, tendonitis, bursitis, varus or valgus deformities, and other conditions of the feet unless otherwise noted in this document.
v. Treatment of subluxation of the foot.
vi. Shoe orthotics, orthopedic shoes and other supportive appliances for feet except as otherwise noted in this document.

8. Medical Supplies and Appliances

i. Devices used specifically as safety items or to affect performance in sports-related activities.
ii. Prescribed or Non-prescribed medical supplies and disposable supplies. Examples include:
    a. Elastic stockings
    b. Ace bandages
    c. Thermometers
    d. Gauze and dressings
    e. Disposable sheets and bags
    f. Fabric supports
    g. Surgical face masks
    h. Incontinent pads, including diapers
    i. Irrigating kits
iii. Pressure leotards
iv. Surgical leggings and support hose (except that jobst stockings or other support hose ordered by a physician and determined to be Medically Necessary are covered, but only two (2) support stockings per Calendar Year are covered.)

a. Exceptions include diabetic supplies covered under the medical benefit; e.g., catheters (urinary and respiratory) and associated supplies such as drainage bags and irrigation kits, sterile surgical wound supplies and ostomy supplies and supplies associated with equipment and home care services that have been provided in accordance with Plan policies and procedures.

v. Orthotic and prosthetic appliances for sports-related activities.

vi. Tubings and masks are not covered except when used with Durable Medical Equipment.

vii. Devices and equipment that are not normally appropriate outside of a Hospital (or other provider) setting, including but not limited to:
   a. Esophageal dilators
   b. Home monitoring devices and supplies, except Medically Necessary cardiac monitoring devices (such as holter monitors and event recorders)
   c. Home prenatal monitoring and associated nursing support

viii. The following are not covered under the medical benefit:
   a. Insulin syringes with needles
   b. Lancets and lancet devices
   c. Glucometers, test strips and related supplies.
   d. Lift Seats.

9. Mental Health/Substance Abuse

i. Services performed in connection with conditions not classified in the current edition of the Diagnostic and Statistical Manual of the American Psychiatric Association.

ii. All therapies and services for maintenance treatment of addiction and all opiate antagonists are excluded.

iii. Treatment provided in connection with or to comply with involuntary commitments, police detentions and other similar arrangements unless Medically Necessary and authorized by the Mental Health/Substance Abuse Designee.

iv. Services or supplies for the diagnosis or treatment of Mental Illness, alcoholism or substance abuse disorders that, in the reasonable judgment of the Mental Health/Substance Abuse Designee, are any of the following:
   a. Not consistent with prevailing national standards of clinical practice for the treatment of such conditions including but not limited to Mental Health Services and Substance Abuse Services that extend beyond the period necessary for short term evaluation, diagnosis, treatment or crisis intervention.
   b. Not consistent with prevailing professional research demonstrating that the services or supplies will have a measurable and beneficial health outcome.
   c. Typically do not result in outcomes demonstrably better than other available treatment alternatives that are less intensive or more cost effective.
   d. Not consistent with the Mental Health/Substance Abuse Designee's level of care guidelines or best practices as modified from time to time.

The Mental Health/Substance Abuse Designee may consult with professional clinical consultants, peer review committees or other appropriate sources for recommendations and information regarding whether a service or supply meets any of these criteria.

10. Nutrition

i. Megavitamin and nutrition based therapy (for any purpose).

ii. Vitamins (other than those prenatal vitamins prescribed for a Covered Individual who is then pregnant).

iii. Nutritional counseling and other Hospital-based educational programs for either individuals or groups, except as authorized by the Plan.

iv. Medical Foods and other nutritional and electrolyte supplements 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, nutritional supplements ordered by a Physician in connection with home care, or where the Covered Individual has a feeding tube as a sole source of nutrition.

v. Non-FDA approved, investigational or experimental medical foods or nutritional supplements given parenterally.

11. Personal/Career

i. Physical, psychiatric or psychological exams, testing, vaccinations, immunizations or treatments that are otherwise covered under the Plan when:
    a. Required solely for purposes of career, education, sports or camp, travel, recreation, employment, insurance, marriage or adoption.
    b. Related to judicial or administrative proceedings or orders.
    c. Conducted for purposes of medical research.
    d. Required to obtain or maintain a license of any type.
ii. Custodial Care.
iii. Domiciliary care or any nursing care on full-time basis in Your home.
iv. Respite care.
v. Rest cures.
vi. Psychosurgery including vagus nerve stimulation.
vii. Medical and surgical treatment of excessive sweating (hyperhidrosis).
viii. Medical and surgical treatment for snoring, except when provided as a part of treatment for documented obstructive sleep apnea.
ix. Oral appliances for snoring.
x. Care for an Injury or Sickness resulting from participation in, or in consequence of having participated in an illegal occupation or the commission of an assault or felony.
xi. Work place evaluations and work hardening treatment.

12. Physical Appearance

i. Cosmetic Procedures. Examples include:
    a. Pharmacological regimens, nutritional procedures or treatments.
    b. Scar, keloid or tattoo removal or revision procedures (such as salabrasion, chemosurgery and other such skin abrasion
ii. Skin abrasion procedures performed as a treatment for acne.
    a. Liposuction.
    b. Correction of asymmetric breasts or abnormal nipple-areolar complexes and protruding ears.
    c. Treatment of surgical complications that is primarily cosmetic in nature, resulting from either covered or non-covered services.
    d. All other Cosmetic Procedures **except** if Medically Necessary:
        i. To repair a functional disorder caused by a disease or an accidental Injury suffered while insured by the Plan;
        ii. To restore or improve function for a structurally abnormal Congenital or developmental defect or anomaly in a Covered Individual under age nineteen (19). Anomaly is defined as a marked deviation beyond the range of normal human variation; or
        iii. For reconstructive breast surgery performed post-mastectomy.
iii. Replacement of an existing breast Implant if the earlier breast Implant was performed as a Cosmetic Procedure.
iv. Physical conditioning programs such as athletic training, bodybuilding, exercise, fitness, flexibility, and diversion or general motivation.
v. Weight loss programs whether or not they are under medical supervision. Weight loss programs for medical reasons are also excluded, except as defined under Covered Services.
vi. Wigs, except for use during or following radiation or chemotherapy treatment and the hair loss is caused by such treatment.
vii. Treatment of benign gynecomastia (abnormal breast enlargement in males).
viii. Surgical and Non-surgical treatment of obesity, including morbid obesity. Treatment includes but is not limited to: stomach stapling; jaw wiring; gastric banding, gastric balloon or bypass surgery; dietary or nutritional supplements; behavioral or community support programs; exercise

programs; and medical testing, medications, and office visits associated with any weight loss program, except as defined under Covered Services.

ix. Growth hormone therapy except for growth hormone deficiencies.
x. Sex transformation operations.
xi. Breast Reduction Surgery (Reduction Mammoplasty) except for Members who meet the medical criteria established by the Plan Administrator in its sole discretion.

13. Providers

i. Charges Incurred in connection with services or supplies provided or ordered by the Covered Individual or the Covered Individual's relative by birth or marriage (including but not limited to, him or herself, a spouse, sibling, parent, child, aunt, uncle, niece, nephew, cousin, grandparent, grandchild, and all such relatives-in-law).
ii. Services performed by a member of the Covered Individual's immediate family or by any person living in the same household as the Covered Individual.
iii. Services provided at a freestanding or Hospital-based diagnostic facility without an order written by a Physician or other provider. Services that are self-directed to a free-standing or Hospital based diagnostic facility. Services ordered by a Physician or other provider
iv. who *is* an Co-worker or representative of a free-standing or Hospital-based diagnostic facility, when that Physician or other provider:
    a. Has not been actively involved in Your medical care prior to ordering the service, or
    b. Is not actively involved in Your medical care after the service is received.
v. This exclusion does not apply to mammography testing.
vi. Charges Incurred for broken appointments with a Participating Physician.

14. Reproduction

i. Health services and associated expenses for Infertility treatments including, but not limited to, medical care or Prescription Drugs used to stimulate ovulation, or assisted reproductive technology (ART). ART includes any combination of chemical and/or mechanical means of obtaining a mature male or female reproductive cell and placing it into a medium (whether internal or external to the human body) to enhance the chance reproduction will occur. Examples of ART include, but are not limited to, artificial insemination, in vitro fertilization, gametic intra fallopian transfer, zygote intra fallopian transfer, pronuclear state tubal transfer and surrogate Pregnancy.
ii. Medical expenses related to the surrogate mother.
iii. Reversal of voluntary sterilization.
iv. Health services and associated expenses for elective abortion. Elective abortion means an abortion for any reason other than a spontaneous abortion or loss of the fetus as a result of the only treatment available to save the life of the mother.
v. Fetal reduction surgery.
vi. Charges for, or health services associated with, the use of non-surgical or drug induced Pregnancy termination.
vii. Services (including pharmaceuticals) provided in connection with treatment or surgery to change gender or restore sexual function.

15. Services Provided under Another Plan

i. Health service for which other coverage is required by Federal, state or local law to be purchased or provided through other arrangements.
ii. Health services for treatment of Injury, Sickness or Mental Illness arising out of or in the course of, any employment, whether or not covered by workers compensation or similar law. If coverage under workers' compensation or similar legislation is optional for You because You could elect it, or could have it elected for You, Benefits will not be paid for any Injury, Sickness or Mental Illness that would have been covered under workers' compensation or similar legislation if that coverage been elected.
iii. Health services for treatment of military service-related disabilities, when You are legally entitled to other coverage and facilities are reasonably available to You.
iv. Health services while on active military duty.

v. Injury or Sickness Incurred while incarcerated in any local, municipal, state or Federal facility.

16. Therapies/Psychological Testing

i. Speech, physical, occupational, and other rehabilitative services solely for speech/language delay or articulation disorders or other developmental delay, regardless of origin unless otherwise covered under this policy. Speech therapy for central processing disorders, dyslexia, attention deficit disorder or other learning disabilities, stammering, stuttering, conceptual handicap, psychosocial speech delay, and voice therapy for vocational or avocational singers, and procedures that may be carried out effectively by the patient, family, or caregivers are not covered Benefits. Speech, physical, occupational, and other rehabilitative services are not covered except as required for treatment of a speech impediment or speech dysfunction that results from Injury, stroke, or a Congenital Anomaly.
ii. Cognitive therapy as a medical treatment (Non-mental health).
iii. Psychological testing except when Medically Necessary and authorized in advanced by the Mental Health/Substance Abuse designee. Medically Necessary care may include any of the following:
    a. Not consistent with prevailing national standards of clinical practice for the treatment of such conditions including but not limited to Mental Health Services and Substance Abuse Services that extend beyond the period necessary for short term evaluation, diagnosis, treatment or crisis intervention.
    b. Not consistent with prevailing professional research demonstrating that the services or supplies will have a measurable and beneficial health outcome.
    c. Typically do not result in outcomes demonstrably better than other available treatment alternatives that are less intensive or more cost effective.
    d. Not consistent with the Mental Health/Substance Abuse Designee's level of care guidelines or best practices as modified from time to time.
iv. Neuropsych testing to assist in planning educational and vocational programs, for the purpose of disability determinations, and/or for forensic determinations is not a covered benefit covered under this policy.
v. All Educational Services, including treatment of learning disorders, acquired cognitive deficits, nutritional counseling and other Hospital-based education programs, except where otherwise specified in the Plan.
vi. Water exercise and other exercises not under the supervision of a physical therapist.
vii. Services or supplies that cannot reasonably be expected to lessen a Covered Individual disability, and enable him/her to live outside an institution.
viii. Long-term therapy for developmental delays.
ix. Charges related to family or marital counseling except as otherwise specified in the Plan.

17. Transplants

i. Health services for organ and tissue transplants, except as otherwise specified in the Plan.
ii. Health services connected with the removal of an organ or tissue from You for purposes of a transplant to another person. (Donor costs for removal are payable for a transplant through the organ recipient's Benefits under the Plan).
iii. Any artificial, mechanical or cross-species organ or tissue transplant, or any organ or tissue transplant procedure which has not been approved by the United States Department of Health and Human Services or the appropriate government agency.
iv. Any multiple organ transplant not listed as a Covered Health Service under the heading “Transplant Services”.

18. Travel

i. Health services provided in a foreign country, unless required as Emergency Health Services.
ii. Travel or transportation expenses, even though prescribed by a Physician, except for Medically Necessary ambulance services. Some travel expenses related to covered transplantation services may be reimbursed at Plan’s discretion.
iii. Air Ambulance Services outside the Continental United States for any reason.

19. Vision and Hearing

i. Routine vision care.
ii. Purchase cost of eye glasses, contact lenses, or hearing aids, except as otherwise noted in this document.
iii. Fitting charge for hearing aids, eye glasses or contact lenses.
iv. Eye exercise therapy (orthoptics or pleoptic training) except in children and adults with documented Conversion Insufficiency
v. Surgery that is intended to allow You to see better without glasses or other vision correction including radial keratotomy, lasik, and other refractive eye surgery.

20. General/Administrative

i. Health services and supplies that do not meet the definition of a Covered Health Service.
ii. Health services received as a result of a commission of a felony or any catastrophic act or incident of war, whether declared or undeclared or caused during service in the armed forces of any country.
iii. Health services received after the date Your coverage under the Plan ends, including health services for medical conditions arising before the date Your coverage under the Plan ends. This exclusion does not apply if You are eligible for and choose Continuation Coverage.
iv. Health services for which You have no legal responsibility to pay, or for which a charge would not ordinarily be made in the absence of coverage under the Plan.
v. Charges in excess of the Usual and Customary Rate or in excess of any specified limitation.
vi. Intoxicants and Narcotics. We shall not be liable for any loss sustained or contracted in consequences of the insured's being intoxicated or under the influence of any narcotic unless administered on the advice of a Physician.
vii. Complications of Health Care Services that are not Covered Health Services, regardless of whether or not the services were provided while covered under this Plan.
viii. Charges made for completion of forms and/or filing of claims in connection with the Benefits provided under this Plan.
ix. Autopsies (post-mortem exams).
x. 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 Doctor employed by such a Hospital or facility, unless (i) the treatment is of an Emergency nature, and (ii) the Covered Individual is not entitled to such treatment without charge by reason of status as a veteran or otherwise.
xi. Injury or sickness while serving active military duty (including reserve duty).
xii. Charges which are in excess of Usual and Customary Rates, except for billed charges with respect to any Network facility.
xiii. To the extent allowed by law, medical expenses Incurred in connection with a Sickness, Injury or Condition for which a third party is responsible.
xiv. Charges submitted for payment more than 12 months after the date of service.
xv. Charges associated with a Never Event.
xvi. 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, even if the expenses were Incurred as a result of an accident, Injury or disease that occurred, began, or existed while coverage was in force. An expense for a service or supply is Incurred on the date the service or supply is furnished.
xvii. Coverage for Emergency Room treatment at an Out-of-Network hospital for conditions that meet the definition of Emergency will be considered at the tier three in-network level of benefits.

With respect to any Injury which is otherwise covered by the Plan, the Plan will not deny benefits otherwise provided for treatment of the Injury if the Injury results from being the victim of an act of domestic violence or a documented medical condition.

PLAN ADMINISTRATION

The Plan Administrator has been granted the authority to administer the Plan. The Plan Administrator has retained the services of the Third Party Administrator to provide certain claims processing and other technical services. Subject to the claims processing and other technical services delegated to the Third Party Administrator, the Plan Administrator reserves the unilateral right and power to administer and to interpret, construe and construct the terms and provisions of the Plan, including without limitation, correcting any error or defect, supplying any omission, reconciling any inconsistency and making factual determinations.

8.01 Plan Administrator

The Plan is administered by the Plan Administrator within the purview of ERISA and in accordance with these provisions. An individual, committee, or entity may be appointed by the Plan Sponsor to be Plan Administrator and serve at the convenience of the Plan Sponsor. If the appointed Plan Administrator or a committee member resigns, dies, is otherwise unable to perform, is dissolved, or is removed from the position, the Plan Sponsor shall appoint a new Plan Administrator as soon as reasonably possible.

The Plan Administrator may delegate to one or more individuals or entities part or all of its discretionary authority under the Plan, provided that any such delegation must be made in writing.

The Plan shall be administered by the Plan Administrator, in accordance with its terms. Policies, interpretations, practices, and procedures are established and maintained by the Plan Administrator. 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 all interpretive and factual determinations as to whether any individual is eligible and entitled to receive any benefit under the terms of this Plan, to decide disputes which may arise with respect to a 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. Benefits will be paid under this Plan only if the Plan Administrator, in its discretion, determines that the Participant is entitled to them.

If due to errors in drafting, any Plan provision does not accurately reflect its intended meaning, as demonstrated by prior interpretations or other evidence of intent, or as determined by the Plan Administrator in its sole and exclusive judgment, the provision shall be considered ambiguous and shall be interpreted by the Plan Administrator in a fashion consistent with its intent, as determined by the Plan Administrator. The Plan may be amended retroactively to cure any such ambiguity, notwithstanding anything in the Plan to the contrary.

The foregoing provisions of this Plan may not be invoked by any person to require the Plan to be interpreted in a manner which is inconsistent with its interpretations by the Plan Administrator. All actions taken and all determinations by the Plan Administrator shall be final and binding upon all persons claiming any interest under the Plan subject only to the claims appeal procedures of the Plan.

8.02 Duties of the Plan Administrator

The duties of the Plan Administrator include the following:

1. To administer the Plan in accordance with its terms;
2. To determine all questions of eligibility, status and coverage under the Plan;
3. To interpret the Plan, including the authority to construe possible ambiguities, inconsistencies, omissions and disputed terms;
4. To make factual findings;
5. To decide disputes which may arise relative to a Participant's rights and/or availability of benefits;
6. To prescribe procedures for filing a claim for benefits, to review claim denials and appeals relating to them and to uphold or reverse such denials;
7. To keep and maintain the Plan documents and all other records pertaining to the Plan;
8. To appoint and supervise a Third Party Administrator to pay claims;
9. To perform all necessary reporting as required by ERISA;

10. To establish and communicate procedures to determine whether a Medical Child Support Order is a QMCSO;
11. To delegate to any person or entity such powers, duties and responsibilities as it deems appropriate; and
12. To perform each and every function necessary for or related to the Plan's administration.

8.03 Amending and Terminating the Plan

This Plan was established for the exclusive benefit of the Employees with the intention it will continue indefinitely; however, as the settlor of the Plan, the Plan Sponsor, through its directors and officers, may, in its sole discretion, at any time, 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). All amendments to this Plan shall become effective as of a date established by the Plan Sponsor.

The process whereby amendments, suspension and/or termination of the Plan is accomplished, or any part thereof, shall be decided upon and/or enacted by resolution of the Plan Sponsor's directors and officers if it is incorporated (in compliance with its articles of incorporation or bylaws and if these provisions are deemed applicable), or by the sole proprietor in his or her own discretion if the Plan Sponsor is a sole proprietorship, but always in accordance with applicable Federal and State law, including – where applicable – notification rules provided for and as required by ERISA.

If the Plan is terminated, the rights of the Plan Participants are limited to expenses Incurred before termination. In connection with the termination, the Plan Sponsor may establish a deadline by which all Claims must be submitted for consideration. Benefits will be paid only for Covered Expenses Incurred prior to the termination date and submitted in accordance with the rules established by the Plan Sponsor. Upon termination, any Plan assets will be used to pay outstanding claims and all expenses of Plan termination. To the extent that any Plan assets remain, they will be used for the benefit of covered Participants in accordance with ERISA.

8.04 Summary of Material Reduction (SMR)

A Material Reduction generally means any modification that would be considered by the average participant to be an important reduction in covered services or benefits. Examples include reductions in benefits or increases in Deductibles or copayments.

The Plan Administrator shall notify all eligible Employees of any plan amendment considered a Material Reduction in covered services or benefits provided by the Plan as soon as administratively feasible after its adoption, but no later than 60 days after the date of adoption of the reduction. Eligible Employees and beneficiaries must be furnished a summary of such reductions, and any changes so made shall be binding on each Participant. The 60 day period for furnishing a summary of Material Reduction does not apply to any Employee covered by the Plan who would reasonably expect to receive a summary through other means within the next 90 days.

Material Reduction disclosure provisions are subject to the requirements of ERISA and the Health Insurance Portability and Accountability Act of 1996 (HIPAA) and any related amendments.

8.05 Summary of Material Modification (SMM)

A Summary of Material Modifications reports changes in the information provided within the Summary Plan Description. Examples include a change to Deductibles, eligibility or the addition or deletion of coverage.

The Plan Administrator shall notify all covered Employees of any plan amendment considered a Summary of Material Modifications by the Plan as soon as administratively feasible after its adoption, but no later than within 210 days after the close of the Plan Year in which the changes became effective.

NOTE: The Affordable Care Act (ACA) requires that if a Plan's Material Modifications are not reflected in the Plan's most recent Summary of Benefits and Coverage (SBC) then the Plan must provide written notice to Participants at least 60 days before the effective date of the Material Modification.

CLAIM PROCEDURES; PAYMENT OF CLAIMS

In accordance with applicable law, the Plan will allow an authorized representative to act on a Claimant's behalf in pursuing or appealing a benefit claim. For the purposes of this Article IX, "Claimant" shall mean any plan Participant or beneficiary submitting a claim to the Plan and thereby seeking to receive Plan benefits.

The availability of health benefit payments is dependent upon Claimants complying with the following:

9.01 Health Claims

Full and final authority to adjudicate claims and make determinations as to their payability by and under the Plan belongs to and resides solely with the Plan Administrator. The Plan Administrator shall make claims adjudication determinations after full and fair review and in accordance with the terms of this Plan, applicable law, and with ERISA. To receive due consideration, claims for benefits and questions regarding said claims should be directed to the Third Party Administrator. The Plan Administrator may delegate to the Third Party Administrator responsibility to process claims in accordance with the terms of the Plan and the Plan Administrator's directive(s). The Third Party Administrator is not a fiduciary of the Plan and does not have discretionary authority to make claims payment decisions or interpret the meaning of the Plan terms.

Written proof that expenses eligible for Plan reimbursement and/or payment were Incurred, as well as proof of their eligibility for payment by the Plan, must be provided to the Plan Administrator via the Third Party Administrator. Although a provider of medical services and/or supplies may submit such claims directly to the Plan by virtue of an Assignment of Benefits, ultimate responsibility for supplying such written proof remains with the Claimant. The Plan Administrator may determine the time and fashion by which such proof must be submitted. No benefits shall be payable under the Plan if the Plan Administrator so determines that the claims are not eligible for Plan payment, or, if inadequate proof is provided by the Claimant or entities submitting claims to the Plan on the Claimant's behalf.

A call from a Provider who wants to know if an individual is covered under the Plan, or if a certain procedure is covered by the Plan, prior to providing treatment is not a "claim," since an actual claim for benefits is not being filed with the Plan. These are simply requests for information, and any response is not a guarantee of benefits, since payment of benefits is subject to all Plan provisions, limitations and exclusions. Once treatment is rendered, a Clean Claim must be filed with the Plan (which will be a "Post-service Claim"). At that time, a determination will be made as to what benefits are payable under the Plan.

A Claimant has the right to request a review of an Adverse Benefit Determination. If the claim is denied at the end of the appeal process, as described below, the Plan's final decision is known as a Final Adverse Benefit Determination. If the Claimant receives notice of a Final Adverse Benefit Determination, or if the Plan does not follow the claims procedures properly, the Claimant then has the right to request an independent external review. The external review procedures are described below.

The claims procedures are intended to provide a full and fair review. This means, among other things, that claims and appeals will be decided in a manner designed to ensure the independence and impartiality of the persons involved in making these decisions.

Benefits will be payable to a Claimant, or to a Provider that has accepted an Assignment of Benefits as consideration in full for services rendered.

According to Federal regulations which apply to the Plan, there are four types of claims: Pre-service (Urgent and Non-urgent), Concurrent Care and Post-service.

1. Pre-service Claims. A "Pre-service Claim" occurs when issuance of payment by the Plan is dependent upon determination of payability prior to the receipt of the applicable medical care; however, if the Plan does not require the Claimant to obtain approval of a medical service prior to getting treatment, then there is no "Pre-service Claim."

