



North American Division Health Care Assistance Plan



Health Care Assistance Plan

PLAN BENEFITS

January 1, 2010 – December 31, 2010

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INTRODUCTION

This Plan document describes the provisions of the Health Care Assistance Plan for employees of the Seventh-day Adventist Organizations of the North American Division working in the United States (“Plan”). Please refer to the North American Division Working Policy Y 22 for the supporting general philosophy of this Plan.

This Plan is an employer-sponsored health care plan. It is not an insurance program or policy. The Plan provides a broad range of benefits for medical, vision, dental, and prescription expenses which you and your eligible dependents may incur in the United States. In addition, the Plan pays benefits for “emergency” expenses incurred anywhere in the world for hospital care, surgery, pre-admission testing and prescription drugs. The Plan pays a portion of the cost of these medical services according to the Schedule of Benefits.

All non-emergency services outside the United States are excluded (see “Specific Exclusions,” Number 8).

Many items are not covered by the Plan even though they may provide significant patient convenience or personal comfort. The Plan does not, and is not intended to, cover all health care services and products that are available, particularly treatment that is not medically necessary.

This Plan document describes the Plan’s provisions for the period of January 1, 2010 through December 31, 2010. The Plan may be amended or terminated at any time without prior notice by a resolution of the North American Division Committee of the General Conference of Seventh-day Adventists or by the North American Division Risk Management Committee. The right to amend includes the right to curtail or eliminate coverage for any treatment procedure, or service, regardless of whether any covered employee is receiving such treatment for an injury, defect, illness, or disease contracted prior to the effective date of the amendment.

ELIGIBILITY

The persons described below referred to throughout this document as Plan Participants, are eligible to participate in the Health Care Assistance Plan.

EMPLOYEES, LITERATURE EVANGELISTS AND SEMINARY STUDENTS

Employees

Once you have completed your probationary period (which may vary by employer), you are eligible to participate in the Plan:

1. If you are classified by your employer as a full time, exempt or non-exempt, regular employee, and you are either working in your position or on an approved leave of absence from your employer. However, you have no probationary period to meet if your employment transfers from one Seventh-day Adventist employer to another and you have been covered within the last 63 days under other denominational plans; or
2. If you simultaneously hold two or more part-time jobs for one or more Seventh-day Adventist employers, and (1) the total number of hours you regularly work per week at your part-time jobs equal or exceeds the number of hours per week required to be considered a full-time employee; (2) you are considered to be a regular employee; and (3) you are either working in your positions or on an approved leave of absence from your employers. Your two employers will share proportionally in the cost of your HCAP coverage, but you will only enroll in the HCAP with one of the employers. Your employers will notify you how to enroll.

Literature Evangelists

You are eligible if you are a literature evangelist, and meet the qualifications required by your employer. (Benefit eligibility is determined according to the North American Division Working Policy (NADWP) Section FP 70, 437-439, which pertains to literature evangelists.)

Seminary Students

You are eligible to participate in the Plan if you are a seminary student sponsored by your employer, and meet the qualifications required by your employer.

However, the following employees are not eligible to participate in the Plan:

Local Hires

Employees, either part-time or full-time, who hold positions classified by the SDA organization or SDA employer as local hires, courtesy staff, courtesy payroll, auxiliary staff, auxiliary payroll or temporary staff and employees holding positions classified with similar titles or status.

Leased Employees

Employees who have been leased by their SDA employer to another entity under a written agreement and such written agreement states that the other entity will provide health coverage to the leased employees

Special Rule for School Employees on Summer Vacation

If you are an employee of a school, college, university, or other educational institution operated by the Seventh-day Adventist Organizations of the North American Division and are classified by your employer as a full-time, exempt or non-exempt, regular employee, you remain eligible for the HCAP during your summer vacation and other similar vacation periods, even if (1) you are not working full-time during these periods; and/or (2) you do not receive pay during these periods. However, if your employment is terminated during your summer or other vacation periods, your eligibility to participate in this Plan will cease at that time.

DEPENDENTS

If you meet the eligibility requirements, your dependents are also eligible to be covered under the Plan as described below. However, no person may be covered at the same time both as an employee and dependent.

Spouses

Under the Plan, your spouse is your marriage partner of the opposite sex recognized under the laws of the state of your permanent residence.

Upon request, you must provide proof satisfactory to the Plan Administrator that you are legally married. If you divorce or legally separate from your spouse under a court order, your spouse becomes ineligible to participate in the Plan.

1. Spouses of Employees, Literature Evangelists, and Seminary Students

- a. In most instances, your unemployed spouse is eligible.

2. Additional Spouse Eligibility

- a. Monthly Contributions. If your employer so permits, your employed spouse may be eligible if you make a monthly contribution to the Plan for spousal coverage at a rate set by your employer.
- b. Employment Transitions. If your spouse has health care benefits through his or her employer and your spouse loses or terminates employment, your spouse is eligible for benefits under this Plan during certain periods of unemployment.
 - i. Your spouse is eligible for coverage under this Plan if your spouse terminates employment.
 - ii. If you have accepted a denominational transfer that requires a move and thus, your spouse terminates his or her employment, your spouse is eligible for coverage from the time your spouse is no longer eligible for health care benefits through his or her former employer until your spouse takes a new job and is once again eligible for employer-provided health benefits. Your spouse is not required to take COBRA or similar continuation coverage from his or her previous employer in order to be eligible for Health Care Assistance Plan coverage under this paragraph.

Dependent Children

Eligibility Rules for All Children

In order to be eligible for the Plan a child must be unmarried and meet one of the following criteria:

1. Children born to you;
2. Children legally adopted by you and/or your spouse (including children living in your home for whom you have documentation showing that the adoption is in process);
3. Children for whom you and/or your spouse are legal guardians in accordance with the laws of the state of your permanent residence; or
4. Your stepchildren.

However, children become permanently ineligible for the Plan if they (1) marry; or (2) become emancipated (adults under state law) for any reasons other than reaching the age of majority under the laws of your state of permanent residence, such as by entering military service or having the parent-child relationship severed by a court.

In addition, the child must fit into one of the following three categories:

a. Eligibility Rules for 18 Years of Age or Younger

Children are eligible to participate in the Plan until December 31 of the year in which they turn 18 years of age. For example, if a child turns 18 on July 20, he or she may participate in the Plan until December 31.

In addition, the child must:

- i. live with the employee for more than 50% of the year. In situations where the employee is divorced, legally separated, or living apart for more than six months from the child's other parent, the child must live with a parent (one or the other or both) for a combined total of at least 50% of the year. For example, if a child lives for 40% of the year with the employee and 20% of the year with the parent who is the employee's ex-spouse, the child would qualify because the child lives with a parent for 60% of the year. Also, absences from home due to illnesses or education are not counted for purposes of this rule.
- ii. not provide more than 50% of his or her own support for the year. Scholarships are not considered support for these purposes.

b. Eligibility Rules for Children Over 18 Years of Age

After December 31 of the year in which the child turns 18, a child can continue to participate in the Plan if the child meets the requirements under any of the following paragraphs:

- i. The child must be enrolled full time in high school, an undergraduate course of study at college or university or in a technical or professional school ("Educational Institution"). Your employer will supply you with a "Full-Time Student Verification Form for Dependent Children." This form must be completed and submitted to and retained by your employer each year for reinsurance verification purposes. Students must meet the full-time status criteria that are determined by the individual educational institution they are attending. Students who are enrolled full time in an Educational Institution are eligible to remain in the Plan until the end of the month in

which the earliest of the following dates occurs: (i) the last day of the semester in which they turn 24 (or up to the last day of the semester in which they turn 25, as described below); (ii) the date they complete their undergraduate degree or their undergraduate or equivalent program at a technical or professional school; or (iii) the date they drop out of the Educational Institution or are no longer enrolled full time in an Educational Institution. If the education of the child was delayed by either volunteer service for the Seventh-day Adventist Church (as described in ii below) and/or a documented medical condition (as described in iii below) which prevented the child from attending full-time classes between the ages of 18 and 24, the age limit for purposes of b)i) above will be extended for a period of time equal to the months of delay from attending an Educational Institution caused by the volunteer service, up to 12 months (ending, at a maximum, at the end of the semester in which the child has his or her 25th birthday). However, in no event will a non-disabled child be eligible to participate in the Plan after the end of the month of the last day of the semester in which semester the child has his or her 25th birthday.

- ii. The child must be engaging in volunteer service for the Seventh-day Adventist church and must intend on enrolling full-time in an Educational Institution upon completion of such volunteer service. Your employer will supply you with a "Dependent Child Volunteer Service Form." This form must be completed and submitted to and retained by your employer for reinsurance verification purposes. Except as provided in section b) i) above, these children are eligible to remain in the Plan until their 25th birthday
- iii. The child must have a documented medical condition which prevents the child from enrolling full time in an Educational Institution. You must provide a certification of a documented medical condition from an independent medical doctor approved in advance by the Plan Administrator. Your employer will supply you with a "Dependent Child Medical Condition Form." This form must be completed and submitted to and retained by your employer each year for reinsurance verification purposes. Except as provided in section b) i) above, these children are eligible to remain in the Plan until the end of the month in which they turn 25 years old.
- iv. The child must have been previously enrolled in an Educational Institution and must intend on enrolling full time in an Educational Institution within the next 12 months after the date the child was last a full-time student. A child is only eligible for coverage under this provision for a one-time break from his or her full-time studies for a period not to exceed 12 months. Your employer will supply you with a "Dependent Child Intention to Return to Full-Time Educational Status Form" which must be completed and submitted to and retained by your employer each year for reinsurance verification purposes in the year(s) in which your child is not enrolled in the Educational Institution. If the child does not enroll as a full-time student in an Educational Institution within 12 months of the date the child last attended an Educational Institution, coverage for the child will be terminated retroactively to the last day of the last attended semester or quarter, and you must reimburse the Plan in full for any benefits paid for the child since the child's last day of attendance in the Educational Institution as a full-time student. Unless these children qualify for an extension under the terms of section b) i) and iii) above (due to a medical condition) while the children were full-time students in an Educational Institution, these children

may only remain in the Plan only until the end of the month in which they turn 24 years old.

- v. A dependent child who loses coverage by marriage or emancipation (other than by reason of reaching the age of majority) is never eligible for coverage as a dependent.

c) Totally and Permanently Disabled Children over the Age of 18

After December 31 of the year in which the child turns 18, a totally and permanently disabled child is eligible to participate in the Plan if the child was eligible for and covered by the Plan as a dependent child under any of the rules stated in a) or b) above and as of the last day the child would otherwise be eligible to participate in this Plan under a) or b), the child was totally and permanently disabled.

A child is considered totally and permanently disabled for purposes of the Plan if, in the determination of the Plan, the child is not able to engage in self-sustaining employment due to a medically determinable physical or mental impairment which can be expected to result in death or which has lasted (or can be expected to last) for a continuous period of at least one year.

In order for your disabled child to be eligible to continue to participate after the date a non-disabled child would lose eligibility for the Plan, you must submit satisfactory evidence of the child's disability from at least two independent medical doctors, one of whom is approved in advance by your employer within thirty-one (31) days of the date the child would otherwise lose eligibility for the Plan. As a condition to the continued coverage of the child, your Employer may require periodic re-certification of the child's disability from an independent medical doctor chosen by your Employer on a periodic basis, but never more frequently than annually.

IRS Dependent Verification Form and Federal Income Tax Consequences Relating to

Coverage of Children Over 18 Years of Age

It is possible that the children over the age of 18 who are eligible to participate in this Plan under subsection b) or c) will not qualify for tax-free health coverage under the Internal Revenue Code. If they do not qualify for tax-free health coverage under the Internal Revenue Code, you will be subject to federal income tax on the value of the Plan's coverage for these children. The value of the Plan's coverage will be determined annually by the Plan Administrator and will be available by contacting your employer.

Below is a summary of the federal income tax rules for determining whether your child is a dependent for health plan purposes, and thus, whether coverage is provided tax-free. These rules are somewhat different than the rules for determining whether your child can be claimed as tax dependant for other purposes. If your child is claimed as your dependant for all purposes under your federal income tax, your child qualifies for tax-free health coverage. However, in certain situations where you are divorced, legally separated, or living apart for more than six months from the child's other parent, the child may qualify for tax-free health coverage even though you cannot claim the child as your dependent for other purposes on your federal income tax return. You should consult your individual income tax advisor if you have any specific questions concerning these rules, or about whether you are subject to state income tax concerning the Plan's coverage of these children.

For the calendar year in which your child reaches 19 years of age and for the years thereafter, your child is considered your dependent for health plan purposes under the Internal Revenue Service (IRS) only if your child fits into one of the two following categories:

Category 1—Dependent Child - The child must meet all of the following requirements, except disabled children are exempt from the first two requirements.

1. The child is no older than 23 as of December 31 of the year in question. There is no such age limit for disabled children.
2. The child must be enrolled as a full-time student in an Educational Institution for at least five months of the calendar year. This rule does not apply to disabled children.
3. The child must live with you for more than 50% of the year. However, in situations where you are divorced, legally separated, or living apart for more than six months from the child's other parent, the child need only live with a parent (one or the other or both) for a combined total of at least 50% of the year. Absences due to education or illness or military service are overlooked for purposes of this 50% test.
4. The child must not have provided more than one-half of his or her own support for the calendar year (scholarships are excluded from this calculation).

Category 2—Dependent Child

1. The child must have received more than 50% of his or her support from you. If you are divorced, legally separated or have lived apart from six months or more from the child's other parent, more than half of the child's support for the year must be provided from a combination of the support provided by you and the child's other parent.
2. The child must not qualify as a Category 1 dependent child of any other taxpayer. This rule does not apply if you are divorced, separated or living apart from the child's other parent and the only other individual for which your child qualifies as a Category 1 dependent child is the child's other parent.

Your employer will supply you with an "IRS Dependent Status Form—Dependent Children Over Age of 18," which must be completed and submitted to and retained by your employer each year for reinsurance verification purposes each year beginning with the calendar year in which the child turns age 19.

PARENTS

The Plan does not provide coverage for parents of Plan Participants regardless of whether the Plan participant has assumed legal guardianship of the parent.

MONTHLY CONTRIBUTIONS

Your employer may require you to make monthly contributions to the Plan. Your employer has sole discretion in determining the extent to which you may be required to contribute to the cost of the Plan. Your share may include a portion of the cost for employee only coverage, spousal coverage, children coverage, or family coverage (which is a combination of spouse and children coverage).

ENROLLMENT

This section describes when your coverage under this Plan begins.

INITIAL ENROLLMENT

New employees enter the Plan as of the first day of employment, unless your employer has a waiting or probationary period (which varies by employer). If your employer has a waiting or probationary period, new employees enter the Plan on the day after they complete this period. During the waiting period, new employees may choose to elect short-term medical plan coverage at their expense by contacting their Employer. Certain conditions may apply.

If you and your dependents meet the eligibility requirements for the Plan and wish to enroll in the Plan, you either must complete and sign a paper enrollment form or submit a completed electronic form. Your employer will provide you with this paper enrollment form and/or provide access to its electronic counterpart via the Internet. Your employer may require you to submit this form annually.

When filling out the enrollment form, you must give accurate and complete information. If relevant information is either misstated or not properly disclosed, your benefits will be adjusted according to the correct information and you will be obligated to refund to the Plan any benefits that you or your dependents should not have received from the Plan.

Once you are eligible to participate in the Plan and your completed enrollment form is received and processed, you will receive your health plan identification cards from your employer.

SUBSEQUENT ENROLLMENT

Persons who do not join the Plan when they first become eligible will be allowed to join the Plan at a later date if they meet the eligibility requirements of the Plan and comply with enrollment rules, if any, of the Employer. For example, employees of an Employer participating in a Section 125 Cafeteria Plan and their family members who do not join the Plan when they first become eligible may have restrictions on when they may enroll in the Plan. See the section entitled "Section 125 Cafeteria Plan" in the Miscellaneous Provisions portions of this booklet.

Special Enrollment No. 1 - New Dependents

If you acquire a child by birth, adoption, or placement for adoption and the child is eligible for coverage under the Plan, you may enroll your new child in the Plan. In addition, at the same time you may enroll yourself and any of your other eligible family members (spouse or children) in the Plan. **However if you enroll any child, you must enroll all of your eligible dependent children.** If you make the enrollment request to your employer within 30 days following the birth, adoption, or placement for adoption of the new child, the effective date of Plan coverage for all new enrollees in your family will be the date of the birth, adoption, or placement for adoption. If you make the enrollment request to your employer after 30 days of the birth, adoption, or placement for adoption, Plan coverage for the new enrollees may be effective at a later date, such as the first day of the month after your enrollment request has been processed by the Plan, or at such other time as determined by the enrollment rules of your employer, if any, such as during your employer's next annual re-enrollment or open enrollment period.

If you marry a new spouse, you may enroll yourself, your new spouse and/or any eligible children in the Plan. **However, if you enroll any child, you must enroll all of your eligible dependent children.** If you make your enrollment request to your employer within 30 days following the date of your marriage, the effective date of the Plan coverage for the new enrollees will be the date of your marriage. If you make the enrollment request to your employer more than 30 days after the marriage, Plan coverage for the new enrollees may be effective at a later date such as the first day of the month after your enrollment request has been processed by the Plan or at such other time as determined by the enrollment rules of your employer, if any, such as during your employer's next annual re-enrollment or open enrollment period.

Special Enrollment No. 2 - Loss of Other Coverage

If an employee or eligible dependent declines coverage under this Plan because that person has coverage under another group health plan or other health insurance, that person may enroll in this Plan by requesting enrollment within thirty (30) days after he or she loses coverage under the other group health plan or health insurance according to the following rules:

1. The employee must sign and deliver a statement to their employer within thirty (30) days after the date the person declined to enroll in the Plan stating that coverage is declined under this Plan for that person because he or she has other coverage. This statement can be provided when the person who declined coverage was first eligible to enroll in the Plan or at a later date when coverage was available to the person, such as during an open enrollment period. Failure to provide such a statement will result in the Plan Participant losing his or her special enrollment rights under this section.
2. If the other coverage was COBRA continuation coverage, the person may enroll in this Plan in the thirty (30) days after the day COBRA continuation coverage was exhausted.
3. If the other coverage was not COBRA continuation coverage, the person may enroll in this Plan in the thirty (30) days after the date
 - a. the person loses eligibility for the other coverage or
 - b. employer contributions for the other coverage cease
4. The employee may be required to provide reasonable proof of
 - a. the existence of other insurance or group health plan coverage as of the date person declined coverage under this Plan;
 - b. the loss of other insurance or health plan coverage and
 - c. the loss of employer contributions for the other coverage
5. Coverage for persons enrolled under this Special Enrollment for Loss of Other Coverage is effective on the first day of the month after your employer receives the request for such enrollment. If you make the enrollment request to your employer more than 30 days after the other coverage has been lost, Plan coverage may be effective at a later date, such as of the first day of the month after your enrollment request has been processed by the Plan or at such other time as determined by the enrollment rules of your employer, if any, such as during your employer's next annual re-enrollment or open enrollment period.

Other Enrollment Periods

Your employer may allow you and/or your eligible dependants to enroll in the Plan other than at Initial Enrollment or during the Special Enrollment periods discussed above. If you enroll at other times, the effective date of your Plan coverage will be determined by your employer.

Special Enrollment No. 3 - Loss of Eligibility for Medicaid or SCHIP Coverage

If you or an eligible dependent spouse or child loses eligibility for Medicaid coverage or coverage under a state Children's Health Insurance Program (SCHIP), you and your dependents may enroll in the Plan if you request enrollment within 60 days after the date of termination of the Medicare or SCHIP coverage due to loss of eligibility. Plan coverage for persons enrolled under this Special Enrollment for Loss of Eligibility for Medicaid or SCHIP Coverage is effective on the first day of the month after your employer receives the request for such enrollment, unless otherwise required by law. If you make the enrollment request to your employer more than 60 days after the termination of Medicare or SCHIP coverage, Plan coverage for the new enrollees may be effective at a later date, such as the first day of the month after your enrollment request has been processed by the Plan, or at such other time as determined by the enrollment rules of your employer, if any, such as during your employer's next annual re-enrollment or open enrollment period. You do not have this special enrollment right if you lose Medicaid or SCHIP coverage due to failure to pay required premiums for such coverage.

Special Enrollment No. 4 - Eligibility for State Premium Assistance under Medicaid or SCHIP

If you or an eligible dependent become eligible for a state program under which Medicaid or a state Children's Health Insurance Program (SCHIP) will provide assistance to pay a portion of the cost of your premiums under the Plan, you may enroll yourself and your eligible dependents in the Plan if you must request enrollment within 60 days after the date you or your dependents become eligible for such assistance. Coverage for persons enrolled under this Special Enrollment for Eligibility for State Premium Assistance under Medicaid or SCHIP is effective on the first day of the month after your employer receives the request for such enrollment, unless otherwise required by law. Please note that not all States have such a program. If you make the enrollment request to your employer more than 60 days after your eligibility for such premium assistance, Plan coverage for the new enrollees may be effective at a later date, such as the first day of the month after your enrollment request has been processed by the Plan, or at such other time as determined by the enrollment rules of your employer, if any, such as during your employer's next annual re-enrollment or open enrollment period.

