SUMMARY PLAN DOCUMENT AND

SCHEDULE OF BENEFITS

FOR

MISSOURI DEPARTMENT OF TRANSPORTATION

AND MISSOURI STATE HIGHWAY PATROL

MEDICAL AND LIFE INSURANCE PLAN

Member HIPAA Notification

Missouri Department of Transportation and Missouri State Highway Patrol Medical and Life Insurance Plan

Your Privacy Matters

In compliance with the Health Insurance Portability and Accountability Act (HIPAA), Missouri Department of Transportation (MoDOT) and Missouri State Highway Patrol (MSHP) Medical and Life Insurance Plan (Plan) is sending you important information about how your medical and personal information may be used and about how you can access this information. Please review the Notice of Privacy Practices carefully. If you have any questions, please call the Participant Services number on the back of your membership identification card. You may also contact the designated privacy officer. The privacy officer for our Plan is Jeff Padgett, Director of Risk and Benefits Management, MoDOT, P.O. Box 270, Jefferson City, MO 65102.

Notice of Privacy Practices

Effective: **4/14/2003 (Revised 4/22/2013)**

THIS NOTICE DESCRIBES HOW MEDICAL AND PERSONAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

Our Commitment to Your Privacy

We understand the importance of keeping your personal and health information secure and private. We are required by law to provide you with this notice. This notice informs you of your rights about the privacy of your personal information and how we may use and share your personal information. We will make sure that your personal information is only used and shared in the manner described. We may, at times, update this notice. Changes to this notice will apply to the information that we already have about you as well as any information that we may receive or create in the future. You may request a copy of this notice at any time. Throughout this notice, examples are provided. Please note that all of these examples may not apply to the services the Plan provides to your particular health benefit plan.

What Types of Personal Information Do We Collect?

To best service your benefits, we need information about you. This information may come from you, your Employer, or other payors or health benefits plan sponsors, and our affiliates. Examples include your name, address, phone number, Social Security number, date of birth, marital status, employment information, or medical history. We also receive information from health care Providers and others about you. Examples include the health care services you receive. This information may be in the form of health care claims and encounters, medical information, or a service request. We may receive your information in writing, by telephone, or electronically. In some instances, we may ask you about your race/ethnicity or language; however, providing this information is entirely voluntary.

How Do We Protect the Privacy of Your Personal Information?

Keeping your information safe is one of our most important duties. We limit access to your personal information, including race/ethnicity and language, to those who need it. We maintain appropriate safeguards to protect it. For example, we protect access to our buildings and computer systems. Our privacy office also assures the training of our staff on our privacy and security policies.

How Do We Use and Share Your Information for Treatment, Payment, and Health Care Operations?

To properly service your benefits, we may use and share your personal information for "treatment," "payment," and "health care operations." Below we provide examples of each. We may limit the amount of information we share about you as required by law. For example, HIV/AIDS, Substance Abuse, and Genetic Information may be further protected by law. Our privacy policies will always reflect the most protective laws that apply.

(1) **Treatment:** We may use and share your personal information with health care Providers for coordination and management of your care. Providers include Physicians, Hospitals, and other caregivers who provide services to you.

(2) **Payment:** We may use and share your personal information to determine your eligibility, coordinate care, review Medical Necessity, pay claims, obtain external review, and respond to Complaints. For example, we may use information from your health care Provider to help process your claims. We may also use and share your personal information to obtain payment from others that may be responsible for such costs.

(3) **Health care operations:** We may use and share your personal information, including race/ethnicity and language, as part of our operations in servicing your benefits. Operations include credentialing of Providers; quality improvement activities such as assessing health care disparities; accreditation by independent organizations; responses to your questions; Grievance or external review programs; and disease management, case management, and care coordination, including designing intervention programs and designing and directing outreach materials. We may also use and share information for our general administrative activities such as pharmacy benefits administration; detection and investigation of fraud; auditing; underwriting and rate-making; securing and servicing reinsurance policies; or in the sale, transfer, or merger of all or a part of the Plan with another entity. For example, we may use or share your personal information in order to evaluate the quality of health care delivered, to remind you about preventive care, or to inform you about a disease management program. We cannot use or disclose your genetic, race/ethnicity or language information for underwriting purposes, to set rates, or to deny Coverage or benefits. We may also share your personal information with Providers and other health plans for their treatment, payment, and certain health care operation purposes. For example, we may share personal information with other health plans identified by you or your Plan Sponsor when those plans may be responsible to pay for certain health care benefits or we may share language data with health care practitioners and Providers to inform them about your communication needs.