Urgent care or Emergency medical services or admissions will not require notice to the Plan prior to the receipt of care. Furthermore, if in the opinion of a Physician with knowledge of the Claimant's medical condition, pre-determination of payability by the Plan prior to the receipt of medical care (a Pre-service Claim) would result in a delay adequate to jeopardize the life or health of the Claimant, hinder the Claimant's ability to regain maximum function (compared to treatment without delay), or subject the Claimant to severe pain that cannot be adequately managed without the care or treatment that is the subject of the claim, said claim may be deemed to be a "Pre-service Urgent Care Claim." In such circumstances, the Claimant is urged to obtain the applicable care without delay, and communicate with the Plan regarding their claim(s) as soon as reasonably possible.

If, due to Emergency or urgency as defined above, a Pre-service claim is not possible, the Claimant must comply with the Plan's requirements with respect to notice required after receipt of treatment, and must file the claim as a Post-service Claim, as herein described.

Pre-admission certification of a non-Emergency Hospital admission is a "claim" only to the extent of the determination made – that the type of procedure or condition warrants Inpatient confinement for a certain number of days. The rules regarding Pre-service Claims will apply to that determination only. Once a Claimant has the treatment in question, the claim for benefits relating to that treatment will be treated as a Post-service Claim.

2. Concurrent Claims. If a Claimant requires an on-going course of treatment over a period of time or via a number of treatments, the Plan may approve of a "Concurrent Claim." In such circumstances, the Claimant must notify the Plan of such necessary ongoing or routine medical care, and the Plan will assess the Concurrent Claim as well as determine whether the course of treatment should be reduced or terminated. The Claimant, in turn, may request an extension of the course of treatment beyond that which the Plan has approved. If the Plan does not require the Claimant to obtain approval of a medical service prior to getting treatment, then there is no need to contact the Plan Administrator to request an extension of a course of treatment, and the Claimant must simply comply with the Plan's requirements with respect to notice required after receipt of treatment, as herein described.

3. Post-service Claims. A "Post-service Claim" is a claim for benefits from the Plan after the medical services and/or supplies have already been provided.

9.01A When Claims Must Be Filed

Post-service health claims (which must be Clean Claims) must be filed with the Third Party Administrator within 365 days of the date charges for the service(s) and/or supplies were Incurred. Benefits are based upon the Plan's provisions at the time the charges were Incurred. Claims filed later than that date shall be denied.

A Pre-service claim (including a Concurrent claim that also is a Pre-service claim) is considered to be filed when the request for approval of treatment or services is made and received by the Third Party Administrator in accordance with the Plan's procedures.

A Post-service Claim is considered to be filed when the following information is received by the Third Party Administrator, together with a Form HCFA or Form UB92:

1. The date of service;
2. The name, address, telephone number and tax identification number of the Provider of the services or supplies;
3. The place where the services were rendered;
4. The Diagnosis and procedure codes;
5. The name of the Plan;
6. The name of the covered Employee; and
7. The name of the patient.

Upon receipt of this information, the claim will be deemed to be initiated with the Plan.

The Third Party Administrator will determine if enough information has been submitted to enable proper consideration of the claim (a Clean Claim). If not, more information may be requested as provided herein. This additional information must be received by the Third Party Administrator within 45 days (48 hours in the case of Pre-service urgent care claims) from receipt by the Claimant of the request for additional information. Failure to do so may result in claims being declined or reduced.

9.01B Timing of Claim Decisions

The Plan Administrator shall notify the Claimant, in accordance with the provisions set forth below, of any Adverse Benefit Determination (and, in the case of Pre-service claims and Concurrent claims, of decisions that a claim is payable in full) within the following timeframes:

1. Pre-service Urgent Care Claims:

    a. If the Claimant has provided all of the necessary information, as soon as possible, taking into account the medical exigencies, but not later than 72 hours after receipt of the claim.
    b. If the Claimant has not provided all of the information needed to process the claim, then the Claimant will be notified as to what specific information is needed as soon as possible, but not later than 72 hours after receipt of the claim.
    c. The Claimant will be notified of a determination of benefits as soon as possible, but not later than 72 hours, taking into account the medical exigencies, after the earliest of:

        i. The end of the period afforded the Claimant to provide the information.
        ii. The Plan's receipt of the specified information; or

    d. If there is an Adverse Benefit Determination, a request for an expedited appeal may be submitted orally or in writing by the Claimant. All necessary information, including the Plan's benefit determination on review, may be transmitted between the Plan and the Claimant by telephone, facsimile, or other similarly expeditious method. Alternatively, the Claimant may request an expedited review under the external review process.

2. Pre-service Non-urgent Care Claims:

    a. If the Claimant has provided all of the information needed to process the claim, in a reasonable period of time appropriate to the medical circumstances, but not later than 15 days after receipt of the claim, unless an extension has been requested, then prior to the end of the 15 day extension period.
    b. If the Claimant has not provided all of the information needed to process the claim, then the Claimant will be notified as to what specific information is needed as soon as possible, but not later than five days after receipt of the claim. The Claimant will be notified of a determination of benefits in a reasonable period of time appropriate to the medical circumstances, either prior to the end of the extension period (if additional information was requested during the initial processing period), or by the date agreed to by the Plan Administrator and the Claimant (if additional information was requested during the extension period).

3. Concurrent Claims:

    a. Plan Notice of Reduction or Termination. If the Plan Administrator is notifying the Claimant of a reduction or termination of a course of treatment (other than by Plan amendment or termination), notification will occur before the end of such period of time or number of treatments. The Claimant will be notified sufficiently in advance of the reduction or termination to allow the Claimant to appeal and obtain a determination on review of that Adverse Benefit Determination before the benefit is reduced or terminated. This rule does not apply if benefits are reduced or eliminated due to plan amendment or termination. A similar process applies for claims based on a rescission of coverage for fraud or misrepresentation.

b. Request by Claimant Involving Urgent Care. If the Plan Administrator receives a request from a Claimant to extend the course of treatment beyond the period of time or number of treatments involving urgent care, notification will occur as soon as possible, taking into account the medical exigencies, but not later than 24 hours after receipt of the claim, as long as the Claimant makes the request at least 24 hours prior to the expiration of the prescribed period of time or number of treatments. If the Claimant submits the request with less than 24 hours prior to the expiration of the prescribed period of time or number of treatments, the request will be treated as a claim involving urgent care and decided within the urgent care timeframe.
c. Request by Claimant Involving Non-urgent Care. If the Plan Administrator receives a request from the Claimant is a claim not involving urgent care, the request will be treated as a new benefit claim and decided within the timeframe appropriate to the type of claim (either as a Pre-service non-urgent claim or a Post-service claim).
d. Request by Claimant Involving Rescission. With respect to rescissions, the following timetable applies:

i. Notification to Claimant	30 days
ii. Notification of Adverse Benefit Determination on appeal	30 days

4. Post-service Claims:

a. If the Claimant has provided all of the information needed to process the claim, in a reasonable period of time, but not later than 30 days after receipt of the claim, unless an extension has been requested, then prior to the end of the 15 day extension period.
b. If such an extension is necessary due to a failure of the Claimant to submit the information necessary to decide the claim, the notice of extension shall specifically describe the required information, and the Claimant shall be afforded at least 45 days from receipt of the notice within which to provide the specified information.
c. If the Claimant has not provided all of the information needed to process the claim and additional information is requested during the initial processing period, then the Claimant will be notified of a determination of benefits prior to the end of the extension period, unless additional information is requested during the extension period, then the Claimant will be notified of the determination by a date agreed to by the Plan Administrator and the Claimant.

i. Extensions – Pre-service Urgent Care Claims. No extensions are available in connection with Pre-service urgent care claims.
ii. Extensions – Pre-service Non-urgent Care Claims. This period may be extended by the Plan for up to 15 days, provided that the Plan Administrator both determines that such an extension is necessary due to matters beyond the control of the Plan and notifies the Claimant, prior to the expiration of the initial 15 day processing period, of the circumstances requiring the extension of time and the date by which the Plan expects to render a decision.
iii. Extensions – Post service Claims. This period may be extended by the Plan for up to 15 days, provided that the Plan Administrator both determines that such an extension is necessary due to matters beyond the control of the Plan and notifies the Claimant, prior to the expiration of the initial 30 day processing period, of the circumstances requiring the extension of time and the date by which the Plan expects to render a decision.

5. Calculating Time Periods. The period of time within which a benefit determination is required to be made shall begin at the time a claim is deemed to be filed in accordance with the procedures of the Plan.

9.01C Notification of an Adverse Benefit Determination

The Plan Administrator shall provide a Claimant with a notice, either in writing or electronically (or, in the case of pre-service urgent care claims, by telephone, facsimile or similar method, with written or electronic notice following within three days), containing the following information:

1. Information sufficient to allow the Claimant to identify the claim involved (including date of service, the healthcare Provider, the claim amount, if applicable, and a statement describing the availability, upon request, of the Diagnosis code and its corresponding meaning, and the treatment code and its corresponding meaning);
2. A reference to the specific portion(s) of the Plan Document upon which a denial is based;
3. Specific reason(s) for a denial, including the denial code and its corresponding meaning, and a description of the Plan's standard, if any, that was used in denying the claim;
4. A description of any additional information necessary for the Claimant to perfect the claim and an explanation of why such information is necessary;
5. A description of the Plan's review procedures and the time limits applicable to the procedures, including a statement of the Claimant's right to bring a civil action under Section 502(a) of ERISA following an Adverse Benefit Determination on final review;
6. A statement that the Claimant is entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records and other information relevant to the Claimant's claim for benefits;
7. The identity of any medical or vocational experts consulted in connection with a claim, even if the Plan did not rely upon their advice (or a statement that the identity of the expert will be provided, upon request);
8. Any rule, guideline, protocol or similar criterion that was relied upon in making the determination (or a statement that it was relied upon and that a copy will be provided to the Claimant, free of charge, upon request);
9. In the case of denials based upon a medical judgment (such as whether the treatment is Medically Necessary or Experimental), either an explanation of the scientific or clinical judgment for the determination, applying the terms of the Plan to the Claimant's medical circumstances, or a statement that such explanation will be provided to the Claimant, free of charge, upon request; and
10. In a claim involving urgent care, a description of the Plan's expedited review process.

9.02 Appeal of Adverse Benefit Determinations

9.02A Full and Fair Review of All Claims

In cases where a claim for benefits is denied, in whole or in part, and the Claimant believes the claim has been denied wrongly, the Claimant may appeal the denial and review pertinent documents. The claims procedures of this Plan provide a Claimant with a reasonable opportunity for a full and fair review of a claim and Adverse Benefit Determination. More specifically, the Plan provides:

1. At least 180 days following receipt of a notification of an initial Adverse Benefit Determination within which to appeal the determination;
2. The opportunity to submit written comments, documents, records, and other information relating to the claim for benefits;
3. The opportunity to review the Claim file and to present evidence and testimony as part of the internal claims and appeals process;
4. A review that does not afford deference to the previous Adverse Benefit Determination and that is conducted by an appropriate named delegate of the Plan, who shall be neither the individual who made the Adverse Benefit Determination that is the subject of the appeal, nor the subordinate of such individual;
5. A review that takes into account all comments, documents, records, and other information submitted by the Claimant relating to the claim, without regard to whether such information was submitted or considered in the prior benefit determination;
6. That, in deciding an appeal of any Adverse Benefit Determination that is based in whole or in part upon a medical judgment, the Plan delegate shall consult with a health care professional who has appropriate training and experience in the field of medicine involved in the medical judgment, who is neither an individual who was consulted in connection with the Adverse Benefit Determination that is the subject of the appeal, nor the subordinate of any such individual;
7. The identity of medical or vocational experts whose advice was obtained on behalf of the Plan in connection with a claim, even if the Plan did not rely upon their advice;

8. That a Claimant will be provided, free of charge: (a) reasonable access to, and copies of, all documents, records, and other information relevant to the Claimant's claim in possession of the Plan Administrator or Third Party Administrator; (b) information regarding any voluntary appeals procedures offered by the Plan; (c) information regarding the Claimant's right to an external review process; (d) any internal rule, guideline, protocol or other similar criterion relied upon, considered or generated in making the adverse determination; and (e) an explanation of the scientific or clinical judgment for the determination, applying the terms of the Plan to the Claimant's medical circumstances; and
9. That a Claimant will be provided, free of charge, and sufficiently in advance of the date that the notice of Final Internal Adverse Benefit Determination is required, with new or additional evidence considered, relied upon, or generated by the Plan in connection with the Claim, as well as any new or additional rationale for a denial at the internal appeals stage, and a reasonable opportunity for the Claimant to respond to such new evidence or rationale.

9.02B Requirements for Appeal

The Claimant must file the appeal in writing (although oral appeals are permitted for pre service urgent care claims) within 180 days following receipt of the notice of an Adverse Benefit Determination.

For Pre-service urgent care claims, if the Claimant chooses to orally appeal, the Participant may telephone:

Mercy Benefit Administrators
PO Box 14230
Springfield, MO 65814
Phone: 877-875-7700

Oral appeals should be submitted in writing as soon as possible after it has been initiated.

To file an appeal in writing, the Claimant's appeal must be addressed as follows and mailed or faxed as follows:

1. For Pre-service Claims:
   Claimants should refer to their identification card for the name and address of the utilization review administrator. All pre service claims must be sent to the utilization review administrator.

2. For Post-service Claims:

Mercy Benefit Administrators
PO Box 14230
Springfield, MO 65814
Phone: 877-875-7700
Fax: 417-820-3816
Email/Website: SPRGBenefitAdmins@mercy.net

It shall be the responsibility of the Claimant to submit proof that the claim for benefits is covered and payable under the provisions of the Plan. Any appeal must include:

1. The name of the Employee/Claimant;
2. The Employee/Claimant's social security number;
3. The group name or identification number;
4. All facts and theories supporting the claim for benefits. Failure to include any theories or facts in the appeal will result in their being deemed waived. In other words, the Claimant will lose the right to raise factual arguments and theories which support this claim if the Claimant fails to include them in the appeal;
5. A statement in clear and concise terms of the reason or reasons for disagreement with the handling of the claim; and
6. Any material or information that the Claimant has which indicates that the Claimant is entitled to benefits under the Plan.

If the Claimant provides all of the required information, it may be that the expenses will be eligible for payment under the Plan.

9.02C Timing of Notification of Benefit Determination on Review

The Plan Administrator shall notify the Claimant of the Plan's benefit determination on review within the following timeframes:

1. Pre-service Urgent Care Claims: As soon as possible, taking into account the medical exigencies, but not later than 72 hours after receipt of the appeal.
2. Pre-service Non-urgent Care Claims: Within a reasonable period of time appropriate to the medical circumstances, but not later than 30 days after receipt of the appeal.
3. Concurrent Claims: The response will be made in the appropriate time period based upon the type of claim: Pre-service Urgent, Pre-service Non-urgent or Post-service.
4. Post-service Claims: Within a reasonable period of time, but not later than 60 days after receipt of the appeal.

Calculating Time Periods. The period of time within which the Plan's determination is required to be made shall begin at the time an appeal is filed in accordance with the procedures of this Plan, without regard to whether all information necessary to make the determination accompanies the filing.

9.02D Manner and Content of Notification of Adverse Benefit Determination on Review

The Plan Administrator shall provide a Claimant with notification, with respect to Pre-service urgent care claims, by telephone, facsimile or similar method, and with respect to all other types of claims, in writing or electronically, of a Plan's Adverse Benefit Determination on review, setting forth:

1. Information sufficient to allow the Claimant to identify the claim involved (including date of service, the healthcare Provider, the claim amount, if applicable, and a statement describing the availability, upon request, of the Diagnosis code and its corresponding meaning, and the treatment code and its corresponding meaning);
2. Specific reason(s) for a denial, including the denial code and its corresponding meaning, and a description of the Plan's standard, if any, that was used in denying the claim, and a discussion of the decision;
3. A reference to the specific portion(s) of the summary plan description on which the denial is based;
4. The identity of any medical or vocational experts consulted in connection with a claim, even if the Plan did not rely upon their advice (or a statement that the identity of the expert will be provided, upon request);
5. A statement that the Claimant is entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the Claimant's claim for benefits;
6. Any rule, guideline, protocol or similar criterion that was relied upon, considered, or generated in making the determination will be provided free of charge. If this is not practical, a statement will be included that such a rule, guideline, protocol or similar criterion was relied upon in making the determination and a copy will be provided to the Claimant, free of charge, upon request;
7. A description of any additional information necessary for the Claimant to perfect the claim and an explanation of why such information is necessary;
8. A description of available internal appeals and external review processes, including information regarding how to initiate an appeal;
9. A description of the Plan's review procedures and the time limits applicable to the procedures. A statement of the Participant's right to bring an action under section 502(a) of ERISA, following an Adverse Benefit Determination on final review; and
10. In the case of denials based upon a medical judgment (such as whether the treatment is Medically Necessary or Experimental), either an explanation of the scientific or clinical judgment for the determination, applying the terms of the Plan to the Claimant's medical circumstances, will be provided. If this is not practical, a statement will be included that such explanation will be provided to the Claimant, free of charge, upon request; and

11. The following statement: "You and your Plan may have other voluntary alternative dispute resolution options, such as mediation. One way to find out what may be available is to contact your local U.S. Department of Labor Office and your State insurance regulatory agency.

9.02E Furnishing Documents in the Event of an Adverse Determination

In the case of an Adverse Benefit Determination on review, the Plan Administrator shall provide such access to, and copies of, documents, records, and other information described in the section relating to "Manner and Content of Notification of Adverse Benefit Determination on Review" as appropriate.

9.02F Decision on Review

If, for any reason, the Claimant does not receive a written response to the appeal within the appropriate time period set forth above, the Claimant may assume that the appeal has been denied. The decision by the Plan Administrator or other appropriate named delegate of the Plan on review will be final, binding and conclusive and will be afforded the maximum deference permitted by law. All claim review procedures provided for in the Plan must be exhausted before any legal action is brought.

9.02G External Review Process

The Federal external review process does not apply to a denial, reduction, termination, or a failure to provide payment for a benefit based on a determination that a Claimant or beneficiary fails to meet the requirements for eligibility under the terms of a group health plan.

The Federal external review process, in accordance with the current Affordable Care Act regulations, applies only to:

1. Any eligible Adverse Benefit Determination (including a Final Internal Adverse Benefit Determination) by a plan or issuer that involves medical judgment (including, but not limited to, those based on the plan's or issuer's requirements for Medical Necessity, appropriateness, health care setting, level of care, or effectiveness of a covered benefit; or its determination that a treatment is Experimental or Investigational), as determined by the external reviewer; and
2. A rescission of coverage (whether or not the rescission has any effect on any particular benefit at that time).

Standard external review

Standard external review is an external review that is not considered expedited (as described in the "expedited external review" paragraph in this section).

1. Request for external review. The Plan will allow a Claimant to file a request for an external review with the Plan if the request is filed within four months after the date of receipt of a notice of an Adverse Benefit Determination or Final Internal Adverse Benefit Determination. If there is no corresponding date four months after the date of receipt of such a notice, then the request must be filed by the first day of the fifth month following the receipt of the notice. For example, if the date of receipt of the notice is October 30, because there is no February 30, the request must be filed by March 1. If the last filing date would fall on a Saturday, Sunday, or Federal holiday, the last filing date is extended to the next day that is not a Saturday, Sunday, or Federal holiday.

2. Preliminary review. Within five business days following the date of receipt of the external review request, the Plan will complete a preliminary review of the request to determine whether:

    a. The Claimant is or was covered under the Plan at the time the health care item or service was requested or, in the case of a retrospective review, was covered under the Plan at the time the health care item or service was provided;
    b. The Adverse Benefit Determination or the Final Adverse Benefit Determination does not relate to the Claimant's failure to meet the requirements for eligibility under the terms of the Plan (e.g., worker classification or similar determination);
    c. The Claimant has exhausted the Plan's internal appeal process unless the Claimant is not required to exhaust the internal appeals process under the interim final regulations;

d. The Claimant has provided all the information and forms required to process an external review. Within one business day after completion of the preliminary review, the Plan will issue a notification in writing to the Claimant. If the request is complete but not eligible for external review, such notification will include the reasons for its ineligibility and contact information for the Employee Benefits Security Administration (toll-free number 866-444-EBSA (3272)). If the request is not complete, such notification will describe the information or materials needed to make the request complete and the Plan will allow a Claimant to perfect the request for external review with the four-month filing period or within the 48 hour period following the receipt of the notification, whichever is later;

3. Referral to Independent Review Organization. The Plan will assign an independent review organization (IRO) that is accredited by URAC or by a similar nationally-recognized accrediting organization to conduct the external review. Moreover, the Plan will take action against bias and to ensure independence. Accordingly, the Plan will contract with (or direct the Claims Processor to contract with, on its behalf) at least three IROs for assignments under the Plan and rotate claims assignments among them (or incorporate other independent unbiased method for selection of IROs, such as random selection). In addition, the IRO may not be eligible for any financial incentives based on the likelihood that the IRO will support the denial of benefits; or

4. Reversal of Plan's decision. Upon receipt of a notice of a final external review decision reversing the Adverse Benefit Determination or Final Internal Adverse Benefit Determination, the Plan will provide coverage or payment for the claim without delay, regardless of whether the plan intends to seek judicial review of the external review decision and unless or until there is a judicial decision otherwise.

Expedited external review

1. Request for expedited external review. The Plan will allow a Claimant to make a request for an expedited external review with the Plan at the time the Claimant receives:

   a. An Adverse Benefit Determination if the Adverse Benefit Determination involves a medical condition of the Claimant for which the timeframe for completion of a standard internal appeal under the interim final regulations would seriously jeopardize the life or health of the Claimant or would jeopardize the Claimant's ability to regain maximum function and the Claimant has filed a request for an expedited internal appeal; or
   b. A Final Internal Adverse Benefit Determination, if the Claimant has a medical condition where the timeframe for completion of a standard external review would seriously jeopardize the life or health of the Claimant or would jeopardize the Claimant's ability to regain maximum function, or if the Final Internal Adverse Benefit Determination concerns an admission, availability of care, continued stay, or health care item or service for which the Claimant received Emergency Services, but has not been discharged from a facility.

2. Preliminary review. Immediately upon receipt of the request for expedited external review, the Plan will determine whether the request meets the reviewability requirements set forth above for standard external review. The Plan will immediately send a notice that meets the requirements set forth above for standard external review to the Claimant of its eligibility determination.

3. Referral to Independent Review Organization. Upon a determination that a request is eligible for external review following the preliminary review, the Plan will assign an IRO pursuant to the requirements set forth above for standard review. The Plan will provide or transmit all necessary documents and information considered in making the Adverse Benefit Determination or Final Internal Adverse Benefit Determination to the assigned IRO electronically or by telephone or facsimile or any other available expeditious method. The assigned IRO, to the extent the information or documents are available and the IRO considers them appropriate, will consider the information or documents described above under the procedures for standard review. In reaching a decision, the assigned IRO will review the claim de novo and is not bound by any decisions or conclusions reached during the Plan's internal claims and appeals process.

4. Notice of final external review decision. The Plan's (or Claim Processor's) contract with the assigned IRO will require the IRO to provide notice of the final external review decision, in accordance with the requirements set forth above, as expeditiously as the Claimant's medical condition or circumstances require, but in no event more than 72 hours after the IRO receives the request for an expedited external review. If the notice is not in writing, within 48 hours after the date of providing that notice, the assigned IRO will provide written confirmation of the decision to the Claimant and the Plan.

9.02H Deemed Exhaustion of Internal Claims Procedures and De Minimis

Exception to the Deemed Exhaustion Rule

A Claimant will not be required to exhaust the internal claims and appeals procedures described above if the Plan fails to adhere to the claims procedures requirements. In such an instance, a Claimant may proceed immediately to the External Review Program or make a claim in court. However, the internal claim and appeals procedures will not be deemed exhausted (meaning the Claimant must adhere to them before participating in the External Review Program or bringing a claim in court) in the event of a de minimis violation that does not cause, and is not likely to cause, prejudice or harm to the Claimant as long as the Plan Administrator demonstrates that the violation was for good cause or due to matters beyond the control of the Plan, the violation occurred in the context of an ongoing, good faith exchange of information between the Plan and the Claimant, and the violation is not reflective of a pattern or practice of non- compliance.