Other Enrollment Periods

Your employer may allow you and/or your eligible dependents to enroll in the Plan other than at Initial Enrollment or during the Special Enrollment periods discussed above. If you enroll at other times, the effective date of your Plan coverage will be determined by your employer.

YOUR RESPONSIBILITY TO REPORT FAMILY CHANGES

Since your employer may be unaware of family changes that might affect you or your family member's eligibility for the Plan or the proper administration of the Plan, it is your responsibility to report changes in eligibility or general family or other status to your employer within 30 days (except the events described in Special Enrollments Nos. 3 and 4 must be reported within 60 days). Failure to do so may hamper your Plan Administrator's ability to effectively administer benefits under the Plan. Failure to notify your employer in a timely manner may also delay the effective date of coverage under this Plan. You must repay to the Plan any benefits that were erroneously paid for ineligible family member (such as a child who lost eligibility for the Plan) due to your failure to report family changes to the Plan. Examples of the types of changes that you must report are: marital status changes such as divorces or legal separations, new health coverage under a dependent spouse or child's employer group health plan, dropping full-time student or volunteer status by a dependent child, loss of disability or medical condition of a dependent child, address/telephone changes, new children, child custody changes, loss of eligibility for Medicaid or SCHIP, and eligibility for Medicaid or SCHIP premium assistance.

BENEFIT PAYMENT PROVISIONS

There are several rules which affect how benefits are calculated under the Plan: in other words, these rules determine how each medical bill is paid by the Plan. These rules are described below. The services that are totally excluded from coverage under the Plan (for which no payment whatsoever is made) are listed in the Limitations and Exclusions Section of this document. Certain services require pre-certification for any benefit payment to be made.

DEDUCTIBLES

1. The Individual Plan Period Deductible is the amount of covered medical expenses that must be paid first by or for each individual Plan Participant each year before benefits are paid by the Plan. Please refer to the Schedule of Benefits for current deductible amounts and treatments that are subject to Plan period deductibles.
2. The Family Plan Period Deductible is the amount of covered medical expenses that must be paid first for all covered family members before benefits are paid by the Plan. Please refer to the Schedule of Benefits for current deductible amounts and treatments that are subject to Plan period deductibles.
3. The Per Occurrence Co-payment is an amount that is applied each time a specific type of medical service is provided before benefits are paid by the Plan (for example, use of emergency room). Amounts you pay for the Per Occurrence Co-payments are not applied toward the Individual or Family Plan Period Deductibles described in the previous paragraph.

Benefit reductions due to non-compliance with policy guidelines will not be credited toward the Deductibles.

USUAL, REASONABLE, AND CUSTOMARY

“Usual, reasonable, and customary”(URC or U&C) fees are the reasonable fees usually charged in the geographic area where you receive the medical services, treatments, products, equipment or other items. If your medical provider charges more than the “usual, reasonable, and customary” level, your benefits will be limited to and based on the usual, reasonable and customary charge for the services that you received. Out-of-network non-participating providers may bill you for differences between the Plan allowance, which is the amount paid by the Plan, and the provider’s actual charge. This amount may be significant. Any charges in excess of the allowance are not covered under the plan.

PLAN’S PAYMENT OR PERCENTAGE RATE

After your deductible has been met, the Plan pays a share of the medical expenses and the participant pays a share. The portion of the expenses that the Plan pays after you have met your deductible (or if no deductible applies to that expense) is known as the Plan’s payment percentage or rate. The portion that the participant pays is known as the out-of-pocket. The co-payment does not apply toward a member’s deductible or out-of-pocket. The Plan’s payment rates for provider charges are outlined in the Schedule of Benefits section of this document.

Participating (par) Provider Co-Payment is a flat dollar amount that must be paid by a Plan Participant first before the Plan pays all or a percentage of the remaining covered charges when provided by a participating provider in the designated preferred provider network.

When you utilize providers in the PPO, the Plan’s payment percentage is higher than the payment

percentage if you use a Non-Participating (non-par) provider. The Plan's rate for provider charges is outlined in the Schedule of Benefits section of this document.

The par provider will charge a flat dollar co-payment amount for office visits. In these instances, the Plan pays the negotiated fee of the PPO provider less the flat dollar co-payment that you pay.

When the plan refers to "charges," "provider charges," "expenses," or "medical expenses," these terms mean the net portions of the charges billed by a provider or supplier of medical services or goods that are eligible for payment by and under the Plan, **after** applying the payment and other rules of the Plan, and not the undiscounted, billed, gross, or full charges or expenses for such services or supplies. For example, prior to applying other rules of the Plan (such as the Plan's payment or percentage rate), the charges billed by the provider are reduced by amounts which are not eligible for consideration and/or payment under the Plan, such as amounts in excess of the URC fees or the amount of billed charges that are reduced under a negotiated fee arrangement with the provider or supplier.

INDEPENDENCE BLUE CROSS (BLUE CARD PPO)

"Blue Card PPO" (Blue) is the official Preferred Provider Organizations for the Plan.

To avoid a reduction in benefits and potential excess charges above U&C, you must use a participating provider if there is one within the appropriate mile radius of where you live or work for your area. While this may be generally 25 miles, the determination is made based on the density of population and provider availability in a geographic area.

By choosing not to use a par provider to which you have access, your benefits are similar to the participating provider program, except for four major differences:

1. The participating provider program's Out-of-Pocket Maximum (OOP) does not apply to non-par provider charges. See the Schedule of Benefits for specific Out-of-Pocket Maximum limits for the participating provider program and the Out-of-Network benefits.
2. After deductibles have been met, charges for hospitals and facilities, outpatient services, office visits and urgent care centers will be paid at the percentage identified in the Schedule of Benefits.
3. Office Visits to non-participating providers are paid at a reduced percentage of eligible charges. The participating provider's office visit co-payment does not apply to non-participating providers. See the current Schedule of Benefits.
4. If the provider is a non-participating provider, all other charges at the non-participating amount are paid at a reduced percentage. See the current Schedule of Benefits.

You are automatically deemed a participant in the participating provider program. However, if you reside outside of the chosen PPO's coverage area, you will be provided with the same benefits as those participating in the participating provider program. Your employer and the Plan Administrator will determine your participation based on PPO access.

There are five medical benefits that are "carved out" of the Blue Cross PPO Contract. While they remain a covered benefit they do not require utilization of an in-network provider. However, they either have a maximum allowable charge or will have U&C applied during claim payment. Charges in excess of allowable will be member's responsibility.

Medical Carve-out Benefits

1. Chiropractic Treatment (U&C applies)

2. Massage Therapy (maximum allowable applies)
3. Acupuncture Therapy (U&C applies)
4. Refractive Eye Surgery (U&C applies; maximum payable applies)
5. Adult immunizations

Dental Care (U&C apply)

Vision Care

Prescription Drugs

PLAN PROVISIONS MAY VARY BASED ON YOUR EMPLOYER AND THE LOCATION OF YOUR EMPLOYMENT

Your benefits and other plan provisions under the Plan may vary from state to state and from employer to employer, depending upon:

1. How Blue and its participating providers operate in your state;
2. Whether your employer provides certain benefits or coverages that are optional under this Plan; or
3. State or local laws that apply to the Plan or benefits provided under the Plan in only one state or city.

The Plan provides benefits if required to do so by state or local law, even if the benefits are not described, or are different than the benefits described, in this booklet. Thus, it is possible that the Plan benefits provided by one SDA employer will differ from the Plan benefits provided by another SDA employer. For example, the Plan may be required to provide a benefit in California that it otherwise does not provide, and thus, the Plan benefits for participants in California may be different than the Plan benefits for participants in other states.

Any Blue adjudication, pre-certification, plan provision or requirement will take precedence over those documented in the NAD HCAP.

OUT-OF-POCKET MAXIMUM (OOP)

After you have reached the Out-of-Pocket Maximum towards all eligible medical services, the Plan will then pay 100% of the covered benefits, subject to any maximum payments provided in the Plan. Please refer to the Schedule of Benefits.

The following guidelines apply to Out-of-Pocket Maximum (OOP):

1. If you use a non-par provider, the Out-of-Pocket Maximum (OOP) will **be greater than that of the participating provider program**. Please refer to the Schedule of Benefits section of this document for the Out-of-Pocket Maximum that applies when you use non-par providers.
2. Benefit reductions due to non-compliance with policy guidelines will not be credited towards the Out-of-Pocket Maximum (OOP).
3. Plan period deductibles, per occurrence co-payment, and office visit co-payments do not apply to

the OOP.

4. See the Schedule of Benefits for specific items that are either included or excluded from the OOP.

LIFETIME MAXIMUM BENEFIT

The Maximum Lifetime Benefit is the maximum amount of covered Plan benefits that will be paid on behalf of each participant by the Plan in the participant's lifetime while covered by the Plan. Please see the Schedule of Benefits for the amount of the Maximum Lifetime Benefit.

GENERAL BENEFIT RULES

Benefits are only paid for medical expenses covered by the Plan if the expenses:

1. are medically necessary
2. represent a commonly accepted form of treatment and meet professionally recognized national standards of quality;
3. are recognized as generally accepted by the American medical community;
4. result from a non-occupational illness, injury or other event or cause;
5. are of a type specifically listed in the Plan Benefit Coverage section of this document;
6. are a type of expense for which the Plan does not otherwise limit or exclude payment; and
7. do not exceed Plan period limits

Medically necessary means a covered procedure, service, or supply that the Plan considers eligible for benefits. All covered services must be medically necessary. The Plan determines what is medically necessary and the decision is final and conclusive. Even though your Provider may recommend a procedure, service or supply, the recommendation does not always mean the care is medically necessary. Medically necessary means that a procedure, service or supply is all of the following:

1. Appropriate and necessary for the symptoms, diagnosis, and direct care or treatment of your illness or injury.
2. Consistent with professionally recognized standards of health care and given at the right time and in the right setting.
3. Not primarily for your convenience or the convenience of your primary care provider or other provider.
4. The most appropriate supply or level of service or supplies that can safely be provided.
5. Enables you to make reasonable progress in treatment.

There may be alternative procedures, services, or supplies that meet medical necessity criteria for diagnosis and treatment of your condition. If the alternatives are substantially equal in clinical effectiveness and use similar therapeutic agents or regimens, the Plan reserves the right to approve the least costly alternative.

Many items are not covered by the Plan even though they may provide significant patient convenience or personal comfort. Such items may include raised toilet seats or sauna baths. Such items do not meet the medical necessity requirement that the item be expected to make a meaningful contribution to the treatment of the illness or injury.

Alternative treatment plans may be proposed by medical peer or utilization review organizations.

The fact that a physician may prescribe, recommend, order or approve a service or supply does not, of itself, determine medical necessity.

Under this Plan, you are considered to have an illness when you have a bodily disorder, disease, physical sickness, mental health infirmity, or functional nervous disorder. A recurrent illness will be considered one illness. Concurrent illnesses will be considered one illness unless the concurrent illnesses are totally unrelated. All such disorders existing simultaneously that are due to the same or related causes are considered one illness.

In addition, expenses must be incurred while the coverage is in effect. All expenses are treated as being incurred on the date that the service or supply is provided to the patient, not on the date the bill was sent. Expenses incurred before your Plan coverage becomes effective or after your Plan coverage has terminated will not be covered.

Plan Benefits Designated Provider Program January 1 – December 31, 2010		Plan Benefits Designated Provider Program January 1 – December 31, 2010	
Lifetime Maximum	\$3,000,000	Therapeutic Services	
Plan Period Deductible	\$250/individual \$500/family	Physical Therapy	Services paid at 80% Maximum of 30 visits
Out-of-Pocket Maximum (OOP)	\$2,000/individual \$4,000/family	Occupational Therapy (Prior Authorization Required)	Services paid at 80% Maximum of 30 visits
Office Visits	Office visits \$20 co-pay, then Plan pays 100% only on office visit charge Office visits do not apply to the Plan period deductible Office visit co-pay not included in the OOP All other charges on the same bill are paid at 80% <i>Applies to Plan period deductible</i> <i>Applies to Plan period OOP</i>	Speech Therapy (Prior Authorization Required)	Services paid at 80% Maximum of 30 visits <i>Appropriate billing codes (CPT) must be included for each charge</i> <i>Applies to Plan period deductible</i> <i>Applies to Plan period OOP</i>
Outpatient Services	Paid at 80% of Provider's charges <i>Applies to Plan period deductible</i> <i>Applies to Plan period OOP</i>	Alternative Therapies	
Inpatient/Outpatient Hospital Stays: Office/Ambulatory Surgical Procedures	Paid at 80% of Provider's charges <i>Applies to Plan period deductible</i> <i>Applies to Plan period OOP</i>	Massage Therapy	Services paid at 80% 30 visits per Plan period Dependents under the age of 10 are not eligible for Massage Therapy Maximum allowable charge for Massage Therapy is \$90 per visit Appropriate billing code (CPT) must be included for each charge.
Emergency	Paid at 80% of Provider's charges Plan period deductible does not apply <i>Applies to Plan period OOP</i>	Chiropractic Treatment	Services paid at 80% 30 visits per Plan period Dependents under the age of 10 are not eligible for Chiropractic Therapy Limited to spinal manipulation only Appropriate billing codes (CPT) must be included for each charge.
Urgent Care Centers	May be paid as an office visit or as an ER visit depending on facility contract Facility fees for office visits are not paid	Acupuncture Therapy	Services paid at 80% 18 visits per Plan period Appropriate billing codes (CPT) must be included for each charge.
Ambulance	Paid at 80% of Provider's charges <i>Applies to Plan period deductible</i> <i>Applies to Plan period OOP</i>		

NOTE: The schedule of benefits is only a brief summary. You should read the appropriate Plan sections for other important information about your coverage.

Any Blue adjudication, pre-certification, plan provision or requirement will take precedence over those documented in the NAD HCAP.

Plan Benefits Designated Provider Program January 1 – December 31, 2010		Plan Benefits Designated Provider Program January 1 – December 31, 2010	
Home Health Care	<ul style="list-style-type: none"> • Paid at 80% of charges • Maximum of 52 visits per Plan period • Pre-certification required to receive Plan benefits <p><i>Applies to Plan period deductible</i> <i>Applies to Plan period OOP</i></p>	Hearing Care	<ul style="list-style-type: none"> • Paid at 80% of charges • \$3,200 maximum payment per Plan period <p><i>Applies to Plan period deductible</i> <i>Applies to Plan period OOP</i></p>
Hospice Care	<ul style="list-style-type: none"> • Paid at 190% of charges • Pre-certification required to receive inpatient or respite Plan benefits 	Durable Medical Equipment	<ul style="list-style-type: none"> • Paid at 80% of charges • \$8,000 maximum payment per Plan period • Charges above \$500 require pre-certification <p><i>Applies to Plan period deductible</i> <i>Applies to Plan period OOP</i></p>
Mental Health Outpatient Services/Partial Hospitalization	<ul style="list-style-type: none"> • \$20 co-pay per office visit/counseling session • Office visits do not apply to the Plan period deductible • Office visit co-pay not included in the OOP <p>All other charges are paid at 80% <i>Applies to Plan period deductible</i> <i>Applies to Plan period OOP</i></p>	Organ/Tissue Transplants	<ul style="list-style-type: none"> • Paid at 80% of charges the same as other medical benefits • Pre-certification required to receive Plan benefits <p><i>Applies to Plan period OOP</i></p>
Mental Health Inpatient Services	<ul style="list-style-type: none"> • Paid at 80% of charges • Pre-certification required to receive Plan benefits <p><i>Applies to Plan period deductible</i> <i>Applies to Plan period OOP</i></p>	Infertility Treatments	<ul style="list-style-type: none"> • Paid at 80% of charges • Lifetime maximum payable benefit of \$16,000 • Pre-certification required to receive Plan benefits • Plan period deductible does not apply • Plan period OOP does not apply
Substance Abuse/Chemical Dependency Outpatient/Partial Facility Visits	<ul style="list-style-type: none"> • \$20 co-pay per office visit/counseling session • Office visits do not apply to the Plan period deductible • Office visit co-pay not included in the OOP <p>All other charges are paid at 80% <i>Applies to Plan period deductible</i> <i>Applies to Plan period OOP</i></p>	Refractive Eye Surgery	<ul style="list-style-type: none"> • Paid at 80% of charges • Lifetime maximum payable benefit of \$2,400 • Plan period deductible does not apply • Plan period OOP does not apply
Substance abuse/Chemical Dependency Inpatient Treatment	<ul style="list-style-type: none"> • Paid at 80% of charges • Pre-certification required to receive Plan benefits <p><i>Applies to Plan period deductible</i> <i>Applies to Plan period OOP</i></p>	Vision Therapy	<ul style="list-style-type: none"> • Paid at 80% of charges • Lifetime maximum of 8 visits • Pre-certification may required to receive Plan benefits <p><i>Appropriate billing codes (CPT) must be included for each charge.</i></p> <p><i>Applies to Plan period deductible</i> <i>Applies to Plan period OOP</i></p>
		Vision Care	<ul style="list-style-type: none"> • Paid at 80% of Provider's Charges • \$560 Maximum Payable per Plan Period • Plan period deductible and OOP do not apply

NOTE: The Schedule of Benefits is only a brief summary. You should read the appropriate Plan sections for other important information about your coverage.

Any Blue adjudication, pre-certification, plan provision, or requirement will take precedence over those documented in the NAD HCAP.

Plan Benefits Designated Provider Program January 1 – December 31, 2010		Plan Benefits Designated Provider Program January 1 – December 31, 2010	
<p>Prescription Drug</p> <p>Retail – 30-day supply</p> <p>Home Delivery – 90-day supply</p> <p>Out-of-Pocket Maximum</p> <p>The OOP for RX will be tracked by your Pharmacy Benefit Manager (PBM). Your pharmacy will be notified if you reach your yearly out-of-pocket limits</p>	<ul style="list-style-type: none"> • Co-payment - \$12 generic/\$18 brand/\$25 non-formulary or 20% (your employer determines which method you use) • Co-payment - \$15 generic/\$25 brand/\$35 non-formulary • \$400/individual • \$800/family <p>The portion of the cost that you pay for prescription drugs applies toward your RX Out-of-Pocket Maximum of \$400 per individual or \$800 per family.</p> <p>Penalties for non-compliance do not apply toward Plan period OOP maximums.</p>	<p>Dental Care</p>	<ul style="list-style-type: none"> • No Plan period deductible • \$3,000 maximum payment per Plan period – individual • \$9,000 maximum payment per Plan period – family • Type A – Preventive Care covered at 100% of charges • Type B – Basic Restorative and • Type C – Major Restorative covered at 80% of Provider's charges • Usual, Reasonable, and Customary (U&C) Applies
		<p>Orthodontic Care</p>	<ul style="list-style-type: none"> • Paid at 50% of Provider's charges • \$2,300 maximum payable as a Lifetime Benefit • Eligible up to age 24
		<p>Temporomandibular Disorders (TMD or TMJ)</p>	<ul style="list-style-type: none"> • Paid at 80% of Provider's charges • Portions may be covered under medical or dental dependent on provider, services and procedure codes • Pre-certification may be required to receive Plan benefits <p><i>Appropriate billing codes (CPT) must be included for each charge.</i></p> <p><i>Applies to Plan period deductible</i></p> <p><i>Applies to Plan period OOP</i></p>

NOTE: The Schedule of Benefits is only a brief summary. You should read the appropriate Plan sections for other important information about your coverage.

Any Blue adjudication, pre-certification, plan provision or requirement will take precedence over those documented in the NAD HCAP.

IMPORTANT NOTICE CONCERNING NON-PARTICIPATING BENEFITS

If you reside in a PPO area, but you elect not to participate in the participating provider program, your covered benefits will be reduced in three major ways:

- The Out-of-Pocket Maximum (OOP) for non-participating provider charges is \$4,500/individual, or \$9,000/family per Plan period.
- Usual, Reasonable, and Customary applies (U&C).
- After required deductibles have been met, charges for hospitals and facilities, outpatient services, office visits and urgent care centers will be paid at 65% of the Provider's charges not to exceed U&C. The member's responsibility is 35% and charges in excess of U&C.
- \$20 office visit co-payment does not apply to non-participating providers

THE BLUE CROSS PPO PRE-CERTIFICATION LIST:

This is an exemplary listing and not intended to be viewed as complete. Your provider must contact the Pre-Certification Department for appropriate guidelines for your specific circumstance.