What Other Ways Do We Use or Share Your Information?

We may also use or share your personal information for the following:

(1) **Medical Home/Accountable Care Organizations:** Aetna may work with your primary care physician, hospitals and other health care providers to help coordinate your

treatment and care. Your information may be shared with your health care providers to assist in a team-based approach to your health.

(2) **Health care oversight and law enforcement:** To comply with federal or state oversight agencies. These may include, but are not limited to, your state department of insurance or the U.S. Department of Labor.

(3) **Legal proceedings:** To comply with a court order or other lawful process.

(4) **Treatment options:** To inform you about treatment options or health-related benefits or services.

(5) **Plan sponsors:** To permit the sponsor of your health benefit plan to service the benefit plan and your benefits. Please see your employer's plan documents for more information.

(6) **Research:** To researchers so long as all procedures required by law have been taken to protect the privacy of the data.

(7) **Others involved in your health care:** We may share certain personal information with a relative, such as your spouse, close personal friend, or others you have identified as being involved in your care or payment for that care. For example, to those individuals with knowledge of a specific claim, we may confirm certain information about it. Also, we may mail an explanation of benefits to the Subscriber. Your family may also have access to such information on our website. If you do not want this information to be shared, please tell us in writing.

(8) **Personal representatives:** We may share personal information with those having a relationship that gives them the right to act on your behalf. Examples include parents of an unemancipated minor or those having a Power of Attorney.

(9) **Business associates:** To persons providing services to us and who assure us that they will protect the information. Examples may include those companies providing your pharmacy or Behavioral Health benefits.

(10) **Other situations:** We also may share personal information in certain public interest situations. Examples include protecting victims of abuse or neglect; preventing a serious threat to health or safety; tracking diseases or medical devices; or informing military or veteran authorities if you are an armed forces member. We may also share your information with coroners; for workers' compensation; for national security; and as required by law.

What About Other Sharing of Information and What Happens If You Are No Longer Enrolled?

We will obtain your written permission to use or share your health information for reasons not identified by this notice and not otherwise permitted or required by law. For example, we will not share your psychotherapy notes, use or share your health information for marketing purposes or sell your health information unless you give written permission or applicable law permits the use or disclosure. If you withdraw your permission, we will no longer use or share your health information for those reasons.

We do not destroy your information when your Coverage ends. It is necessary to use and share your information, for many of the purposes described above, even after your Coverage ends.

However, we will continue to protect your information regardless of your Coverage status, as required by law.

Rights Established by Law

(1) **Requesting restrictions:** You can request a restriction on the use or sharing of your health information for treatment, payment, or health care operations; however, we may not agree to a requested restriction.

(2) **Confidential communications:** You can request that we communicate with you about your health and related issues in a certain way, or at a certain location. For example, you may ask that we contact you by mail, rather than by telephone, or at work, rather than at home. We will accommodate reasonable requests.

(3) **Access and copies:** You can inspect and obtain a copy of certain health information. We may charge a fee for the costs of copying, mailing, labor, and supplies related to your request. We may deny your request to inspect or copy in some situations. In some cases denials allow for a review of our decision. We will notify you of any costs pertaining to these requests, and you may withdraw your request before you incur any costs. You may also request your health information in an alternative format.

(4) **Amendment:** You may ask us to amend your health information if you believe it is incorrect or incomplete. You must provide us with a reason that supports your request. We may deny your request if the information is accurate, or as otherwise allowed by law. You may send a statement of disagreement.