If a Claimant believes the Plan Administrator has engaged in a violation of the claims procedures and would like to pursue an immediate review, the Claimant may request that the Plan provide a written explanation of the violation, including a description of the Plan's basis for asserting that the violation should not result in a "deemed exhaustion" of the claims procedures. The Plan will respond to this request within ten days. If the External Reviewer or a court rejects a request for immediate review because the Plan has met the requirements for the "de minimis" exception described above, the Plan will provide the Claimant with notice of an opportunity to resubmit and pursue an internal appeal of the claim.

9.03 Appointment of Authorized Representative

A Claimant may designate another individual to be an authorized representative and act on his or her behalf and communicate with the Plan with respect to a specific benefit claim or appeal of a denial. This authorization must be in writing, signed and dated by the Claimant, and include all the information required in the authorized representative form. The appropriate form can be obtained from the Plan Administrator or the Third Party Administrator.

The Plan will permit, in a medically urgent situation, such as a claim involving Urgent Care, a Claimant's treating health care practitioner to act as the Claimant's authorized representative without completion of the authorized representative form.

Should a Claimant designate an authorized representative, all future communications from the Plan will be conducted with the authorized representative instead of the Claimant, unless the Plan Administrator is otherwise notified in writing by the Claimant. A Claimant can revoke the authorized representative at any time. A Claimant may authorize only one person as an authorized representative at a time.

Recognition as an authorized representative is completely separate from a Provider accepting an Assignment of Benefits, requiring a release of information, or requesting completion a similar form. An Assignment of Benefits by a Claimant shall not be recognized as a designation of the Provider as an authorized representative. Assignment and its limitations under this Plan are described below.

9.04 Physical Examinations

Should there be, in the Plan Administrator's discretion, any question as to the Claimant's health or physical condition, such that the Medical Necessity of care sought by the Claimant is called into question, the Plan may, at its own expense, have a Physician of its choice perform a physical examination, as necessary to confirm Medical Necessity. Should the Claimant refuse to comply with said exam, the care may be deemed to be excluded by the Plan, at the Plan Administrator's discretion.

9.05 Autopsy
Upon receipt of a claim for a deceased Claimant for any condition, Sickness, or Injury is the basis of such claim, the Plan maintains the right to request an autopsy be performed upon said Claimant. The request for an autopsy may be exercised only where not prohibited by any applicable law.

9.06 Payment of Benefits
Where benefit payments are allowable in accordance with the terms of this Plan, payment shall be made in U.S. Dollars (unless otherwise agreed upon by the Plan Administrator). Payment shall be made, in the Plan Administrator's discretion, to an assignee of an Assignment of Benefits, but in any instance may alternatively be made to the Claimant, on whose behalf payment is made and who is the recipient of the services for which payment is being made. Should the Claimant be deceased, payment shall be made to the Claimant's heir, assign, agent or estate (in accordance with written instructions), or, if there is no such arrangement and in the Plan Administrator's discretion, the Institute and/or Provider who provided the care and/or supplies for which payment is to be made – regardless of whether an Assignment of Benefits occurred.

9.06A Assignments
Assignment by a Claimant to the Provider of the Claimant's right to submit claims for payment to the Plan, and receive payment from the Plan, may be achieved via an Assignment of Benefits, if and only if the Provider accepts said Assignment of Benefits as consideration in full for services rendered. If benefits are paid, however, directly to the Claimant – despite there being an Assignment of Benefits – the Plan shall be deemed to have fulfilled its obligations with respect to such payment, and it shall be the Claimant's responsibility to compensate the applicable Provider(s). The Plan will not be responsible for determining whether an Assignment of Benefits is valid; and the Claimant shall retain final authority to revoke such Assignment of Benefits if a Provider subsequently demonstrates an intent not to accept it as payment in full for services rendered. As such, payment of benefits will be made directly to the assignee unless a written request not to honor the assignment, signed by the Claimant, has been received.

No Claimant shall at any time, either during the time in which he or she is a Claimant in the Plan, or following his or her termination as a Claimant, in any manner, have any right to assign his or her right to sue to recover benefits under the Plan, to enforce rights due under the Plan or to any other causes of action which he or she may have against the Plan or its fiduciaries.

A Provider which accepts an Assignment of Benefits, in accordance with this Plan as consideration in full for services rendered, is bound by the rules and provisions set forth within the terms of this document.

Benefits due to any Network Provider will be considered "assigned" to such Provider and will be paid directly to such Provider, whether or not a written Assignment of Benefits was executed. Notwithstanding any assignment or non-Assignment of Benefits to the contrary, upon payment of the benefits due under the Plan, the Plan is deemed to have fulfilled its obligations with respect to such benefits, whether or not payment is made in accordance with any assignment or request.

Providers and any other person or entity accepting payment from the Plan or to whom a right to benefits has been assigned, in consideration of services rendered, agrees to be bound by the terms of this Plan and agrees to submit claims for reimbursement in strict accordance with applicable law, ICD, and/or CPT standards, Medicare guidelines, HCPCS standards, or other standards approved by the Plan Administrator or insurer.

9.06C Recovery of Payments
Occasionally, benefits are paid more than once, are paid based upon improper billing or a misstatement in a proof of loss or enrollment information, are not paid according to the Plan's terms, conditions, limitations or exclusions, or should otherwise not have been paid by the Plan. As such this Plan may pay benefits that are later found to be greater than the Maximum Allowable Charge. In this case, this Plan may recover the amount of the overpayment from the source to which it was paid, primary payers, or from the party on whose behalf the charge(s) were paid. As such, whenever the Plan pays benefits exceeding the amount of benefits payable under the terms of the Plan, the Plan Administrator has the right to

recover any such erroneous payment directly from the person or entity who received such payment and/or from other payers and/or the Claimant or Dependent on whose behalf such payment was made.

A Claimant, Dependent, Provider, another benefit plan, insurer, or any other person or entity who receives a payment exceeding the amount of benefits payable under the terms of the Plan or on whose behalf such payment was made, shall return or refund the amount of such erroneous payment to the Plan within 30 days of discovery or demand. The Plan Administrator shall have no obligation to secure payment for the expense for which the erroneous payment was made or to which it was applied.

The person or entity receiving an erroneous payment may not apply such payment to another expense. The Plan Administrator shall have the sole discretion to choose who will repay the Plan for an erroneous payment and whether such payment shall be reimbursed in a lump sum. When a Claimant or other entity does not comply with the provisions of this section, the Plan Administrator shall have the authority, in its sole discretion, to deny payment of any claims for benefits by the Claimant and to deny or reduce future benefits payable (including payment of future benefits for other injuries or Illnesses) under the Plan by the amount due as reimbursement to the Plan. The Plan Administrator may also, in its sole discretion, deny or reduce future benefits (including future benefits for other injuries or Illnesses) under any other group benefits plan maintained by the Plan Sponsor. The reductions will equal the amount of the required reimbursement.

Providers and any other person or entity accepting payment from the Plan or to whom a right to benefits has been assigned, in consideration of services rendered, payments and/or rights, agrees to be bound by the terms of this Plan and agree to submit claims for reimbursement in strict accordance with their State's health care practice acts, ICD-9 or CPT standards, Medicare guidelines, HCPCS standards, or other standards approved by the Plan Administrator or insurer. Any payments made on claims for reimbursement not in accordance with the above provisions shall be repaid to the Plan within 30 days of discovery or demand or incur prejudgment interest of 1.5% per month. If the Plan must bring an action against a Claimant, Provider or other person or entity to enforce the provisions of this section, then that Claimant, Provider or other person or entity agrees to pay the Plan's attorneys' fees and costs, regardless of the action's outcome.

Further, Claimant and/or their Dependents, beneficiaries, estate, heirs, guardian, personal representative, or assigns (Claimants) shall assign or be deemed to have assigned to the Plan their right to recover said payments made by the Plan, from any other party and/or recovery for which the Claimant(s) are entitled, for or in relation to facility-acquired condition(s), Provider error(s), or damages arising from another party's act or omission for which the Plan has not already been refunded.

The Plan reserves the right to deduct from any benefits properly payable under this Plan the amount of any payment which has been made:

1. In error;
2. Pursuant to a misstatement contained in a proof of loss or a fraudulent act;
3. Pursuant to a misstatement made to obtain coverage under this Plan within two years after the date such coverage commences;
4. With respect to an ineligible person;
5. In anticipation of obtaining a recovery if a Claimant fails to comply with the Plan's Third Party Recovery, Subrogation and Reimbursement provisions; or
6. Pursuant to a claim for which benefits are recoverable under any policy or act of law providing for coverage for occupational Injury or Disease to the extent that such benefits are recovered. This provision (6) shall not be deemed to require the Plan to pay benefits under this Plan in any such instance.

The deduction may be made against any claim for benefits under this Plan by a Claimant or by any of his covered Dependents if such payment is made with respect to the Claimant or any person covered or asserting coverage as a Dependent of the Claimant.

If the Plan seeks to recoup funds from a Provider, due to a claim being made in error, a claim being fraudulent on the part of the Provider, and/or the claim that is the result of the Provider's misstatement,

said Provider shall, as part of its assignment to benefits from the Plan, abstain from billing the Claimant for any outstanding amount(s).

9.06D Medicaid Coverage

A Claimant's eligibility for any State Medicaid benefits will not be taken into account in determining or making any payments for benefits to or on behalf of such Claimant. Any such benefit payments will be subject to the State's right to reimbursement for benefits it has paid on behalf of the Claimant, as required by the State Medicaid program; and the Plan will honor any Subrogation rights the State may have with respect to benefits which are payable under the Plan.

9.06E Limitation of Action

A Claimant cannot bring any legal action against the Company or the Third Party Administrator to recover reimbursement until 90 days after the Claimant has properly submitted a request for reimbursement as described in this section and all required reviews of the Claimant's claim have been completed. If the Claimant wants to bring a legal action against the Company or the Third Party Administrator, he/she must do so within three years from the expiration of the time period in which a request for reimbursement must be submitted or he/she loses any rights to bring such an action against the Company or the Third Party Administrator.

A Claimant cannot bring any legal action against the Company or the Third Party Administrator for any other reason unless he/she first completes all the steps in the appeal process described in this section. After completing that process, if he/she wants to bring a legal action against the Company or the Third Party Administrator he/she must do so within three years of the date he/she is notified of the final decision on the appeal or he/she will lose any rights to bring such an action against the Company or the Third Party Administrator.

COORDINATION OF BENEFITS

10.01 Benefits Subject to This Provision
This following shall apply to the entirety of the Plan and all benefits described therein.

10.02 Excess Insurance
If at the time of Injury, Sickness, Disease or disability there is available, or potentially available any coverage (including but not limited to Coverage resulting from a judgment at law or settlements), the benefits under this Plan shall apply only as an excess over such other sources of Coverage.

The Plan's benefits will be excess to, whenever possible:

1. Any primary payer besides the Plan;
2. Any first party insurance through medical payment coverage, personal injury protection, no-fault coverage, uninsured or underinsured motorist coverage;
3. Any policy of insurance from any insurance company or guarantor of a third party;
4. Workers' compensation or other liability insurance company; or
5. Any other source, including but not limited to crime victim restitution funds, any medical, disability or other benefit payments, and school insurance coverage.

10.03 Vehicle Limitation
When medical payments are available under any vehicle insurance, the Plan shall pay excess benefits only, without reimbursement for vehicle plan and/or policy Deductibles. This Plan shall always be considered secondary to such plans and/or policies. This applies to all forms of medical payments under vehicle plans and/or policies regardless of its name, title or classification.

10.04 Allowable Expenses
"Allowable Expenses" shall mean the Usual and Customary charge for any Medically Necessary, Reasonable, and eligible item of expense, at least a portion of which is covered under a plan. When some Other Plan pays first in accordance with the Application to Benefit Determinations Section, this Plan's Allowable Expenses shall in no event exceed the Other Plan's Allowable Expenses. When some Other Plan provides benefits in the form of services instead of cash payments, the reasonable cash value of each service rendered, in the amount that would be payable in accordance with the terms of the Plan, shall be deemed to be the benefit. Benefits payable under any Other Plan include the benefits that would have been payable had claim been duly made therefore.

In the case of HMO (Health Maintenance Organization) plans, this Plan will not consider any charges in excess of what an HMO Provider has agreed to accept as payment in full. Also, when an HMO is primary and the Participant does not use an HMO Provider, this Plan will not consider as an Allowable Expenses any charge that would have been covered by the HMO had the Participant used the services of an HMO Provider.

10.05 Claim Determination Period
"Claim Determination Period" shall mean each Calendar Year.

10.06 Effect on Benefits

10.06A Application to Benefit Determinations
The plan that pays first according to the rules in the section entitled "Order of Benefit Determination" will pay as if there were no Other Plan involved. The secondary and subsequent plans will pay the balance due up to 100% of the total Allowable Expenses. When there is a conflict in the rules, this Plan will never pay more than 50% of Allowable Expenses when paying secondary. Benefits will be coordinated on the basis of a Claim Determination Period.

When medical payments are available under automobile insurance, this Plan will pay excess benefits only, without reimbursement for automobile plan Deductibles. This Plan will always be considered the

secondary carrier regardless of the individual's election under personal injury protection (PIP) coverage with the automobile insurance carrier.

In certain instances, the benefits of the Other Plan will be ignored for the purposes of determining the benefits under this Plan. This is the case when:

1. The Other Plan would, according to its rules, determine its benefits after the benefits of this Plan have been determined; and
2. The rules in the section entitled "Order of Benefit Determination" would require this Plan to determine its benefits before the Other Plan.

10.06B Order of Benefit Determination

For the purposes of the section entitled "Application to Benefit Determinations," the rules establishing the order of benefit determination are:

1. A plan without a coordinating provision will always be the primary plan;
2. The benefits of a plan which covers the person on whose expenses claim is based, other than as a Dependent, shall be determined before the benefits of a plan which covers such person as a Dependent;
3. If the person for whom claim is made is a Dependent Child covered under both parents' plans, the plan covering the parent whose birthday (month and day of birth, not year) falls earlier in the year will be primary, except:

    a. When the parents are separated or divorced, and the parent with the custody of the Child has not remarried, the benefits of a plan which covers the Child as a Dependent of the parent with custody will be determined before the benefits of a plan which covers the Child as a Dependent of the parent without custody; or
    b. When the parents are divorced and the parent with custody of the Child has remarried, the benefits of a plan which covers the Child as a Dependent of the parent with custody shall be determined before the benefits of a plan which covers that Child as a Dependent of the stepparent, and the benefits of a plan which covers that Child as a Dependent of the stepparent will be determined before the benefits of a plan which covers that Child as a Dependent of the parent without custody.

Notwithstanding the above, if there is a court decree which would otherwise establish financial responsibility for the Child's health care expenses, the benefits of the plan which covers the Child as a Dependent of the parent with such financial responsibility shall be determined before the benefits of any Other Plan which covers the Child as a Dependent Child; and

4. When the rules above do not establish an order of benefit determination, the benefits of a plan which has covered the person on whose expenses claim is based for the longer period of time shall be determined before the benefits of a plan which has covered such person the shorter period of time.

10.07 Right to Receive and Release Necessary Information

The Plan Administrator may, without notice to or consent of any person, release to or obtain any information from any insurance company or other organization or individual any information regarding coverage, expenses, and benefits which the Plan Administrator, at its sole discretion, considers necessary to determine, implement and apply the terms of this provisions or any provision of similar purpose of any Other Plan. Any Participant claiming benefits under this Plan shall furnish to the Plan Administrator such information as requested and as may be necessary to implement this provision.

10.08 Facility of Payment

A payment made under any Other Plan may include an amount that should have been paid under this Plan. The Plan Administrator may, in its sole discretion, pay an amount pay any organizations making such other payments any amounts it shall determine to be warranted in order to satisfy the intent of this provision. Any such amount paid under this provision shall be deemed to be benefits paid under this

Plan. The Plan Administrator will not have to pay such amount again and this Plan shall be fully discharged from liability.

10.09 Right of Recovery

In accordance with the Recovery of Payments provision, whenever payments have been made by this Plan with respect to Allowable Expenses in a total amount, at any time, in excess of the Maximum Amount of payment necessary at that time to satisfy the intent of this Article, the Plan shall have the right to recover such payments, to the extent of such excess, from any one or more of the following as this Plan shall determine: any person to or with respect to whom such payments were made, or such person's legal representative, any insurance companies, or any other individuals or organizations which the Plan determines are responsible for payment of such Allowable Expenses, and any future benefits payable to the Participant or his or her Dependents. Please see the Recovery of Payments provision above for more details.

MEDICARE

11.01 Applicable to Active Employees and Their Spouses Ages 65 and Over

An active Employee and his or her spouse (ages 65 and over) may, at the option of such Employee, elect or reject coverage under this Plan. If such Employee elects coverage under this Plan, the benefits of this Plan shall be determined before any benefits provided by Medicare. If coverage under this Plan is rejected by such Employee, benefits listed herein will not be payable even as secondary coverage to Medicare.

11.02 Applicable to All Other Participants Eligible for Medicare Benefits

To the extent required by Federal regulations, this Plan will pay before any Medicare benefits. There are some circumstances under which Medicare would be required to pay its benefits first. In these cases, benefits under this Plan would be calculated as secondary payor (as described under the Article entitled "Coordination of Benefits"). The Participant will be assumed to have full Medicare coverage (that is, both Part A & B) whether or not the Participant has enrolled for the full coverage. If the Provider accepts assignment with Medicare, Covered Expenses will not exceed the Medicare approved expenses.

11.03 Applicable to Medicare Services Furnished to End Stage Renal Disease ("ESRD") Participants Who Are Covered Under This Plan

If any Participant is eligible for Medicare benefits because of ESRD, the benefits of the Plan will be determined before Medicare benefits for the first 18 months of Medicare entitlement (with respect to charges Incurred on or after February 1, 1991 and before August 5, 1997), and for the first 30 months of Medicare entitlement (with respect to charges Incurred on or after August 5, 1997), unless applicable Federal law provides to the contrary, in which event the benefits of the Plan will be determined in accordance with such law.

THIRD PARTY RECOVERY, SUBROGATION AND REIMBURSEMENT

12.01 Payment Condition

1. The Plan, in its sole discretion, may elect to conditionally advance payment of benefits in those situations where an Injury, Sickness, Disease or disability is caused in whole or in part by, or results from the acts or omissions of Participants, and/or their Dependents, beneficiaries, estate, heirs, guardian, personal representative, or assigns (collectively referred to hereinafter in this section as "Participant(s)") or a third party, where any party besides the Plan may be responsible for expenses arising from an incident, and/or other funds are available, including but not limited to no-fault, uninsured motorist, underinsured motorist, medical payment provisions, third party assets, third party insurance, and/or guarantor(s) of a third party (collectively "Coverage").

2. Participant(s), his or her attorney, and/or legal guardian of a minor or incapacitated individual agrees that acceptance of the Plan's conditional payment of medical benefits is constructive notice of these provisions in their entirety and agrees to maintain 100% of the Plan's conditional payment of benefits or the full extent of payment from any one or combination of first and third party sources in trust, without disruption except for reimbursement to the Plan or the Plan's assignee. By accepting benefits the Participant(s) agrees the Plan shall have an equitable lien on any funds received by the Participant(s) and/or their attorney from any source and said funds shall be held in trust until such time as the obligations under this provision are fully satisfied. The Participant(s) agrees to include the Plan's name as a co-payee on any and all settlement drafts.

3. In the event a Participant(s) settles, recovers, or is reimbursed by any Coverage, the Participant(s) agrees to reimburse the Plan for all benefits paid or that will be paid by the Plan on behalf of the Participant(s). If the Participant(s) fails to reimburse the Plan out of any judgment or settlement received, the Participant(s) will be responsible for any and all expenses (fees and costs) associated with the Plan's attempt to recover such money.

4. If there is more than one party responsible for charges paid by the Plan, or may be responsible for charges paid by the Plan, the Plan will not be required to select a particular party from whom reimbursement is due. Furthermore, unallocated settlement funds meant to compensate multiple injured parties of which the Participant(s) is/are only one or a few, that unallocated settlement fund is considered designated as an "identifiable" fund from which the plan may seek reimbursement.

12.02 Subrogation

1. As a condition to participating in and receiving benefits under this Plan, the Participant(s) agrees to assign to the Plan the right to subrogate and pursue any and all claims, causes of action or rights that may arise against any person, corporation and/or entity and to any Coverage to which the Participant(s) is entitled, regardless of how classified or characterized, at the Plan's discretion.

2. If a Participant(s) receives or becomes entitled to receive benefits, an automatic equitable lien attaches in favor of the Plan to any claim, which any Participant(s) may have against any Coverage and/or party causing the Sickness or Injury to the extent of such conditional payment by the Plan plus reasonable costs of collection.

3. The Plan may, at its discretion, in its own name or in the name of the Participant(s) commence a proceeding or pursue a claim against any party or Coverage for the recovery of all damages to the full extent of the value of any such benefits or conditional payments advanced by the Plan.

4. If the Participant(s) fails to file a claim or pursue damages against:

a. The responsible party, its insurer, or any other source on behalf of that party;
b. Any first party insurance through medical payment coverage, personal injury protection, no-fault coverage, uninsured or underinsured motorist coverage;
c. Any policy of insurance from any insurance company or guarantor of a third party;
d. Workers' compensation or other liability insurance company; or
e. Any other source, including but not limited to crime victim restitution funds, any medical, disability or other benefit payments, and school insurance coverage;

the Participant(s) authorizes the Plan to pursue, sue, compromise and/or settle any such claims in the Participant(s)' and/or the Plan's name and agrees to fully cooperate with the Plan in the prosecution of any such claims. The Participant(s) assigns all rights to the Plan or its assignee to pursue a claim and the recovery of all expenses from any and all sources listed above.

12.03 Right of Reimbursement

1. The Plan shall be entitled to recover 100% of the benefits paid, without deduction for attorneys' fees and costs or application of the common fund doctrine, make whole doctrine, or any other similar legal theory, without regard to whether the Participant(s) is fully compensated by his/her recovery from all sources. The Plan shall have an equitable lien which supersedes all common law or statutory rules, doctrines, and laws of any State prohibiting assignment of rights which interferes with or compromises in any way the Plan's equitable lien and right to reimbursement. The obligation to reimburse the Plan in full exists regardless of how the judgment or settlement is classified and whether or not the judgment or settlement specifically designates the recovery or a portion of it as including medical, disability, or other expenses. If the Participant(s)' recovery is less than the benefits paid, then the Plan is entitled to be paid all of the recovery achieved.

2. No court costs, experts' fees, attorneys' fees, filing fees, or other costs or expenses of litigation may be deducted from the Plan's recovery without the prior, expressed written consent of the Plan.

3. The Plan's right of subrogation and reimbursement will not be reduced or affected as a result of any fault or claim on the part of the Participant(s), whether under the doctrines of causation, comparative fault or contributory negligence, or other similar doctrine in law. Accordingly, any lien reduction statutes, which attempt to apply such laws and reduce a subrogating Plan's recovery will not be applicable to the Plan and will not reduce the Plan's reimbursement rights.

4. These rights of subrogation and reimbursement shall apply without regard to whether any separate written acknowledgment of these rights is required by the Plan and signed by the Participant(s).

5. This provision shall not limit any other remedies of the Plan provided by law. These rights of subrogation and reimbursement shall apply without regard to the location of the event that led to or caused the applicable Sickness, Injury, Disease or disability.

12.04 Excess Insurance

If at the time of Injury, Sickness, Disease or disability there is available, or potentially available any Coverage (including but not limited to Coverage resulting from a judgment at law or settlements), the benefits under this Plan shall apply only as an excess over such other sources of Coverage, except as otherwise provided for under the Plan's Coordination of Benefits section.

The Plan's benefits shall be excess to:

1. The responsible party, its insurer, or any other source on behalf of that party;
2. Any first party insurance through medical payment coverage, personal injury protection, no-fault coverage, uninsured or underinsured motorist coverage;
3. Any policy of insurance from any insurance company or guarantor of a third party;
4. Workers' compensation or other liability insurance company; or

5. Any other source, including but not limited to crime victim restitution funds, any medical, disability or other benefit payments, and school insurance coverage.

12.05 Separation of Funds

Benefits paid by the Plan, funds recovered by the Participant(s), and funds held in trust over which the Plan has an equitable lien exist separately from the property and estate of the Participant(s), such that the death of the Participant(s), or filing of bankruptcy by the Participant(s), will not affect the Plan's equitable lien, the funds over which the Plan has a lien, or the Plan's right to subrogation and reimbursement.