SERVICE	IN-NETWORK	OUT-OF-NETWORK
ALL NON-EMERGENCY INPATIENT ADMISSIONS (EXCEPT MATERNITY ADMISSIONS)	Required	Required
OUTPATIENT SURGICAL PROCEDURES		
Bunionectomy	Required	Required
Cataract Surgery	NOT Required	Required
Laparoscopic Cholecystectomy	Required	Required
Hemorrhoidectomy	Required	Required
Hernia Repair	NOT Required	Required
Arthroscopic Knee Surgery/Diagnostic Arthroscopy	Required	Required
Ligation and Stripping of Varicose Veins	Required	Required
Obesity Surgery	Required	Required
Prostate Surgery	NOT Required	Required
Spinal/Vertebral Surgery	NOT Required	Required
Submucous Resection (nasal surgery)	Required	Required
Tonsillectomy and/or Adenoidectomy	Required	Required
TRANSPLANTS	Required	Required
OPERATIVE AND DIAGNOSTIC ENDOSCOPIES	Not Required	Required
MRI Required	Required	
CT SCAN	Required	Required
PET SCAN	Required	Required
OUTPATIENT THERAPIES	Required	Required
Speech, Occupational, Cardiac, Pulmonary, Respiratory, Infusion		
OUTPATIENT PRIVATE DUTY NURSING	Required	Required
OTHER FACILITY SERVICES	Required	Required
Skilled Nursing, Inpatient Hospice, Home Health, Birth Center		
NON-EMERGENCY AMBULANCE	Required	Required
DURABLE MEDICAL EQUIPMENT	Required	Required
Purchase items over \$500, including Repairs And Replacements, and ALL Rentals		
PROSTHETICS	Required	Required
Purchase items over \$500, including Repairs And Replacements		

PREVENTIVE CARE SERVICES

The Plan pays benefits for certain Preventive Care Services listed in this Section. If you utilize an in-network Provider, the Plan pays 100% of the cost of these Covered Services, without co-payments, and the Plan deductibles do not apply. The Plan provides benefits for Preventive Care Covered Services performed by an out-of-network provider at the rate of 65% of the usual, reasonable and customary charges for the Covered Service, and the Plan deductibles apply.

Preventive Care services are generally performed to prevent disease or to catch the early warning signs of health problems. Preventive Care Covered Services are only covered if you have no symptoms of disease. You are not eligible for these benefits if you are receiving medical services to treat an illness or injury, although you are eligible for benefits for services to treat an illness or injury under other provisions of the Plan.

Independence Blue Cross periodically reviews the appropriateness of Preventive Care covered Services and may change the frequency or type of Preventive Care Covered Services. The Plan will provide notice of any such changes to your employer or by amendment to the Plan.

This only describes the Preventive Care Covered Services for which benefits are paid by the Plan. The Plan does not provide medical advice and is not to be considered a substitute for the medical judgment of your attending physician or other health care provider. Even though the Plan covers a test or an immunization, your physician may recommend that you do not undertake the test or immunization, and may recommend that you have tests or immunizations not covered by the Plan. In all instances, the final and ultimate decisions concerning the appropriate and desired immunizations, tests, and other preventive care measures and medical treatments are up to you and the physician or other professional providing your treatment.

1. Pediatric Preventive Care Covered Services

The Plan pays benefits for the following Pediatric Preventive Care Covered Services:

- a. Physical Examination, Routine History, Routine Diagnostic Tests. Benefits for well baby care, which generally includes a medical history, height and weight measurement, physical examination and counseling, are limited to Plan participants who are less than eighteen (18) years of age in accordance with the schedule shown below. When a range is given (i.e. 2-3 months), the dash indicates that benefits are provided for one service from two (2) months through three (3) months of age.

Twenty-four (24) examinations up to age seventeen (17) – according to each of the following age groupings:

- Eight (8) exams between the ages of 0-24 months, consisting of one (1) exam within each of the following age ranges:

0-1 months	9-11 months
2-3 months	12-14 months
4-5 months	15-17 months
6-8 months	18-24 months
- One (1) exam every calendar year between two (2) and seventeen (17) years of age

- b. Blood Lead Screening. This blood test detects elevated lead levels in the blood.

Children participating in the Plan are covered for:

- One (1) test between 9-12 months of age
 - One (1) test at twenty-four (24) months of age
- c. Hemoglobin/Hematocrit. This blood test measures the size, shape, number and content of red blood cells. Children participating in the Plan are covered for:
- One (1) test between 0-12 months of age
 - One (1) test between one (1) and four (4) years of age
 - One (1) test between five (5) and twelve (12) years of age
 - One (1) test between thirteen (13) and seventeen (17) years of age
- d. Rubella Titer Test. The rubella titer blood test checks for the presence of rubella antibodies. If no antibodies are present, your physician may recommend that a rubella immunization should be given. The rubella titer blood test may be recommended by your physician if there is uncertainty whether the child has ever been immunized. Children participating in the Plan are covered for one (1) test and immunization between eleven (11) and seventeen (17) years of age.
- e. Urinalysis. This test detects numerous abnormalities. Children are covered for:
- One (1) test every 365 days between 0-24 months of age
 - One (1) test every calendar year between two (2) and seventeen (17) years of age

2. Pediatric Immunizations Preventive Care Covered Services

Benefits will be provided for those pediatric immunizations, including the immunizing agents, which conform to the Standards of the Advisory Committee on Immunization Practices of the Center for Disease Control, U.S. Department of Health and Human Services (HHS). Benefits are limited to Covered Persons under twenty-one (21) years of age. Please contact Blue Cross to determine if a particular immunization is covered.

3. Adult Preventive Care Covered Services (18 Years or Older)

- a. Physical Examination, Routine History. The Plan provides benefits for well-person physical examination and counseling for Plan participants eighteen (18) years of age or older in accordance with the following schedule:
- One (1) examination every calendar year at eighteen (18), nineteen (19), twenty (20), and twenty-one (21) years of age
 - One (1) examination every three (3) calendar years between twenty-two (22) and thirty-nine (39) years of age
 - One (1) examination every calendar year, beginning at forty (40) years of age
- b. Adult Tetanus Toxoid (TD) Immunization. The Plan provides benefits for this immunization against tetanus and diphtheria as follows:
- One (1) immunization every ten (10) calendar years, beginning at eighteen (18) years of age
- c. Blood Cholesterol Test. High blood cholesterol is one of the risk factors for coronary artery disease. The Plan provides benefits for a blood test measuring the total serum cholesterol

- level in accordance with the following schedule
- One (1) test every four (4) calendar years between eighteen (18) and thirty-nine (39) years of age
 - One (1) test every calendar year, beginning at forty (40) years of age
- d. Complete Blood Count (CBC). The Plan provides benefits for this blood test which checks the red and white blood cell levels, hemoglobin and hematocrit as follows:
- One (1) test every calendar year at eighteen (18), nineteen (19), twenty (20), and twenty-one years of age
 - One (1) test every three (3) calendar years between twenty-two (22) and thirty-nine (39) years of age
 - One (1) test every calendar year, beginning at forty (40) years of age
- e. Fecal Occult Blood Test. The Plan provides benefits for this test checking the presence of blood in the feces, which is an early indicator of colorectal cancer as follows:
- One (1) test every calendar year beginning at fifty (50) years of age
- f. Flexible Sigmoidoscopy. The Plan provides benefits for this test, which is conducted to detect possible colorectal cancer by use of a flexible fiber optic sigmoidoscope, as follows:
- One (1) test every three (3) calendar years, beginning at fifty (50) years of age
- g. Influenza Vaccine. The Plan provides benefits for immunizations against influenza type A and B viruses as follows:
- One (1) vaccine every calendar year, beginning at eighteen (18) years of age
- h. Pneumococcal Vaccine. Pneumococcal disease may cause pneumonia and other infections such as meningitis and bronchitis. The Plan provides benefits for immunization against pneumococcal disease as follows:
- One (1) vaccine every five (5) calendar years, beginning at sixty-four (64) years of age
- i. Prostate Specific Antigen (PSA). The Plan provides benefits for this blood test which may be used to detect tumors of the prostate, as follows:
- One (1) test every calendar year for men, beginning at fifty (50) years of age
- j. Routine Colonoscopy. The Plan provides benefits for this test used to detect colorectal cancer by use of a flexible fiber optic colonoscope, as follows:
- One (1) test every ten (10) calendar years, beginning at fifty (50) years of age
- k. Rubella Titer Test. The Plan pays benefits for rubella titer blood test, which checks for the presence of rubella antibodies. If no antibodies are present, your physician may recommend that the rubella immunization should be given. The rubella titer blood test may be recommended by your physician if there is uncertainty you have ever been immunized.
- One (1) test and immunization between eighteen (18) and forty-nine (49) years of age
- l. Thyroid Function Test. The Plan pays benefits for this test to detect hyperthyroidism and hypothyroidism, as follows:

- One (1) series of test every calendar year, beginning at eighteen (18) years of age
- m. Urinalysis. The Plan pays benefits for this test to detect numerous abnormalities, as follows:
 - One (1) test every calendar year, beginning at eighteen (18) years of age
- n. Varicella Vaccine. This vaccine may be recommended by your physician for women of childbearing age who have not been previously exposed to the chicken pox virus. The Plan pays benefits for this vaccine as follows:
 - One (1) immunization for women between eighteen (18) and forty-nine (49) years of age
- o. Fasting Blood Glucose Test. The Plan pays benefits for this test used for detection for diabetes, as follows:
 - One (1) test every three (3) years beginning at forty-five (45) years if age
- p. Abdominal Aortic Aneurysm screening. The Plan pays benefits for one (1) screening per lifetime for men only (this screening is not recommended by HHS for women). Your physician may recommend this screening for men with a smoking history.
 - One (1) ultrasound between sixty-five (65) and seventy-five (75) years of age

4. Routine Gynecological Examination, Pap Smear

Benefits are provided for women covered by the Plan who are eighteen years of age or older for one (1) routine gynecological examination each calendar year, including a pelvic examination and clinical breast examination; and routine Pap smears in accordance with the recommendation of the American College of Obstetricians and Gynecologists.

5. Mammograms

Benefits are provided for women covered by the Plan who are eighteen (18) years of age or older, coverage for screening and diagnostic mammograms. Benefits for mammography are payable only if performed by a qualified mammography service provider who is properly certified by the appropriate state or federal agency in accordance with the Mammography Quality Assurance Act of 1992.

6. Osteoporosis Screening (Bone Mineral Density Testing or BMDT)

Benefits are provided for Bone Mineral Density Testing using a U.S. Food and Drug Administration approved method. This test determines the amount of mineral in a specific area of the bone. It is used to measure bone strength, which is the aggregate of bone density and bone quality. Bone quality refers to architecture, turnover and mineralization of bone. The BMDT must be prescribed by a Covered Provider legally authorized under law to prescribe such a test.

- One (1) screening test every two calendar years beginning at age 65

7. Additional Immunizations for High Risk Participants

If you are considered to be in a “high risk” population as determined by Blue Cross, benefits may be provided for certain immunizations not otherwise covered by the Plan. Please contact Blue Cross to determine if you are in a high risk population, and if so, which additional immunizations are covered by the Plan.

BENEFIT PLAN COVERAGE

This section describes the benefits provided by your Health Care Assistance Plan. Please refer to the Schedule of Benefits for the specific payment percentages, maximum amounts payable, and co-payment requirements.

AMBULANCE SERVICES

The Plan pays a percentage of the charges for necessary professional emergency ambulance transportation to the hospital for inpatient treatment or outpatient treatment of an accident, and any medical services provided en route. It is expected that ambulance services will be used only when medically necessary and involving life threatening conditions such as severe bleeding, severe breathing difficulty, unconsciousness or serious injury.

Your Plan will cover Ambulance Transport Services (professional air or ground) to the nearest adequate hospital, urgent care center, or nursing facility to treat your illness or injury. Local air and ground ambulance means that you or your eligible dependents are transported to a hospital, urgent care center, or nursing facility in the surrounding area where your ambulance transportation began.

The Plan will cover your ambulance transport provided the following criteria are met:

1. No other method of transportation is appropriate.
2. The services necessary to treat this illness or injury are not available in the hospital or nursing facility where you may be an inpatient.
3. The hospital or nursing facility is nearby and adequate facilities are available to treat your medical condition.
4. Coverage for air ambulance services has been pre-authorized by the Plan Administrator. Any ambulance transportation other than to a facility for urgent treatment must have prior approval. Non-approved charges will not be paid.

EMERGENCY/URGENT CARE SERVICES

If a covered Plan Participant receives emergency medical care for an accidental injury or medical emergency the Plan will cover physician services in the emergency room, urgent care center, office, or hospital outpatient department including X-rays, MRIs, laboratory and machine diagnostic tests. Please refer to the Schedule of Benefits section of this document for the amount of coverage provided and deductible provision for emergency care. If an Urgent Care Center is available and you choose to use its services for your care, the physician charges may be paid as office visits, or as an ER visit. This is dependent on the facility and its billing process, the treatment diagnosis and services rendered. Facility charges for office visits are not covered.

HOSPITALIZATION AND SURGERY

Hospital

When this Plan refers to an inpatient, it means a person admitted as a bed patient to a hospital for treatment and charges made for room and board to the Plan Participant as a result of such treatment. An outpatient is a Plan Participant who receives treatment while not admitted as a bed patient in a hospital.

Payment for inpatient care is limited to semi-private room rate charges. If you voluntarily elect to occupy a private room instead of a semi-private room, you are responsible for paying the difference in cost between the private room rate and the hospital's most common semi-private room rate. There is one exception to this rule: isolation or private room charges will be covered if a private room is essential due to the patient's severely compromised defenses against infection, due to a contagious disease, or otherwise medically necessary to protect the patient's life.

In order for the Plan to cover charges as those of a hospital, the institution must meet all of the following requirements:

1. It must meet all state licensing requirements.
2. It must be accredited by the Joint Commission on Accreditation of Healthcare Organizations (JCAHO) or by the Accreditation Association for Ambulatory Health Care (AAAHC).
3. It must be eligible to receive payments under Medicare.
4. It must be primarily engaged in providing, for compensation and on an inpatient basis, facilities for the surgical and medical diagnosis, treatment, and care of injured and sick persons under the supervision of a staff of physicians.
5. It must continuously provide 24-hour registered nursing service.
6. It must have at least a Certified Anesthesiologist or Certified Anesthetist at the site when surgery that requires general or spinal anesthesia is performed and during the recovery period.
7. It must not be, other than incidentally, an extended care facility, a nursing home, a place for rest, an institution for exceptional children, the aged, drug addicts, or alcoholics, or a custodial or domiciliary institution having as its primary purpose the furnishing of food, shelter, training, or non-medical personal services.

Ambulatory Surgery Center

In order for the Plan to cover charges as those of a surgery center, the institution must meet all of the following requirements:

1. It must meet state licensing standards.
2. It must be set-up, equipped, and run to provide general surgery.
3. It must make charges on its own behalf.
4. It must be directed by physicians.
5. At least one physician must be on the premises when surgery is performed and during the recovery period.

6. It must have a minimum of one Certified Registered Nurse Anesthetist (CRNA) at the site when surgery that requires general or spinal anesthesia is performed and during the recovery period.
7. It must extend surgical staff privileges to physicians who practice surgery and to dentists who perform oral surgery.
8. It must have at least two operating rooms and one recovery room.
9. It must provide, or arrange with a medical facility in the area for diagnostic x-ray and lab services needed in connection with surgery.
10. It must provide, in the operating and recovery rooms, full-time skilled nursing services directed by a registered nurse.
11. It must be equipped and have trained staff to handle medical emergencies. It must have:
 - a. A physician trained in cardiopulmonary resuscitation;
 - b. A defibrillator;
 - c. A tracheotomy set; and
 - d. A blood volume expand
12. It must have a written agreement with a hospital in the area for immediate emergency transfer of patients. Written procedures for such a transfer must be displayed and the staff must be aware of them.
13. It must provide an ongoing quality assurance program. The program must include reviews by M.D.'s or D.O.'s who do not own or direct the facility.
14. It must keep a medical record on each patient.

Covered Services and Expenses

Like all other expenses, hospitalization and inpatient surgery are covered only when medically necessary and are subject to payment provisions outlined in the Schedule of Benefits.

The Plan covers:

1. Charges for a semiprivate room.
2. Miscellaneous hospital expenses.
3. Hospital surgical and anesthesia charges. Where two procedures are performed through the same incision, only the fee for the more expensive procedure will be covered. Assistant surgeons will be paid an amount not to exceed 20% of primary surgeon's allowable charges for the surgery. Anesthesiologists will be paid as billed but not to exceed 50% of the primary surgeon's allowable charges of the surgery. If a Certified Registered Nurse Anesthetist (CRNA) is utilized, the Plan covers the allowable fees of the CRNA as billed by either the CRNA or the supervising anesthesiologist, but coverage for the fees of the supervising anesthesiologist is limited to 20% of the allowable fees of CRNA. Nurse Assistant charges are not covered.
4. Expenses for a mastectomy (removal of all or a portion of the breast) due to cancer or when otherwise medically necessary. When a mastectomy is performed, the Plan also covers the following:

- a. Reconstruction of the breast(s) on which the mastectomy is performed.
 - b. Treatment of physical complications, if any, at all stages of the mastectomy, including swelling of the lymph nodes (lymph edema).
 - c. Breast prosthetic devices (an artificial device to replace all or part of the breast which was removed) prescribed after a mastectomy is performed.
 - d. If a mastectomy is only performed on one breast, the Plan will cover surgery and reconstruction of the other breast on which the mastectomy is not performed so that the breasts will be symmetrical (of a similar size and shape).
5. Cancer therapy. Cancer therapy includes non-experimental, FDA approved, oral therapies, intravenous chemotherapy (the treatment of a malignancy involving the administration of strong, usually toxic drugs which require close medical supervision) or radiation administered under the direct supervision of a physician and/or radiation therapist for the treatment of a malignancy, related professional fees, services and tests for monitoring progress of the treatment.
 6. Kidney dialysis services. These services include the dialysis process (a technique used to remove waste products from the blood and excess fluids from the body) and any medically necessary services or supplies necessary in the dialysis process. There are special rules governing when Medicare pays for persons suffering from End Stage Renal Disease that are explained in the Plan's Coordination of Benefits section of this document. Please contact the Plan Administrator for guidance related to dialysis services.
 7. In order to receive coverage for surgical or suction D&C, the operative report and pathology report must be submitted with the surgical charges.

ORGAN/TISSUE TRANSPLANT

Covered Services and Expenses

The Plan covers necessary expenses relating to organ and tissue transplants. Services and expenses related to organ/tissue transplant benefits must be pre-certified. Once services and/or treatment are pre-certified, a Plan participant will be directed to a facility for the necessary services and/or treatment. Lack of pre-certification may result in forfeiture of all Plan benefits relating to the organ/tissue transplant.

A Plan Participant may be eligible as a recipient or donor under this benefit. A recipient is a Plan Participant who receives a body organ or tissue transplant and a donor is a Plan Participant, either living or deceased, who donates tissue or a body organ for transplant.

In order to receive benefits under this provision, the type of transplant must not be experimental or investigative and must be from a human donor.

This benefit covers services and supplies as listed below up to the benefit amounts shown in the Schedule of Benefits section of this document.

Recipient Benefits

If a Plan participant (recipient) is receiving a transplant, the Plan covers inpatient hospital and professional services and supplies furnished to the recipient during the hospital stay in which the transplant is performed.

Benefits for bone marrow/stem cell transfer transplants include coverage for chemotherapy and radiation therapy that is a part of the inpatient care under this provision.

Donor Costs for Plan Participants

The Plan also provides benefits for the medical expenses of participants in this Plan who act as organ or tissue donors or are evaluated as a potential donor, but only if the recipient is a Plan participant. The Plan will cover the evaluation, removal and transport of the donor organ or tissue, including expenses of the surgical/harvesting team. The Plan will also cover donor testing and typing of a potential donor, if the potential donor is a participant in the Plan. The Plan covers medically necessary expenses of a donor who is not a participant in the Plan who donates to a covered Plan Participant. Prior approved services and charges are paid only on the matched donor.

HOME HEALTH CARE

Definitions

1. *Home Health Care Agency.* A Home Health Care Agency is an agency that:
 - a. mainly provides skilled nursing and other therapeutic services
 - b. is associated with a professional group containing at least one physician and one registered nurse who makes policy
 - c. has full-time supervision by a physician or an RN
 - d. keeps complete medical records on each person and
 - e. meets licensing standards
2. *Home Health Care Plan.* A Home Health Care Plan is a plan that provides for continued care and treatment after discharge from a hospital by a home health agency, private duty nursing agency or independent private duty nurse and is subject to limitations stated in the Schedule of Benefits section of the Plan. Other therapies, such as physical therapy, occupational therapy, and all other eligible therapies are subject to separate limitations as stated in the Schedule of Benefits section of the Plan. The home health care and treatment must be in lieu of hospitalization.

Covered Services and Expenses

Covered home health care expenses are charges for:

1. part-time or intermittent care by an R.N. (or by an L.P.N. if an R.N. is not available)
2. part-time or intermittent home health aide services for patient care
3. physical, occupational and speech therapy or
4. the following to the extent the expenses would have been covered under this Plan if the person had stayed in the hospital:
 - a. medical supplies, drugs and medicines prescribed by a physician or
 - b. laboratory services provided by or for a Home Health Care Agency

As part of this benefit, the Plan provides coverage for certain certified medically necessary Enteral and Parenteral therapy subject to prior approval by the Plan's Pre-Certification Department. The therapy must be for a permanent non-function or disability from disease or impaired absorption. Please contact the Pre-Certification Department for guidance on the coverage provided for these types of therapies.

Pre-Certification Requirements

You must obtain pre-certification from the Pre-Certification Department. The home health agency must submit a Home Health Care Plan for approval prior to rendering of home health care services that are provided in lieu of hospitalization.