(5) **Accounting of disclosures:** You may request a report of certain times we have shared your information. Examples include sharing your information in response to court orders or with government agencies that license us. All requests for an accounting of disclosures must state a time period that may not include a date earlier than six (6) years prior to the date of the request and may not include dates before April 14, 2003. We will notify you of any costs pertaining to these requests, and you may withdraw your request before you incur any costs.

(6) **Breach notification:** You have a right to receive notice from us if there is a breach of your unsecured health information.

To Receive More Information or File a Complaint

Please contact Member Services to find out how to exercise any of your rights listed in this notice, if you have any questions about this notice, or to receive a copy in an alternative format or a translated version. Para recibir una copia traducida de este document, llame al servicio para miembros. The telephone number or address is listed in your benefit documents or on your membership card. If you believe we have not followed the terms of this notice, you may file a Complaint with us or with the Secretary of the Department of Health and Human Services. To file a Complaint with the Secretary, write to 200 Independence Avenue, S.W. Washington, D.C. 20201 or call 1-877-696-6775. You will not be penalized for filing a Complaint. To contact us, please follow the Complaint, Grievance, or Appeal process in your benefit documents.

[i] For purposes of this notice, the pronouns "we", "us" and "our" and the name "MoDOT/ MSHP" refers to Missouri Department of Transportation (MoDOT) and Missouri State Highway Patrol

(MSHP) Medical and Life Insurance Plan. These entities abide by the privacy practices described in this Notice.

[ii] Under various laws, different requirements can apply to different types of information. Therefore, we use the term "health information" to mean information concerning the provision of, or payment for, health care that is individually identifiable. We use the term "personal information" to include both health information and other nonpublic identifiable information that we obtain in providing Benefits to you.

THE MISSOURI DEPARTMENT OF TRANSPORTATION
AND MISSOURI STATE HIGHWAY PATROL
MEDICAL AND LIFE INSURANCE PLAN

Effective January 1, 2017, the Missouri Highways and Transportation Commission (Commission), acting by and through the Board of Trustees of the Missouri Department of Transportation (MoDOT) and the Missouri State Highway Patrol (MSHP) Medical and Life Insurance Plan (Board), hereby adopts the amended and restated Missouri Department of Transportation and Missouri State Highway Patrol Medical and Life Insurance Plan (Plan). This amended and restated Plan is the basis for calculating Benefits for medical care services and supplies received.

For Plan year 2017, the non-Medicare Preferred Provider Organization (PPO) Plan and the High Deductible Health Plan/Health Savings Account (HDHP/HSA) Plan will be referenced as Choice POS II (CPII) in the Plan Administrator's claims system. Choice POS II (CPII) will also be listed on your member ID card and member portal (when logged in to Plan Administrator's system). The Choice POS II and PPO names can be used interchangeably and, in no instance, impacts your benefits. These plans will be administered based on the schedules outlined in Article 4 of this Summary Plan Document. The purpose of the Plan is to provide Hospital, surgical, medical, prescription drug, and life insurance Coverage for certain individuals and Dependents who are eligible in accordance with the terms and conditions of the Plan. The Plan shall be construed and administered to comply in all respects with applicable federal and state law.

NOTE: Prior Authorization for certain health services is required as stated in Article 9.2. Your Participating Provider is responsible for obtaining Prior Authorization from the Claims Administrator for In-Network services; however, Non-Participating Providers are not obligated to request that authorization. Participants are responsible for verifying whether the health service received Out-of-Network is Covered under the Plan and the required Prior Authorization has been granted before receiving the health service. To verify Coverage or Prior Authorization, you may call the Participant Services number on the back of your identification card.

Failure to obtain Prior Authorization for Inpatient Hospitalization received Out-of-Network will result in a twenty percent (20%) penalty (not to exceed one-thousand dollars ($1,000) of the total Out-of-Network Rate before Plan Benefits are determined). The penalty will be assessed on each Inpatient occurrence where Prior Authorization is required but not obtained and will not apply to the Participant's Deductible or maximum out-of-pocket Benefit. Plan guidelines for Benefit determination will apply to all Claims including those requiring Prior Authorization. One hundred percent (100%) of costs incurred for services, not Covered by the Plan for any reason will be deducted before Plan payment on Covered Services is determined.