12.06 Wrongful Death

In the event that the Participant(s) dies as a result of his or her Injuries and a wrongful death or survivor claim is asserted against a third party or any Coverage, the Plan's subrogation and reimbursement rights shall still apply, and the entity pursuing said claim shall honor and enforce these Plan rights and terms by which benefits are paid on behalf of the Participant(s) and all others that benefit from such payment.

12.07 Obligations

1. It is the Participant's/Participants' obligation at all times, both prior to and after payment of medical benefits by the Plan:

    a. To cooperate with the Plan, or any representatives of the Plan, in protecting its rights, including discovery, attending depositions, and/or cooperating in trial to preserve the Plan's rights;
    b. To provide the Plan with pertinent information regarding the Sickness, Disease, disability, or Injury, including accident reports, settlement information and any other requested additional information;
    c. To take such action and execute such documents as the Plan may require to facilitate enforcement of its subrogation and reimbursement rights;
    d. To do nothing to prejudice the Plan's rights of subrogation and reimbursement;
    e. To promptly reimburse the Plan when a recovery through settlement, judgment, award or other payment is received; and
    f. To not settle or release, without the prior consent of the Plan, any claim to the extent that the Participant may have against any responsible party or Coverage.

2. If the Participant(s) and/or his or her attorney fails to reimburse the Plan for all benefits paid or to be paid, as a result of said Injury or condition, out of any proceeds, judgment or settlement received, the Participant(s) will be responsible for any and all expenses (whether fees or costs) associated with the Plan's attempt to recover such money from the Participant(s).

3. The Plan's rights to reimbursement and/or subrogation are in no way dependent upon the Participant(s)' cooperation or adherence to these terms.

12.08 Offset

If timely repayment is not made, or the Participant and/or his/her attorney fails to comply with any of the requirements of the Plan, the Plan has the right, in addition to any other lawful means of recovery, to deduct the value of the Participant's amount owed to the Plan. To do this, the Plan may refuse payment of any future medical benefits and any funds or payments due under this Plan on behalf of the Participant(s) in an amount equivalent to any outstanding amounts owed by the Participant to the Plan.

12.09 Minor Status

1. In the event the Participant(s) is a minor as that term is defined by applicable law, the minor's parents or court-appointed guardian shall cooperate in any and all actions by the Plan to seek and obtain requisite court approval to bind the minor and his or her estate insofar as these subrogation and reimbursement provisions are concerned.

2. If the minor's parents or court-appointed guardian fail to take such action, the Plan shall have no obligation to advance payment of medical benefits on behalf of the minor. Any court costs or

legal fees associated with obtaining such approval shall be paid by the minor's parents or court-appointed guardian.

12.10 Language Interpretation

The Plan Administrator retains sole, full and final discretionary authority to construe and interpret the language of this provision, to determine all questions of fact and law arising under this provision, and to administer the Plan's subrogation and reimbursement rights. The Plan Administrator may amend the Plan at any time without notice.

12.11 Severability

In the event that any section of this provision is considered invalid or illegal for any reason, said invalidity or illegality shall not affect the remaining sections of this provision and Plan. The section shall be fully severable. The Plan shall be construed and enforced as if such invalid or illegal sections had never been inserted in the Plan.

MISCELLANEOUS PROVISIONS

13.01 Applicable Law
This is a self-funded benefit plan coming within the purview of the Employee Retirement Income Security Act of 1974 ("ERISA"). The Plan is funded with Employee and/or Employer contributions. As such, when applicable, Federal law and jurisdiction preempt State law and jurisdiction.

13.02 Clerical Error/Delay
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 to such records will not invalidate coverage otherwise validly in force or continue coverage validly terminated. Contributions made in error by Participants due to such clerical error will be returned to the Participant; coverage will not be inappropriately extended. Contributions that were due but not made, in error and due to such clerical error will be owed immediately upon identification of said clerical error. Failure to so remedy amounts owed may result in termination of coverage. Effective Dates, waiting periods, deadlines, rules, and other matters will be established based upon the terms of the Plan, as if no clerical error had occurred. 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.

13.03 Conformity With Applicable Laws
Any provision of this Plan that is contrary to any applicable law, regulation or court order (if such a court is of competent jurisdiction) will be interpreted to comply with said law, or, if it cannot be so interpreted, shall be automatically amended to satisfy the law's minimum requirement.
It is intended that the Plan will conform to the requirements of ERISA, as it applies to Employee welfare p lans, as well as any other applicable law.

13.04 Fraud
Under this Plan, coverage may be retroactively canceled or terminated (rescinded) if a Participant acts fraudulently or intentionally makes material misrepresentations of fact. It is a Participant's responsibility to provide accurate information and to make accurate and truthful statements, including information and statements regarding family status, age, relationships, etc. It is also a Participant's responsibility to update previously provided information and statements. Failure to do so may result in coverage of Participants being canceled, and such cancellation may be retroactive.

If a Participant, or any other entity, submits or attempts to submit a claim for or on behalf of a person who is not a Participant of the Plan; submits a claim for services or supplies not rendered; provides false or misleading information in connection with enrollment in the Plan; or provides any false or misleading information to the Plan as it relates to any element of its administration; that shall be deemed to be fraud. If a Participant is aware of any instance of fraud, and fails to bring that fraud to the Plan Administrator's attention, that shall also be deemed to be fraud. Fraud will result in immediate termination of all coverage under this Plan for the Participant and their entire Family Unit of which the Participant is a member.

A determination by the Plan that a rescission is warranted will be considered an Adverse Benefit Determination for purposes of review and appeal. A Participant whose coverage is being rescinded will be provided a 30 day notice period as described under The Affordable Care Act (ACA) and regulatory guidance. Claims Incurred after the retroactive date of termination shall not be further processed and/or paid under the Plan. Claims Incurred after the retroactive date of termination that were paid under the Plan will be treated as erroneously paid claims under this Plan.

13.05 Headings

The headings used in this Plan Document are used for convenience of reference only. Participants are advised not to rely on any provision because of the heading.

13.06 No Waiver or Estoppel

All parts, portions, provisions, conditions, and/or other items addressed by this Plan shall be deemed to be in full force and effect, and not waived, absent an explicit written instrument expressing otherwise; executed by the Plan Administrator. Absent such explicit waiver, there shall be no estoppel against the enforcement of any provision of this Plan. Failure by any applicable entity to enforce any part of the Plan shall not constitute a waiver, either as it specifically applies to a particular circumstance, or as it applies to the Plan's general administration. If an explicit written waiver is executed, that waiver shall only apply to the matter addressed therein, and shall be interpreted in the most narrow fashion possible.

13.07 Plan Contributions

The Plan Administrator shall, from time to time, evaluate the funding method of the Plan and determine the amount to be contributed by the Participating Employer and the amount to be contributed (if any) by each Participant.

The Plan Sponsor shall fund the Plan in a manner consistent with the provisions of the Internal Revenue Code, ERISA, and such other laws and regulations as shall be applicable to the end that the Plan shall be funded on a lawful and sound basis. The manner and means by which the Plan is funded shall be solely determined by the Plan Sponsor, to the extent allowed by applicable law.

Notwithstanding any other provision of the Plan, the Plan Administrator'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 paragraph. Payment of said claims in accordance with these procedures shall discharge completely the Company's obligation with respect to such payments.

In the event that the Company terminates the Plan, then as of the effective date of termination, the Employer and eligible Employees shall have no further obligation to make additional contributions to the Plan and the Plan shall have no obligation to pay claims Incurred after the termination date of the Plan.

13.08 Right to Receive and Release Information

The Plan Administrator may, without notice to or consent of any person, release to or obtain any information from any insurance company or other organization or person any information regarding coverage, expenses, and benefits which the Plan Administrator, at its sole discretion, considers necessary to determine and apply the provisions and benefits of this Plan. In so acting, the Plan Administrator shall be free from any liability that may arise with regard to such action. Any Participant claiming benefits under this Plan shall furnish to the Plan Administrator such information as requested and as may be necessary to implement this provision.

13.09 Written Notice

Any written notice required under this Plan which, as of the Effective Date, is in conflict with the law of any governmental body or agency which has jurisdiction over this Plan shall be interpreted to conform to the minimum requirements of such law.

13.10 Right of Recovery

In accordance with the Recovery of Payments provision, whenever payments have been made by this Plan in a total amount, at any time, in excess of the Maximum Amount of benefits payable under this Plan, the Plan shall have the right to recover such payments, to the extent of such excess, from any one or more of the following as this Plan shall determine: any person to or with respect to whom such payments were made, or such person's legal representative, any insurance companies, or any other individuals or organizations which the Plan determines are responsible for payment of such amount, and any future benefits payable to the Participant or his or her Dependents. See the Recovery of Payments provision for full details.

13.11 Statements

All statements made by the Company or by a Participant will, in the absence of fraud, be considered representations and not warranties, and no statements made for the purpose of obtaining benefits under

this document will be used in any contest to avoid or reduce the benefits provided by the document unless contained in a written application for benefits and a copy of the instrument containing such representation is or has been furnished to the Participant.

Any Participant who knowingly and with intent to defraud the Plan, files a statement of claim containing any materially false information, or conceals for the purpose of misleading, information concerning any material fact, commits a fraudulent act. The Participant may be subject to prosecution by the United States Department of Labor. Fraudulently claiming benefits may be punishable by a substantial fine, imprisonment, or both.

13.12 Protection Against Creditors

No benefit payment under this Plan shall be subject in any way to alienation, sale, transfer, pledge, attachment, garnishment, execution or encumbrance of any kind, and any attempt to accomplish the same shall be void. If the Plan Administrator shall find that such an attempt has been made with respect to any payment due or to become due to any Participant, the Plan Administrator in its sole discretion may terminate the interest of such Participant or former Participant in such payment. And in such case the Plan Administrator shall apply the amount of such payment to or for the benefit of such Participant or former Participant, his/her spouse, parent, adult Child, guardian of a minor Child, brother or sister, or other relative of a Dependent of such Participant or former Participant, as the Plan Administrator may determine, and any such application shall be a complete discharge of all liability with respect to such benefit payment. However, at the discretion of the Plan Administrator, benefit payments may be assigned to health care Providers.

SUMMARY OF BENEFITS

14.01 General Limits
Payment for any of the expenses listed below is subject to all Plan exclusions, limitations and provisions. All coverage figures are after the out of pocket Deductible has been satisfied. Benefits for Pregnancy expenses, which are covered for Employee and spouse only, are paid the same as any other Sickness.

Failure to comply with Utilization Management will result in a higher cost to Participants. "Utilization Management" includes Hospital pre-admission certification, continued stay review, length of stay determination and discharge planning. These programs are designed to ensure that Medically Necessary, high quality patient care is provided and enables maximum benefits under the Plan.

14.01A Services that Require Prior-Authorization or Notification
See Section 15.04A for a list of services that require Prior-Authorization (or reimbursement from the Plan may be reduced).

14.01B Prior-Authorization or Notification Procedures and Contact Information
See Section 15.04B for Prior-Authorization or Notification Procedures and Contact Information.

14.01C Prior-Authorization Penalty
See Section 15.02C for Prior-Authorization Penalty information.

14.01D Network and Non-Network Provider Arrangement
The Plan contracts with the medical Provider Networks to access discounted fees for service for Participants. Hospitals, Physicians and other Providers who have contracted with the medical Provider Networks are called "Network Providers." Those who have not contracted with the Networks are referred to in this Plan as "non-Network Providers." This arrangement results in the following benefits to Participants:

1. The Plan provides different levels of benefits based on whether the Provider Participants use is a Network or non-Network Provider. Unless one of the exceptions shown below applies, if a Participant elects to receive medical care from the non-Network Provider, the benefits payable are generally lower than those payable when a Network Provider is used. The following exceptions apply:

    a. The Network Provider level of benefits is payable when a Participant receives Emergency care either Out of Area or at a non-Network Hospital for an Accident (Mal Bodily Injury or Emergency).

2. If the charge billed by a non-Network Provider for any covered service is higher than the Usual and Customary Fees determined by the Plan, Participants are responsible for the excess. Since Network Providers have agreed to accept a negotiated discounted fee as full payment for their services, Participants are not responsible for any billed amount that exceeds that fee.

3. To receive benefit consideration, Participants must submit claims for services provided by non-Network Providers to the Third Party Administrator. Network Providers have agreed to bill the Plan directly, so that Participants do not have to submit claims themselves.

4. Benefits available to Network Providers are limited such that if a Network Provider advances or submits charges which exceed amounts that are eligible for payment in accordance with the terms of the Plan, or are for services or supplies for which Plan coverage is not available, or are otherwise limited or excluded by the Plan, benefits will be paid in accordance with the terms of the Plan.

Please note affirmation that a treatment, service, or supply is of a type compensable by the Plan is not a guarantee that the particular treatment, service, or supply in question, upon receipt of a Clean Claim and review by the Plan Administrator, will be eligible for payment.

14.03 Choice of Providers

The Plan is not intended to disturb the Physician-patient relationship. Each Participant has a free choice of any Physician or surgeon, and the Physician-patient relationship shall be maintained. Physicians and other healthcare Providers are not agents or delegates of the Plan Sponsor, Company, Plan Administrator, Employer or Third Party Administrator. The delivery of medical and other healthcare services on behalf of any Participant remains the sole prerogative and responsibility of the attending Physician or other healthcare Provider. The Participant, together with his or her Physician, is ultimately responsible for determining the appropriate course of medical treatment, regardless of whether the Plan will pay for all or a portion of the cost of such care.

14.04 Preferred Provider Information

This Plan contains provisions under which a Participant may receive more benefits by using certain Providers. These Providers are individuals and entities that have contracted with the Plan to provide services to Participants at pre-negotiated rates. The Network Providers are merely independent contractors; neither the Plan nor the Plan Administrator make any warranty as to the quality of care that may be rendered by any Network Provider.

A current list of Network Providers is available, without charge, through the Third Party Administrator's website (located at www.mercyoptions.net). The Network Provider list changes frequently; therefore, it is recommended that a Participant verify with the Provider that the Provider is still a Network Provider before receiving services. Please refer to the Participant identification card for the website address.

14.06 Claims Audit

In addition to the Plan's Medical Record Review process, the Plan Administrator may use its discretionary authority to utilize an independent bill review and/or claim audit program or service for a complete claim. While every claim may not be subject to a bill review or audit, the Plan Administrator has the sole discretionary authority for selection of claims subject to review or audit.

The analysis will be employed to identify charges billed in error and/or charges that are not Usual and Customary and/or Medically Necessary and Reasonable, if any, and may include a patient medical billing records review and/or audit of the patient's medical charts and records.

Upon completion of an analysis, a report will be submitted to the Plan Administrator or its agent to identify the charges deemed in excess of the Usual and Customary and Reasonable amounts or other applicable provisions, as outlined in this Plan Document.

Despite the existence of any agreement to the contrary, the Plan Administrator has the discretionary authority to reduce any charge to a Usual and Customary and Reasonable charge, in accord with the terms of this Plan Document.

14.07 Calendar Year Year Maximum Benefit

The following Calendar Year Year maximums apply to each Participant.

	TIER 1	TIER 2	OUT-OF-NETWORK
Benefit Period Maximum per Covered Person	Unlimited		
Deductible			
Individual	Not applicable	$2,000	$3,500
Family	Not applicable	$4,000	$7,000
Out-of-Pocket Maximum-Medical (includes deductible, coinsurance &			

copayments)			
Individual	$3,500		Unlimited
Family	$7,000		Unlimited
Out-of-Pocket Maximum-Prescription Drug (includes prescription copayments)			
Individual	$4,350.00		Unlimited
Family	$8,700.00		Unlimited
Out-of-Pocket Maximum does not share between In-Network & Out-of-Network			
The Plan will pay the designated percentage of Covered Expenses until the Out-of-Pocket Maximum Amounts are reached, at which time the Plan will pay 100% of the remainder of Covered Expenses for the rest of the Benefit Period unless stated otherwise. The following charges do not apply to the Out-of-Pocket Maximum and are never paid at 100%: ***** penalty amounts for failure to pre-certify a Hospital admission * expenses not covered by the Plan * expenses in excess of amounts covered by the Plan * expenses in excess of Usual, Customary and Reasonable amounts * non-network charges * prescription drug co-payments			
Standard Benefit Percentage	100%	80%	50%
Covered services at an In-Network facility rendered by an Out-of-Network Provider when the member has no choice of provider; for Ancillary Services such as Radiology, Pathology, Laboratory, Anesthesia and Emergency Room Physician			Tier 2
Services received Out-of-Network while traveling or Dependents living outside the Network area			Out-of-Network Rate
Services provided by an Out-of-Network Dialysis Provider must be prior authorized.			

COVERED SERVICES	TIER 1	TIER 2	OUT-OF-NETWORK
Physician Services			
Primary Care Office visit (Includes OB/GYN)	$30 Co-Pay then 100%	$50 Co-Pay then 100% Deductible Waived	50% after Deductible
Specialist Office Visit	$30 Co-Pay then 100%	$50 Co-Pay then 100% Deductible Waived	50% after Deductible
All Other Services in Physician's Office (including allergy testing, injections and serums)	100%	80% after Deductible	50% after Deductible
CT Scan	$100 Co-Pay then 100%	80% after Deductible	50% after Deductible
MRI	$150 Co-Pay then 100%	80% after Deductible	50% after Deductible
Outpatient Diagnostic Lab and X-Ray	$30 Co-Pay then 100%	80% after Deductible	50% after Deductible
	Radiology Interpretation Services rendered by Cape Radiology, when billed in conjunction with a facility charge for Radiology services performed at Hermann Area Hospital District will be allowed at 80%, Deductible Waived		

Urgent Care Services	Not Available	$150 Co-Pay, then 100% Deductible Waived	$300 Co-Pay, then 100% Deductible Waived
Inpatient Services	100%	80% after Deductible	50% after Deductible
Outpatient Surgery	$150 Co-Pay then 100%	80% after Deductible	50% after Deductible
Outpatient Services -other than specifically listed	100%	80% after Deductible	50% after Deductible
Emergency Room	$100 Co-Pay, then 100% Deductible Waived	$200 Co-Pay, then 100% Deductible Waived	$300 Co-Pay, then 100% Deductible Waived
Ambulance	70% after In-Network Deductible		
Organ Transplant	Not Available	80% after Deductible	50% after Deductible
Hospice Care	Not Available	80% after Deductible	50% after Deductible
Home Health Care	100%	80% after Deductible	50% after Deductible
Private Duty Nursing (Does not include Respite Care)	Not Available	80% after Deductible	50% after Deductible
Skilled Nursing Facility	100%	80% after Deductible	50% after Deductible
Outpatient Physical, Speech, and Occupational Therapy	$30 Co-Pay per therapy per day, then 100%	80% after Deductible	50% after Deductible
Respiratory, Cardiac and Pulmonary Therapy	$30 Co-Pay per therapy per day, then 100%	80% after Deductible	50% after Deductible
Sleep Study	$150 Co-Pay then 100%	80% after Deductible	50% after Deductible
Chemotherapy/Radiation Therapy	15% Co-Pay per therapy, then 100%	80% after Deductible	50% after Deductible
Chiropractic Care	Not Available	80% after Deductible	50% after Deductible
		$1000 max benefit	

14.08 Summary of Benefits - Prescription Drug

The following benefits are per Participant for a 30 day supply when filled at a participating retail pharmacy:

Type	Copay
Preferred Drugs	The greater of $40 or 25%
Non-Preferred Drugs	The greater of $55 or 25%
Generic Drugs	The greater of $15 or 25%
Specialty Drugs	25% coinsurance

The following benefits are per Participant for a 90 day supply when filled at a participating retail pharmacy:

Type	Copay
Preferred Drugs	The greater of $95 or 25%
Non-Preferred Drugs	The greater of $130 or 25%
Generic Drugs	The greater of $25 or 25%

The following benefits are per Participant when filled at the Hermann Area District Hospital Pharmacy:

Hospital Cost	Employee Cost
Less than $10	Cost + 10%, Minimum $1
Greater than $10 and less than $30	$10.00
Greater than $30 and less than $50	$15.00
Greater than $50 and less than $200	$25.00
Greater than $200 and less than $500	$45.00
Greater than $500 and less than $1499.99	$150.00
Greater than $1500.00 and less than $2999.99	$250.00
Greater than $3000	$350.00

The following Out-Of-Pocket Maximum applies for all Covered Prescription services:

Out-of-Pocket Maximum-Prescription Drug (includes prescription copayments)		
	In-Network	Out-Of-Network
Individual	$4,350.00	Unlimited
Family	$8,700.00	Unlimited

MEDICAL BENEFITS

15.01 Medical Benefits

Subject to the Plan's provisions, limitations and exclusions, the following are covered major medical benefits:

1. **Allergy Services.** Charges related to the Treatment of allergies;

2. **Ambulance.** Transportation by professional ambulance, including approved available air and train transportation (excluding chartered air flights), to a local Hospital or transfer to the nearest facility having the capability to treat the condition, if the transportation is connected with an Inpatient confinement;

3. **Ambulatory Surgical Center.** Services of an Ambulatory Surgical Center for Medically Necessary care provided;

4. **Anesthesia.** Anesthesia, anesthesia supplies, and administration of anesthesia by facility staff;

5. **Birthing Center.** Services of a birthing center for Medically Necessary care provided within the scope of its license;

6. **Chemotherapy.** Charges for chemotherapy/radiation;

7. **Chiropractic Care.** Spinal adjustment and manipulation, x rays for manipulation and adjustment and other modalities performed by a Physician or other licensed practitioner, as limited in the Summary of Benefits;

8. **Contraceptives.** All FDA approved contraceptives Drugs and methods, in accordance with HRSA guidelines;

9. **Diagnostic Tests; Examinations.** Charges for x-rays, microscopic tests, laboratory tests, esophagoscopy, gastroscopy, proctosigmoidoscopy, colonoscopy and other diagnostic tests and procedures;

10. **Durable Medical Equipment.** Charges for rental, up to the purchase price, of Durable Medical Equipment, including glucose home monitors for insulin dependent diabetics. At its option, and with its advance written approval, the Plan may cover the purchase of such items when it is less costly and more practical than rental. The Plan does not pay for:

    a. Any purchases without its advance written approval;
    b. Replacements or repairs; or
    c. The rental or purchase of items which do not fully meet the definition of "Durable Medical Equipment";

11. **Glaucoma.** Treatment of glaucoma, cataract surgery and one set of lenses (contacts or frame-type);

12. **Home Health Care.** Charges by a Home Health Care Agency:

    a. Registered Nurses or Licensed Practical Nurses;
    b. Certified home health aides under the direct supervision of a Registered Nurse;
    c. Registered therapist performing physical, occupational or speech therapy;
    d. Physician calls in the office, home, clinic or outpatient department;
    e. Services, Drugs and medical supplies which are Medically Necessary for the treatment of the Participant that would have been provided in the Hospital, but not including Custodial Care; and

f. Rental of Durable Medical Equipment or the purchase of this equipment if economically justified, whichever is less.

NOTE: Transportation services are not covered under this benefit;

13. **Hospice Care.** Charges relating to Hospice Care, provided the Participant has a life expectancy of six months or less, subject to the maximums, if any, stated in the Summary of Benefits. Covered Hospice expenses are limited to:

a. Room and Board for confinement in a Hospice;
b. Ancillary charges furnished by the Hospice while the patient is confined therein, including rental of Durable Medical Equipment which is used solely for treating an Injury or Sickness;
c. Medical supplies, Drugs and medicines prescribed by the attending Physician, but only to the extent such items are necessary for pain control and management of the terminal condition;
d. Physician services and nursing care by a Registered Nurse, Licensed Practical Nurse or a Licensed Vocational Nurse (L.V.N.);
e. Home health aide services;
f. Home care furnished by a Hospital or Home Health Care Agency, under the direction of a Hospice, including Custodial Care if it is provided during a regular visit by a Registered Nurse, a Licensed Practical Nurse or a home health aide;
g. Medical social services by licensed or trained social workers, Psychologists or counselors;
h. Nutrition services provided by a licensed dietitian;
i. Respite care; and
j. Bereavement counseling, which is a supportive service provided by the Hospice team to Participants in the deceased's family after the death of the terminally ill person, to assist the Participants in adjusting to the death. Benefits will be payable up to 6 months visits per family if the following requirements are met:

i. On the date immediately before his or her death, the terminally ill person was in a Hospice Care Program and a Participant under the Plan; and
ii. Charges for such services are Incurred by the Participants within six months of the terminally ill person's death.