Limitations

Home Health Care does not include charges made for:

1. services or supplies that are not a part of the Home Health Care Plan
2. services of a person who usually lives with you or is a member of you or your spouse's family
3. transportation or
4. custodial care

SKILLED NURSING FACILITIES

In order for the charges to be covered under the Plan, the Skilled Nursing Facility must meet all of the following requirements:

1. The Skilled Nursing Facility must be licensed to provide and be engaged in providing 24- hour-per-day professional nursing services on an inpatient basis for persons recovering from injury or disease by a registered nurse (R.N.) or by a licensed practical nurse (L.P.N.) under the direction of an R.N.
2. Physical restoration services must be provided to assist patients to reach a degree of body functioning to permit self-care in essential daily living activities.
3. A Skilled Nursing Facility confinement must take place within 14 days from a hospital discharge and must represent care for the same condition for which the hospitalization was required.
4. The care provided must not be custodial in nature.
5. The Skilled Nursing Facility must maintain a complete record on each patient.
6. The Skilled Nursing Facility must have an effective utilization review plan.
7. Limitation: 30 day stay per Plan period.

Skilled Nursing Facility Confinement Pre-Certification Requirements

Any Skilled Nursing Facility confinement must be pre-authorized by contacting the Plan's Pre-Certification Department who must pre-approve a treatment plan in order for the expenses to be covered by the Plan

HOSPICE CARE**Covered Services and Expenses**

Hospice care is an alternative to hospitalization. It is care that offers a coordinated program of home care and inpatient care for a terminally ill patient and the patient's family. The program provides supportive

care to meet the special needs from physical, psychological, spiritual, social, and economic stresses often experienced during the final stages of life and during dying and bereavement. For purposes of this Plan, a “terminally ill patient” is someone who has a life expectancy of approximately six months or less, as certified in writing by the physician in charge of the patient’s care and treatment. The Plan will assist on covered charges for:

1. services of a physician and
2. health care services as an inpatient or at home, including part-time nursing care, part-time or intermittent home health care aid, use of medical equipment, rental of wheelchairs, and hospital-type beds and
3. emotional support services and physical and chemical therapies

Pre-Certification Requirements

In order to receive in-patient or respite benefits, you must obtain pre-certification before hospice care services are initiated.

Other Limitations

The Plan only covers those services provided by a qualified hospice program that meets the standards of the National Hospice Organization (NHO) and applicable state licensing requirements.

See the Limitations and Exclusions section of this document for more information.

DURABLE MEDICAL EQUIPMENT

Covered Services and Expenses

The Plan covers durable medical and surgical equipment that meets all of the following requirements. The equipment must:

1. be able to stand repeated use, and be of a type that could normally be rented and used by successive patients
2. be primarily and customarily used to serve a medical purpose (examples of items that do not primarily and customarily provide a “medical purpose” include, for example, humidifiers, exercise equipment, gel pads, water mattresses, heat lamps)
3. generally not be useful to a person in the absence of an injury or illness;
4. be appropriate for home use and
5. meet the guidelines used by the Center for Medicare and Medicaid Services (CMS), the agency that administers the Medicare, Medicaid and Child Health Insurance Programs

Pre-Certification Requirements

To receive any benefits for durable medical equipment, your physician must recommend the equipment or device. The Plan’s Pre-Certification Department must receive satisfactory evidence that the items involved are medically necessary and not for convenience purposes. If you have any questions whether a device is covered, please contact the Plan’s Member Services number on the back of your benefit identification card.

Rental Charges

The Plan covers a portion of the charges for the rental of medically necessary durable medical and surgical equipment and accessories needed to operate it. The pre-certification department will determine if purchase would be less expensive than rental depending on the likely length of time that the equipment will be needed.

Purchase Charges

The Plan will pay a percentage of the cost of the initial purchase of durable medical equipment and accessories needed to operate it if the Pre-Certification Department determines that:

1. long term use is planned and the equipment cannot be rented or
2. it is likely to cost less to buy it than to rent it

Repair and Replacement

The Plan covers charges for repair of purchased equipment and accessories. Replacement of purchased equipment is covered only if the Pre-Certification Department determines that:

1. it is needed due to change in the person's physical condition or
2. it is likely to cost less to buy a replacement than to repair the existing equipment or to rent like equipment

Other Limitations or Exclusions

The Plan does not cover charges for more than one item of equipment for the same or similar purpose.

See the Limitations and Exclusions section of this document for more information.

PROSTHETICS

Pre-certification of preferred supplies is required for items with a billed amount that exceeds \$500 (including replacement and repairs). Failure to pre-certify preferred services will result in a reduction in payable benefits.

THERAPEUTIC CARE**Physical Therapy**

The Plan provides coverage for Physical Therapy within certain limitations stated in the Schedule of Benefits section of this document.

No referral from your MD/DO is necessary.

Registered Physical Therapist services are covered whether performed in a clinical or home setting.

Occupational Therapy

The Plan provides coverage for Occupational Therapy within certain limitations stated in the Schedule of Benefits section of this document. Occupational Therapy is a covered service whether performed in a

home or clinical setting if the provider of such services is a Registered Occupational Therapist (OTR) or a Certified Occupational Therapy Assistant (COTA). Sensorimotor therapy, cognitive therapy, and psychosocial therapy are covered services under the umbrella of Occupational Therapy. Services that are recreational in nature are not covered.

OTR and COTA services are covered whether performed in a clinical or home setting. OTR and COTA services require pre-certification.

Speech and Language Pathology Therapy

The Plan provides coverage for Speech Therapy with certain visit limitations stated in the Schedule of Benefits contained in this document.

Attempting to improve public presentation skills with the assistance of a Speech and Language Pathologist is not considered a covered expense under this Plan.

Speech and Language Pathology services require pre-certification to be considered for coverage and payment. Charges will be denied without pre-certification.

Vision Therapy

Vision Therapy services require pre-certification to be considered for coverage and payment. Charges will be denied without pre-certification.

Other Plan Limitations and Exclusions

There is a maximum number of visits for each type of care covered per Plan period and these services are subject to a co-payment percentage. See the Schedule of Benefits that describes the applicable visit limits and co-payment amounts.

See the Limitations and Exclusions section of this document for additional information.

ALTERNATIVE THERAPIES

Complementary and Alternative Medicine

The Plan recognizes the National Center for Complementary and Alternative Medicine (NCCAM) as the authority in defining complementary and alternative medicines (CAM). CAM, as defined by the NCCAM, is a group of diverse medical and health care systems, practices, and products that are not presently considered part of conventional medicine. Coverage for CAM is limited under the Plan. The coverage is limited to Therapeutic Massage Therapy, Acupuncture Treatment, and Chiropractic Treatment. All other CAM therapies, services, tests, laboratory tests, procedures, products, and practices are not covered under the Plan.

Massage Therapy

Massage Therapy has both a maximum allowable charge and a maximum number of visits. CPT 97124 is the only allowable procedure recognized under the massage therapy benefit. The maximum allowable charge regardless of the length of the massage therapy service is \$90 per visit. Please see the Schedule of Benefits.

Massage therapy must be provided by a licensed massage therapist (LMT) per regulatory requirements of the state in which services were rendered. If your massage therapist is a new provider, your submitted charges will be denied unless you provide a copy of the therapist's license.

Dependents under the age of 10 are not eligible for massage therapy benefits.

Chiropractic Treatment

The Plan limits chiropractic treatment coverage to manipulation (subluxation, whether performed manually or mechanically) of the spine. Certain maximums are stated in the Schedule of Benefits section of this document.

Services other than chiropractic manipulative treatment (i.e. hot or cold packs or supplies, muscle stimulation) are not covered. Patient is responsible for these charges. Covered office visit and x-ray charges during chiropractic treatment sessions are limited to one eligible charge per Plan period.

Dependents under the age of 10 are not eligible for chiropractic benefits.

Acupuncture Treatment

The Plan provides coverage for acupuncture treatment within certain limitations stated in the Schedule of Benefits section of this document. Acupuncture treatment is a covered service when performed in a clinical setting and by recognized providers including physicians, osteopaths, chiropractors, and non-physician acupuncturists who have met all state license requirements. See the Schedule of Benefits that describes the applicable visit limits and co-payment amounts.

HEARING CARE

Covered services for hearing care assistance include:

1. audiometricians
2. hearing specialists
3. hearing aids and repairs and
4. surgically placed devices such as cochlear implants upon prior certification by the Plan's Pre-Certification Department

MENTAL HEALTH SERVICES

Covered Services and Expenses

The Plan covers physicians' and other authorized providers' charges for inpatient and outpatient/partial hospitalization, of mental health disorders, and for counseling services for marital and family conflicts, and social adjustment subject to the limitations indicated below.

Inpatient mental health services are subject to pre-certification by the Pre-Certification Department.

There is an office co-payment that applies to each out-patient visit. These co-payment amounts are outlined in the Schedule of Benefits section of this document. Any other services are paid at 80% and do apply to the deductible and OOP.

Pre-Certification Requirements

You must obtain approval from the Plan's Pre-Certification Department in order to receive assistance under this section of the Plan.

Residential care and treatment are not covered.

SUBSTANCE ABUSE AND CHEMICAL DEPENDENCY TREATMENT**Covered Services and Expenses**

The Plan covers physician's and other authorized provider's charges for substance abuse and chemical dependency treatment.

Inpatient substance abuse and chemical dependency treatments are subject to pre-certification by the Pre-Certification Department.

There is an office co-payment that applies to each out-patient visit. These co-payment amounts are outlined in the Schedule of Benefits section of this document. Any other services are paid at 80% and do apply to the deductible and OOP.

Pre-Certification Requirements

You must obtain approval from the Plan's Pre-Certification Department prior to being admitted to an inpatient treatment program in order to receive assistance under this section of the Plan.

Residential care and treatment are not covered.

See the Limitations and Exclusions section of this document for additional information.

INFERTILITY TREATMENT BENEFITS**Covered Services and Limitations**

This benefit is only available to plan participants who are legally married to a person of the opposite sex. Plan participants must obtain pre-certification in order to receive benefits related to infertility treatment. Upon receipt of this approval the Plan will cover the evaluation and treatment of infertility, including prescriptions. If sterilization and/or tubal ligation procedures have been reversed, infertility treatment and associated medication are not covered under the Plan. There is a lifetime maximum payable benefit for infertility benefits that is set forth in the Schedule of Benefits.

MATERNITY & OBSTETRIC BENEFITS**Covered Services and Expenses**

Under the Plan, pregnancy-related and obstetric expenses are covered in the same way as medical expenses for illness or injury, except that coverage is provided only to employees and their spouses (and not to dependent children).

Inpatient maternity expenses that are incurred by a child during hospitalization for delivery may be considered incurred by the child's mother, or may be considered incurred by the child and thus subject to

a separate deductible and OOP at birth of the baby, depending upon the facility's billing structure. However, the child is always considered to begin incurring his/her own medical expenses:

1. after the mother is discharged from the hospital following the delivery; or
2. if the baby is transferred to another facility.

The Plan provides coverage for Midwives who are certified midwives (called nurse midwives) who have met the graduate training standards of the American College of Nurse Midwives and are licensed to practice in that state. The majority of qualified midwives practice in a hospital, or in a free standing or hospital based facility that provides a "home-like" atmosphere for childbirth. A midwife often attends childbirth, or a physician may assist a midwife, although deliveries may also be in the home. The midwife must meet all state licensing requirements and provide proof of liability insurance. **The Plan will not pay for nor reimburse for midwife services if no proof of liability insurance is provided even if the state does not require liability insurance.**

Limitations

The Plan provides coverage for at least a 48-hour hospital stay for a normal delivery and 96-hour hospital stay for a Cesarean delivery. Inpatient maternity expenses will be limited to a single 48-hour stay after a normal delivery unless it can be established that a longer inpatient stay is medically necessary or is mandated by specific state laws.

Medical expenses for childbirth, miscarriage, or abortion are subject to all limitations, exclusions and required authorizations contained in the Plan, except that pregnancy is never considered to be a pre-existing condition. Charges incurred before your coverage is effective or after your coverage terminates will not be covered.

See the Limitations and Exclusions section of this document for additional information.

DENTAL CARE

The dental plan pays up to a maximum amount based on usual, reasonable and customary per Plan period for individual coverage and family coverage. Please refer to the Schedule of Benefits in this document for the Plan's percentage of coverage.

Dental Care expenses are paid in accordance with the Schedule of Benefits based on Type of service as follows:

Type A Expenses – Preventive Care

Covered Type A expenses are:

1. Routine oral examinations and prophylaxis (cleaning of teeth), but not more than two times in a Plan period;
2. One set of bitewing x-rays per Plan period
3. Topical application of fluoride, but not more than two times per Plan period and
4. Full-mouth x-rays or panorex limited to once every three Plan periods

Type B Expenses - Basic Restorative Care

Covered Type B expenses are:

1. amalgam, silicate, acrylic, resin, synthetic porcelain and composite filling restorations to restore diseased or fractured teeth
2. root canal therapy
3. diagnostic x-rays
4. pit and fissure sealant on permanent molars and bicuspid teeth without prior restorations
5. space maintainers that replace prematurely lost teeth for dependent children under age 19
6. periodontal scaling and root planning; and
7. extractions

Type C Expenses - Major Restorative Care

Covered Type C expenses are:

1. periodontal procedures (other than scaling & root planning)
2. oral surgery
3. general anesthesia when medically necessary
4. installation of crowns or fixed bridgework (including inlays and crowns as abutments)
5. initial partial or full removable denture (to include any adjustments during the six month period following installation)
6. replacement of an existing partial or full removable denture or fixed bridgework by a new denture or by new bridgework, or the addition of teeth to an existing partial removable denture or to bridgework
7. dental implants

Dental or Related Medical Prior Authorization Requirements

The following procedures require a written proposal from dental providers or an oral surgeon, for review and approval by the Plan:

1. Temporomandibular Disorders: Pre-Certification by Blue required
2. Jaw Surgery: Pre-Certification by Blue required

These services may have both a medical and a dental component. In-network provider utilization and appropriate pre-certification protocol must be followed to obtain full benefit for these services. The medical components will apply to your plan-year deductible and OOP. The dental components will apply to your plan year dental benefit maximum payable.

Payment Limits

There are annual individual and family limits on the amount of Type A, B, and C dental expenses covered under the Plan. Please refer to the Schedule of Benefits for the maximum payable benefits and coverage

percentages per Plan period.

Coverage Limits and Exclusions

The Plan does not cover, or limits coverage, for the following types of dental services:

1. Any dental charges in which treatment is started before the Participant was participating in this Plan are not covered
2. Diagnosis or treatment by any method of any condition related to the temporomandibular joint disorder (TMD) or associated musculature, nerves, and other tissues are not covered except to the extent described in the Benefit Plan Coverage section of this document entitled "Temporomandibular Disorders (TMD)."
3. Fees charged for infection control are not covered.
4. Temporary crowns or bridges are not covered.
5. Services or supplies that do not meet accepted standards of dental practice, including charges for services or supplies that are experimental in nature are not covered.
6. Oral hygiene instruction and oral hygiene aids are not covered.
7. Cosmetic services, including teeth whitening and veneers are not covered.

See the Limitations and Exclusions section of this document for additional information.

ORTHODONTIA TREATMENT

Covered Services and Expenses

The Plan provides coverage for orthodontia expenses as a percentage rate of the provider's charges up to a maximum stated amount per Plan period as outlined in the Schedule of Benefits. Payment for Orthodontia services is also subject to the limitations outlined below.

Payment and Other Limitations

1. Payment by the Plan will begin when the Plan Administrator is notified of the banding date. Subsequent payments will be made on a monthly basis as services are rendered and provider billing is received during the course of treatment.
2. Plan participants are not eligible for Orthodontia benefits after attaining 24 years of age.
3. The orthodontic lifetime maximum in effect at the time of banding is the orthodontic lifetime maximum benefit that will apply for these services.
4. If a person becomes ineligible for coverage under the Plan during the course of his or her treatment, payments will end when the person is no longer eligible for coverage regardless of whether the treatment is complete.
5. Payments by the Plan are on a monthly basis as services are rendered during the course of treatment subject to age and benefit limitations.

See the Limitations and Exclusions section of this document for additional information.

TEMPOROMANDIBULAR DISORDERS (TMD)

Covered Services and Expenses

Treatment for Temporomandibular Disorders (TMD) is covered by the Plan in the same manner as other medical treatments. TMD may have both medical and dental components. Pre-certification for the treatment of the medical portion including but not limited to TMD is required and such treatment must be deemed medically necessary, including but not limited to X-rays, MRIs, CT, or physical therapy.

Other Limitations

Plan participants must obtain pre-certification in order to receive benefits under the Plan. No orthodontic benefits are available for TMD treatment.

See the Limitations and Exclusion section of this document for additional information.

PRESCRIPTION BENEFIT MANAGEMENT PROGRAM

The Plan covers the majority of the cost for prescription drugs while participants are required to pay a smaller portion themselves. Please refer to the Schedule of Benefits Section of this document that outlines the amount the Plan pays and the amount you pay. As an alternative to a flat-dollar co-payment, your employer may utilize a co-payment percentage for prescription drugs.

The following are covered under this benefit:

1. Prescription drugs, which under applicable state law, may only be dispensed by written prescription of a physician or dentist and are included in the Prescription Selections Formulary of your Pharmacy Benefit Manager (PBM).
2. Insulin, including syringes and test supplies.
3. Compounds with National Drug Code (NDC) ingredients. (Compounds without NDC ingredients are not covered.)

Certain medications require prior authorization. Your pharmacist or physician will consult with you if prior authorization is required for your particular medication.

Identification (ID) Card (Prescription Drugs)

Under the Plan, your employer provides retail and home delivery prescription drug coverage. When you enroll in the Plan, you will receive an identification (ID) card. This ID card gives you a convenient method of purchasing prescription drugs.

If you do not receive your ID card within 30 days after the effective date of your enrollment, or if you need replacement cards, call ARM's Member Services Department at 888-ARM-4SDA (888-276-4732).

Prescriptions purchased without the use of your prescription ID card must be submitted directly to the designated Pharmacy Benefit Manager.

Member Pays the Difference Program

For prescription drug charges, the Plan requires that you pay a portion of the cost in the form of a co-payment (either a flat dollar amount or percentage of charges). You may also be required to pay the cost differential between a brand name and a generic medication. You also must pay the cost differential if you choose a brand name drug over a generic after your prescribing physician has allowed for a generic substitution.

Home Delivery Drug Program

You may choose Home Delivery for purchasing prescriptions drugs which are used for more than 30 days. The cost of the prescription will be billed to the Plan. There are specific co-payments for Home Delivery (see the Schedule of Benefits).

The original physician's prescription should be mailed along with the prescription request form and applicable co-payment or deductible to the designated mail order company. The prescription will be filled and mailed directly to your home address. Prescriptions filled through the mail order program are filled yearly but limited to a 90-day supply per prescription at one time. Refills may be obtained via the Internet. Brochures on this mail order and Internet refill program are available through the Plan's Administrator

Prescription Drug Prior Authorization Requirement

When obtaining prescription medication through your retail pharmacist or mail order program, the following categories of medications are subject to review and/or restrictions by the Plan's prescription benefit manager:

1. Alzheimer's Therapy Drugs
2. Amphetamines
3. Analgesics
4. Anti-Emetics
5. Anti-Narcoleptic Agents
6. Appetite Suppressants
7. Biotechnological Agents
8. CNS Stimulants
9. COX 2 Inhibitors
10. Dermatologicals
11. Erectile Dysfunction
12. Erythroid Stimulants
13. Fertility Agents
14. Growth Hormones
15. Immune Globulins
16. Immunomodulatory Agents
17. Interferons

18. Migraine Therapy Drugs

19. Myeloid Stimulants

20. Smoking Deterrents

Smart Prior Authorization

The Plan participates in Medco's Smart Prior Authorization program. Please call Medco's Customer Services, or visit Medco's website for details.

Formulary

Formulary is a list of preferred drugs that are designed to be used as a guide for prescribing and dispensing. The formulary used by the Plan is incentive-based – products both off and on the formulary are covered, however, the Plan in most instances pays higher benefits when you use drugs on the formulary list.

REFRACTIVE EYE SURGERY

Refractive eye surgery reshapes the cornea to redirect light rays so that they focus accurately on the retina, reducing or eliminating the need for corrective lenses. Refractive surgery is used to correct myopia (near sightedness), hyperopia (farsightedness), astigmatism (distorted vision). Refractive eye surgical procedures are covered up to a lifetime maximum amount set forth in the Schedule of Benefits. In order to be covered, procedures must meet Federal Food and Drug Administration (FDA) approval and guidelines. Covered procedures include Radial Keratotomy (RK), Photorefractive Keratotomy (PRK), Laser In Situ Keratomileusis (LASIK), and Intracorneal rings.

While refractive eye surgery is a medical procedure, it has been carved out of the Plan's Blue Cross PPO contract. As such, there is no requirement to utilize a Blue Cross network provider; however U&C will apply.