First Edition - January 1, 1991
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Third Edition – May 1, 1999
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Fifth Edition – January 1, 2003
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Thirteenth Edition – July 1, 2011
Fourteenth Edition – January 1, 2012
Fifteenth Edition – January 1, 2013
Sixteenth Edition – January 1, 2014
Seventeenth Edition – January 1, 2015
Eighteenth Edition – April 8, 2015
Nineteenth Edition – January 1, 2016
Twentieth Edition – January 1, 2017

IF YOU NEED INFORMATION

To ensure that you receive accurate information regarding your medical and life insurance Benefits you should direct your questions **ONLY** to the sources listed below. **NO ONE ELSE** is authorized to give you information.

For information about your medical Benefits, Mental Health Benefits or Prescription Drug Coverage or Claims, call the toll-free number of the Claims Administrator listed on the back of your medical insurance identification card or Prescription Drug card.

For information regarding enrollment in the medical and life insurance Plans, contact Employee Benefits or the insurance representative at your district, division, or troop assignment as follows:

Employee Benefits Contacts:

Toll-free ..... (877) 863-9406
Benefits Specialist..... (573) 526-0138
Benefits Specialist..... (573) 522-8121
Benefits Specialist ..... (573) 526-5173

MoDOT Districts: Contact your district insurance representative.

Northwest District - St. Joseph..... (816) 387-2405
Northeast District - Hannibal ..... (660) 385-8252
Kansas City District - Kansas City..... (816) 607-2143
Central District - Jefferson City ..... (573) 522-5168
St. Louis District - St. Louis ..... (314) 453-1717 or (314) 453-1714
Southwest District -Springfield ..... (417) 621-6528
Southeast District -Sikeston ..... (573) 472-5363

MSHP Contact – Contact the insurance representative:

GHQ – Jefferson City..... (573) 526-6356 or (573) 526-6136

MSHP Troops: Contact your troop insurance representative.

Troop A – Lee's Summit ..... (816) 622-0800, ext. 3119
Troop B – Macon ..... (660) 385-2132, ext. 3239
Troop C – Weldon Springs..... (636) 300-2800, ext. 3333
Troop D – Springfield ..... (417) 895-6868, ext. 3452
Troop E – Poplar Bluff..... (573) 840-9500, ext. 3521
Troop F – Jefferson City..... (573) 751-1000, ext. 3622
Troop G – Willow Springs ..... (417) 469-3121, ext. 3726
Troop H – St. Joseph ..... (816) 387-2345, ext. 3816
Troop I – Rolla ..... (573) 368-2345, ext. 3917

The Plan document is also available on the MoDOT/MSHP Employee Benefits website: www.modot.mo.gov/newsandinfo/benefits.htm.

CONTACT INFORMATION

For quick reference, we are providing you with selected telephone numbers, websites and addresses as follows:

Aetna– Claims and Network Administrator

Participant Services Phone..... (800)627-6406
Prior Authorization Phone..... (888)632-3862
Informed Health (Nurse Line)..... (800)556-1555
Mental Health or Chemical Dependency:
Aetna Behavioral Health... ..... (800)424-4047
Tobacco Cessation Program..... (866)213-0153
Wellness Coordinator…….. (314)506-1632
Web Address..... www.aetnanavigator.com

Medical Claims Mailing Address:
MoDOT/MSHP Claims
P. O. Box 981106
El Paso, TX 79998-1106

Mental Health Claims Mailing Address:
Aetna Behavioral Health
P. O. Box 981106
El Paso, TX 79988-1106

MedImpact Healthcare Systems, Inc. - Prescription Drug Program Administrator

Non-Medicare Participants
Retail/Mail Order Prescription Drug Questions ..... (844)513-6005

Medicare Participants
Retail/Mail Order Prescription Drug Questions .....(844)513-6006