The Hospice Care program must be renewed in writing by the attending Physician every 30 days. Hospice Care ceases if the terminal Illness enters remission;

14. **Hospital.** Charges made by a Hospital for:

a. Inpatient Treatment

i. Daily semi private Room and Board charges;
ii. Intensive Care Unit (ICU) and Cardiac Care Unit (CCU) Room and Board charges;
iii. General nursing services; and
iv. Medically Necessary services and supplies furnished by the Hospital, other than Room and Board;

b. Outpatient Treatment

i. Emergency room;
ii. Treatment for chronic conditions;
iii. Physical therapy treatments;
iv. Hemodialysis; and
v. X ray, laboratory and linear therapy;

22. **Mastectomy.** The Federal Women's Health and Cancer Rights Act, signed into law on October 21, 1998, contains coverage requirements for breast cancer patients who elect reconstruction in

connection with a Mastectomy. The Federal law requires group health plans that provide Mastectomy coverage to also cover breast reconstruction Surgery and prostheses following Mastectomy.

As required by law, you are being provided this notice to inform you about these provisions. The law mandates that individuals receiving benefits for a Medically Necessary Mastectomy will also receive coverage for:

a. Reconstruction of the breast on which the Mastectomy has been performed;
b. Surgery and reconstruction of the other breast to produce a symmetrical appearance; and
c. Prostheses and physical complications from all stages of Mastectomy, including lymphedemas;

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

This coverage will be subject to the same annual Deductible and coinsurance provisions that currently apply to Mastectomy coverage, and will be provided in consultation with you and your attending Physician;

23. **Medical Supplies.** Dressings, casts, splints, trusses, braces and other Medically Necessary medical supplies;

24. **Mental Health, Psychiatric and Substance Abuse Benefits.** Subject to the limitations contained in the Summary of Benefits, the Plan will pay Covered Expenses for:

a. Inpatient Benefits. The benefits above are also available when receiving treatment during the day only or during the night only at a day/night Psychiatric Hospital or at a Substance Abuse Treatment Center and/or Rehabilitation Hospital.

i. Semi private Hospital Room and Board;
ii. Miscellaneous facility charges on days a Room and Board charge is covered;
iii. Individual psychotherapy;
iv. Group psychotherapy;
v. Psychological testing;
vi. Family counseling; and
vii. Convulsive therapy treatment.

b. Outpatient Benefits.

i. Individual psychotherapy;
ii. Group psychotherapy;
iii. Psychological testing;
iv. Family counseling;
v. Convulsive therapy treatment; and
vi. Prescription Drugs or medicines for the treatment of mental Illness or chemical dependency.

26. **Newborn Care.** Hospital and Physician nursery care for newborns who are natural Children of the Employee or spouse and properly enrolled in the Plan, as set forth below. Benefits will be provided under the Mother's coverage, and the Mother's Deductible and coinsurance provisions will apply until such time as the Mother is discharged. Upon Mother's discharge, Child's own coverage and Child's own Deductible and coinsurance provisions will apply. The following services are covered as detailed above:

a. Hospital routine care for a newborn during the Child's initial Hospital confinement at birth; and
b. The following Physician services for well baby care during the newborn's initial Hospital confinement at birth:

i. The initial routine newborn examination and routine examinations performed until discharge from the Hospital; and
ii. Circumcision.

27. **Nicotine Addiction.** Nicotine withdrawal programs, facilities, Drugs or supplies;

28. **Nursing Services.** Services of a Registered Nurse or Licensed Practical Nurse;

29. **Occupational Therapy.** Treatment or services rendered by a registered occupational therapist, under the direct supervision of a Physician, in a home setting or at a facility or Institution whose primary purpose is to provide medical care for an Illness or Injury, or at a free standing outpatient facility;

30. **Oral Surgery.** Oral surgery in relation to the bone, including tumors, cysts and growths, not related to the teeth and extraction of soft tissue impacted teeth by a Physician or Dentist;

31. **Pathology Services.** Charges for pathology services;

32. **Physical Therapy.** Treatment or services rendered by a physical therapist, under direct supervision of a Physician, in a home setting or a facility or Institution whose primary purpose is to provide medical care for an Illness or Injury, or at a free standing duly licensed outpatient therapy facility;

33. **Physician Services.** Services of a Physician for Medically Necessary care, including office visits, home visits, Hospital Inpatient care, Hospital outpatient visits and exams, clinic care and surgical opinion consultations;

34. **Pregnancy Expenses.** Expenses attributable to a Pregnancy. Pregnancy expenses of Dependent Children are not covered.

    Under the Newborns' and Mothers' Health Protection Act of 1996, group health plans and health insurance issuers 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 cesarean section. However, Federal law generally does not prohibit the mother's or newborn's attending Provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours as applicable). In any case, plans and issuers may not, under Federal law, require that a Provider obtain authorization from the Plan or the issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours). In no event will an "attending Provider" include a plan, Hospital, managed care organization, or other issuer.

    In accordance with the "Summary of Benefits" and this section, benefits for the care and treatment of Pregnancy that are covered will be subject to all applicable Plan limitations and maximums, and are payable in the same manner as medical or surgical care of an Illness.

35. **Preventive Care.** Charges for Preventive Care services.
    Benefits mandated through the ACA legislation include Preventive Care such as immunizations, screenings, and other services that are listed as recommended by the United States Preventive Services Task Force (USPSTF), the Health Resources Services Administration (HRSA), and the Federal Centers for Disease Control (CDC).

    See http://www.uspreventiveservicestaskforce.org or https://www.healthcare.gov/preventive-care-benefits/ for more details.

    Important Note: The Preventive Care services identified through this link are recommended services, not mandated services. It is up to the Provider and/or Physician of care to determine which services to provide; the Plan Administrator has the authority to determine which services will be covered;

Preventive and Wellness Services for Adults and Children - In compliance with section (2713) of the Patient Protection and Affordable Care Act, benefits are available for evidence-based items or services that have in effect a rating of "A" or "B" in the current recommendations of the United States Preventive Services Task Force (USPSTF).

Immunizations that have in effect a recommendation from the Advisory Committee on Immunization Practices (ACIP) of the Centers for Disease Control and Prevention with respect to the individual involved. With respect to infants, Children, and adolescents, evidence-informed Preventive Care and screenings as provided for in the comprehensive guidelines supported by the Health Resources and Services Administration (HRSA).

A description of Preventive and Wellness Services can be found at: https://www.healthcare.gov/preventive-care-benefits/

Women's Preventive Services - With respect to women, such additional Preventive Care and screenings as provided for in comprehensive guidelines supported by the Health Resources and Services Administration not otherwise addressed by the recommendations of the United States Preventive Service Task Force, which will be commonly known as HRSA's Women's Preventive Services Required Health Plan Coverage Guidelines. The HRSA has added the following eight categories of women's services to the list of mandatory preventive services:

1. Well-woman visits ;
2. Gestational diabetes screening;
3. HPV DNA testing;
4. Sexually transmitted infection counseling;
5. HIV screening and counseling;
6. FDA-approved contraception methods and contraceptive counseling;
7. Breastfeeding support, supplies and counseling; and
8. Domestic violence screening and counseling.

A description of Women's Preventive Services can be found at: http://www.hrsa.gov/womensguidelines/ or at https://www.healthcare.gov/preventive-care-benefits/.

36. **Prosthetics, Orthotics, Supplies and Surgical Dressings.** Prosthetic devices (other than dental) to replace all or part of an absent body organ or part, including replacement due to natural growth or pathological change, but not including charges for repair or maintenance. Orthotic devices, but excluding orthopedic shoes and other supportive devices for the feet;

37. **Radiation Therapy.** Charges for radiation and dialysis therapy and treatment;

38. **Respiration Therapy.** Respiration therapy services, when rendered in accordance with a Physician's written treatment plan;

39. **Routine Patient Costs for Participation in an Approved Clinical Trial.** Charges for any Medically Necessary services, for which benefits are provided by the Plan, when a Participant is participating in a phase I, II, III or IV clinical trial, conducted in relation to the prevention, detection or treatment of a life-threatening Disease or condition, as defined under the ACA, provided:

    a. The clinical trial is approved by:

i. The Centers for Disease Control and Prevention of the U.S. Department of Health and Human Services;
ii. The National Institute of Health;
iii. The U.S. Food and Drug Administration;
iv. The U.S. Department of Defense;

v. The U.S. Department of Veterans Affairs; or
vi. An Institutional review board of an Institution in MO that has an agreement with the Office for Human Research Protections of the U.S. Department of Health and Human Services; and

b. The research Institution conducting the Approved Clinical Trial and each health professional providing routine patient care through the Institution, agree to accept reimbursement at the applicable Allowable Expense, as payment in full for routine patient care provided in connection with the Approved Clinical Trial.

Coverage will not be provided for:

a. The cost of an Investigational new drug or device that is not approved for any indication by the U.S. Food and Drug Administration, including a drug or device that is the subject of the Approved Clinical Trial;
b. The cost of a service that is not a health care service, regardless of whether the service is required in connection with participation in an Approved Clinical Trial;
c. The cost of a service that is clearly inconsistent with widely accepted and established standards of care for a particular Diagnosis;
d. A cost associated with managing an Approved Clinical Trial;
e. The cost of a health care service that is specifically excluded by the Plan; or
f. Services that are part of the subject matter of the Approved Clinical Trial and that are customarily paid for by the research Institution conducting the Approved Clinical Trial.

40. **Second Surgical Opinions.** Charges for second surgical opinions;

41. **Skilled Nursing Facility.** Charges made by a skilled nursing facility or a convalescent care facility, up to the limits set forth in the Summary of Benefits, in connection with convalescence from an Illness or Injury (excluding drug addiction, chronic brain syndrome, alcoholism, senility, mental retardation or other Mental or Nervous Disorders) for which the Participant is confined;

42. **Speech Therapy.** Speech therapy by a Physician or qualified speech therapist, when needed due to a Sickness or Injury (other than a functional Nervous Disorder) or due to Surgery performed as the result of a Sickness or Injury, excluding speech therapy services that are educational in any part or due to articulation disorders, tongue thrust, stuttering, lisping, abnormal speech development, changing an accent, dyslexia, hearing loss which is not medically documented or similar disorders;

43. **Sterilization.** All FDA approved charges related to sterilization procedures, to the extent required by the Affordable Care Act (ACA);

44. **Surgery.** Surgical operations and procedures, unless otherwise specifically excluded under the Plan, and limited as follows:

a. Multiple procedures adding significant time or complexity will be allowed at:

i. 100% of the full Usual and Customary Fee value for the first or major procedure;
ii. 50% of the Usual and Customary Fee value for the secondary and subsequent procedures;
iii. Bilateral procedures which add significant time or complexity, which are provided at the same operative session, will be allowed at 100% of Usual and Customary Fee value for the major procedure, and 50% of the Usual and Customary Fee value for the secondary or lesser procedure;

b. Charges made for services rendered by an assistant surgeon will be allowed at 25% of the Usual, and Customary Fee value for the type of Surgery performed;
c. No benefit will be payable for incidental procedures, such as appendectomy during an abdominal Surgery, performed during a single operative session;

49. **Surgical Treatment of Jaw.** Surgical treatment of Diseases, Injuries, fractures and dislocations of the jaw by a Physician or Dentist;

50. **Transplants.** Organ or tissue transplants are covered for the following human to human organ or tissue transplant procedures:

a. Bone marrow;
b. Heart;
c. Lung;
d. Heart and lung;
e. Liver;
f. Pancreas;
g. Kidney; and
h. Cornea.

In addition, the Plan will cover any other transplant that is not Experimental.

Covered Expenses will be considered the same as any other Sickness for Employees or Dependents as a recipient of an organ or tissue transplant. Covered Expenses include:

a. Organ or tissue procurement from a cadaver consisting of removing, preserving and transporting the donated part;
b. Services and supplies furnished by a Provider; and
c. Drug therapy treatment to prevent rejection of the transplanted organ or tissue.

Surgical, storage and transportation costs, directly related to the procurement of an organ or tissue used in a transplant described herein will be covered. If covered organ or tissue is sold rather than donated, no benefits will be available for the purchase price of such organ or tissue.

51. **Weight Loss**

Office services and related lab services for Tier 1 providers for no more than 3 months. Charges must be related to an approved weight management program and must be properly coded in order for benefits to apply.

15.02 Cost Containment

15.02A Services that Require Prior-Authorization or Notification

Certain services will require Prior-Authorization (or reimbursement from the Plan may be reduced). Please see the attached list in Appendix A for the complete list of services.

Remember that although the Plan will automatically pre-authorize a maternity length of stay that is 48 hours or less for a vaginal delivery or 96 hours for a cesarean delivery, it is important to have your Physician call to obtain Prior-Authorization in case there is a need to have a longer stay.

Prior-Authorization does not verify eligibility for benefits nor guarantee benefit payments under the Plan. It is the Participant's responsibility to verify that the services in Appendix A have been pre-certified as outlined below.

15.02B Prior-Authorization or Notification Procedures and Contact Information

The Inpatient Utilization Management Service is simple and easy for Participants to use. Whenever a Participant is advised that Inpatient Hospital care is needed, it is the Participant's responsibility to call the Prior-Authorization department at its toll free number, which is 1-844-841-3891. The review process will continue, as outlined below, until the Participant is discharged from the Hospital.

Urgent Care or Emergency Admissions:

If a Participant needs medical care for a condition which could seriously jeopardize his or her life, obtain such care without delay, and communicate with the Plan as soon as reasonably possible.

If a Participant must be admitted on an Emergency basis, the Participant should follow the Physician's instructions carefully and contact the Prior-Authorization department as follows:

1. For Emergency admissions after business hours on Friday, on a weekend or over a holiday weekend, a call to the Prior-Authorization department must be made within 48 hours after the admission date, but no later than the first business day following the Emergency admission, by or on behalf of the covered patient; and

2. For Emergency admissions on a weekday, a call to the Prior-Authorization department must be made within 24 hours after the admission date.

If a medical service is provided in response to an Emergency situation or urgent care scenario, prior approval from the Plan is not required. The Plan may require notice after the Participant's receipt of treatment, once the Participant is able to so provide notice and/or the treating Provider is able to provide notice. Such a claim shall then be deemed to be a Post-service Claim.

Non-Emergency Admissions:
For Inpatient Hospital stays that are scheduled in advance, a call to the Prior-Authorization department should be completed as soon as possible before actual services are rendered. Once the Prior-Authorization call is received, it will be routed to an appropriate review specialist who will create an on-line patient file. The review specialist will contact the Participant's attending Physician to obtain information and to discuss the specifics of the admission request. If appropriate, alternative care will be explored with the Physician.

If, after assessing procedure necessity, the need for an Inpatient confinement is confirmed, the review specialist will determine the intensity of management required and will remain in contact with the Physician or Hospital during the confinement.

If, at any time during the review process, Medical Necessity cannot be validated, the review specialist will refer the episode to a board certified Physician advisor who will immediately contact the attending Physician to negotiate an appropriate treatment plan. At the end of the Hospital confinement, the review specialist is also available to assist with discharge planning and will work closely with the attending Physician and Hospital to ensure that medically appropriate arrangements are made.

The pre certification department hours of operations are 8am-5pm CST. On weekends and evenings, the Participant can call 1-844-841-3841.

15.02C Prior-Authorization Penalty
The program requires the support and cooperation of each Participant. If a Participant follows the instructions and procedures, he or she will receive the normal Plan benefits for the services. However, for non-network providers, if a Participant fails to notify the Prior-Authorization department of any services as required in the section entitled "Prior-Authorization or Notification Procedures and Contact Information," allowed charges will be reduced for those services. The Participant will be responsible for any balance billed by the provider.

15.02D Second Surgical Opinion
If a Physician recommends Surgery for a Participant, the Participant may request a second opinion as to whether or not the Surgery is Medically Necessary.

When a second opinion is requested, the Plan will pay 100% of Usual and Customary Fees Incurred for that opinion along with laboratory, x-ray and other Medically Necessary services ordered by the second Physician without application of the Deductible. Second opinions for Cosmetic Surgery, normal obstetrical delivery and Surgeries that require only local anesthesia are not covered. If the second

opinion does not concur with the first, the Plan will pay for a third opinion as outlined above. The second or third opinion must be given within 90 days of the first.

In all cases where a second opinion is requested, the original recommendation for Surgery must have been obtained from a Physician licensed in the medical specialty under which the recommended Surgery falls. The Physician consulted for the second opinion must be licensed in the same medical specialty and may not be a partner of or in association with the original Physician.

PRESCRIPTION DRUG BENEFITS

Participating pharmacies ("Participating Pharmacies") have contracted with the Plan to charge Participants reduced fees for covered Drugs. MedTrak is the administrator of the prescription drug plan. Participants will be issued an identification card to use at the pharmacy at time of purchase. Participants will be held fully responsible for the consequences of any pharmacy identification card after termination of coverage. No reimbursement will be made when a Drug is purchased from a non-Participating Pharmacy or when the identification card is not used.

The Mail Order Option is available for maintenance medications (those that are taken for long periods of time, such as Drugs sometimes prescribed for heart Disease, high blood pressure, asthma, etc.). Because of the volume buying, MedTraks, the mail order pharmacy, is able to offer Participants significant savings on their prescriptions.

The copayment is applied to each charge and is shown below.

16.01 Prescription Benefits

SCHEDULE A

This **Schedule A** shall apply to drugs and medications not dispensed directly by a Hospital or Physician. All benefits described in this Schedule are subject to all limitations and exclusions of the Plan. The Plan has designated an independent entity as the provider of drugs and medicines covered under the Plan. This entity, which may change from time to time, shall be known as the Pharmacy Benefit Manager (PBM). Benefits under the Plan will be provided only for those drugs and medicines listed on the drug formulary of the PBM. Those drugs and medicines listed on the Formulary are called Covered Drugs.

Covered Drugs shall consist of three classifications of drugs: (a) generic drugs that are chemically and therapeutically equivalent to brand-name drugs but are not protected by patent, (b) brand-name drugs that are designated by the Plan as superior or equal to other brand-name drugs but are more cost-effective, and (c) brand-name drugs that the Plan has determined are not usually clinically necessary and that have more cost-effective therapeutic alternatives. These three categories of Covered Drugs shall be determined from time to time by the PBM. The Formulary itself may be changed from time to time which means that Covered Drugs may also change.

Covered Drugs may be purchased through one of the PBM's participating pharmacies. An abbreviated list of Covered Drugs is set forth in the attached **Schedule** A-1.

Those Covered Individuals enrolled in the Plan will purchase the Covered Drugs by payment of the applicable copayment set forth in this **Schedule** A. Charges for Covered Drugs not obtained directly from a Participating Pharmacy shall not be covered under the Plan, except as provided in paragraph I.C. of this **Schedule** A.

1. Copayments for Covered Individuals Enrolled in the Plan

   For each Covered Drug, a Covered Individual enrolled in the Plan shall pay the following copayment at the time of purchase:

   a. At Participating Pharmacies up to a 30-day supply

The lesser of (i) the usual and customary charge that the Participating Pharmacy charges for the particular drug on the date dispensed or (ii):

Type	Copay

Preferred Drugs	The greater of $40 or 25%
Non-Preferred Drugs	The greater of $55 or 25%
Generic Drugs	The greater of $15 or 25%
Specialty Drugs	25% coinsurance

In the event a Covered Individual does not present to the Participating Pharmacy the appropriate membership card for the Plan or the Participating Pharmacy is otherwise not able to verify participation in the Plan, the Covered Individual shall only be entitled to reimbursement as provided in paragraph I.C. below.

b. At Participating Performance 90 Pharmacies up to a 90-day supply

The lesser of (i) the usual and customary charge that the Participating Pharmacy charges for the particular drug on the date dispensed or (ii):

Type	Copay
Preferred Drugs	The greater of $95 or 25%
Non-Preferred Drugs	The greater of $130 or 25%
Generic Drugs	The greater of $25 or 25%

c. Member Submitted Claims

When a Covered Individual purchases a Covered Drug from a pharmacy which is not a Participating Pharmacy, the Covered Individual may file a claim with PBM and shall be reimbursed for that amount the Plan would have paid if the Covered Drug had been purchased through a Participating Pharmacy less the above stated copayments.

d. For Hermann Area Hospital District Pharmacy please see 16.04

2. The following Out-Of-Pocket Maximum applies for all Covered Prescription services:

Out-of-Pocket Maximum-Prescription Drug (includes prescription copayments)		
	In-Network	**Out-Of-Network**
Individual	$4,350.00	Unlimited
Family	$8,700.00	Unlimited

3. Covered Drugs Requiring Prior Authorization

Prior authorization by the Pharmacy Contractor is required for the following drugs and medications ("Covered Drugs Requiring Prior Authorization"):

Acne Drugs (over age 35)	Viagra and similar drugs (dose not to exceed lower of FDA or manufacturer's recommended dose for a 30 day period)
Egrifta	Anorexiants (over age 18)
Fertility Agents	Specialty Drugs

If prior authorization is not obtained for any Covered Drug Requiring Prior Authorization, such drug shall not be covered under the Plan.

4. Generic Substitution

If a Generic Drug is available but a Covered Individual under the Plan purchases a brand-name drug, then such Covered Individual shall pay the difference between the ingredient cost of the brand-name drug and the Generic Drug plus the brand drugs copayment. This difference shall be calculated before applying any applicable copayment. This paragraph III shall not apply if the Physician mandates Dispense as Written, the Covered Individual will pay only the preferred or non-preferred brand-name drug copayment.

5. Participating Pharmacies

It is the Covered Individual's responsibility to determine at the time of purchase whether a pharmacy is a Participating Pharmacy.

6. Formulary

It is the Covered Individual's responsibility to determine at the time of purchase whether a drug or medicine is a Covered Drug and, if so, under what category it fits.

7. Special Exclusions

In addition to other exclusions set forth in the Plan, no benefits will be provided for the following:

a. Drugs and medications not listed on **Schedule** A-1

b. Drugs and medications listed on **Schedule** A-2

c. Drugs and medicines not listed on the Formulary at the time of purchase.

d. Replacements necessitated by loss, theft or breakage.

16.02 Schedule A-1 PLAN COVERED DRUGS

1. Federal Legend prescription drugs
2. Drugs requiring a prescription under the applicable state law
3. Compounded medications when at least one ingredient is a Federal Legend Drug
4. Injectable insulin
5. Insulin syringes
6. Birth control pills, injectables and implantables
7. Prenatal Vitamins
8. Diabetic supplies
9. Diabetic test strips

16.03 Schedule A-2 PLAN EXCLUDED DRUGS

1. Non-Legend drugs other than insulin
2. Therapeutic devices or appliances, support garments and other non-medical substances
3. Drugs intended for use in a physician's office or another setting other than home use.
4. Experimental or Investigational drugs; including compounded medications for non-FDA approved use.
5. Prescriptions which an eligible person is entitled to receive without charge under any workers' compensation law, or any municipal, state or federal program.

6. Rogaine
7. Vitamins (other than prenatal)

16.04 Employee Discounts and Pharmacy Ref: 2411a

1. With a physician's order, employees, Board members, independent contractors that are on hospital's health insurance coverage, and immediate dependents may purchase prescription medications or medical supplies from HADH at the below cost structure, Employees are encouraged to check the price through the hospital pharmacy and through retail sources, depending on the medication an employee's out-of-pocket will vary as to which method may be less expensive. The items filled through the hospital pharmacy will count towards the out-of-pocket maximum on the HADH employee's health plan.
2. Some prescriptions may not be available through the hospital pharmacy.
3. Employee prescriptions may only be paid through payroll deduction. Prescriptions in most cases, will not be available until the next business day and can only be picked up when the pharmacist is in-house, which is from 7 AM -8:45 AM. There will be a calendar on the pharmacy door showing the days the pharmacists will not be in the hospital and medications cannot be pick-up.
4.

Hospital Cost	Employee Cost
Less than $10	Cost + 10%, Minimum $1
Greater than $10 and less than $30	$10.00
Greater than $30 and less than $50	$15.00
Greater than $50 and less than $200	$25.00
Greater than $200 and less than $500	$45.00
Greater than $500 and less than $1499.99	$150.00
Greater than $1500.00 and less than $2999.99	$250.00
Greater than $3000	$350.00

5. Cost of Medication over Employee Cost will be assigned to Employee Benefits Expense

HIPAA PRIVACY

The Plan provides each Participant with a separate Notice of Privacy Practices. This Notice describes how the Plan uses and discloses your personal health information. It also describes certain rights you have regarding this information. Additional copies of our Notice of Privacy Practices are available by calling 1-877-875-7700.