VISION THERAPY

Vision related diagnosis and treatments including routine diagnostic procedures and retinal exams, apply to the medical plan benefits. See the Schedule of Benefits that describes the applicable visit limits and co-payment amounts.

VISION CARE

Covered Services and Expenses

The Plan provides vision care benefits for the following necessary vision care services and expenses:

1. eye examination
2. prescription eye glasses and
3. contact lenses

Limitations

Vision care benefits are covered at the same percentage rate as other medical benefits, but there is a maximum benefit amount in each Plan period. The Plan's percentage rate of payment and maximum amount payable for each covered Plan participant is specified in the Schedule of Benefits. The vision care benefits do not include payment for non-prescription lenses. (Other vision-related diagnosis and treatments, including routine diagnostic procedures and retinal exams, apply to the medical plan benefits and a PPO provider is required.)

COORDINATION OF BENEFITS

When a Plan Participant also has coverage under another group health plan, the Plan coordinates benefits with the other plan. The Plan follows the rules set forth below to determine whether this Plan pays first, or whether this Plan pays second. If this Plan pays first, benefits under this Plan are determined without considering the benefits available to the Plan Participant under another group health plan. When this Plan is second, the benefits under this Plan are determined after those of the other plan and may be reduced because of the other plan's benefits. Total payments between this Plan and another group plan will not exceed this Plan's payment responsibility.

COORDINATION OF BENEFITS DEFINITIONS

The following definitions will apply only to this Coordination of Benefits section of this document:

1. "Adventist Plan" means the Plan described in this booklet.
2. "Benefit Plan" means any group health plan, including the Adventist Plan, which provides benefits or services for medical care or treatment that is a plan of:
 - a. Group insurance and group subscriber coverage and any other program of benefits or services for individuals as a group, whether insured or not
 - b. Group prepaid coverage plans
 - c. Group or group-type coverage through HMOs and other prepayment, group practice, blanket or service plans
 - d. Any coverage through labor-management trusted plans
 - e. Medicare or any other governmental program except for Medicaid or
 - f. Automobile or no-fault insurance policy (group or individual). The term does not include individual or family insurance contracts or policies, individual or family coverage through HMOs, except for automobile or no-fault insurance policies.
3. "Other Plan" means any Benefit Plan other than the Adventist Plan.
4. "Birthday" means the month and day in a calendar year, and does not consider the year in which the person was born.

COORDINATION WITH MEDICARE BENEFITS

Medicare is the program of medical care benefits provided under Title XVIII of the Social Security Act of 1965 as amended. The coordination of benefit rules for Medicare and the Adventist Plan are as follows:

1. **Persons Who Reject Adventist Coverage.** Persons who are entitled to Medicare may elect to reject coverage under the Adventist Plan and choose coverage under Medicare as their primary payer. If such an election is made, coverage under the Adventist Plan will cease for all categories of medical services.
2. **Persons Covered by Both Medicare and the Adventist Plan.** To the extent required by federal law, the Adventist Plan will be first and Medicare benefits will be second. In all other instances,

Medicare benefits will be first and the Adventist Plan second. The most important federal law Medicare coordination of benefits rules are as follows:

- a. Employees. For an employee and the spouse or other dependent of an employee covered by the Adventist Plan, the Adventist Plan pays first and Medicare pays second.
- b. End Stage Renal Disease. The Adventist Plan pays first, and Medicare pays second during the first thirty (30) consecutive months after a Plan Participant is first eligible for Medicare due to End Stage Renal Disease (“ESRD”) if a Plan Participant is eligible for Medicare benefits solely because of ESRD.

After the first thirty (30) consecutive months after a Plan Participant is first eligible for Medicare due to ESRD, Medicare will pay first; and the Adventist Plan second. Plan Participants are required to apply for Medicare Part A and Part B benefits for ESRD as soon as they are diagnosed with ESRD. Coverage will automatically be coordinated with any governmental plan, such as Medicare or Medicare Advantage, for which a Plan Participant would be eligible at the time the Plan Participant incurs a medical expense, whether or not the Plan Participant has actually applied for such governmental coverage, is covered to receive payment from the governmental plan, or whether the provider is an eligible provider for the governmental plan. Thus, once a Plan Participant is eligible for Medicare or other governmental plan and the Plan would be secondary to Medicare or other governmental plan, the Plan will treat the Participant’s bills as having been paid by the governmental plan such as Medicare (on a primary basis) whether or not the bills have so been paid by the governmental plan. The Plan Participant’s benefits under this Plan are limited to what this Plan would have paid, including deductions or benefits under the Plan’s coordination of benefits rules, if the Plan Participant had applied for, been eligible for the governmental plan and had received services from an eligible provider for the governmental plan.

Regarding this provision in this Plan which operates to carve out of the Plan’s coverage an amount equivalent to the Medicare payment that would be made if the services were provided by a provider to whom payment would be made under Part A or Part B of Medicare or other governmental plan, this Plan specifically disallows payment as the primary payer to all medical providers to whom payment would be made and would not be made under Medicare or other governmental plan (including payment under Part A, Part B, a Medicare HMO, or a Medicare Advantage Plan).

COORDINATION OF BENEFITS WITH AUTOMOBILE POLICIES

Except as otherwise required by state law, the automobile or no-fault insurance pays first and the Adventist Plan pays second.

COORDINATION OF BENEFITS WITH OTHER PLANS

When a person is covered by the Adventist Plan and is also covered by another plan that is not Medicare or an automobile or no-fault insurance policy, the rules for deciding which Benefit Plan pays first are as follows:

Other Plan with No Coordination of Benefits Rules

If the Other Plan does not have a coordination of benefits provision, the Other Plan always pays first and the Adventist Plan pays second.

Employee/Dependent

The benefits of a Benefit Plan that covers the person as an employee, member, or subscriber (that is, other than a dependent) are determined before those of the Benefit Plan that covers the person as a dependent.

Dependent Children of Parents Not Separated or Divorced—“Birthday Rule”

When the Adventist Plan and another Plan cover the same child as a dependent of married parents, and the parents are not separated or divorced:

1. The benefits of the Benefit Plan of the parent (covered as an employee, member or subscriber, and not as a dependent) whose birthday is first in the year are determined to be primary before those of the Benefit Plan of the parent whose birthday falls later in that year.
2. If both parents have the same birthday, the benefits of the Benefit Plan that covered the parent longer are determined before those of the Benefit Plan that covered the other parent for a shorter period of time.

Dependent Child with Separated or Divorced Parents or Parents Who Have Never Married

If two (2) or more Benefit Plans cover a person as a dependent child of divorced or separated parents, or of parents who have never been married, benefits for the child are determined in this order

1. First, the Benefit Plan of the parent with custody of the child
2. Then the Benefit Plan of the spouse of the parent with the custody of the child and
3. Finally, the Benefit Plan of the parent not having custody of the child.

However, there are two exceptions to these rules:

1. If a court decree states that one of the parents is financially responsible for the health care expenses and the Adventist Plan has knowledge of the ruling, the benefits of the Benefit Plan of that parent are in all instances determined first.
2. If a court decree states that parents share joint custody, without stating that one of the parents is responsible for the health care expenses of the child, and the Adventist Plan has knowledge of the ruling, the determination of which Benefit Plan is first follows the “Birthday Rule” described above.

Active, Laid-Off or Retired Employee

The benefits of a Benefit Plan which cover a person as an employee who is neither laid-off nor retired (or as that employee’s dependent) are determined before those of a Benefit Plan which covers that person as a laid-off or retired employee (or as that employee’s dependent). If the Other Plan does not have this rule, and if, as a result, the Benefit Plans do not agree on the order of benefits, this rule in the Adventist Plan is ignored.

Longer/Shorter Length of Coverage Rule

If none of the above rules determines the order of benefits, the benefits of the Benefit Plan that covered an employee, member or subscriber longer are determined before those of the plan that covered that person for the shorter time.

Special Coordination of Benefit Rules

Notwithstanding the rules stated above, the Adventist Plan coordinates benefits as follows in the situation listed below.

Rule For Other Plans, Which Are Always Excess or Second. If the Other Plan provides that its coverage is “excess” to all others or that it is always second, the Adventist Plan shall pay as primary.

Coordination of Benefits-Effects on Benefits

1. If the Adventist Plan is Primary - Under the rules set forth above, Plan benefits are paid without consideration of the benefits available or paid under the Other Plan.
2. If Adventist Plan is Secondary - When the Adventist Plan is secondary under the rules set forth above to any Other Plan, the Adventist Plan pays an amount equal to the Plan benefits or an amount that, when added to the primary payer payment amount, equals no more than this Plan's total payment responsibility.
3. Both Parents Employed by Seventh-day Adventist - If both parents of a dependent child are employed by different Adventist employers, and each parent covers the child as a dependent, the employer of the parent with the earlier birthday pays the Plan benefits for the child and the other employer pays no benefits.

EXCHANGE OF INFORMATION AND PAYMENT

Allocation of Benefits and Deductibles

When benefits provided under an Other Plan are not allocated to a specific service, the benefits will be deemed by the Adventist Plan to apply pro rata to the services for which the benefits are paid. When a deductible amount applies to the benefits under an Other Plan, the deductible shall be deemed by the Adventist Plan to apply pro rata to each of the benefits factors under the Other Plan.

Discovery of Other Plans

The Adventist Plan assumes no obligation to discover the existence of coverage under Other Plans or for benefits payable under Other Plans when they are discovered.

Release of Information

Information may be released or obtained about coverage, expenses, and benefits under the Adventist Plan that is needed to apply the Coordination of Benefits provisions of the Adventist Plan or an Other Benefit Plan, without the prior notice or consent by you. Any person who claims benefits under the Adventist Plan shall, as a condition precedent to payment of benefits under the Adventist Plan, give his or her employer or the Plan Administrator any necessary information concerning coverage under Other Plans that is required to apply the Coordination of Benefit provisions.

Overpayments

If the Adventist Plan makes an overpayment, your employer, acting on behalf of the Adventist Plan, has the right at any time to recover the amount of the overpayment from anyone who benefited from the overpayment, including, but not limited to, any person to whom payments are made, a covered employer, a provider or any Other Plan. The Adventist Plan has the right, when benefits have been paid by an Other Plan, to pay to the Other Plan any portion of the benefits available under the Adventist Plan in order to give effect to the intent of the Coordination of Benefit rules. The amounts so paid to the Other Plan

shall be deemed to be benefits provided under the Adventist Plan.

Estimate of Benefits

If the Adventist Plan is secondary, but is unable to determine the benefits of the coverage of the Other Plan for the charges involved, the Plan Administrator will estimate in good faith the benefits of the Other Plan and provide benefits under the Adventist Plan on the basis of that estimate. The Plan Administrator may make adjustments if the actual benefits under the Other Plan are later determined within 24 months of the date of service.

Special rules for Idaho participants:

Instead of the coordination of benefit rules set forth above the National Association of Insurance Commissions (NAIC) Model Coordination of Benefits provisions shall apply.

If a child is adopted by or placed for adoption with an Idaho employee and such child is enrolled in the HCAP within 60 days of the date the child is born, HCAP coverage for the child shall be effective as of the date of the child's birth.

PRE-CERTIFICATION

The Plan has certain procedures that must be followed to reduce the cost of Plan benefits, such as a pre-admission review process called pre-certification. The Plan's Pre-Certification Department can be reached by calling the number on the back of your benefit ID card.

The purpose of utilization management is to contain the cost of Plan benefits by encouraging prudent and reasonable use of health care and health care facilities. These measures are only decisions on the benefits the Plan will cover, not what course of medical treatment is appropriate or desired.

The Plan does not provide medical advice and is not to be considered a substitute for the medical judgment of your attending physician or other health care provider. In all instances, the final and ultimate decisions concerning the appropriate and desired medical treatments are up to you and the physician or other professional providing your treatment.

Your employer, the Plan, the Plan Administrator, and their employees, members, agents and representatives, are not liable for any act or omission by any hospital, physician, other providers or supplier, their agents or employees, in caring for a person covered by this Plan, and no responsibility attaches under this Plan for any error or inability of any supplier to furnish accommodations or services to you.

PRE-CERTIFICATION PROCESS

Pre-certification is a process that takes place when a doctor recommends hospitalization or certain other types of medical services for a Plan participant. The process involves pre-certification staff members who evaluate proposed admissions and other treatments to verify whether the Plan will pay benefits for the proposed Admission to a hospital or other treatments and/or to discuss other alternative care options that may exist.

Your Responsibility

You do not need to obtain pre-certification for routine health care performed in a provider's office, urgent care center, or emergency room. It is your responsibility to obtain appropriate pre-certification for diagnostic testing, out-patient procedures, etc., as per Plan guidelines. Your provider can initiate this by calling the number on the back of your benefit card for pre-certification. If your care results in a hospital admission your provider must call the Pre-Certification Department no later than the next business day after the admission.

When you know in advance that you or a covered family member needs to be hospitalized, you or your doctor must contact the Pre-Certification Department prior to admission at the number on the back of your benefit ID card.

In case of an emergency hospital admission or surgery, you or your doctor must notify the Pre-Certification Department within 24 hours of the admission or on the next business day following admission.

Required Information

You or your provider will need to furnish all of the following information to the Pre-Certification Department:

1. Member's name, employee's name and relationship to member
2. Member's ID number

3. Date of birth of the employee and member
4. Member's date of admission or surgery date
5. Address of the employee and patient
6. Telephone number of the employee and patient
7. Name of employer
8. Provider's name and telephone number and
9. Hospital or facility name, address, and telephone number

A nurse from the Pre-Certification Department will call your doctor to review the proposed treatment plan, the proposed hospital admission, and proposed length of hospital stay. If your doctor recommends that you stay in the hospital longer than the length of stay originally proposed, you or your doctor must contact the Pre-Certification Department, which will determine if benefits for additional days will be authorized.

Failure to Adhere to the Pre-Certification Process

If pre-certification was not obtained your hospitalization benefits will be paid at the appropriate rate stated in the Schedule of Benefit, less appropriate reduction for each day that the hospitalization is not authorized. It is your responsibility to make sure that the pre-admission process has been followed.

SERVICES REQUIRING PRE-CERTIFICATION BY THE PRE-CERTIFICATION DEPARTMENT

In addition to the in-patient hospital admission discussed above, there are additional services under the Plan in which you may not receive benefits or you may receive reduced benefits if you fail to obtain prior approval from the Plan's Pre-Certification Department before obtaining the service or incurring the expense.

Please call the Plan's Pre-Certification Department at the phone number on the back of your benefit card to fulfill any pre-certification requirements and obtain prior authorization approvals or guidance for those services. As the PPO network on behalf of the Plan, Blue Cross handles all pre-certification and prior authorizations, and follows the guidelines set forth by the American Medical Association (AMA) in determining medical necessity and appropriateness of these services.

For an exemplary listing, please see the addendum following the summary schedule of benefits.

CLAIM REVIEW

The Plan conducts appropriate claim editing procedures to examine all charges for proper billing practices, including such things as unbundling of procedures for increased charges or wrong sex billing codes.

EFFECT ON OUT-OF-POCKET LIMIT AND DEDUCTIBLES

If you assume additional expenses for the medical bills due to the application of the Pre-Certification provisions described in this document, any additional expenses so assumed will not be used to meet the Out-of-Pocket Maximum (OOP) described in the Benefit Payment Provisions Section of this document, and are not credited towards meeting any of the Plan deductibles.

LIMITATIONS AND EXCLUSIONS

In addition to the Limitations and Exclusions found elsewhere in the Plan, the Plan does not cover the expenses described in the following General Exclusions and Specific Exclusions.

GENERAL EXCLUSIONS

Occupational Illness and Injury

The Plan does not provide coverage for charges of expenses for injuries or sicknesses which are job, employment or work related, or for which benefits are provided or payable under any Worker's Compensation or Occupational Disease Act or Law; or for which coverage was available under any Worker's Compensation or Occupational Disease Act or Law, regardless of whether such coverage was actually applied for. If benefits are paid and it is determined that a Plan Participant is eligible to receive Workers' Compensation for the same incident, illness or injury, the Plan has a right to recover the benefits paid under this Plan as described in the Recovery Rights provision. As a condition of receiving benefits on a contested workers' compensation claim, Plan Participants must consent to reimburse the Plan when entering into any settlement and compromise agreement or at any Workers' Compensation Division Hearing. The Plan reserves its right to exercise this right to recover against a Plan Participant even though:

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

A Plan Participant will not enter into a compromise or hold harmless agreement relating to any work related claims paid by the Plan, whether or not such claims are disputed by the workers' compensation insurer, without the express written agreement of the Plan.

If satisfactory proof is furnished to the Plan Administrator that a person covered under a Workers' Compensation law (or other like law) has made claim under such law in connection with a distinct disease and no benefit, award, settlement or redemption has been or will be made under that law for such illness or injury, that illness or injury will be considered non-occupational for purposes of the Plan.

Medical Necessity

Coverage is not provided for services and supplies that are not medically necessary.

Plan Limits

The Plan does not cover charges in excess of the Plan limits.

Usual Reasonable and Customary

In certain situations (such as use of a non-participating provider or for dental charges), the Plan does not cover medical expenses which exceed the Usual, Reasonable and Customary (U&C) fees as determined

by the Plan Administrator.

SPECIFIC EXCLUSIONS

Coverage is NOT provided for the following charges or expenses:

1. Abortions. The Plan does not cover the expenses of an elective abortion, including medical complications that arise from an elective abortion, except in cases where continuation of the pregnancy endangers the life of the mother and in cases where pregnancy is the result of incest. In order to receive coverage for surgical or suction D&C, the operative report and pathology report must be submitted with the surgical charges.
2. Career or Financial Counseling Services.
3. Charges for Missed Appointments.
4. Complementary and Alternative Medicine. The Plan recognizes the National Center for Complementary and Alternative Medicine (NCCAM) as the authority in defining complementary and alternative medicines (CAM). CAM, as defined by the NCCAM, is a group of diverse medical and health care systems, practices, and products that are not presently considered part of conventional medicine. Coverage for CAM is limited under the Plan. The exceptions are limited to acupuncture therapy, massage therapy, and chiropractic treatment. All other CAM therapies, services, tests, laboratory tests, procedures, products, and practices are not covered under the Plan.
5. Vitamins, (except for physician prescribed vitamin B12 injections and prenatal care vitamin supplements), dietary supplements and foods, herbs, minerals, nutritional supplements.
6. Custodial Care and Services. The Plan does not cover custodial care and services. Custodial care and services are services and supplies that are furnished mainly to train or assist a person in personal hygiene and other activities of daily living rather than to provide therapeutic treatment. Activities of daily living includes such things as bathing, feeding, dressing, walking, and taking oral medicines and any other services which can safely and adequately be provided by persons without the technical skills of a nurse or health care professional. Such care is considered to be custodial regardless of who recommends, provides or directs the care, where the care is provided and whether or not the individual family member can be or is being trained to care for him or herself. The Plan also considers any care or services to be custodial if they are or would be considered custodial for Medicare purposes.
7. Elective surgeries for preventive reasons.
8. All non-emergency medical services outside the United States without prior written approval of the Plan Administrator. (Note: Acupuncture, Chiropractic, Dental Care, Lasik, Massage, Orthodontic Care, and Vision Care services, meeting all other Plan requirements, i.e. coding, licensing, prior authorization, etc, are NOT excluded if secured outside the United States. All claims must be submitted in English.)
9. Experimental Services and Procedures. The Plan does not cover procedures, services, drugs and other supplies that are determined by the Plan Administrator to be experimental or still under clinical investigation by health professionals. A procedure is considered to be experimental if it is generally deemed so by medical professionals, the Food and Drug Administration, the National Institutes of Health or by Medicare and/or Medicaid guidelines.
10. First Aid Supplies.

11. Genetic testing (except as medically necessary).
12. Governmental Treatment. Except as otherwise provided by law, the Plan does not cover services or supplies for care or treatment provided by the United States Government or any state or local government when, without Plan coverage, the person would not be required to make payment.
13. Health Enhancement Programs, Life Style Center Programs, Residential Diabetes Treatment Programs, or any regimen designed to prevent future health problems or to influence adoption of a healthier lifestyle with a secondary objective of providing necessary medical treatment.
14. Late Hospital Charges. The Plan does not cover charges submitted more than 60 days after the date of the service was provided by a hospital.
15. Licensing Exams. The Plan does not cover physical examinations for the purpose of licensing or regulatory requirements.
16. Military Injuries. The Plan does not provide benefits for the illnesses and injuries of employees returning from military leave under Uniformed Services Employment and Reemployment Rights Act of 1994 ("USERRA"), if the Secretary of Veterans Affairs determines that the illness or injury was incurred in, or aggravated during, performance of service in the Uniformed Services (as that term is defined by USERRA).
17. Nail Debridement. The Plan does not cover nail debridement, except for Plan Participants with the diagnosis of diabetes.
18. Non-Emergency Ground or Air Ambulance Travel. The Plan's Utilization Review Manager must review and pre-authorize all exceptions to this exclusion.
19. Non-prescription glasses or sunglasses.
20. Nutritional counseling (except when medically necessary).
21. Obesity Related Treatment, including Gastric Surgery, or Prescription Drug Therapy for obesity treatment. Upon review by the Plan's Pre-Certification Department and/or the Prescription Drug Plan Administrator, exceptions for those diagnosed with "Clinically Severe Obesity" or a significantly high "Body Mass Index" and certain co-morbidities may be granted.
22. Plastic, Reconstructive, Cosmetic Procedures and Surgeries. The Plan does not cover charges for plastic, reconstructive, or cosmetic procedures, surgeries, services or supplies (whether or not for psychological or emotional reasons) for the purpose of enhancing, altering, or improving personal appearance or comfort. Limited exceptions may be obtained after first being reviewed by the Plan's Pre-Certification Department, to the extent that the surgery or procedure is necessary to:
 - a. improve the function of a part of the body that is malformed; or
 - b. correct a condition resulting from a severe birth defect; or
 - c. correct a condition that is a direct result of a disease or surgery performed to treat a disease or injury; or
 - d. repair an injury, but only if the surgery is performed within twenty-four months of the accident causing the injury
23. Pre-existing Conditions. The Plan does not cover certain Pre-existing Conditions as described in the Pre-Existing Conditions section of this document.