Definitions

- **Breach** means an unauthorized acquisition, access, use or disclosure of Protected Health Information ("PHI") or Electronic Protected Health Information ("ePHI") that violates the HIPAA Privacy Rule and that compromises the security or privacy of the information.
- **Protected Health Information ("PHI")** means individually identifiable health information, as defined by HIPAA, that is created or received by us and that relates to the past, present, or future physical or mental health or condition of an individual; the provision of health care to an individual; or the past, present, or future payment for the provision of health care to an individual; and that identifies the individual or for which there is a reasonable basis to believe the information can be used to identify the individual. PHI includes information of persons living or deceased.

Commitment to Protecting Health Information
The Plan will comply with the Standards for Privacy of Individually Identifiable Health Information (i.e., the "Privacy Rule") set forth by the U.S. Department of Health and Human Services ("HHS") pursuant to the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"). Such standards control the dissemination of "protected health information" ("PHI") of Participants. Privacy Standards will be implemented and enforced in the offices of the Employer and Plan Sponsor and any other entity that may assist in the operation of the Plan.

The Plan is required by law to take reasonable steps to ensure the privacy of the Participant's PHI, and inform him/her about:

1. The Plan's disclosures and uses of PHI;
2. The Participant's privacy rights with respect to his/her PHI;
3. The Plan's duties with respect to his/her PHI;
4. The Participant's right to file a complaint with the Plan and with the Secretary of HHS; and
5. The person or office to contact for further information about the Plan's privacy practices.

Within this provision capitalized terms may be used, but not otherwise defined. These terms shall have the same meaning as those terms set forth in 45 CFR Sections 160.103 and 164.501. Any HIPAA regulation modifications altering a defined HIPAA term or regulatory citation shall be deemed incorporated into this provision.

How Health Information May be Used and Disclosed
In general, the Privacy Rules permit the Plan to use and disclose, the minimum necessary amount, an individual's PHI, without obtaining authorization, only if the use or disclosure is:

1. To carry out Payment of benefits;
2. For Health Care Operations;
3. For Treatment purposes; or
4. If the use or disclosure falls within one of the limited circumstances described in the rules (e.g., the disclosure is required by law or for public health activities).

Disclosure of PHI to the Plan Sponsor for Plan Administration Purposes
In order that the Plan Sponsor may receive and use PHI for plan administration purposes, the Plan Sponsor agrees to:

1. Not use or further disclose PHI other than as permitted or required by the Plan documents or as required by law (as defined in the Privacy Standards);
2. Ensure that any agents, including a subcontractor, to whom the Plan Sponsor provides PHI received from the Plan, agree to the same restrictions and conditions that apply to the Plan Sponsor with respect to such PHI;
3. Establish safeguards for information, including security systems for data processing and storage;
4. Maintain the confidentiality of all PHI, unless an individual gives specific consent or authorization to disclose such data or unless the data is used for health care payment or Plan operations;
5. Receive PHI, in the absence of an individual's express authorization, only to carry out Plan administration functions;
6. Not use or disclose genetic information for underwriting purposes;
7. Not use or disclose PHI for employment-related actions and decisions or in connection with any other benefit or Employee benefit plan of the Plan Sponsor, except pursuant to an authorization which meets the requirements of the Privacy Standards;
8. Report to the Plan any PHI use or disclosure that is inconsistent with the uses or disclosures provided for of which the Plan Sponsor becomes aware;
9. Make available PHI in accordance with section 164.524 of the Privacy Standards (45 CFR 164.524);
10. Make available PHI for amendment and incorporate any amendments to PHI in accordance with section 164.526 of the Privacy Standards (45 CFR 164.526);
11. Make available the information required to provide an accounting of disclosures in accordance with section 164.528 of the Privacy Standards (45 CFR 164.528);
12. Make its internal practices, books and records relating to the use and disclosure of PHI received from the Plan available to the Secretary of the U.S. Department of Health and Human Services ("HHS"), or any other officer or Employee of HHS to whom the authority involved has been delegated, for purposes of determining compliance by the Plan with part 164, subpart E, of the Privacy Standards (45 CFR 164.500 et seq);
13. Report to the Plan any inconsistent uses or disclosures of PHI of which the Plan Sponsor becomes aware;
14. Train Employees in privacy protection requirements and appoint a privacy compliance coordinator responsible for such protections;
15. If feasible, return or destroy all PHI received from the Plan that the Plan Sponsor still maintains in any form and retain no copies of such PHI when no longer needed for the purpose for 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 PHI infeasible; and
16. Ensure that adequate separation between the Plan and the Plan Sponsor, as required in section 164.504(f)(2)(iii) of the Privacy Standards (45 CFR 164.504(f)(2)(iii)), is established as follows:

    a. The following Employees, or classes of Employees, or other persons under control of the Plan Sponsor, shall be given access to the PHI to be disclosed:

        i. Privacy Officer: The access to and use of PHI by the individuals described above shall be restricted to the plan administration functions that the Plan Sponsor performs for the Plan.

    b. In the event any of the individuals described above do not comply with the provisions of the Plan documents relating to use and disclosure of PHI, the Plan Administrator shall impose reasonable sanctions as necessary, in its discretion, to ensure that no further non-compliance occurs. The Plan Administrator will promptly report such violation or non-compliance to the Plan, and will cooperate with the Plan to correct violation or non-compliance and to impose appropriate disciplinary action or sanctions. Such sanctions shall be imposed progressively (for example, an oral warning, a written warning, time off without pay and termination), if appropriate, and shall be imposed so that they are commensurate with the severity of the violation.

Disclosure of Summary Health Information to the Plan Sponsor

The Plan may disclose PHI to the Plan Sponsor of the group health plan for purposes of plan administration or pursuant to an authorization request signed by the Participant. The Plan may use or

disclose “summary health information” to the Plan Sponsor for obtaining premium bids or modifying, amending, or terminating the group health plan.

Disclosure of Certain Enrollment Information to the Plan Sponsor
Pursuant to section 164.504(f)(1)(iii) of the Privacy Standards (45 CFR 164.504(f)(1)(iii)), the Plan may disclose to the Plan Sponsor information on whether an individual is participating in the Plan or is enrolled in or has un-enrolled from a health insurance issuer or health maintenance organization offered by the Plan to the Plan Sponsor.

Disclosure of PHI to Obtain Stop-loss or Excess Loss Coverage
The Plan Sponsor may hereby authorize and direct the Plan, through the Plan Administrator or the Third Party Administrator, to disclose PHI to stop-loss carriers, excess loss carriers or managing general underwriters (“MGUs”) for underwriting and other purposes in order to obtain and maintain stop-loss or excess loss coverage related to benefit claims under the Plan. Such disclosures shall be made in accordance with the Privacy Standards.

Other Disclosures and Uses of PHI:

Primary Uses and Disclosures of PHI

1. Treatment, Payment and Health Care Operations: The Plan has the right to use and disclose a Participant’s PHI for all activities as included within the definitions of Treatment, Payment, and Health Care Operations and pursuant to the HIPAA Privacy Rule;
2. Business Associates: The Plan contracts with individuals and entities (Business Associates) to perform various functions on its behalf. In performance of these functions or to provide services, Business Associates will receive, create, maintain, use, or disclose PHI, but only after the Plan and the Business Associate agree in writing to contract terms requiring the Business Associate to appropriately safeguard the Participant’s information; and
3. Other Covered Entities: The Plan may disclose PHI to assist health care Providers in connection with their treatment or payment activities or to assist other covered entities in connection with payment activities and certain health care operations. For example, the Plan may disclose PHI to a health care Provider when needed by the Provider to render treatment to a Participant, and the Plan may disclose PHI to another covered entity to conduct health care operations. The Plan may also disclose or share PHI with other insurance carriers (such as Medicare, etc.) in order to coordinate benefits, if a Participant has coverage through another carrier.

Other Possible Uses and Disclosures of PHI

1. Required by Law: The Plan may use or disclose PHI when required by law, provided the use or disclosure complies with and is limited to the relevant requirements of such law;
2. Public Health and Safety: The Plan may use or disclose PHI when permitted for purposes of public health activities, including disclosures to:

    a. a public health authority or other appropriate government authority authorized by law to receive reports of Child abuse or neglect;
    b. report reactions to medications or problems with products or devices regulated by the Federal Food and Drug Administration or other activities related to quality, safety, or effectiveness of FDA-regulated products or activities;
    c. locate and notify persons of recalls of products they may be using; and
    d. a person who may have been exposed to a communicable Disease or may otherwise be at risk of contracting or spreading a Disease or condition, if authorized by law;

3. The Plan may disclose PHI to a government authority, except for reports of Child abuse or neglect, when required or authorized by law, or with the Participant’s agreement, if the Plan reasonably believes he/she to be a victim of abuse, neglect, or domestic violence. In such case, the Plan will promptly inform the Participant that such a disclosure has been or will be made unless the Plan believes that informing him/her would place him/her at risk of serious harm (but only to someone in a position to help prevent the threat). Disclosure generally may be made to a

minor's parents or other representatives although there may be circumstances under Federal or State law when the parents or other representatives may not be given access to the minor's PHI;

4. Health Oversight Activities: The Plan may disclose PHI to a health oversight agency for oversight activities authorized by law. This includes civil, administrative or criminal investigations; inspections; claim audits; licensure or disciplinary actions; and other activities necessary for appropriate oversight of a health care system, government health care program, and compliance with certain laws;
5. Lawsuits and Disputes: The Plan may disclose PHI when required for judicial or administrative proceedings. For example, the Participant's PHI may be disclosed in response to a subpoena, discovery requests, or other required legal processes when the Plan is given satisfactory assurances that the requesting party has made a good faith attempt to advise the Participant of the request or to obtain an order protecting such information, and done in accordance with specified procedural safeguards;
6. Law Enforcement: The Plan may disclose PHI to a law enforcement official when required for law enforcement purposes concerning identifying or locating a suspect, fugitive, material witness or missing person. Under certain circumstances, the Plan may disclose the Participant's PHI in response to a law enforcement official's request if he/she is, or are suspected to be, a victim of a crime and if it believes in good faith that the PHI constitutes evidence of criminal conduct that occurred on the Sponsor's or Plan's premises;
7. Decedents: The Plan may disclose PHI to family members or others involved in decedent's care or payment for care, a coroner, funeral director or medical examiner for the purpose of identifying a deceased person, determining a cause of death or as necessary to carry out their duties as authorized by law. The decedent's health information ceases to be protected after the individual is deceased for 50 years;
8. Research: The Plan may use or disclose PHI for research, subject to certain limited conditions;
9. To Avert a Serious Threat to Health or Safety: The Plan may disclose PHI in accordance with applicable law and standards of ethical conduct, if the Plan, in good faith, believes the use or disclosure is necessary to prevent or lessen a threat to health or safety of a person or to the public;
10. Workers' Compensation: The Plan may disclose PHI when authorized by and to the extent necessary to comply with workers' compensation or other similar programs established by law; and
11. Military and National Security: The Plan may disclose PHI to military authorities of armed forces personnel under certain circumstances. As authorized by law, the Plan may disclose PHI required for intelligence, counter-intelligence, and other national security activities to authorized Federal officials.

Required Disclosures of PHI

1. Disclosures to Participants: The Plan is required to disclose to a Participant most of the PHI in a Designated Record Set when the Participant requests access to this information. The Plan will disclose a Participant's PHI to an individual who has been assigned as his/her representative and who has qualified for such designation in accordance with the relevant State law. Before disclosure to an individual qualified as a personal representative, the Plan must be given written supporting documentation establishing the basis of the personal representation.

   The Plan may elect not to treat the person as the Participant's personal representative if it has a reasonable belief that the Participant has been, or may be, subjected to domestic violence, abuse, or neglect by such person, it is not in the Participant's best interest to treat the person as his/her personal representative, or treating such person as his/her personal representative could endanger the Participant; and

2. Disclosures to the Secretary of the U.S. Dept of Health and Human Services: The Plan is required to disclose the Participant's PHI to the Secretary of the U.S. Department of Health and Human Resources when the Secretary is investigating or determining the Plan's compliance with the HIPAA Privacy Rule.

Instances When Required Authorization Is Needed From Participants Before Disclosing PHI

1. Most uses and disclosures of psychotherapy notes;
2. Uses and disclosures for marketing;
3. Sale of PHI; and
4. Other uses and disclosures not described in this section can only be made with authorization from the Participant. The Participant may revoke this authorization at any time.

Participant's Rights
The Participant has the following rights regarding PHI about him/her:

1. Request Restrictions: The Participant has the right to request additional restrictions on the use or disclosure of PHI for treatment, payment, or health care operations. The Participant may request that the Plan restrict disclosures to family members, relatives, friends or other persons identified by him/her who are involved in his/her care or payment for his/her care. The Plan is not required to agree to these requested restrictions;
2. Right to Receive Confidential Communication: The Participant has the right to request that he/she receive communications regarding PHI in a certain manner or at a certain location. The request must be made in writing and how the Participant would like to be contacted. The Plan will accommodate all reasonable requests;
3. Right to Receive Notice of Privacy Practices: The Participant is entitled to receive a paper copy of the plan's Notice of Privacy Practices at any time. To obtain a paper copy, contact the Privacy Compliance Coordinator;
4. Accounting of Disclosures: The Participant has the right to request an accounting of disclosures the Plan has made of his/her PHI. The request must be made in writing and does not apply to disclosures for treatment, payment, health care operations, and certain other purposes. The Participant is entitled to such an accounting for the six years prior to his/her request. Except as provided below, for each disclosure, the accounting will include: (a) the date of the disclosure, (b) the name of the entity or person who received the PHI and, if known, the address of such entity or person; (c) a description of the PHI disclosed, (d) a statement of the purpose of the disclosure that reasonably informs the Participant of the basis of the disclosure, and certain other information. If the Participant wishes to make a request, please contact the Privacy Compliance Coordinator;
5. Access: The Participant has the right to request the opportunity to look at or get copies of PHI maintained by the Plan about him/her in certain records maintained by the Plan. If the Participant requests copies, he/she may be charged a fee to cover the costs of copying, mailing, and other supplies. To inspect or copy PHI, or to have a copy of your PHI transmitted directly to another designated person, contact the Privacy Compliance Coordinator. A request to transmit PHI directly to another designated person must be in writing, signed by the Participant and the recipient must be clearly identified. The Plan must respond to the Participant's request within 30 days (in some cases, the Plan can request a 30 day extension). In very limited circumstances, the Plan may deny the Participant's request. If the Plan denies the request, the Participant may be entitled to a review of that denial;
6. Amendment: The Participant has the right to request that the Plan change or amend his/her PHI. The Plan reserves the right to require this request be in writing. Submit the request to the Privacy Compliance Coordinator. The Plan may deny the Participant's request in certain cases, including if it is not in writing or if he/she does not provide a reason for the request; and
7. Fundraising contacts: The Participant has the right to opt out of fundraising contacts.

Questions or Complaints
If the Participant wants more information about the Plan's privacy practices, has questions or concerns, or believes that the Plan may have violated his/her privacy rights, please contact the Plan using the following information. The Participant may submit a written complaint to the U.S. Department of Health and Human Services or with the Plan. The Plan will provide the Participant with the address to file his/her complaint with the U.S. Department of Health and Human Services upon request.

The Plan will not retaliate against the Participant for filing a complaint with the Plan or the U.S. Department of Health and Human Services

Please contact your Human Resources representative for any additional information regarding the Plan's privacy practices at:

Hermann Area Hospital District
509 W 18th St
Hermann, MO 65041
Phone: 573-486-2191
Fax: 573-486-3743
Website: www.hadh.org

HIPAA SECURITY

Disclosure of Electronic Protected Health Information ("Electronic PHI") to the Plan Sponsor for Plan Administration Functions

STANDARDS FOR SECURITY OF INDIVIDUALLY IDENTIFIABLE HEALTH INFORMATION ("SECURITY RULE")

The Health Insurance Portability and Accountability Act (HIPAA) and other applicable law shall override the following wherever there is a conflict, or a term or terms is/are not hereby defined.

The Security Rule imposes regulations for maintaining the integrity, confidentiality and availability of protected health information that it creates, receives, maintains, or maintains electronically that is kept in electronic format (ePHI) as required under HIPAA.

Definitions

- **Electronic Protected Health Information (ePHI),** as defined in Section 160.103 of the Security Standards (45 C.F.R. 160.103) and means individually identifiable health information transmitted or maintained in any electronic media.
- **Security Incidents,** as defined within Section 164.304 of the Security Standards (45 C.F.R. 164.304) and means the attempted or successful unauthorized access, use, disclosure, modification, or destruction of information or interference with systems operation in an information system.

Plan Sponsor Obligations

To enable the Plan Sponsor to receive and use Electronic PHI for Plan Administration Functions (as defined in 45 CFR §164.504(a)), the Plan Sponsor agrees to:

1. Implement administrative, physical, and technical safeguards that reasonably and appropriately protect the confidentiality, integrity and availability of the Electronic PHI that it creates, receives, maintains, or transmits on behalf of the Plan;
2. Ensure that adequate separation between the Plan and the Plan Sponsor, as required in 45 CFR § 164.504(f)(2)(iii), is supported by reasonable and appropriate Security Measures;
3. Ensure that any agent, including a subcontractor, to whom the Plan Sponsor provides Electronic PHI created, received, maintained, or transmitted on behalf of the Plan, agrees to implement reasonable and appropriate administrative, physical, and technical safeguards to protect the confidentiality, integrity, and availability of the Electronic PHI and report to the Plan any security incident of which it becomes aware; and
4. Report to the Plan any security incident of which it becomes aware.

Notification Requirements in the Event of a Breach of Unsecured PHI

The required breach notifications are triggered upon the discovery of a breach of unsecured PHI. A breach is discovered as of the first day the breach is known, or reasonably should have been known.

When a breach of unsecured PHI is discovered, the Plan will:

1. Notify the Participant whose PHI has been, or is reasonably believed to have been, assessed, acquired, used, or disclosed as a result of the breach, in writing, without unreasonable delay and in no case later than sixty (60) calendar days after discovery of the breach. Breach Notification must be provided to individual by:

    a. Written notice by first-class mail to Participant (or next of kin) at last known address or, if specified by Participant, e-mail;
    b. If Plan has insufficient or out-of-date contact information for the Participant, the Participant must be notified by a "substitute form;
    c. If an urgent notice is required, Plan may contact the Participant by telephone.

        i. The breach notification will have the following content:

1. Brief description of what happened, including date of breach and date discovered;
2. Types of unsecured PHI involved (e.g., name, Social Security number, date of birth, home address, account number);
3. Steps Participant should take to protect from potential harm;
4. What the Plan is doing to investigate the breach, mitigate losses and protect against further breaches;

2. Notify the media if the breach affected more than 500 residents of a State or jurisdiction. Notice must be provided to prominent media outlets serving the State or jurisdiction without unreasonable delay and in no case later than 60 calendar days after the date the breach was discovered;

3. Notify the HHS Secretary if the breach involves 500 or more individuals, contemporaneously with the notice to the affected individual and in the manner specified by HHS. If the breach involves less than 500 individuals, an internal log or other documentation of such breaches must be maintained and annually submitted to HHS within 60 days after the end of each Calendar Year; and

4. When a Business Associate, which provides services for the Plan and comes in contact with PHI in connection with those services discovers a breach has occurred, that Business Associate will notify the Plan without unreasonable delay and in no case later than 60 calendar days after discovery of a breach so that the affected Participants may be notified. To the extent possible, the Business Associate should identify each individual whose unsecured PHI has been, or is reasonably believed to have been, breached.

PARTICIPANT'S RIGHTS

As a Participant in the Plan, you are entitled to certain rights and protections under ERISA. ERISA provides that all Participants are entitled to:

Receive Information About Your Plan and Benefits
Examine, without charge, at the Plan Administrator's office and at other specified locations, such as worksites and union halls (if any), all documents governing the Plan, including insurance contracts, collective bargaining agreements (if any), and copies 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.

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

Receive a summary of the Plan's annual financial report. The Plan Administrator is required by law to furnish each Participant with a copy of this summary annual report.

Continue Group Health Plan Coverage
Continue health care coverage for yourself, spouse or Dependents if there is a loss of coverage under the Plan as a result of a Qualifying Event. You or your Dependents may have to pay for such coverage. Review this Plan Document and the documents governing the Plan on the rules governing your COBRA Continuation Coverage rights.

Prudent Actions by Plan Fiduciaries
In addition to creating rights for Participants, ERISA imposes duties upon the people who are responsible for the operation of the Plan. The people who operate your Plan, called "fiduciaries" of the Plan, have a duty to do so prudently and in the interest of you and other Participants and beneficiaries. No one, including your Employer, your union (if any), or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a welfare benefit or exercising your rights under ERISA.

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

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

Assistance with Your Questions
If you have any questions about the Plan, you should contact the Plan Administrator. If you have any questions about this statement or about your rights under ERISA, or if you need assistance in obtaining

documents from the Plan Administrator, you should contact the nearest Office of the Employee Benefits Security Administration, U.S. Department of Labor, listed in your telephone directory or the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue, N.W., Washington, D.C., 20210. You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefits Security Administration.

Appendix A-Prior Authorization List

Observation for greater than 23 hours

All Inpatients

- Behavioral Health
- Chemical Dependency
- Skilled Nursing
- Long-term Acute Care
- Rehabilitation admissions
- Hospice
- Emergency admissions (require plan notification within 24 hours)
- Maternity admission require prior authorization under the following circumstances: Newborn stays beyond mother's discharge
- Mother stays beyond 48 hours for vaginal delivery or 72 hours for C-section

Hospice

Home Health Care including

- Private duty nursing
- Physical Therapy
- Occupational Therapy
- Speech Therapy

Durable Medical Equipment (DME) over $1,000 single line item purchase price or cumulative rental of a single item (does not include oxygen and oxygen equipment).