24. Pregnancies of Dependent Children are not covered, including medical complications resulting from a pregnancy.
25. Prenatal and Parent Training Classes.
26. Sexual Transformations and Trans Gender procedures.
27. Telephone Consultations.
28. Treatment by Household Members. The Plan does not cover services of a person who ordinarily resides in the home of the patient.
29. Virtual scans and physicals are not covered.

The NAD Health Care Assistance Plan follows the CMS approval guidelines.

AUTHORIZED PROVIDERS

Your Plan covers services received only from professional medical care providers who meet certain licensing, accreditation, and certification standards.

The Plan considers the following to be Authorized Providers when they perform services within the scope of their license or certification:

1. Physician - Doctors of medicine (M.D.); osteopathy (D.O.); dental surgery (D.D.S.); medical dentistry (D.M.D.); podiatric medicine (D.P.M.); and optometry (O.D.).
2. Independent Laboratory - A laboratory that is licensed under State law or, where no licensing requirement exists, that is approved by the Plan or your employer.
3. Qualified Clinical Psychologist - A psychologist who:
 - a. is licensed or certified in the state where the services are performed
 - b. has a doctoral degree in psychology (or an allied degree, if the academic licensing/certification requirement for clinical psychologist in that state is met by an allied degree) or is approved by the Local Plan and
 - c. has met the clinical psychological experience requirements of the individual State Licensing Board
4. MS in psychology - A person who:
 - a. has a MS in psychology and
 - b. is licensed or certified to provide services based on state licensing guidelines
5. Nurse Midwife - A person who is certified by the American College of Nurse Midwives and, is licensed or certified to provide services based on state licensing guidelines.
6. Nurse Practitioner/Clinical Specialist - A person who:
 - a. has an active R.N. license in the United States
 - b. has a baccalaureate or higher degree in nursing and

- c. Is licensed or certified to provide services based on state licensing guidelines

The services of a nurse practitioner/clinical nurse specialist are covered only if provided under the supervision of a medical doctor (unless state law overrides this requirement).

7. Clinical Social Worker - A social worker who:
 - a. has a master's or doctoral degree in social work
 - b. has at least two years of clinical social work practice and
 - c. Is licensed or certified, to provide services based on state licensing guidelines
8. Physical, Speech, and Occupational Therapist - Professionals who are licensed in the areas where the services are performed.
9. Acupuncturist - A professional therapist licensed in the state of residency and/or certified by the National Certification Commission for Oriental Medicine.
10. Audiologist - A professional who, is licensed or certified to provide services based on state licensing guidelines.
11. Dietician - A professional who is licensed or certified to provide services based on state licensing guidelines.
12. Nutritionist - A professional who is licensed or certified to provide services based on state licensing guidelines.
13. Certified Registered Nurse Anesthetist (CRNA).
14. Doctor of Chiropractic (DC).
15. Certified Licensed Massage Therapist (CLMT).
16. Physician Assistant - A professional who is licensed or certified to provide services based on state licensing guidelines.

Excluded Providers

The services of the following Providers are NOT covered by the Plan:

1. Doctors of Naturopathy except as required by State Law.
2. Recreational Therapists, Ayurnouvedic Physicians, Christian Scientist Practitioners, Homeopaths, Naturopaths, Certified Clinical Hypnotherapists, Oriental Body Works Practitioners, Aroma Therapists, Masters of Iridology, Certified Healing Touch Practitioners, Myotherapists, Certified Rebalancing Therapists, Rolfing Practitioners, and Dulan Practioners.

PRE-EXISTING CONDITIONS

The Plan does not pay benefits for pre-existing conditions, as described in this section.

Definition

For purposes of this Plan, a Pre-Existing Condition means a condition, injury or illness for which medical advice, diagnosis, care, or treatment was recommended by or received from a physician within a certain

six-month “treatment” period. If you are subject to a waiting or probationary period before you may enter this Plan, the six-month treatment period is the six months before the date you were hired. If you enter this Plan without a waiting or probationary period, the six-month treatment period is the six months before the date you enter the plan.

Exclusion Period

For a certain period there are no benefits under the Plan for your Pre-Existing Conditions. This period is called the “exclusion” period. If you enter the Plan when you are hired or as soon as you have completed a waiting or probationary period the exclusion period is the twelve months after the date you are hired. If you enter this Plan during a special enrollment period described in the Enrollment section of this document, your exclusion period is the twelve months after you enter the Plan. If you enter this Plan at any other time, such as during an open enrollment period, your exclusion period is the eighteen months after you enter the Plan.

Exceptions

However, there are several exceptions to these rules:

1. Pregnancy is never considered to be a Pre-Existing Condition.
2. Genetic information is never considered to be a Pre-Existing Condition.
3. “Health Coverage” and “Significant Break in Health Coverage Rules.”

If you had Health Coverage prior to entering this Plan, your exclusion period may be shortened or you may have no exclusion period for Pre-Existing Conditions whatsoever. “Health Coverage” means coverage under this Plan or any other group health plan, health insurance, COBRA, Medicare, Medicaid and certain other public health plans. [However, workers’ compensation coverage, automobile medical payment coverage, disability insurance, and other related types of coverage are not considered to be Health Coverage.] Your rights to a shortened exclusion period depend upon whether you have had a “Significant Break in Health Coverage.” You have a “Significant Break in Health Coverage” under these rules if you do not have Health Coverage for a period of 63 consecutive days. Any introductory period you may have (which varies by employer) before you join this Plan or any other plan does not count when calculating whether you have been without Health Coverage for 63 consecutive days.

Rules Applicable to Children Only

There are two special Pre-Existing Condition rules that apply only to dependent children.

1. **Newborns.** If a newborn child becomes covered by any Health Coverage within 30 days of the date of his or her birth, the Plan will never impose its Pre-Existing Condition clause on the child if the child has remained covered by any Health Coverage since birth without a Significant Break in Health Coverage.
2. **Adopted Children.** If a child is adopted or placed for adoption before the child reaches his or her eighteenth birthday, and the child is covered by any Health Coverage within 30 days of the date of his or her adoption or placement for adoption, the Plan will never impose its Pre-Existing Condition clause on the child if the child has remained covered by any Health Coverage since adoption or placement for adoption without a Significant Break in Health Coverage.

Rules Applicable to All Plan Participants

This rule on Pre-Existing Conditions applies to both adults and children who are covered under the Plan. In particular, please note that a child who does not meet the qualifications above can still have his or her exclusion period reduced or eliminated under this paragraph.

1. **Reduction of Exclusion Period Due to Prior Health Coverage.** The exclusion period for Pre-Existing Conditions is reduced by the number of days of Health Coverage that a person has had prior to certain dates. For new or rehired employees and their dependents who enter the Plan immediately upon employment or after a probationary or waiting period, the Plan reduces the twelve-month exclusion period by the number of days of Health Coverage the person had prior to the employee's first day of employment. For all other persons, the Plan reduces the exclusion period by the number of days of Health Coverage the person had prior to the date of enrollment in the Plan. However, the Plan does not reduce the length of the exclusion period by days of Health Coverage, which a Plan Participant had prior to a Significant Break in Health Coverage.
2. **Proving Prior Health Coverage.** Federal law requires that employers, insurance companies, and other providers of Health Coverage issue "Certificates of Creditable Coverage" when your Health Coverage ceases. This Certificate will show the number of days of Health Coverage that was provided to you by that employer, the health insurance company or other provider, and will suffice as proof of prior Health Coverage for determining the length of the Pre-Existing Condition exclusion under this Plan. If you are enrolling in this Plan for the first time and you have had other Health Coverage, you should request this Certificate from your previous employers, insurance companies and other providers of Health Coverage. If a Certificate is not provided, the Plan Administrator or your employer may be able to assist you in obtaining these Certificates from your previous providers of Health Coverage. You should present this Certificate to your employer when you enroll in the Plan.

WHEN COVERAGE ENDS UNDER THE PLAN

Except as provided in **CONTINUATION COVERAGE** below, coverage under the Plan ends on the following dates:

1. **Employees**

An employee's coverage under the Plan ends the earliest of the following dates:

- a. The date on which your employment terminates or you retire.
- b. The date on which you cease to be paid for full time work.
- c. The date on which you fail to meet the eligibility requirements of the Plan.
- d. The final date through which you have paid for coverage, if you are required to make a contribution to the Plan and you cancel your payroll deduction for the Plan or fail to submit required contributions to the Plan.

2. **Spouses**

A spouse's coverage under the Plan ends the earliest of the following dates:

- a. The date on which your spouse does not meet eligibility requirements of the Plan.
- b. The date on which your marriage ends by divorce or annulment.
- c. The date on which you legally separate from your spouse pursuant to a court order.
- d. The date on which the employee's coverage terminates.

3. Children

Your dependent children's coverage under the Plan ends the earliest of the following dates:

- a. The date on which the children no longer meet each of the eligibility requirements for dependent children under the Plan, including the age/disability requirements outlined in the Eligibility section of this document.
- b. The date they are married.
- c. The date on which your coverage terminates.
- d. The date of marriage or emancipation, and the child is never again eligible for coverage as a dependent.

Participation in the Plan also can be terminated for cause by the Plan Administrator or your employer if you and/or your family members present, prepare, or cause to be prepared or presented, false information to the Plan, or if you and/or your family members embezzle or otherwise wrongfully obtain Plan funds, or otherwise commit fraud or make a material misrepresentation on the Plan. This includes, but is not limited to, such actions as making false statements on a claim form, an application to enroll, or other Plan form or document. You can also be terminated for cause if you refuse to repay, when asked to do so, the Plan for claims or benefits wrongfully paid by the Plan.

CONTINUATION COVERAGE

The Plan does not generally provide continuation coverage, such as coverage under COBRA. The Plan is not required by law to provide COBRA coverage. However, the Plan may provide limited continuation coverage in the following situations:

Medical Coverage

If other health care coverage is not available at the time coverage terminates for an employee or dependent, the former participant may be eligible for continued benefits under this Plan for a short period after coverage terminates, provided that the employer offers such coverage. The coverage may be granted for a period of up to two months (60 days) or until the former participant has obtained other health coverage, whichever comes first. The employer may require the employee or former participant to pay a contribution for the cost of providing such coverage. In lieu of this coverage, an employer may choose to offer the former participant short-term medical plan coverage at his or her expense or may not offer either type of coverage.

Certain Divorce Situations

The employer may, in its sole discretion, allow the spouse or ex-spouse of employee or ex-employee and certain children to remain on the Plan after legal separation or divorce from the employee or ex-employee, if the separation or divorce was due to unlawful actions of the employee or ex-employee or to circumstances beyond the control of the spouse or ex-spouse of the employee or ex-employee or in other situations approved by the employer. The following persons who were participating in the Plan prior to the divorce or separation may continue to participate in the Plan for a period not to exceed twelve (12) months if allowed to do so by the employer and they would otherwise meet the eligibility rules for the Plan if the separation or divorce and, if applicable, the ex-employee's termination of employment, had not occurred: (1) the spouse or ex-spouse of the employee or ex-employee; (2) children of the spouse or ex-spouse of the employee or ex-employee; and/or (3) children of the employee or ex-employee. The employer, however, is not obligated to extend coverage under this provision and the employer may charge a contribution for participation.

Disability

If your employment terminates due to your total disability and you and/or your covered dependents are not eligible for coverage under another plan, coverage under this Plan for you and/or your covered dependents that is in effect at the time of your total disability may continue for up to 24 months following the date of your total disability. You are considered to have a total disability when you have a disability that is expected to last at least 90 days and your doctor has certified your complete inability to perform any duty pertaining to your occupation or employment and the long term disability carrier has approved the disability claim. After the initial 90-day of elimination period, you and your covered dependents are eligible for an additional 21 months of coverage through the Health Care Assistance Plan. However, your continuation coverage for you and your covered dependents will cease under this paragraph prior to such periods as soon as any other health care coverage is available to you.

Death

If your employment terminates due to death and your covered dependents are not eligible for coverage under another plan, coverage under this Plan that is in effect at the time of your death will continue for your covered dependents for up to six months following the date of your death. The right to continuation coverage will cease under this paragraph prior to the end of such six month period as soon as your covered dependents are eligible for other health care coverage.

LEAVES OF ABSENCE

Military Leave

This paragraph sets forth the Plan's provisions concerning continuation of coverage under the Uniformed Services Employment and Reemployment Rights Act of 1994 (USERRA).

Twenty-Four Month Period. An employee on military leave remains in the Plan for thirty (30) days under the same rules as an employee not on leave. After thirty (30) days of absence, the employee has the right to elect to continue coverage under the Uniformed Services Employment and Reemployment Rights Act of 1994 (USERRA) for the employee and his or her dependents for an additional period not to exceed twenty-four (24) months, beginning as of the thirty-first (31st) day of leave. Your coverage will end prior to the 24-month maximum if you (1) are required to apply for or return to a position of employment and fail to do so; or (2) fail to make the required contributions for Plan coverage.

Contributions. The amount of the contribution for the additional 24-month period will be equal to the sum of the usual employer and employee contributions to the Plan for the Plan Participant(s), plus a two percent (2%) administrative fee. Payment must be made in accordance with the rules set forth below under caption titled "Payments for Persons on Leave."

Electing USERRA Coverage. Employees going on military leave desiring USERRA continuation coverage must elect USERRA continuation coverage. This election must be in writing on a form provided by the Plan Administrator and must be completed and returned to your employer or the Plan Administrator within 30 days of the beginning of the leave, except as provided below concerning leaves in which you are excused from giving advance notice to the Company. You must make the election, and you may elect USERRA continuation coverage for yourself and for your covered family members. If such an election is not received within such time period, you will lose any rights you and your family members have to USERRA continuation coverage. Your covered family members do not have the right to USERRA continuation coverage unless you elect USERRA continuation coverage for yourself.

In most instances, you are required by USERRA to give advance notice of your impending military leave. However, in certain situations under USERRA, you are excused from giving advance notice to your employer or the Plan Administrator of your military service because the giving of advance notice is impossible, unreasonable or precluded by military necessity. In these cases, you may elect USERRA continuation coverage by notifying your employer or the Plan Administrator of such election in writing within 30 days of the date that the giving of notice is possible, reasonable or no longer precluded by military necessity. This election must be accompanied by the following: (1) a statement of the reason(s) why you were unable to give advance notice; and (2) payment in full for the unpaid contribution amounts due for each month of coverage beginning as of the date you were first absent from work due to the USERRA leave up to the contribution amount due for the month of such election. However, if you give such election after the maximum time period for USERRA coverage has elapsed, coverage shall be only for such maximum USERRA time period and the payment must be for the entire time period. If a timely election form is filed in accordance with this paragraph, your coverage will be retroactively reinstated to the date you were first absent from work and shall continue for a period of time up to the maximum time period described above.

Your first payment for USERRA continuation coverage is due no later than the last day of the month in which the Plan Administrator or your employer received the written election to obtain USERRA continuation coverage, and must cover the month or months since your absence from work began through the month in which the election was received by the Plan Administrator. If full payment is not received by the due date, the USERRA continuation coverage will cease retroactively effective as of the last day of the month for which a payment was received on a timely basis.

The following persons do not have USERRA continuation coverage rights under the Plan:

1. Your family members if you do not elect USERRA continuation coverage for yourself
2. Your family members who go into military service

Other Leaves

If you and/or your dependents have coverage under the Plan and you take an approved leave of absence (other than a leave under USERRA), you and your dependents may, but are not required to, continue to participate in the Plan for as long as the leave lasts.

Participation During Leave

Employees on approved leaves of absence may choose not to participate in the Plan during the leave. If an employee so elects not to participate, his or her dependents also shall not be eligible to participate during the leave. Employees (and their dependents) returning to work after an approved leave of absence shall immediately become eligible for participation in the Plan upon return to full-time employment (if they otherwise meet the requirements to participate in the Plan), even if their coverage under the Plan has ceased during the leave for failure to make a required contribution.

Adding Dependents During Leave

An employee on an approved leave of absence may add dependents to the Plan under the same rules and at the same time as employees who are not on leaves of absences.

Payments for Persons on Leave

If you are on a paid leave of absence, any contributions you are required to make to the Plan will be made by payroll deduction. If you are on unpaid leave, other than Family and Medical leave, payments must be made by the last day of the month or your coverage under the Plan will cease.

Family and Medical Leave

Employees on full-time leaves of absence under the Family and Medical Leave Act (“FMLA”) and their dependents will cease to be covered by the Plan for the remainder of the FMLA leave if payment is more than thirty (30) days late, if written notice of the termination of coverage is mailed to the employee at least fifteen (15) days before the coverage is terminated. Employees on full-time leaves of absences may, but are not required to, prepay contribution payments through the employer’s Section 125 Plan to the extent allowed by law.

Recovery of Employer Payments-FMLA Leave

Your employer retains the right to recover, on behalf of the Plan, your employer’s contributions to the Plan made on behalf of an employee (and his or her dependents) during full-time absence under the FMLA if the employee chooses not to return to work for reasons other than a continued serious health condition or circumstances beyond the employee’s control.

CLAIMS, PAYMENTS & CLAIMS REVIEW PROCESS

PLAN ADMINISTRATION

Your employer is responsible for funding, and in some instances paying, the benefits provided by this Plan. Adventist Risk Management (“ARM”) has been designated by your employer to administer the Plan and serves as Plan Administrator. Adventist Risk Management oversees the Plan, and through its contracted representatives, coordinates pre-certification, receives, reviews and pays the claims presented, in accordance with the provisions of the Plan.

Questions about your health plan should be directed to Member Services at the phone number on the back of your benefit ID card. Adventist Risk Management Inc. also provides internet service for this purpose (see www.adventistrisk.org)

Final Authority

Except for Level 2 claims appeals, the Plan Administrator has the final authority for the administration and interpretation of this Plan document; however, the Plan Administrator may not discriminate unfairly between individuals in similar situations at the time of such actions.

Powers of Plan Administrator

The Plan Administrator has all powers and discretion necessary to fully discharge its duties described in the Plan, including but not by way of limitation, the following powers and duties:

1. to construe and interpret the Plan, decide all questions of eligibility and determine the amount, manner and time of payment of Plan benefits
2. to prescribe procedures to be followed by employees and providers in obtaining benefits
3. to make a determination as to the right of any person to a benefit
4. to make factual determinations upon which decisions as to benefits are based and
5. to receive from employees and other information that may be necessary for proper administration of the Plan

CLAIMS PROCESSING PROCEDURES

All medical claims should be routed by your provider to their Local Blue Cross claims office. Claims for medical carve-out services, dental, or vision benefits should be routed to the address on the back of your “ARM/Medco” benefit ID card. Claims for prescriptions purchased without the use of the prescription ID card must be submitted directly to the Pharmacy Benefits Manager.

FILING A CLAIM

Because of the large number of medical and dental claims submitted each year, it is necessary to have some rules to facilitate processing. It is imperative that you follow these rules.

Procedure

When visiting a provider, you should always present the appropriate health care benefit ID card to the provider for the services you are receiving. This ensures that the provider obtains the appropriate billing information for you, the Plan, and the Plan Administrator.

1. Be sure the patient information on the claim form is correct.
2. Original bills of the providers must be provided and they cannot be returned. If you cannot submit original bills because you have already submitted the bill to another plan which is the “primary plan” (see the Plan’s coordination of benefit rules), photocopies of these bills will be accepted when submitted with the primary plan’s explanation of benefits. Original bills of providers are acceptable if they are on the appropriate claim form, and contain the following information:
 - a. Provider’s name, address, and Federal Identification Number
 - b. Name of patient and name of employee
 - c. Member ID number
 - d. Date of service, treatment or purchase
 - e. Type of treatment
 - f. Diagnosis
 - g. CPT code related to service provided
 - h. Each item or service for which you are charged and
 - i. Amount of charge (Non-itemized receipts or billings are not acceptable)

Claim Deadline

All claims for a benefit payment should be filed promptly. Generally, you should submit requests for payment as soon as you receive bills or receipts. In this way providers can be paid promptly and your records can be kept as up-to-date as possible. The deadline for filing a claim is within one year of date of service. Claims filed after that date will not be covered by the Plan.

Complete and Accurate Information Required

When filing a claim for benefits under the Plan, it is necessary that accurate and complete information be given. If relevant information is misstated or not disclosed, the benefit payments will be recalculated based upon the correct information and you will be obligated to refund the Plan any overpayment received. If you refuse to submit any documentation requested by the Plan Administrator or otherwise fail to cooperate in the processing of your claim, the claim may be denied on that basis alone.

Record keeping

Please keep records of your claims. If you want to maintain personal records, be certain to keep copies of each medical/dental bill and claim that is submitted along with the explanation of benefit (EOB) document you receive as claims are processed and paid. This information is also available to you online. To learn how to set up your own User-ID and password, please contact Member Services.

Payments

In most instances the payments of benefits under this Plan are made to the provider or supplier that rendered the service or supply. However, the Plan Administrator has the discretion in most instances to make payments directly to the employee, rather than to the provider or supplier, if the employee has paid the provider or supplier and the employee so informs the Plan Administrator at the time the claim is made. In addition, Plan payments may be made to any other person, such as a custodial parent, an adult child or a state agency, in accordance with a medical child support order. Any benefits which are payable to an employee, if unpaid at his or her death, are paid to the surviving spouse of the employee. If the employee does not have a surviving spouse, then the Plan benefits shall be paid to the employee's estate. Any benefits payable to any other natural person, if unpaid at the person's death, shall be paid to the person's estate.

Claims for benefits are processed when the Plan Administrator receives the complete, necessary written proof to support your claim. In general, claims are processed in the order received by the Plan Administrator. The date the expense was incurred is used to determine if there were any deductibles, Plan maximums, and/or other limitations applicable to those claims.

HOW TO APPEAL A CLAIM

The following procedures have been adopted to ensure that your appeal of the claim will be handled promptly and in a fair, reasonable, and consistent manner. It is important for you to follow the deadlines set forth below for the filing of an appeal of a claim. Any appeal not submitted on time will be denied automatically.

Level 1 Appeal

If you think that your benefit payment or claim denial was incorrect, you may have your claim reconsidered by submitting an appeal in writing.

An appeal for a claim processed by Blue Cross must be submitted to: Independence Blue Cross, Member Appeals Unit, P.O. Box 41820, Philadelphia, PA 19101.

All other appeals can be submitted in writing to: Adventist Risk Management, Member Appeals Unit, P.O. Box 4759, Silver Spring, MD 20914; or by email to healthcare@adventistrisk.org.

Appeals telephonically submitted will never be considered an appeal. The deadline for requesting reconsideration (a Level 1 appeal) is 60 days after you receive the payment or notice of the denial. An appeal can be submitted by you or, if you choose, by your representative. You may also submit an appeal on behalf of your covered spouse or children under 18. If the appeal is being submitted by a representative, appropriate documentation of authorization of this representative must be included with the appeal. This would include your spouse authorizing you to submit an appeal on his or her behalf. However, you (the employee) may submit an appeal for your minor child without any special documentation or authorization (under HIPAA or otherwise) from your minor child.

Contents of Appeal

1. The appeal should clearly state the reason that you believe your claim should be handled differently.
2. You should include any facts, other information or issues you consider important and wish to submit in support of your appeal.
3. You must include a copy of the official Payment Advice indicating the reduction in payment or denial of services or benefits.

Review of Documents - In preparing your appeal, you may request to review any appropriate documents.

Medical Exam - In order to decide your appeal, the Plan Administrator may request that you be examined by a medical consultant selected by the Plan Administrator.

Timing of Decision - Once the appropriate Appeals Unit receives your appeal, it will be reviewed and you will be notified of the decision within 60 days from receipt of the appeal. When special circumstances require more time for a fair decision, the Appeals Unit will notify you in writing of the potential delay within 60 days and will send you its written decision no later than within 120 days of receipt of your Level 1 appeal.

Contents of Decision - If your appeal is denied in whole or in part, the written decision will include specific reasons and specific references to the Plan provisions upon which it is based, and will refer you to the Level 2 appeal procedure under which you may appeal the decision further. If applicable, the notice will briefly describe any additional material or information necessary for reconsideration and explain why such information is necessary.

Level 2 Appeal

In most instances, questions concerning your assistance or claim denial can be resolved to your satisfaction with the Level 1 appeal to the Appeals Unit. If however, after receiving a decision on your Level 1 appeal, you still believe that your claim has not been handled properly or that there are some points that the Appeals Unit may have overlooked, you may submit a Level 2 appeal in writing to the Plan Administrator who will then submit your appeal to the controlling committee of your employer. Direct these Level 2 appeals to Adventist Risk Management, Level 2 Appeals Unit, P.O. Box 4759, Silver Spring, MD 20914. This process will assure that your Private Health Information (PHI) is kept confidential in so far as required by state or federal laws in effect at the time of your Level 2 appeal.

Since Level 2 appeals generally are requests for exceptions to the Plan benefit provisions you should be aware that any payment by your employer or the Plan may generate taxable income for you. Any payment of exceptions by the Plan administrator will not be included in any specific or aggregate stop loss calculation by your employer's stop loss carrier. In addition, a processing fee of \$125 for any exceptions to the Plan relating to medical benefits administered by Blue. Your employer may pass this charge on to you.

Timing of Appeal - The deadline for filing a written appeal under Level 2 is 60 days after you receive the Appeals Unit's decision under Level 1 of the appeal procedure.

Contents of Appeal - The Level 2 appeal is the final step of the review process. Therefore, include all the information you submitted with your Level 1 appeal, as well as any additional information that will be of assistance in the review of your appeal.

Review of Documents - In preparing your appeal, you may request to review any pertinent documents.

Decision on Appeal - Once the controlling committee of your employer receives your request for review, it will then carefully review the facts, the reasons for the Plan Administrator's decision, and the points you have raised about your claim, as well as the documents provided by you and the Plan Administrator. The controlling committee may request that the patient be examined by a medical consultant recommended by the Plan Administrator at the Employers expense. The Plan Administrator will notify you of the controlling committee's final decision within 60 days after your appeal is received. If a longer time is required, you will be notified in writing. Except in extraordinary situations, a decision will be rendered within an additional 60 days. The decision will be in writing and will include specific reasons and specific references to the pertinent Plan provisions on which the decision is based. The decision of the controlling committee upon review shall be final and binding.

MISCELLANEOUS PROVISIONS

RECOVERY RIGHTS (SUBROGATION AND REIMBURSEMENT)

Definition of Subrogation and Reimbursement

When you or your dependent has an illness or injury caused by another, a third party (including an insurance company) may be liable for damages or may be willing to pay money in settlement of a claim. When the Plan pays benefits for the illness or injury, the Plan has the right to recover benefits paid or payable under this Plan and is subrogated to all and any of your rights and your dependent's rights to recover from the third party and to any money paid in settlement of a claim, whether or not such recovery or settlement represents medical expenses, but only up to the amount of the benefits provided by the Plan. Each Plan participant, whether an employee or a dependent is individually obligated to comply with the provisions of this section.

- 1. Reimbursement to Plan.** When you and your dependents receive or claim Plan benefits for an illness or injury caused by another, you and your dependents agree to immediately reimburse the Plan for benefits paid out of any recovery from any third party as a result of judgment, settlement, award or otherwise. In situations where the Plan Administrator determines that a third party may be liable for medical expenses, the Plan Administrator may nonetheless agree to conditionally pay the claims relating to such expenses in advance pending a final determination of a) whether a third party or the Plan Participant is responsible for such expenses instead of the Plan; and/or b) the claims are excluded from coverage under this Plan. Each Plan Participant agrees to reimburse the Plan for such conditional payments when a final determination is made by the Plan Administrator that the Plan is not responsible for the payment of such claims. The Plan is entitled to reimbursement and/or recovery under this section from any judgment, award, and other types of recovery or settlement received by a Plan Participant, regardless of whether the recovery is characterized as relating to medical expenses.
- 2. Cooperation.** You and your dependents are also required under this Plan to cooperate with the Plan Administrator to effectuate the terms of this Recovery Rights (Subrogation and Reimbursement) section and to do whatever may be necessary to secure the recovery by the Plan of the amount of the benefits paid, including execution of all appropriate papers, furnishing of information and assistance. You and your dependents also agree not to interfere with the Plan's rights under this Section.
- 3. Actions to Recover.** The Plan Administrator is entitled to institute actions in its own name or in your or your dependent's name or to join any action brought by you, your dependents or your representatives, with or without specific consent, and to participate in any judgment, award or settlement to the extent of the Plan's interest. You and your dependents may not take any action that may prejudice the Plan's rights of recovery. You and your dependents must notify the Plan Administrator before filing any suit or settling any claim so as to enable the Plan Administrator to participate in the suit or settlement to protect and enforce the Plan's rights under this subrogation provision. You and your dependents agree to keep the Plan Administrator fully informed and advised of all developments in any such suit or settlement negotiations. The Plan also is entitled to recover from you and your dependents the value of the services provided and benefits paid for, when you or your dependents are reimbursed or paid by another party, specifically unreduced by any legal or other fees and costs incurred by you or your dependents in seeking recovery from such other party (whether the other party is the responsible party or is an insurer), except if the Plan Administrator specifically agrees to participate in the attorney's fees under the item 6 below.
- 4. No Benefits; Refusal to Pay Benefits.** In situations in which the Plan Administrator determines, in its sole discretion, that it has or may have rights of recovery and that its rights of recovery may be

or have been compromised, threatened or jeopardized, the Plan Administrator may refuse to pay benefits otherwise covered under this Plan. This Plan does not pay benefits for illnesses and injuries when your medical expenses are the responsibility of, or are paid by, a third party (or a third party's insurer) who has caused your illness or injury.

5. **Binding Effect.** The Plan's provisions regarding recovery are binding upon you and your dependents and binding upon your and your dependent's guardians, heirs, executors, assigns and other representatives.
6. **Participation Attorney's Fees.** The Plan does not normally participate in the costs of recovering amounts from a third party, such as attorney's fees and litigation costs. However, if the Plan Administrator determines, in its discretion that participating in such costs would benefit the Plan, it may agree to participate in such fees as follows:
 - a. When the amount of the recovery or settlement from the third party is equal to or less than the amount of Plan benefits payable relating to the incident, the Plan Administrator may agree to waive its rights of subrogation in an amount equal to up to one-third of the recovery or settlement amount for payment or reimbursement of legal and litigation costs. For example, if the Plan has paid \$30,000 in claims and you settle a claim for \$30,000, the Plan Administrator may agree to waive the Plan's subrogation rights in an amount not to exceed \$10,000 for the payment of attorney's fees and litigation costs. If the Plan has paid \$30,000 in claims and you settle a claim for \$15,000, the Plan Administrator may agree to waive the Plan's subrogation rights in an amount not to exceed \$5,000.
 - b. When the amount of the recovery or settlement from the third party is greater than the amount of Plan benefits relating to the incident, the Plan Administrator may agree to waive its rights of subrogation for reimbursement of legal and litigation costs up to the following amount:
7. One-third of amount of Plan benefits paid or payable minus the amount by which the settlement or recovery exceeds the amount of Plan benefits paid or payable.
 - a. For example, if the Plan has paid \$30,000 in claims, and you settle the claim for \$35,000, the Plan could waive up to \$5,000 (\$10,000 minus \$5,000) of its subrogation rights for the payment of attorney's fees and litigation costs.
 - b. The Plan Administrator also has the right, in its sole discretion, to approve alternative methods of participating in attorney's fees and litigation costs when the Plan Administrator determines that such methods are in the best interest of the Plan or the Plan may engage its own counsel at its own expense.
8. **Written Agreement.** You and your dependents must execute a written recovery agreement as a condition of payment on claims arising from injuries or illnesses caused by third parties. If your dependent is so injured or has such an illness, both you and your dependent are required to execute the written recovery agreement. If the injured or ill person is a minor or legally incompetent, the written recovery agreement must be executed by the person's parent(s), managing conservator and/or guardian. If you or your dependent has died, you or your dependent's legal representative must execute the agreement. Employees and all other parties in interest discussed above are jointly and severally liable for reimbursing the Plan in these situations. Any Plan benefits paid must be returned to the Plan immediately in the event that the Plan Administrator requests that a recovery agreement be signed and there is a failure of refusal to execute the recovery agreement. The Plan's Rights of Recovery are not waived if the Plan does not request a Written Agreement under this section. In addition, no plan benefits will be provided by the Plan unless all information, documentation and agreements required by the Plan Administrator to process a claim, including an executed recovery agreement, are filed with the Plan Administrator within one year of the date of the injury.

9. **Recovery Rights.** As a condition to receiving benefits under this Plan, you and your dependents agree not to bring or assert a make whole, common fund, collateral source or other apportionment action or claim in contravention of the Plan's Recovery Rights described above.
10. **Plan's Rights If a Plan Participant Fails to Comply with this Section.** If a Plan Participant fails to comply with this Recovery Rights section, the Plan may a) offset the amount of recovery or reimbursement due the Plan against future benefits under the Plan; b) enforce its rights through garnishment or attachment of your wages; c) enforce its rights in any other manner allowed by law.

PRIVACY AMENDMENT AND SECURITY

The Health Insurance Portability and Accountability Act of 1996 ("HIPAA") protects the privacy of certain types of individual health information, regulates the use of such information by the Plan and imposes certain security protection measures concerning electronic health information. The Department of Health and Human Services has issued regulations on this subject that can be found at 45 CFR parts 160 and 164 ("HIPAA Regulations"). The individual health information that is protected ("Protected Health Information" or "PHI") is any information created or received by the Plan that relates to:

1. Your past, present or future physical or mental health or your past, present or future physical or mental condition
2. the provision of health care to you or
3. past, present, or future payment for health care

However, HIPAA allows medical information, including PHI, to be disclosed by the Plan to the Plan Sponsor and to be used by the Plan Sponsor (the General Conference of the Seventh-day Adventist Church, North American Division). The permitted disclosures to and uses by the Plan Sponsor of medical information are as follows:

1. The Plan may disclose summary health information to the Plan Sponsor if the Plan Sponsor requests the summary information for the purpose of a) obtaining premium bids for providing insurance coverage; or b) modifying, amending, or terminating the Plan ("Summary Information"). The Plan Sponsor may use Summary Information so received from the Plan only for these two listed purposes.
2. The Plan may disclose to the Plan Sponsor, and the Plan Sponsor may use, information on whether an individual is participating in the Plan or is enrolling or disenrolling in the Plan.
3. The Plan may disclose PHI to the Plan Sponsor and/or the Plan Sponsor may use such PHI if you have specifically authorized in writing such disclosure and/or use.
4. The Plan may disclose PHI to the Plan Sponsor, and the Plan Sponsor may use PHI, to carry out plan administration functions, such as activities relating to:
 - a. obtaining premiums or to determining or fulfilling responsibility for coverage and provision of benefits under the Plan
 - b. payment for or obtaining or providing reimbursement for health care services - Payments under this Plan generally are made either to the health care provider or to the employee. All Participants should be aware that the Plan and the Plan Sponsor will be providing PHI concerning all dependents of an employee to the employee as part of the Explanation of Benefits and when reimbursing the employee for covered services under the Plan. If

there is some reason why a dependent (spouse or child) of an employee does not want the employee to receive PHI, the dependent should so inform his or her health care provider and should also contact the Plan Administrator

- c. determining eligibility for the Plan or eligibility for one or more types of coverage or benefits provided under the Plan
- d. coordination of benefits or determinations of co-payments or other cost sharing mechanisms
- e. adjudication and subrogation of claims, billing, claims management, collection activities and related health care data processing
- f. payment under a contract for reinsurance
- g. review of health care services with respect to medical necessity, coverage under the health plan, appropriateness of care, or justification of charges
- h. utilization review activities, including precertification and preauthorization of services and concurrent and retrospective review of services
- i. disclosure to consumer reporting agencies of any of the following PHI regarding collection of premiums or reimbursement: name and address, date of birth, Social Security Number, payment history, account number and name and address of the health plan
- j. medical review, legal services and auditing functions, including fraud and abuse detection and compliance programs
- k. business planning and development, such as conducting cost-management and planning-related analyses relating to managing and operating the Plan, including formulary development and administration and/or the development or improvement of methods of payment
- l. resolution of internal grievances
- m. prosecution or defense of administrative claims or lawsuits involving the Plan or Plan Sponsor
- n. conducting quality assurance and improvement activities, case management and care coordination
- o. evaluating health care provider performance or Plan performance
- p. securing or placing a contract for reinsurance of risk relating to health care claims, other activities relating to the renewal or replacement of stop-loss or excess of loss insurance and
- q. contacting health care providers and patients with information about treatment alternatives

These uses and disclosures are consistent with HIPAA Regulations.

The Plan Sponsor has agreed to (and the Plan has received a certification from the Plan Sponsor evidencing such agreement) the following restrictions:

1. The Plan Sponsor will not use or further disclose the PHI except a) as described above or b) as

otherwise required by law.

2. Any agents or subcontractors of the Plan Sponsor to whom the Plan Sponsor provides PHI will agree to the same restrictions and conditions on the use and disclosure of PHI that apply to the Plan Sponsor. Any agents or subcontractors of the Plan Sponsor to whom the Plan Sponsor provides electronic PHI must agree to implement reasonable and appropriate security measures to protect the information.
3. The Plan Sponsor will 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.
4. The Plan Sponsor will report to the Plan any use or disclosure of the PHI that is inconsistent with the permitted uses and disclosures of which the Plan Sponsor becomes aware. The Plan Sponsor will report to the Plan any security incident of which the Plan Sponsor becomes aware.
5. The Plan Sponsor will give you access and provide copies to you of your PHI in accordance with the HIPAA Regulations.
6. The Plan Sponsor will allow you to amend your PHI in accordance with the HIPAA Regulations.
7. The Plan Sponsor will make available PHI to you in order to make an accounting of PHI in accordance with the HIPAA Regulations.
8. The Plan Sponsor will make available its internal practices, books and records relating to the use and disclosure of PHI received from the Plan to the Secretary of Health and Human Services (or the Secretary's designee) for determining compliance by the Plan with the HIPAA Regulations.
9. The Plan Sponsor will, if feasible, return or destroy all protected PHI received from the Plan and retain no copies of the PHI when no longer needed for the purpose for which the 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.
10. The Plan Sponsor will ensure that adequate separation between the Plan and Plan Sponsor is established. Only the following employees or classes of employees or other persons under the control of the Plan Sponsor will be given access to the PHI to be disclosed:
 - a. Officers of the Plan Administrator
 - b. Employees of the Plan Administrator (Adventist Risk Management Health Care Department)
 - c. Plan Sponsor's designated Benefit Coordinator and Controlling Committee
11. The Plan Sponsor will ensure that this adequate separation is supported by reasonable and appropriate security measures to the extent that these individuals have access to electronic PHI.
12. The Plan Sponsor will implement administrative, physical and technical safeguards that reasonably and appropriately protect the confidentiality, integrity and availability of electronic PHI that the Plan Sponsor creates, receives, maintains or transmits on behalf of the Plan, except enrollment/disenrollment information and Summary Information, which are not subject to these restrictions.

The access to and use by the employees described above is limited to the plan administration functions that the Plan Sponsor performs for the Plan. Employees who violate this section are subject to disciplinary action by the Plan Sponsor, including, but not limited to, reprimands and termination.

The Plan has issued a Privacy Notice which explains the Plan's privacy practices and your rights under

HIPAA. This Notice is available by contacting the Plan's Privacy/Security Officer at the following address: **Adventist Risk Management, P.O. Box 4759, Silver Spring, MD 20914-4759 or email, privacyofficer@adventistrisk.org. The Privacy Notice is also available at www.adventistrisk.org.**

RELEASE OF MEDICAL INFORMATION

Any employee covered by the Plan, on behalf of himself or herself and the employee's covered dependents, shall be deemed to have authorized any attending physician, nurse, hospital, or other provider of services or supplier to furnish the Plan Administrator with all information and records or copies of records relating to the diagnosis, treatment, or care of any person covered by the Plan. Plan Participants shall, by asserting a claim for Plan benefits, be deemed to have waived all provisions of law forbidding the disclosure of such information and records. If so requested or required by law, each Plan Participant shall sign any release or authorization form in order to facilitate the release of such medical records.

FURNISHING INFORMATION

A person covered by the Plan must furnish all information needed to effect coverage under the Plan and termination or changes in such coverage. The Plan Administrator may require that a Plan Participant provide certain personal data (including reasonable proof of the accuracy of the data) necessary for the determination of the person's benefits. Failure to furnish the data (or proof of its accuracy) may delay the payment of benefits. Benefit payments may be adjusted to reflect correction of inaccurate or incomplete information, and an employee, other Plan Participant and/or medical provider may be required to make up any overpayments, and the Plan may make up any underpayments.

NO ASSIGNMENT OF BENEFITS

Plan benefits are not assignable except to the specific person or entity that provided the service or supply and except as otherwise required by law.

LEGAL ACTIONS

No action at law or in equity may be brought to recover under this Plan unless brought within three years after the date of rendition of the services for which a claim is made.