In addition, the following items require prior authorization regardless of cost:

- PAP units (**not supplies**) E0601, E0471
- Home ventilators (invasive and non-invasive)
- Oscillatory devices for airway clearance including high frequency chest compressions and intrapulmonary percussive ventilation
- Nutritional support (enteral and parenteral feeding)
- TENS units (**not supplies**)
- Bone growth stimulators
- Neuromuscular stimulators
- Functional Electrical Stimulation (FES)
- Threshold Electrical Stimulation (TES) for the treatment of Meniere's disease
- Hospital beds, including, but not limited to: rocking beds, cribs, mattresses
- Wheelchairs and accessories
- Insulin pumps (**not supplies**), external continuous insulin infusion pump
- Continuous glucose monitors
- Wearable Cardiac Defibrillator
- Standing frames
- Pneumatic pressure devices
- Cooling devices and combined cooling/heating devices
- Augmentative and Alternative Communication (AAC) Devices, Speech Generating Devices

- All custom made items
- Orthotics over $1,000, all foot orthotics, diabetic shoes and any custom orthotic
- Prosthetics including but not limited to Cochlear implants and auditory brainstem implants
- Non-emergent ambulance transfers
- Air and water ambulances
- Phototherapy
- Clinical Trials
- Accidental dental services
- All xxxxT codes (Category III Codes
- All "99" codes (NO
- Clinical Trials Genetic testing
- Genetic testing
- Bone and cartilage grafts excluding
  middle ear and nasal surgery

Behavioral Health /Substance Abuse (MHSA)
Professionals are available 24 hours a day, 7 days a week
Specially trained professional will handle referrals and coordinate care for mental health and substance abuse

All facility based care

- Inpatient admissions
- Intensive outpatient therapy
- Partial hospitalization
- Residential care

ABA (Applied Behavioral Analysis)
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
Neuropsychological testing
Psychoanalysis
Narcosynthesis
Psychological testing by a computer with interpretation
mental health services by a non-physician
Behavioral health day treatment
Therapeutic behavioral services

Medical Benefit Specialty Drug precert list under separate attachment

CPT code	Code description
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
11950	Subcutaneous injection of filling material (eg, collagen); 1 cc or less
11951	Subcutaneous injection of filling material (eg, collagen); 1.1 to 5.0 cc
11952	Subcutaneous injection of filling material (eg, collagen); 5.1 to 10.0 cc
11954	Subcutaneous injection of filling material (eg, collagen); over 10.0 cc
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	Insertion, non-biodegradable drug delivery implant;
11982	Removal, non-biodegradable drug delivery implant
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 (eg, for acne scarring, fine wrinkling, rhytids, general keratosis)
15781	Dermabrasion; segmental, face
15782	Dermabrasion; regional, other than face
15783	Dermabrasion; superficial, any site (eg, tattoo removal)
15786	Abrasion; single lesion (eg, 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

15819	Cervicoplasty
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
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	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
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 transferl1
15847	Excision, excessive skin and subcutaneous tissue (includes lipectomy), abdomen (eg, abdominoplasty) (includes umbilical transposition and fascial plication)
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
19105	Ablation, cryosurgical, of fibroadenoma, including ultrasound guidance, each fibroadenoma
19300	Mastectomy for gynecomastia

19316	Mastopexy
19318	Reduction mammaplasty
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	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
19355	Correction of inverted nipples
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
20930	Allograft, morselized, or placement of osteopromotive material, for spine surgery only
20974	Electrical stimulation to aid bone healing; noninvasive
20975	Electrical stimulation to aid bone healing; invasive (operative)
20979	Low intensity ultrasound stimulation to aid bone healing, noninvasive (nonoperative)

20982	Ablation therapy for reduction or eradication of 1 or more bone tumors (eg, metastasis) including adjacent soft tissue when involved by tumor extension, percutaneous, including imaging guidance when performed; radiofrequency
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
20985	Insertion or replacement of spinal neurostimulator pulse generator or receiver, direct or inductive coupling;
20999	Unlisted procedure, musculoskeletal system, general
21010	Arthrotomy, temporomandibular joint
21050	Condylectomy, temporomandibular joint (separate procedure);
21060	Meniscectomy, partial or complete, temporomandibular joint
21070	Coronoidectomy (separate procedure)
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, includesl removal (separate procedure)l1
21110	Application of interdental fixation device for conditions other thanl fracture or dislocation, includes removall1
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)
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	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)
21209	Osteoplasty, facial bones; reduction
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)
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	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	Reconstruction of orbit with osteotomies (extracranial) and with bone grafts
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	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	Reconstructive repair of pectus excavatum or carinatum; open;
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 vertebralsegment; 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	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);
22216	Osteotomy of spine, posterior or posterolateral approach, 1 vertebral segment; each additional vertebral segment
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
22505	Manipulation of spine requiring anesthesia, any region
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
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	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)
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

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	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	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
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
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

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
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
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
22870	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)
22999	Unlisted procedure, abdomen, musculoskeletal system
23473	Revision of total shoulder arthroplasty, including allograft when performed; humeral or glenoid component
23474	Revision of total shoulder arthroplasty, including allograft when performed; humeral and glenoid component
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
26340	Manipulation, finger joint, under anesthesia, each joint
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	Osteotomy, intertrochanteric or subtrochanteric including internal or external fixation and/or cast
27170	Bone graft, femoral head, neck, intertrochanteric or subtrochanteric area
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
27412	Autologous chondrocyte implantation, knee
27415	Osteochondral allograft, knee, open
27416	Osteochondral autograft(s), knee, open (e.g., mosaicplasty)
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
27702	Arthroplasty, ankle; with implant (total ankle)
27703	Arthroplasty, ankle; revision, total ankle
28890	Extracorporeal shock wave, high energy, performed by a physician or other qualified health care professional, requiring anesthesia other than local, including ultrasound guidance, involving the plantar fascia
28899	Unlisted procedure, foot or toes
29866	Arthroscopy, knee, surgical; osteochondral autograft(s)
29867	Arthroscopy, knee, surgical; osteochondral allograft
29999	Unlisted procedure, arthroscopy
30110	Excision, nasal polyp(s), simple

30115	Excision, nasal polyp(s), extensive
30120	Excision or surgical planing of skin of nose for rhinophyma
30160	Rhinectomy; total
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	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 (e.g., spreader grafting, lateral nasal wall reconstruction)
30520	Septoplasty or submucous resection, with or without cartilage scoring, contouring or replacement with graft
30560	Lysis intranasal synechia
30620	Septoplasty or submucous resection, with or without cartilage scoring, contouring or replacement with graft
30630	Repair nasal septal perforations
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 (i.e., submucosal)
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
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

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
32664	Thoracoscopy with thoracic sympathectomy
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
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
33282	Implantation of patient-activated cardiac event recorder
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)
33548	Surgical ventricular restoration procedure, includes prosthetic patch, when performed (e.g., ventricular remodeling, SVR, SAVER, Dor procedures)
33782	Insertion of ventricular assist device, percutaneous including radiological supervision and interpretation; both arterial and venous access, with transseptal puncture
33783	Aortic root translocation with ventricular septal defect and pulmonary stenosis repair (i.e., Nikaidoh procedure); with reimplantation of 1 or both coronary ostia
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
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
33999	Unlisted procedure, cardiac surgery

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
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
36516	Therapeutic apheresis; with extracorporeal selective absorption or selective filtration and plasma reinfusion
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
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)
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
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
38243	Hematopoietic progenitor cell (HPC); HPC Boost
40840	Vestibuloplasty; anterior
40842	Vestibuloplasty; posterior, unilateral
40843	Vestibuloplasty; posterior, bilateral
40844	Vestibuloplasty; entire arch
40845	Vestibuloplasty; complex (including ridge extension, muscle repositioning)
41512	Tongue suspension
41530	Tongue base volume reduction
41800	Drainage of abscess, cyst, hematoma from dentoalveolar structures
41805	Removal of embedded foreign body from dentoalveolar structures; soft tissues;
41806	Removal of embedded foreign body from dentoalveolar structures; bone;
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),
41826	dentoalveolar structures; without repair
41827	Excision of lesion or tumor (except listed above),
41828	dentoalveolar structures; with complex repair;
41830	Alveolectomy, including curettage of osteitis or sequestrectomy

41850	Destruction of lesion (except excision), dentoalveolar structures
41870	Periodontal mucosal grafting
41872	Gingivoplasty, each quadrant
41874	Alveoloplasty, each quadrant
41899	Unlisted procedure, dentoalveolar structures
42140	Uvulectomy, excision of uvula
42145	Palatopharyngoplasty
43206	Esophagoscopy with optical endomicroscopy
43252	Upper GI endoscopy with optical endomicroscopy
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
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
43647	Laparoscopy, surgical; implantation or replacement of gastric neurostimulator electrodes, antrum
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 (i.e., 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
44705	Preparation of fecal microbiota for instillation, including assessment of donor specimen
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
49411	Placement of interstitial device(s) for radiation therapy guidance (e.g., fiducial markers, dosimeter), percutaneous, intra-abdominal, intra-pelvic (except prostate), and/or retroperitoneum, single or multiple
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
51715	Endoscopic injection of implant material into the submucosal tissues of the urethra and/or bladder neck
52287	Cystourethroscopy, with injection(s) for chemodenervation of the bladder
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
53860	Transurethral radiofrequency micro-remodeling of the female bladder neck and proximal urethra for stress urinary incontinence
54125	Amputation of penis; complete
54360	Plastic operation on penis to correct angulation
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

54440	Plastic operation of penis for injury
54520	Orchiectomy, simple (including subcapsular), with or without testicular prosthesis, scrotal or inguinal approach
54660	Insertion of testicular prosthesis (separate procedure)
54690	Laparoscopy, surgical; orchiectomy
55180	Scrotoplasty; complicated
55400	Vasovasostomy, vasovasorrhaphy
55873	Cryosurgical ablation of the prostate (includes ultrasonic guidance and monitoring)
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
56810	Perineoplasty, repair of perineum, nonobstetrical
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
59897	Unlisted fetal invasive procedure, including ultrasound guidance, when performed
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
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
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
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	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
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	Laminectomy with myelotomy (e.g., Bischof or DREZ type), cervical, thoracic, or 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
63270	Laminectomy for excision of intraspinal lesion other than neoplasm, intradural; cervical
63271	Laminectomy for excision of intraspinal lesion other than neoplasm, intradural; thoracic
63272	Laminectomy for excision of intraspinal lesion other than neoplasm, intradural; lumbar
63273	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
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
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
64553	Percutaneous implantation of neurostimulator electrode array; cranial nerve
64555	Percutaneous implantation of neurostimulator electrode array; peripheral nerve (excludes sacral nerve)
64561	Percutaneous implantation of neurostimulator electrode array; sacral nerve (transforaminal placement) including image guidance, if performed
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
64575	Incision for implantation of neurostimulator electrode array; peripheral nerve (excludes sacral nerve)
64580	Incision for implantation of neurostimulator electrode array; neuromuscular
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	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), excluding muscles of the larynx, unilateral (e.g., for cervical dystonia, spasmodic torticollis)
64615	Chemodenervation of muscle(s); muscle(s) innervated by facial, trigeminal, cervical spinal and accessory nerves, bilateral (e.g., for chronic migraine)
64632	Destruction by neurolytic agent; plantar common digital nerve
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
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
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
64804	Sympathectomy, cervicothoracic
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
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
65760	Keratomileusis

65771	Radial keratotomy
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
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
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)
67299	Suprachoroidal delivery of pharmacologic agent (does not include supply of medication)
67345	Chemodenervation of extraocular muscle
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
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);
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)
68404	Sympathectomy, cervicothoracic
69090	Ear piercing
69300	Otoplasty, protruding ear, with or without size reduction
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
69930	Cochlear device implantation, with or without mastoidectomy
69949	Unlisted procedure, inner ear
69955	Total facial nerve decompression and/or repair
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
74261	Computed tomographic (CT) colonography, diagnostic, including image post processing; without contrast material
74262	Computed tomographic (CT) colonography, diagnostic, including image post processing; with contrast material(s) including non-contrast images, if performed
74263	Computed tomographic (CT) colonography, screening, including image post processing
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 post processing, 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 post processing, 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 post processing (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	Ultrasound bone density measurement and interpretation, peripheral site(s), any method
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
77078	Computed tomography, bone mineral density study, 1 or more sites; axial skeleton (e.g., hips, pelvis, spine)
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
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
77520	Proton treatment delivery; simple, without compensation
77522	Proton treatment delivery; simple, with compensation
77523	Proton treatment delivery; intermediate
77525	Proton treatment delivery; complex
78350	Bone density (bone mineral content) study, 1 or more sites; single photon absorptiometry
78459	Myocardial imaging, positron emission tomography (PET), metabolic evaluation
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	Brain imaging, positron emission tomography (PET); metabolic evaluation
78609	Brain imaging, positron emission tomography (PET); perfusion evaluation
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
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
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
88749	Unlisted in vivo (e.g., transcutaneous) laboratory service
89398	Unlisted reproductive medicine laboratory procedure
90378	Respiratory syncytial virus, monoclonal antibody, recombinant, for intramuscular use, 50 mg, each
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	Biofeedback training by any modality
90911	Biofeedback training, perineal muscles, anorectal or urethral sphincter, including EMG and/or manometry
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	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
93580	Percutaneous transcatheter closure of congenital interatrial communication (i.e., Fontan fenestration, atrial septal defect) with implant
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 (i.e., psychologist), with review of test results and report
96116	Neurobehavioral status exam (clinical assessment of thinking, reasoning and judgment, e.g., acquired knowledge, attention, language, memory, planning and problem solving, and visual spatial abilities), per hour of the psychologist's or physician's time, both face-to-face time with the patient and time interpreting test results and preparing the report
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	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)
97033	Iontophoresis
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	Work hardening/conditioning; initial 2 hours
97546	Work hardening/conditioning; each additional hour (List separately in addition to code for primary procedure)
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
97911	Correction of lid retraction

99183	Physician or other qualified health care professional attendance and supervision of hyperbaric oxygen therapy, per session
0054T	Computer-assisted musculoskeletal surgical navigational orthopedic procedure, with image-guidance based on fluoroscopic images
0055T	Computer-assisted musculoskeletal surgical navigational orthopedic procedure, with image-guidance based on CT/MRI images
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
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
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
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
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
0331T	Myocardial sympathetic innervation imaging, planar qualitative and quantitative assessment
0332T	Myocardial sympathetic innervation imaging, planar qualitative and quantitative assessment; with tomographic SPECT

0335T	Extra-osseous subtalar joint implant for talotarsal stabilization
0340T	Ablation, pulmonary tumor(s), including pleura or chest wall when involved by tumor extension, percutaneous, cryoablation, unilateral, includes imaging guidance
A4638	Replacement battery for patient-owned ear pulse generator, each
C1821	Artificial Intervertebral Discs
E2120	Pulse generator system for tympanic treatment of inner ear endolymphatic fluid
E2500	Speech generating device, digitized speech, using pre-recorded messages, less than or equal to 8 minutes recording time
E2502	Speech generating device, digitized speech, using pre-recorded messages, greater than 8 minutes but less than or equal to 20 minutes recording time
E2504	Speech generating device, digitized speech, using pre-recorded messages, greater than 20 minutes but less than or equal to 40 minutes recording time
E2506	Speech generating device, digitized speech, using pre-recorded messages, greater than 40 minutes recording time
E2508	Speech generating device, synthesized speech, requiring message formulation by spelling and access by physical contact with the device
E2510	Speech generating device, synthesized speech, permitting multiple methods of message formulation and multiple methods of device access
E2511	Speech generating software program, for personal computer or personal digital assistant
E2512	Accessory for speech generating device, mounting system
E2599	Accessory for speech generating device, not otherwise classified
G0151	Services performed by a qualified physical therapist in the home health or hospice setting, each 15 minutes
G0152	Services performed by a qualified occupational therapist in the home health or hospice setting, each 15 minutes
G0153	Services performed by a qualified speech-language pathologist in the home health or hospice setting, each 15 minutes
G0166	External counterpulsation, per treatment session; (35 treatments over 9 weeks)
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)
G0297	Low dose ct scan (ldct) for lung cancer screening
G0299	Direct skilled nursing services of a registered nurse (rn) in the home health or hospice setting, each 15 minutes
G0300	Direct skilled nursing services of a license practical nurse (lpn) in the home health or hospice setting, each 15 minutes

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
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
J0585	Injection, onabotulinumtoxina Botox
J0586	Injection, abobotulinumtoxina, 5 units
J0587	Injection, rimabotulinumtoxinb, 100 units
J0588	Injection, incobotulinumtoxin a, 1 unit
J1745	Injection, infliximab, excludes biosimilar, 10 mg
J3396	Injection, verteporfin, 0.1 mg
L8614	Cochlear device, includes all internal and external components
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
L8699	Prosthetic implant, not otherwise specified
S2083	Adjustment of gastric band diameter via subcutaneous port by injection or aspiration of saline
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)
T1000	Private duty / independent nursing service(s) - licensed, up to 15 minutes
V2788	Presbyopia correcting function of intraocular lens

PRODUCT NAME	Generic Name	Drug Category	Drug Class or Indication	Route	HCPCS Code	NCH	Notes	PA Required or Excluded	Clinical Guideline or Policy
Abelcet	amphotericin B	Anti-Infectives	Anti-Fungal	IV	J0287			N	
ABILIFY	aripiprazole	Psychiatric	Anti-Psychotic	IM	J0400			N	
ABILIFY MAINTENA	aripiprazole	Psychiatric	Anti-Psychotic	IM	J0401			N	
ABRAXANE	paclitaxel protein-bound particles	Anti-Cancer	Oncologic	IV	J9264	Y		Y	CG-D-50
ACTEMRA	tocilizumab	Rheumatology	Rheumatoid Arthritis	IV	J3262			Y	DRUG-43
ACTHAR HP	corticotropin	Endocrine	Steroid	IM	J0800			Y	CG-D-24
Acthib	haemophilus b conjugate	Anti-Infectives	Vaccine	IM	90648			N	
acyclovir	acyclovir	Anti-Infectives	Anti-Infective	IV	J0133			N	
Adacel	tet tox/diph/acell pertussis	Anti-Infectives	Vaccine	IM	90715			N	
ADAGEN	pegademase bovine	Endocrine	Metabolic Enzyme (adenosine deaminase def.)	IM	J2504			Y	
ADASUVE	loxapine	Psychiatric	Anti-Psychotic	Inhaled	C9497		Non-Formulary	Exclude	
ADCETRIS	brentuximab	Anti-Cancer	Oncologic	IV	J9042	Y		Y	DRUG-47
ADRENALIN	epinephrine	Cardiovascular	Hypersensitivity	IM, IV, SQ	J0171			N	
ADRIAMYCIN	doxorubicin	Anti-Cancer	Oncologic	IV	J9000	Y		N	
ADRUCIL	fluorouracil	Anti-Cancer	Oncologic	IV	J9190	Y		N	
ADVATE	antihemophilic factor	Blood Modifiers	Hemophilia	IV	J7192			Y	DRUG-66
ADYNOVATE	factor VIII recombinant pegylated	Blood Modifiers	Hemophilia	IV	J7207			Y	DRUG-66
Afluria	influenza virus	Anti-Infectives	Vaccine	IM	Q2035			N	
AFSTYLA KIT	antihemophilic fac recmb single chain	Blood Modifiers	Hemophilia	IV	C9140			Y	DRUG-66
Agriflu	influenza virus types A & B PF	Anti-Infectives	Vaccine	IM	Q2034			N	
ALBUKED	albumin (human)	Blood Modifiers	Plasma Volume Expander	IV	P9045			N	
ALBUKED	albumin (human)	Blood Modifiers	Plasma Volume Expander	IV	P9046			N	
ALBUKED	albumin (human)	Blood Modifiers	Plasma Volume Expander	IV	P9047			N	
ALDURAZYME	laronidase	Endocrine	Metabolic Enzyme (MPS I)	IV	J1931			Y	CG-D-58
ALFERON N	interferon alfa-n3	Anti-Cancer	Anti-Infective	Intra-lesional	J9215	Y		N	
ALIMTA	pemetrexed disodium	Anti-Cancer	Oncologic	IV	J9305	Y		Y	CG-D-38
ALKERAN	melphalan	Anti-Cancer	Oncologic	IV	J9245	Y		N	
ALOPRIM	allopurinol	Pain Management	Gout	IV				N	
ALOXI IV	palonosetron	Gastrointestinal	Anti-Emetic	IV	J2469			Y	CG-D-33
ALPHANATE	antihemophilic factor/von Willebrand	Blood Modifiers	Hemophilia	IV	J7186			Y	DRUG-66
ALPHANINE SD	antihemophilic factor/von Willebrand	Blood Modifiers	Hemophilia	IV	J7193			Y	DRUG-66
ALPROLIX	coagulation factor IX (recomb)	Blood Modifiers	Hematological Agents	IV	J7201			Y	DRUG-66
Ambisome	amphotericin B liposome	Anti-Infectives	Anti-Fungal	IV	J0289			N	
Ameluz	aminolevulinic acid HCl	Topical	Dermatologicals	Topical				N	
amikacin	amikacin	Antibiotics	Anti-Infective	IV	J0278			N	
aminophylline	aminophylline	Respiratory	Anti-Asthmatic and Bronchodilator Agents	IV	J0280			N	
AMPHOCIN	amphotericin B	Anti-Infectives	Anti-Infective	IV	J0285			N	
Amphotec	amphotericin B cholesteryl sulfate complex	Anti-Infectives	Anti-Fungal	IV	J0288			N	
ampicillin	ampicillin	Antibiotics	Anti-Infective	IV	J0290			N	
ANCEF	cefazolin	Antibiotics	Anti-Infective	IV	J0690			N	
Angiomax	bivalirudin	Blood Modifiers	Anti-Coagulants	IV	J0583			N	
Antiemetic drug, oral, not otherwise specified	Unspecified				J8597			N	
Antiemetic drug, rectal/suppository, not otherwise specified	Unspecified				J8498			N	
Antivenin Kit	antivenin latrodectus mactans	Anti-Infectives	Anti-Venin	IM, IV				N	
Antivenin MI Kit	antivenin micrurus fulvius	Anti-Infectives	Anti-Venin	IV				N	
ANZEMET	dolasetron	Gastrointestinal	Anti-Emetic	IV	J1260	Y		N	
ARALAST-NP	alpha-1 proteinase inhibitor	Respiratory	Alpha-1 Antitrypsin Deficiency	IV	J0256			Y	DRUG-72
ARANESP	darbepoetin alfa	Blood Modifiers	Colony Stimulating Factor	IV, SQ	J0881		Non-ESRD	Y	CG-D-05
ARANESP (ESRD, 1 MCG)	darbepoetin alfa	Blood Modifiers	Colony Stimulating Factor	IV, SQ	J0882		ESRD	Y	CG-D-05
ARCALYST	rilonacept	Pain Management	CAPS	SQ	J2793			Y	DRUG-73
AREDIA	pamidronate	Endocrine	Oncologic	IV	J2430	Y		N	
argatroban	argatroban	Blood Modifiers	Anti-Coagulants	IV	C9121			N	CG-D-04
ARISTADA	aripiprazole lauroxil	Psychiatric	Anti-Psychotic	IM	C9399 or J3490			N	
Aristospan	triamcinolone hexacetonide	Endocrine	Corticosteroid	Intra-articular/ Intralesional	J3303			N	
ARRANON	nelarabine	Anti-Cancer	Oncologic	IV	J9261	Y		Y	
ARZERRA	ofatumumab	Anti-Cancer	Oncologic	IV	J9302	Y		Y	DRUG-63
ATIVAN	lorazepam	Psychiatric	Anxiety	IM, IV	J2060			N	
ATROPINE	atropine sulfate		Anti-Cholinergic	IM, IV, SQ	J0461			N	
AVASTIN	bevacizumab	Topical	Ophthalmic Agents	IV	C9257		Per 0.25mg	Y	DRUG-28
AVASTIN	bevacizumab	Anti-Cancer	Oncologic	IV	J9035	Y	Per 10mg	Y	DRUG-28 DRUG-38
AVEED	testosterone undecanoate	Endocrine	Androgens	IM	J3145			Y	CG-D-59