NO WAIVER

Failure of the Plan Administrator or your employer to insist upon compliance with any provision of this Plan at any given time or times or under any given set or sets of circumstances shall not operate to waive or modify such provision or in any manner whatsoever to render it unenforceable, as to any other time or times or as to any other occurrence or occurrences, whether the circumstances are, or are not, the same.

STOP LOSS COVERAGE

The Plan or Plan Sponsor may (but is not required to) purchase stop-loss insurance. Any stop-loss

insurance purchased shall provide payments solely to the Plan or Plan Sponsor. No stop-loss benefits are provided directly to any participant in the Plan.

PLAN AMENDMENT AND TERMINATION

The Plan may be amended or terminated at any time without prior notice by a resolution of the North American Division Committee of the General Conference of Seventh-day Adventists or by the North American Division Risk Management Committee. The right to amend includes the right to curtail or eliminate coverage for any treatment, procedure, or service, regardless of whether any covered employee is receiving such treatment for an injury, defect, illness, or disease contracted prior to the effective date of the amendment.

CONTRIBUTIONS

The contributions of all covered employees and participating employers are planned to be sufficient to support benefits provided by the Plan. However, these benefits are not guaranteed or insured. In the event the Plan is terminated or your employer terminates participation in the Plan, benefits will be paid from the account under the Plan in which the contributions from your particular participating employer (plus employee contributions, if any, from all covered employees of your employer) have been deposited, but only to the extent there are assets in such account to make the payments. Claims will be processed in the order received by the Plan Administrator until the funds in your participating employer's account are depleted.

RIGHTS UNDER NEWBORNS' AND MOTHERS' HEALTH PROTECTION ACT

Under federal law, group health plans such as this Plan generally may not restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a delivery by cesarean section. However, the plans may pay for a shorter stay if the attending provider (e.g., your physician, nurse midwife, or physician assistant), after consultation with the mother, discharges the mother or newborn earlier. Also, under federal law, plans may not set the level of benefits or out-of-pocket costs so that any later portion of the 48 hour (or 96 hour) stay is treated in a manner less favorable to the mother or newborn than any earlier portion of the stay. In addition, a plan may not, under federal law, require that a physician or other health care provider obtain authorization for prescribing a length of stay of up to 48 hours (or 96 hours).

RIGHTS UNDER THE WOMEN'S HEALTH AND CANCER RIGHTS ACT

The Women's Health and Cancer Rights Act of 1998 was enacted on October 21, 1998 and requires that health plans cover post-mastectomy reconstructive breast surgery if they provide medical and surgical coverage for mastectomies. Specifically, health plans must cover:

1. Reconstruction of the breast on which the mastectomy has been performed;
2. Surgery and reconstruction of the other breast to produce a symmetrical appearance; and
3. Prostheses and physical complications of all stages of mastectomy, including lymph edemas.

Benefits required under the Women's Health and Cancer Rights Act will be provided in consultation between the patient and attending physician. These benefits are subject to the Plan's regular co-

payments and deductibles. These types of benefits are provided under this Plan.

SECTION 125 CAFETERIA PLAN

Your employer may participate in and offer a Section 125 Cafeteria Plan program at your workplace. (Section 125 refers to the section of the Internal Revenue Code authorizing cafeteria plans.) Section 125 programs allow employees to elect to contribute part of their salary to be used to pay, on a pre-tax basis:

1. qualifying out-of-pocket medical expenses not reimbursed by this Plan or any other health plan or insurance, such as co-payments, deductibles and coinsurance; and
2. contributions or premiums, if any, required to be paid for Plan coverage.

If your employer has a Section 125 program, there are restrictions on when you are allowed to enroll in the program and when you can change your elections and coverage under the program. Please contact your employer for more information about these restrictions and other requirements and features of the Section 125 program.

FOREIGN LANGUAGE NOTICE

This booklet contains a summary in English of your rights and benefits under the Plan. If you have any difficulty understanding any part of this booklet, please contact your employer or the Plan Administrator.

OTHER PLAN INFORMATION

Plan Name

The official name of the Plan is the Health Care Assistance Plan for Employees of Seventh-day Adventist Organizations of the North American Division. The Plan is an employee welfare benefit plan maintained for the purpose of providing participating employees of participating employers with medical, surgical, hospital, vision and dental care assistance.

Plan Sponsor

The Plan is sponsored by the North American Division of the General Conference of Seventh-day Adventists and affiliated organizations. As such it qualifies as a "Church Plan" as defined by the Internal Revenue Service. Seventh-day Adventist organizations of the North American Division who comply with its provisions are exempt from the continuation of benefit requirements of COBRA and ERISA and certain other laws that do not apply to church plans.

Plan Documents

The current full NAD Health Care Assistance Plan document is available online at www.adventistrisk.org and can be downloaded or printed.

**IMPORTANT NOTICE FROM THE HEALTH CARE ASSISTANCE PLAN FOR
EMPLOYEES OF THE SEVENTH-DAY ADVENTIST ORGANIZATIONS OF THE
NORTH AMERICAN DIVISION OF THE GENERAL CONFERENCE OF SEVENTH-
DAY ADVENTIST CHURCH (“PLAN”)**

**TO: ALL PLAN PARTICIPANTS WHO HAVE MEDICARE OR WHO WILL BECOME ELIGIBLE FOR
MEDICARE IN THE NEXT 12 MONTHS**

**If you or your family members are not eligible for Medicare or will not soon become eligible for
Medicare, please disregard this Notice.**

PRESCRIPTION DRUG COVERAGE AND MEDICARE PART D

Please read this notice carefully and keep it where you can find it. This notice has information about your current prescription drug coverage from the Plan and about your options under Medicare’s prescription drug coverage. This information can help you decide whether or not you want to join a Medicare drug plan. Information about where you can get help to make decisions about your prescription drug coverage is provided at the end of this notice.

1. Medicare prescription drug coverage became available in 2006 to everyone with Medicare. You can get this coverage if you join a Medicare Prescription Drug Plan or join a Medicare Advantage Plan (like an HMO or PPO) that offers prescription drug coverage. This coverage is sometimes referred to as Medicare Part D prescription drug coverage. In general Medicare Part D provides coverage for prescription drugs not covered under Medicare Part A and Part B. All Medicare prescription drug plans provide at least a standard level of coverage set by Medicare. Some Medicare plans may also offer more coverage for a higher monthly premium.
2. The Plan has determined that the prescription drug coverage offered by the Plan is, on average for all plan participants, expected to pay out as much as the standard Medicare prescription drug coverage pays and is considered Creditable Coverage under Medicare.

Because your prescription drug coverage under the Plan is, on average, at least as good as standard Medicare prescription drug coverage, you can keep the Plan’s coverage (instead of enrolling in a Medicare prescription drug plan) and not pay a higher premium (a penalty) if you later decide to enroll in a Medicare prescription drug plan.

Individuals eligible for Medicare can join a Medicare prescription drug plan when they first become eligible for Medicare and each year thereafter from November 15th to December 31st. This may mean that you may have to wait to join a Medicare drug plan and that you may pay a higher premium (a penalty) if you join later. You may pay that higher premium (a penalty) as long as you have Medicare prescription drug coverage. However, if you lose creditable prescription drug coverage, through no fault of your own, you will be eligible for a sixty (60) day Special Enrollment Period (SEP) because you lost creditable coverage to join a Part D plan. In addition, if you lose or decide to drop Plan coverage, you will be eligible to join a Part D plan at that time using an Employer Group Special Enrollment Period. You should compare your

current coverage, including which drugs are covered at what cost, with the coverage and costs of the plans offering Medicare prescription drug coverage in your area.

If you do decide to enroll in a Medicare prescription drug plan and drop your coverage under the Plan, be aware that you will not be able to get your Plan coverage back.

Participants in the Plan who also have Medicare have the following three options concerning prescription drug coverage:

1. You may stay in the Plan and not enroll in the Medicare prescription drug coverage at this time. You will be able to enroll in the Medicare prescription drug coverage at a later date without penalty, either (1) during a Medicare prescription drug open enrollment period (November 15 – December 31 of each year); or (2) if you lose coverage under the Plan.
2. You may stay in the Plan and also enroll in Medicare prescription drug coverage at this time. This Plan will pay prescription drug benefits as the primary payer in most instances. Medicare will pay benefits as a secondary payer, and thus the value of your Medicare prescription drug coverage will be greatly reduced. Your current coverage under the Plan, which pays for other health benefits as well as prescription drugs, will not change if you choose to enroll in a Medicare prescription drug coverage program.
3. You may reject all coverage under the Plan and choose coverage under Medicare as your primary and only payer for all medical and prescription drug expenses. If you do so, you will not be able to receive coverage under the Plan, including the Plan's prescription drug coverage, at a later date. Your current coverage pays for other types of health expenses, in addition to prescription drugs, and you will not be eligible to receive any of your current health and prescription drug benefits if you reject coverage under the Plan and choose to enroll in a Medicare, including a Medicare prescription drug plan, as your primary and only payer.

Here is some information to help you compare the benefits under the Plan and a Medicare prescription drug plan. In doing this comparison, you also should compare the premiums charged for each plan.

Prescription Drug Benefits for the Plan (January 1, 2010 - December 31, 2010)

Prescription Drugs- Retail	Co-payments of \$12 generic/\$18 brand/\$25 non-formulary Alternative: 20% co-payment for all drugs
Prescription Drugs- Home Delivery	For a 90-day supply, \$15 generic, \$25 brand/ \$35 non-formulary
Prescription Drug-Maximum	\$400 per person/\$800 per family per year

Out of Pocket

The standard Medicare prescription drug plan has the following features. The threshold amounts are subject to annual adjustments by the Centers for Medicare and Medicaid Services. The thresholds for 2010 are shown below:

1. Annual Deductible of \$310.
2. After you have met the annual deductible, Medicare pays 75% of the next \$2,520 and you will be responsible for paying 25% coinsurance.
3. After you have incurred \$2,830 in prescription drug costs, Medicare will pay nothing and you will pay 100% until your prescription costs for the year reach \$6,440, at which point you will be out of pocket \$4,550.00. This gap in Medicare coverage is referred to as the "donut hole."

4. After you have reached the \$6,440 threshold, Medicare pays most of the cost of your drugs.
5. Premiums are expected to be approximately \$30-\$50 per month for standard Medicare prescription drug plans. You should consult the Medicare prescription drug plans in your area for the exact premium amounts.

Although the Plan cannot state that in all cases that the Plan's prescription drug coverage will be more advantageous than the Medicare prescription drug coverage, in almost all cases you will have better and less expensive prescription drug coverage under the Plan's prescription drug coverage.

You also should know that if you drop or lose your coverage with the Plan, and don't enroll in Medicare prescription drug plan within 63 continuous days after your current coverage ends, you may pay a higher premium (a penalty) to join a Medicare prescription drug plan later.

If you go 63 days or longer without prescription drug coverage that's at least as good as Medicare's prescription drug coverage, your monthly premium for Medicare prescription drug coverage may go up at least 1% per month of the base beneficiary premium per month for every month that you did not have that coverage. For example, if you go nineteen months without coverage, your premium may consistently be at least 19% higher than the base beneficiary premium. You may have to pay this higher premium (a penalty) as long as you have Medicare prescription drug coverage. In addition, you may have to wait until the next November to enroll.

For more information about this notice or your current prescription drug coverage:

Contact Adventist Risk Management for further information about the Plan's prescription drug coverage. However, please note that our office cannot assist you with information about a Medicare Prescription Drug Plan.

NOTE: You will receive this notice every year. You will also get it before the next period you can join a Medicare drug plan, and if the Plan's prescription drug coverage changes. You also may request a copy.

For more information about your options under Medicare prescription drug coverage:

More detailed information about Medicare plans that offer prescription drug coverage is available in the "Medicare & You" handbook. You'll get a copy of the handbook every year in the mail from Medicare. You may also be contacted directly by Medicare prescription drug plans.

For more information about Medicare prescription drug coverage:

1. Visit www.medicare.gov
2. Call your State Health Insurance Assistance Program (see the inside back cover of your copy of the "Medicare & You" handbook for their telephone number) for personalized help.
3. Call 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048.

For people with limited income and resources, extra help paying for a Medicare prescription drug plan is available. For more information about this extra help, visit Social Security on the web at www.socialsecurity.gov, or call them at 1-800-772-1213 (TTY 1-800-325-0778)

Remember: Keep this Creditable Coverage notice. If you decide to join one of the Medicare drug plans, you may be required to provide a copy of this notice when you join to show whether or not you have maintained creditable coverage and whether or not you are required to pay a higher premium amount.

Date: January 1, 2010

Name of Entity/Sender: Health Care Assistance Plan for Employees of the Seventh-day Adventist Organizations of the North American Division (USA) of the General Conference of Seventh-day Adventist (“Plan”), by its Plan Administrator, Adventist Risk Management, Inc.

Contact-Position/Office: Plan Administrator

Address: 12501 Old Columbia Pike, Silver Spring, MD 20904

Phone Number: 888-SDA-4ARM



DEPENDENT CHILD MEDICAL CONDITION FORM

I certify that my child, _____ is _____ years of age and that my child has a medical condition that prevents my child from enrolling in an educational institution at this time.

Type of Medical Condition

Social Security Number: ____ - ____ - ____

Printed Name: _____

Signature of Employee (Parent) *Date*

Child's Social Security Number: ____ - ____ - ____

Please attach a certification of your child's medical condition from AN independent medical doctor approved in advance by the Plan Administrator.

I certify that I have a medical condition that prevents me from enrolling in an educational institution at this time.

Signature of Child *Date*

Is the child covered by any other medical plan? _____

If so, please provide the name, plan/ group number, address, and phone number of the plan(s):

This form must be submitted in the calendar year in which your child turns age 19 and every year thereafter that the child is eligible to participate in the Plan.

PLEASE SUBMIT THIS FORM TO YOUR BENEFITS COORDINATOR.



DEPENDENT CHILD VOLUNTEER SERVICE FORM

I certify that my child, _____ is _____ years of age and is now engaged full-time in volunteer service for the Seventh-day Adventist Church. I also certify that my child intends to enroll full-time in an educational institution upon completion of such volunteer service.

Type of Volunteer Service:

Location of Volunteer Service:

Scheduled Completion Date (Month and Year) for Volunteer Service: _____

Social Security Number: ____ - ____ - ____

Printed Name: _____

Signature of Employee (Parent)

Date

Child's Social Security Number: ____ - ____ - ____

I certify that I am engaged in full-time volunteer service for the Seventh-day Adventist Church and that I intend to enroll full-time in an educational institution upon completion of my volunteer service.

Signature of Child

Date

Is the child covered by any other medical plan? _____

If so, please provide the name, plan(s) group number, address, and phone number of the plan(s):

This form must be submitted in the calendar year in which your child turns age 19 and every year thereafter that the child is eligible to participate in the Plan.

PLEASE SUBMIT THIS FORM TO YOUR BENEFITS COORDINATOR.

**DEPENDENT STATUS FORM
DEPENDENT CHILDREN OVER AGE OF 18**

CALENDAR YEAR 2010

Name of Employee (or parent if no employee is participating in the Plan):

Employee's (or Parents') Social Security Number: ____ - ____ - ____

This form relates to the following child of mine who is over the age of 18:

Name of Child:

Child's Birthday: (month/date/year): _____

Child's Current Age: _____

Child's Social Security Number: ____ - ____ - ____

I hereby certify that my unmarried child listed above:

I further certify that I will immediately notify the Plan Administrator (Adventist Risk Management) should the status of my child under these requirements change during the calendar year.

- Meets the requirements of either Category 1 or Category 2 Dependent Child listed below.
- Does not meet the requirements of either Category 1 or Category 2 Dependent Child listed below.

Signature

Date

PLEASE SEE BACK SIDE OF FORM FOR DEFINITIONS AND EXPLANATIONS

In general, your child over the age of 18 will qualify for tax-free coverage under the HCAP if your child fits into one of the two following categories:

Category 1—Dependent Child The child must meet all of the following requirements, except that a disabled child must meet only 3-5.

1. My child is no older than 23 as of December 31 of this calendar year. A disabled child¹ does not have such an age limit.
2. My child is enrolled full-time in an educational institution (high school, college or university as an undergraduate, technical or professional school) for at least 5 months in this calendar year. A disabled child does not have this requirement.
3. My child will live with me for more than one half of the year. If I am divorced, separated or living apart from the child's other parent, the child lives with a parent (one or the other or both) for a combined total of at least 50% of the year. Absences due to special circumstances, such as illness, education or military service are disregarded for purposes of this requirement.
4. My child will not provide more than one half of his or her support for the year. Support does not include scholarships my child is receiving for study at an educational institution.
5. My child is a citizen, national or resident of the United States, or is a resident of Mexico or Canada.

Category 2 Dependent Child The child must meet all of the following requirements.

1. I provide more than half of my child's support for the year. Or, if I am divorced, separated or have lived apart for six months or more from the child's other parent, more than half of the child's support for the year is provided from a combination of the support provided by me and the child's other parent. Support does not include scholarships the person receives for study at an educational institution.
2. My child does not meet
 - a. the Category 1 Dependant Child tests with respect to anyone; or
 - b. if I am divorced, separated or living apart from the child's other parent, the child does not meet the Category 1 Dependant Child tests with respect to anyone other than the child's other parent.
3. My child is a citizen, national or resident of the United States, or is a resident of Mexico or Canada.

You should consult your tax professional if you have any questions concerning whether your child meets the requirements for a Category 1 or Category 2 child for purposes of federal income tax/Internal Revenue Code.

This form must be submitted in the calendar year in which your child turns age 19 and every year thereafter that the child is eligible to participate in the Plan.

If your child does not fit into Category 1 or Category 2, you will be subject to federal income tax on the value of the Plan coverage for your child.

¹ A disabled child is a child unable to engage in any substantial gainful activity due to any medically determinable physical or mental impairment which can be expected to result in death or which has lasted (or can be expected to last) for a continuous period of not less than 12 months.



DEPENDENT CHILD INTENTION TO RETURN TO FULL-TIME EDUCATIONAL STATUS FORM

1. I certify that my child, _____ is _____ years of age and has been (or is) a full-time student in an educational institution (high school, undergraduate course of study at college or university or a technical or professional school). The name and address of the educational institution is:

2. I certify that the last date my child attended (or will attend) such educational institution on a full-time basis was (or is) _____ (month/year).

3. I also certify that my child intends to enroll or re-enroll in an educational institution within 12 months of the date set forth in Section 2. If known, please name the educational institution my child next intends to attend on a full-time basis:

4. I understand and agree that if my child does not enroll in an educational institution within 12 months of the date my child last attended an educational institution on a full-time basis, I will reimburse the Health Care Assistance Plan in full for any benefits paid for the child since the child's last day of attendance in an educational institution on a full-time basis.

Employee Social Security Number: ____ - ____ - ____

Printed Name: _____

Signature of Employee (Parent) *Date*

Student's Social Security Number: ____ - ____ - ____

I certify that I intend to enroll full-time in an Educational Institution within 12 months of the date set forth in section 2.

Signature of Child *Date*

Is the child covered by any other medical plan? _____. If so, please provide the name, plan/group number, address, and phone number of the plan).

This form must be submitted in the calendar year in which your child turns age 19 and every year thereafter that the child is eligible to participate in the Plan.



FULL-TIME STUDENT VERIFICATION FORM FOR DEPENDENT CHILDREN

1. I certify that my child, _____ is _____ years of age and is now a full-time student enrolled in high school, in an undergraduate course of study at college or university or in a technical or professional school. The name of the educational institution is: _____

2. The address of the educational institution’s registration office is: _____

3. I authorize the educational institution to release any information regarding the enrollment status of my son/daughter.

Employee Social Security Number: _____ - _____ - _____

Printed Name: _____

Signature of Employee (Parent) *Date*

Student’s Social Security Number: _____ - _____ - _____

I authorize the educational institution to release any information regarding my enrollment.

Signature of Student *Date*

Is the child covered by any other medical plan? _____.

If so, please provide the name, plan/group number, address, and phone number of the plan(s):

This form must be submitted in the calendar year in which your child turns age 19 and every year thereafter that the child is eligible to participate in the Plan.

MICHELLE’S LAW NOTICE

Pursuant to Michelle’s Law, a child who would otherwise be eligible for coverage under the Plan due to full-time student status will remain eligible to participate in the Plan if a medical condition prevents the child from enrolling in an educational institution or requires the child to take a medically necessary leave of absence from the educational institution. Please see section b)iii) of the Dependent Children section of the Plan for more information.

This **Health Care Assistance Plan** is administered by

Adventist Risk Management, Inc.
www.adventistrisk.org

Major Medical Claims Office (out-of-network)

Personal Choice Claims Processing
P.O. Box 69362
Harrisburg, PA 17106-9352
Voice (888) ARM-4SDA or (888) 276-4732

Dental, Vision, Medical Carve-Out Claims Office

P.O. Box 1021
Horsham, PA 19044-1021
Voice (888) ARM-4SDA or (888) 276-4732

Retiree Claims Office

P.O. Box 1928
Grapevine, TX 76099-1928
Voice (800) 447-5002

Member Services

Voice (888) ARM-4SDA or (888) 276-4732

Pre-Certification Department

Voice (800) 275-2583

Privacy Officer

(888) 276-4732
privacyofficer@adventistrisk.org