PRODUCT NAME	Generic Name	Drug Category	Drug Class or Indication	Route	HCPCS Code	NCH	Notes	PA Required or Excluded	Clinical Guideline or Policy
Avelox	moxifloxacin	Antibiotics	Anti-Infective	IV	J2280			N	
AVYCAZ	ceftazidime/avibactam sodium	Antibiotics	Anti-Infective	IV	J0714			Y	
Azactam	aztreonam	Anti-Infectives	Anti-Infective	IM, IV	S0073			N	
Azactam/Dex	aztreonam/dextrose	Anti-Infectives	Anti-Infective	IV				N	
bacitracin	bacitracin	Anti-Infectives	Anti-Infective	IM				N	
BEBULIN VH	coagulation factor IX complex	Blood Modifiers	Hemophilia	IV	J7194			Y	DRUG-66
BELEODAQ	belinostat	Anti-Cancer	Oncologic	IV	J9032	Y		Y	
BENADRYL	diphenhydramine	Respiratory	Anti-Histamine	IM, IV	J1200			N	
BENDEKA	bendamustine HCl	Anti-Cancer	Oncologic	IV	J9034	Y		Y	DRUG-79
BENEFIX	coagulation factor IX	Blood Modifiers	Hemophilia	IV	J7195			Y	DRUG-66
BENLYSTA	belimumab	Rheumatology	Lupus	IV	J0490			Y	DRUG-44
Bentyl	dicyclomine	Gastrointestinal	Ulcer Drugs	IM	J0500			N	
benztropine	benztropine	Neurologic	Anti-Parkinson Agents	IM/IV	J0515			N	
BERINERT	C-1 Inhibitor	Blood Modifiers	Hereditary Angioedema	IV	J0597			Y	DRUG-58
Bexsero	meningococcal vaccine B (recomb adsorbed)	Anti-Infectives	Vaccine	IM	90620		NTMLO	N	
BEXXAR	tositumomab	Anti-Cancer	Oncologic	IV	A9545, J9999	Y		Y	
Bicillin C-R	penicillin G benzathine & procaine	Antibiotics	Anti-Infective		J0558			N	
Bicillin L-A	penicillin G benzathine	Antibiotics	Anti-Infective		J0561			N	
BICNU	carmustine	Anti-Cancer	Oncologic	IV	J9050	Y		Y	
Biothrax	anthrax	Anti-Infectives	Vaccine	IM	90581			N	
BIVIGAM	immune globulin	Immunology	Immune Globulin	IV	J1556			Y	CG-D-09
BLENOXANE	bleomycin	Anti-Cancer	Oncologic	IV	J9040	Y		N	
BLINCYTO	blinatumomab	Anti-Cancer	Oncologic	IV	J9039	Y		Y	DRUG-76
BONIVA IV	ibandronate	Endocrine	Osteoporosis	IV	J1740			Y	
Boostrix	tet tox/diph/acell pertussis AD	Anti-Infectives	Vaccine	IM	90715			N	
BOTOX	onabotulinumtoxinA	Neurologic	Botulinum Toxin Derivative	IM	J0585			Y	DRUG-6
BRAVELLE	urofollitropin	Endocrine	Infertility	IM, SQ	J3355			Exclude	CG-D-11
Briviact	brivaracetam	Neurologic	Anti-Convulsants	IV				N	
Buprenex	buprenorphine	Pain Management	Analgesics-Opioid	IM/IV	J0592			N	
BUSULFEX	busulfan	Anti-Cancer	Oncologic	IV	J0594	Y		Y	
Calcijex	calcitriol	Endocrine	Endocrine	IV	J0636		IM up to 0.1mcg	N	
Calcijex	calcitriol	Endocrine	Endocrine	IV	S0169		Inj up to 0.25mcg	N	
CALCIUM GLUCONATE	calcium gluconate	Nutritional	Vitamins/Minerals	IV	J0610			N	
Caldolor	ibuprofen	Pain Management	Analgesics-Anti-Inflammatory	IV	J1741			N	
CAMPATH	alemtuzumab	Anti-Cancer	Oncologic	IV	J9010	Y	10mg	Y	
CAMPTOSAR	irinotecan	Anti-Cancer	Oncologic	IV	J9206	Y		N	
CANCIDAS	caspofungin	Anti-Infectives	Anti-Fungal	IV	J0637			Y	
Capastat	capreomycin	Antibiotics	Tuberculosis	IM, IV				N	
CARIMUNE NF	immune globulin	Immunology	Immune Globulin	IV	J1566			Y	CG-D-09
Carnitor	levocarnitine	Endocrine	Endocrine	IV	J1955			N	
CARTICEL	autologous enzymes cultured chondrocytes	Neurologic	Musculoskeletal Therapy	IX	J7330		Implant. UM will process requests	Y	
CATHFLO ACTIVASE	alteplase	Blood Modifiers	Thrombosis	IV	J2997			N	
CAVERJECT	Alprostadil	Genitourinary	Erectile Dysfunction	Intra-cavernous	J0270			Exclude	
Cefotan	cefotetan	Antibiotics	Anti-Infective	IV	S0074			N	
Cefoxitin	cefoxitin	Antibiotics	Anti-Infective	IV	J0694			N	
Celestone	betamethasone acetate & sodium phosphate	Endocrine	Corticosteroid	IM	J0702			N	
CEREZYME	imiglucerase	Blood Modifiers	Metabolic Enzyme (Gaucher Dz)	IV	J1786			Y	CG-D-08
CERUBIDINE	daunorubicin HCl	Anti-Cancer	Oncologic	IV	J9150	Y		N	
CERVARIX	human papillomavirus bival (type 16 &18)	Anti-Infectives	Vaccine	IM	90650			Y (if age > 26)	ADMIN.00007
CETROTIDE	cetrorelix	Endocrine	Infertility	SQ				Exclude	CG-D-11
chloramphenicol	chloramphenicol	Anti-Infectives	Anti-Infective	IV	J0720			N	
CHLORPROMAZINE	chlorpromazine	Psychiatric	Anti-Psychotic	IM, IV	J3230			N	
CHORIONIC GONADOTROPIN	chorionic gonadotropin	Endocrine	Infertility	IM	J0725			Exclude	CG-D-11
CIMZIA LYOPHILIZED POWDER	certolizumab	Gastrointestinal	TNF Inhibitor	SQ	J0717			Y	DRUG-2
CINQAIR	reslizumab	Respiratory	Anti-Asthmatic-Monoclonal Antibodies	IV	C9481, J2786			Y	DRUG-80
CINRYZE	C-1 Inhibitor	Blood Modifiers	Hereditary Angioedema	IV	J0598			Y	DRUG-58
Cipro	ciprofloxacin	Antibiotics	Anti-Infective	IV	J0744			N	
Claforan	cefotaxime	Antibiotics	Anti-Infective	IV	J0698			N	
Cleocin	clindamycin	Anti-Infectives	Anti-Infective	IV	S0077			N	
Clin Single Use Kit	clindamycin phosphate	Anti-Infectives	Anti-Infective	IM,IV				N	
Clinimix E (>100g of mix)	amino acid electrolyte with calcium infusion	Nutritional	TPN	IV	B4199			N	
Clinimix E (10-51g of mix)	amino acid electrolyte with calcium infusion	Nutritional	TPN	IV	B4189			N	
Clinimix E (52-73g of mix)	amino acid electrolyte with calcium infusion	Nutritional	TPN	IV	B4193			N	
Clinimix E (74-100g of mix)	amino acid electrolyte with calcium infusion	Nutritional	TPN	IV	B4197			N	
CLOLAR	clofarabine	Anti-Cancer	Oncologic	IV	J9027	Y		Y	

PRODUCT NAME	Generic Name	Drug Category	Drug Class or Indication	Route	HCPCS Code	NCH	Notes	PA Required or Excluded	Clinical Guideline or Policy
clonidine	clonidine	Pain Management	Analgesics	IV	J0735			N	
COAGADEX	coagulation factor X (human)	Blood Modifiers	Hematological Agents	IV	J7175			Y	DRUG-66
codeine	codeine phosphate	Pain Management	Analgesics-Opioid	SQ/IM	J0745			N	
COLISTIN	colistimethate	Anti-Infectives	Anti-Infective	IM, IV	J0770			N	
COMPAZINE	prochlorperazine edisylate	Psychiatric	Anti-Emetic	IM, IV	J0780			N	
Comvax	haemophilus b polysac/hepatitis b (recomb)	Anti-Infectives	Vaccine	IM	90748			N	
CORIFACT	factor XIII concentrate (human)	Blood Modifiers	Hemophilia	IV	J7180			Y	DRUG-66
COSMEGEN	dactinomycin	Anti-Cancer	Oncologic	IV	J9120	Y		Y	
CRESEMBA	isavuconazonium sulfate	Anti-Infectives	Anti-Fungal	IV	J1833			Y	
Crysticillin	penicillin G procaine	Antibiotics	Anti-Infective		J2510			N	
CUBICIN	daptomycin	Antibiotics	Anti-Infective	IV	J0878			Y	
CUVITRU	immune globulin (human)	Immunology	Immune Serums	SQ				Y	CG-D-09
cyanocobalamin	cyanocobalamin	Blood Modifiers	Hematopoietic Agents	IM	J3420			N	
CYRAMZA	ramucirumab	Anti-Cancer	Oncologic	IV	J9308	Y		Y	DRUG-67
Cytogam	CMV immune globulin	Immunology	Immune Globulin	IV	J0850			N	
CYTOSAR-U	cytarabine	Anti-Cancer	Oncologic	IV	J9100	Y		N	
CYTOVENE	ganciclovir	Anti-Infectives	Anti-Infective	IV	J1570	Y		N	
CYTOXAN	cyclophosphamide	Anti-Cancer	Oncologic	IV	J9070	Y		N	
DACOGEN	decitabine	Anti-Cancer	Oncologic MDS	IV	J0894	Y		N	
DALVANCE	dalbavancin HCl	Antibiotics	Anti-Infective	IV	J0875			Y	
Daptacel	diph, acellular pert & tet tox	Anti-Infectives	Vaccine	IM	90700			N	
DARZALEX	daratumumab	Anti-Cancer	Oncologic	IV	J9145	Y		Y	DRUG-82
DAUNOXOME	daunorubicin liposomal	Anti-Cancer	Oncologic	IV	J9151	Y		Y	
Decavac	tetanus/diphtheria toxoids (TD)	Anti-Infectives	Vaccine	IM	90714			N	
Defitelio	defibrotide sodium	Blood Modifiers	Anti-Platelet	IV				N	
DELESTROGEN	estradiol valerate	Endocrine	Hormone Replacement	IM	J1380			N	
DEMEROL	meperidine	Pain Management	Analgesic	IM, SQ	J2175			Exclude	
Depacon	valproate sodium	Neurologic	Anti-Convulsants	IV				N	
DEPOCYT	cytarabine liposome	Anti-Cancer	Oncologic	IT	J9098	Y		Y	
DEPO-ESTRADIOL	estradiol cypionate	Endocrine	Hormone Replacement	IM	J1000			N	
Depo-Medrol	methylprednisolone	Endocrine	Corticosteroid	IM	J1020			N	
Depo-Medrol	methylprednisolone	Endocrine	Corticosteroid	IM	J1030			N	
Depo-Medrol	methylprednisolone	Endocrine	Corticosteroid	IM	J1040			N	
DEPO-PROVERA	medroxyprogesterone	Endocrine	Contraception	IM	J1050		1mg	Exclude	
DESFERAL	deferoxamine	Topical	Toxicity	IM, IV	J0895			N	DRUG-3
DEXAMETHASONE SODIUM PHOS	dexamethasone sodium phos	Endocrine	Steroid	IA, IM, IV	J1100			N	
DEXFERRUM	iron dextran	Blood Modifiers	Iron Deficiency	IM, IV	J1750			Y	
Diflucan	fluconazole	Anti-Infectives	Anti-Fungal	IV	J1450			N	
DILAUDID	hydromorphone	Pain Management	Analgesic	IM, IV	J1170			N	
dimenhydrinate	dimenhydrinate	Gastrointestinal	Anti-Emetics	IV/IM	J1240			N	
dip/tet ped	diphtheria and tetanus toxoids (TD)	Anti-Infectives	Vaccine	IM	90702			N	
DIPYRIDAMOLE	dipyridamole		Cardiac	IV	J1245			N	
DOBUTAMINE	dobutamine	Cardiovascular	Cardiac	IV	J1250			N	
Docetaxel	docetaxel (non-alcohol)	Anti-Cancer	Oncologic	IV		Y		N	
Doribax	doripenem	Anti-Infectives	Anti-Infective	IV	J1267			N	
DOXIL	doxorubicin liposomal	Anti-Cancer	Oncologic	IV	Q2050	Y		Y	CG-D-49
doxycycline hyclate	doxycycline hyclate	Antibiotics	Anti-Infective	IV				N	
DTIC-DOME	dacarbazine	Anti-Cancer	Oncologic	IV	J9130	Y		N	
Dyloject	diclofenac sodium	Pain Management	Analgesics-Anti-Inflammatory	IV			NTMLO	N	
DYSPORT	abobotulinumtoxinA	Neurologic	Botulinum Toxin Derivative	IM	J0586			Y	DRUG-6
EDEX	Alprostadil	Genitourinary	Erectile Dysfunction	Intra-cavernous	J0270			Exclude	
ELAPRASE	idursulfase	Endocrine	Metabolic Enzyme (MPS II)	IV	J1743			Y	CG-D-57
ELELYSO	taliglucerase alfa	Blood Modifiers	Metabolic Enzyme (Gaucher Dz)	IV	J3060			Y	CG-D-08
ELIGARD	leuprolide	Anti-Cancer	Oncologic GnRh Analog	SQ	J1950		SQ per 3.75mg	Y	CG-D-11 (Fertility) CG-D-60 (Oncology) CG-D-61 (Non-Onc)
ELIGARD	leuprolide	Anti-Cancer	Oncologic GnRh Analog	IM	J9217		IM up to 7.5mg	Y	CG-D-60 CG-D-61
ELITEK	rasburicase	Anti-Cancer	Oncologic Adj	IV	J2783	Y		N	
ELLENCE	epirubicin	Anti-Cancer	Oncologic	IV	J9178	Y		N	
ELOCTATE	antihemophilic factor (recomb) RFVIIIFC	Blood Modifiers	Hemophilia	IV	J7205			Y	DRUG-66
ELOXATIN	oxaliplatin	Anti-Cancer	Oncologic	IV	J9263	Y		N	
ELSPAR	asparaginase (E.coli)	Anti-Cancer	Oncologic	IM, IV	J9019	Y	Per 1000 IU	Y	CG-D-42
ELSPAR	asparaginase (E.coli)	Anti-Cancer	Oncologic	IM, IV	J9020	Y	Per 10,000 IU	Y	CG-D-42
EMEND	fosaprepitant	Gastrointestinal	Anti-Emetic	IV	J1453			Y	CG-D-46
EMPLICITI	elotuzumab	Anti-Cancer	Oncologic	IV	J9176	Y		Y	DRUG-83
Engerix-B	hepatitis B (recombinant)	Anti-Infectives	Vaccine	IM	90743			N	

PRODUCT NAME	Generic Name	Drug Category	Drug Class or Indication	Route	HCPCS Code	NCH	Notes	PA Required or Excluded	Clinical Guideline or Policy
Engerix-B	hepatitis B (recombinant)	Anti-Infectives	Vaccine	IM	90746			N	
ENTYVIO	vedolizumab	Gastrointestinal	Inflammatory Bowel Agents	IV	J3380			Y	DRUG-68
epinephrine	epinephrine	Respiratory	Anti-Asthmatic and Bronchodilator Agents	IM	J0171			N	
EPOGEN	epoetin alfa	Blood Modifiers	Colony Stimulating Factor	IV, SQ	J0885		Non-ESRD	Y	CG-D-05
ERAXIS	anidulafungin	Anti-Infectives	Anti-Fungal	IV	J0348			Y	
ERBITUX	cetuximab	Anti-Cancer	Oncologic	IV	J9055	Y		Y	DRUG-36
ERWINAZE	asparaginase (Erwinia)	Anti-Cancer	Oncologic	IM	J9019	Y	1000 units	Y	CG-D-42
Erythrocin	erythromycin lactobionate	Antibiotics	Anti-Infective	IV	J1364			N	
ETHYOL	amifostine	Anti-Cancer	Oncologic Toxicity	IV	J0207	Y		N	
EUFLEXXA	hyaluronate sodium	Neurologic	Osteoarthritis	IA	J7323			N	CG-D-29 DRUG-17
EXONDYS 51 SOLN	eteplirsen	Neurologic	Muscular Dystrophy	IV				Y	DRUG-81
EYLEA	aflibercept	Topical	Ophthalmic Agents	Intravitreal	J0178			Y	DRUG-28
EZ Use Flu Kit	influenza types A and B	Anti-Infectives	Vaccine	IM				N	
FABRAZYME	agalsidase beta	Endocrine	Metabolic Enzyme (Fabry Dz)	IV	J0180			Y	CG-D-54
FASLODEX	fulvestrant	Anti-Cancer	Oncologic	IM	J9395	Y		Y	CG-D-62
FEIBA NF AND FEIBA VH	anti-inhibitor coagulant complex	Blood Modifiers	Hemophilia	IV	J7198			Y	DRUG-66
Fentanyl Cit Inj	fentanyl citrate/NaCl	Pain Management	Analgesics-Opioid	Inj			NTMLO	N	
fentanyl citrate	fentanyl citrate	Pain Management	Analgesics-Opioid	IV	J3010			N	
Fentanyl/Bup	fentanyl cit/bupivacaine/NaCl	Pain Management	Analgesics-Opioid	Inj			NTMLO	N	
FERAHEME	ferumoxytol (elemental)	Blood Modifiers	Iron Deficiency (CKD)	IV	Q0138		Non-ESRD	Y	
FERAHEME	ferumoxytol (elemental)	Blood Modifiers	Iron Deficiency (CKD)	IV	Q0139		ESRD	Y	
FERRLECIT	sodium ferric gluc complex	Blood Modifiers	Iron Deficiency	IV	J2916			Y	
FIRMAGON	degarelix	Anti-Cancer	Oncologic GnRh Analog	SQ	J9155			Y	CG-D-60 CG-D-61
FLEBOGAMMA	immune globulin	Immunology	Immune Globulin	IV	J1572			Y	CG-D-09
FLEBOGAMMA DIF	immune globulin	Immunology	Immune Globulin	IV	J1572			Y	CG-D-09
FLOLAN	epoprostenol	Cardiovascular	Pulmonary Arterial HTN	IV	J1325			Y	DRUG-4
Flucelvax	influenza virus vaccine tissue-cultured	Anti-Infectives	Vaccine	IM	90661			N	
FLUDARA	fludarabine	Anti-Cancer	Oncologic	IV	J9185	Y		N	
FLUPHENAZINE	fluphenazine HCl	Psychiatric	Anti-Psychotic	IM				N	
FLUPHENAZINE DECANOATE	fluphenazine decanoate	Psychiatric	Anti-Psychotic	IM	J2680			N	
Fluvirin	influenza virus types A & B	Anti-Infectives	Vaccine	IM	Q2037			N	
Fluzone	influenza virus (intradermal)	Anti-Infectives	Vaccine	ID	Q2038			N	
Fluzone HD Inj PF	influenza virus split HD PF	Anti-Infectives	Vaccine	IM	90662			N	
FOLLISTIM AQ	follitropin beta	Endocrine	Infertility	IM, SQ	S0128			Exclude	CG-D-11
FOLOTYN	pralatrexate	Anti-Cancer	Oncologic	IV	J9307	Y		Y	
Fortaz	ceftazidime	Antibiotics	Anti-Infective	IV	J0713			N	
Foscavir	foscarnet	Anti-Infectives	Anti-Infective	IV	J1455			N	
FOSPHENYTOIN	fosphenytoin	Neurologic	Seizures	IM, IV	Q2009			N	
FREAMINE III	amino acid electrolyte	Nutritional	TPN	IV	B4168			N	
FREAMINE III	amino acid electrolyte	Nutritional	TPN	IV	B4172			N	
FREAMINE III	amino acid electrolyte	Nutritional	TPN	IV	B4176			N	
FREAMINE III	amino acid electrolyte	Nutritional	TPN	IV	B4178			N	
FUDR	floxuridine	Anti-Cancer	Oncologic	IA	J9200	Y		N	
FUSILEV	levoleucovorin	Anti-Cancer	Oncologic Toxicity	IV	J0641			Y	CG-D-63
Gablofen	baclofen	Neurologic	Musculoskeletal Therapy	IT	J0475		10mcg	N	
Gablofen	baclofen	Neurologic	Musculoskeletal Therapy	IT	J0476		50mcg	N	
GAMASTAN SD	immune globulin	Immunology	Immune Globulin	IM	J1460		1ml	Y	CG-D-09
GAMASTAN SD	immune globulin	Immunology	Immune Globulin	IM	J1560		> 10ml	Y	CG-D-09
GAMMAGARD	immune globulin	Immunology	Immune Globulin	SQ, IV	J1569			Y	CG-D-09
GAMMAGARD SD	immune globulin	Immunology	Immune Globulin	SQ, IV	J1569			Y	CG-D-09
GAMMAKED	immune globulin	Immunology	Immune Globulin	SQ, IV	J1561			Y	CG-D-09
GAMMAPLEX	immune globulin	Immunology	Immune Globulin	IV	J1557			Y	CG-D-09
GAMUNEX	immune globulin	Immunology	Immune Globulin	SQ, IV	J1561			Y	CG-D-09
GAMUNEX-C	immune globulin	Immunology	Immune Globulin	SQ, IV	J1561			Y	CG-D-09
GANIRELIX	ganirelix acetate	Endocrine	Infertility	SQ	S0132			Exclude	CG-D-11
Ganite	gallium nitrate	Endocrine	Endocrine	IV	J1457			N	
GARDASIL	human papillomavirus quadrivalent recomb	Anti-Infectives	Vaccine	IM	90649			Y (if age > 26)	ADMIN.00007
GAZYVA	obinutuzumab	Anti-Cancer	Oncologic	IV	J9301	Y		Y	DRUG-62
Gel-One	cross-linked hyaluronate	Neurologic	Osteoarthritis	IA	J7326			N	CG-D-29 DRUG-17
Gelsyn-3 Inj	sodium hyaluronate	Neurologic	Osteoarthritis	IA	J7328			N	CG-D-29 DRUG-17
GEMZAR	gemcitabine	Anti-Cancer	Oncologic	IV	J9201	Y		N	
gentamicin sulfate	gentamicin	Antibiotics	Anti-Infective	IM, IV	J1580			N	
GenVisc	hyaluronate sodium	Neurologic	Osteoarthritis	IA	J7320			N	CG-D-29 DRUG-17
GEODON	ziprasidone mesylate	Psychiatric	Anti-Psychotic	IM	J3486			N	
GLASSIA	alpha-1 proteinase inhibitor	Respiratory	Alpha-1 Antitrypsin Deficiency	IV	J0257			Y	DRUG-72
Glucagen	glucagon HCl (RDNA)	Endocrine	Anti-Diabetic	SQ/IM/IV	J1610			N	

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glycopyrrolate	glycopyrrolate	Gastrointestinal	Ulcer Drugs	IV	J7642		concentrated	N	
glycopyrrolate	glycopyrrolate	Gastrointestinal	Ulcer Drugs	IV	J7643		unit dose	N	
GONAL-F	follitropin alpha	Endocrine	Infertility	SQ	S0126			Exclude	CG-D-11
GONAL-F RFF	follitropin alpha	Endocrine	Infertility	SQ	S0126			Exclude	CG-D-11
GONAL-F RFF PEN	follitropin alpha	Endocrine	Infertility	SQ	S0126			Exclude	CG-D-11
GRANIX	TBO-filgrastim	Blood Modifiers	Colony Stimulating Factor	SQ	J1447			Y	CG-D-16
HALAVEN	eribulin	Anti-Cancer	Oncologic	IV	J9179	Y		Y	DRUG-48
HALDOL	haloperidol lactate	Psychiatric	Anti-Psychotic	IM	J1630			N	
HALDOL DECANOATE	haloperidol decanoate	Psychiatric	Anti-Psychotic	IM	J1631			N	
Hectorol IV	doxercalciferol	Endocrine	Endocrine	IV	J1270			N	
HELIXATE FS	antihemophilic factor	Blood Modifiers	Hemophilia	IV	J7192			Y	DRUG-66
HEMABATE	carboprost tromethamine	Endocrine	Abortifacient/Postpartum Hemorrhage	IM				Exclude	
HEMOFIL-M	antihemophilic factor	Blood Modifiers	Hemophilia	IV	J7190			Y	DRUG-66
HEMOPHILIA CLOTTING FACTOR, NOT OTHERWISE CLASSIFIED		Blood Modifiers	Hemophilia		J7199			Y	DRUG-66
Hepagam B	hepatitis B immune globulin	Immunology	Immune Globulin	IM	J1571			N	
Hepagam B	hepatitis B immune globulin	Immunology	Immune Globulin	IV	J1573			N	
HEPARIN	heparin	Blood Modifiers	Anti-Coagulants	IV, SQ	J1644		1,000U	N	
HEPLOCK FLUSH	heparin	Blood Modifiers	Anti-Coagulants	IV, SQ	J1642		10U	N	
HERCEPTIN	trastuzumab	Anti-Cancer	Oncologic	IV	J9355	Y		N	
Hiberix	haemophilus b polysaccharide conjugate	Anti-Infectives	Vaccine	IM	90648			N	
HIZENTRA	immune globulin	Immunology	Immune Globulin	SQ	J1559			Y	CG-D-09
Honey Bee Venom	honey bee venom	Anti-Infectives	Venom	SQ				N	
Hornet Venum	white faced hornet venom	Anti-Infectives	Venom	SQ				N	
HUMATE-P	antihemophilic factor/von Willebrand	Blood Modifiers	Hemophilia	IV	J7187			Y	DRUG-66
HYALGAN	hyaluronate sodium	Neurologic	Osteoarthritis	IA	J7321			N	CG-D-29 DRUG-17
HYCAMTIN	topotecan	Anti-Cancer	Oncologic	IV	J9351	Y		Y	
Hydromorphone Inj	hydromorphone HCl/NaCl	Pain Management	Analgesics-Opioid	Inj			NTMLO	N	
hydroxocobalamin	hydroxocobalamin	Blood Modifiers	Hematopoietic Agents	IM	J3420			N	
HYDROXYZINE	hydroxyzine hcl	Psychiatric	Anti-Histamine	IM	J3410			N	
Hymovis Inj	hyaluronate	Neurologic	Osteoarthritis	IA	J7322			N	CG-D-29 DRUG-17