MedImpact Web Address:…….....www.mp.medimpact.com

Mail Order Pharmacy Information:
Postal Prescription Services (PPS)…….…....(800)552-6694
Web Address…….……..……www.ppsrx.com

Minnesota Life Insurance Company – Optional and Basic Life Insurance
Customer Service Number……..... (866)293-6047

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ARTICLE 1

DEFINED TERMS

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

1.1 Abortion

(1) The act of using or prescribing any instrument, device, medicine, drug, or any other means or substance with the intent to destroy the life of an embryo or fetus in his or her mother's womb; or

(2) The intentional termination of the pregnancy of a mother by using or prescribing any instrument, device, medicine, drug, or other means or substance with an intention other than to increase the probability of a live birth or to remove a dead or dying unborn child.

a) Medically Necessary Abortion

The termination of a pregnancy when the life of the mother is endangered if the fetus is carried to term or when continuation of the pregnancy will create a serious risk of substantial and irreversible physical impairment of a major bodily function of the mother.

b) Elective Abortion

The termination of pregnancy for other than medical reasons as described in Medically Necessary Abortion.

1.2 Acute

An Illness or Injury that is both severe and of recent onset.

1.3 Allowed Amount

Maximum dollar amount for which payment is based for Covered Health Care Services. This may be called "eligible expense," "payment allowance," "negotiated rate," or "Out-of-Network Rate." If a Provider charges more than the Allowed Amount, Participants may have to pay the difference. Refer to Article 1.8 for the definition of Balance Billing.

1.4 Ambulatory Care Facility

A Provider with an organized staff of Physicians that:

(1) has permanent facilities and equipment for the primary purpose of performing surgical and/or medical procedures on an Outpatient basis;

(2) provides continuous nursing services and treatment by Physicians whenever the Participant is in the facility;

(3) does not provide Inpatient accommodations;

(4) is not, other than incidentally, a facility used as an office or clinic for the private practice of a Physician; and

(5) is licensed as an Ambulatory Care Facility.

1.5 Appeal

A request for a health insurer or Plan to review a decision or a Grievance again.

1.6 Applied Behavioral Analysis (ABA)

The design, implementation, and evaluation of environmental modifications, using behavioral stimuli and consequences, to produce socially significant improvement in human behavior, including the use of direct observation, measurement, and functional analysis of the relationships between environment and behavior.

1.7 Autism Spectrum Disorders

A neurobiological disorder and/or an Illness of the nervous system which includes: Autistic Disorder, Asperger's Disorder, Pervasive Developmental Disorder Not Otherwise Specified, Rett's Disorder, and Childhood Disintegrative Disorder, as defined in the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders of the American Psychiatric Association.

1.8 Balance Billing

When a Provider bills Participants for the difference between the Provider's charge and the Allowed Amount. For example, if the Provider's charge is $100 and the Allowed Amount is $70, the Provider may bill Participants for the remaining $30. A Preferred Provider may ***not*** balance bill Participants for Covered services.

1.9 Benefit

The Plan's payment or reimbursement for Covered services as outlined in Appendices A and B of Article 4 for non-Medicare Participants and Appendix D of Article 8 for Medicare Participants.

1.10 Birth Control

The practice of preventing or terminating pregnancies, including the use of Abortion, Contraceptives and Sterilization.

(1) Abortion

Refer to the definition of Abortion in Article 1.1.

(2) Contraceptives

A device, drug, or chemical agent that prevents conception.

(3) Sterilization

Any procedure by which an individual is made incapable of reproduction.

1.11 Board of Trustees (Board)

The body established by the Commission to provide for the general administration of the Plan. The Board consists of eight (8) members as follows:

(1) four (4) MoDOT Employees appointed by its Director;

(2) two (2) MSHP Employees appointed by its Superintendent;

(3) one (1) retired MoDOT Employee appointed by its Director; and

(4) one (1) retired MSHP Employee appointed by its Superintendent.

The Commission must approve all appointees prior to performing any Board duties.

1.12 Claim

A Claim is defined as any request for a Plan Benefit, made by a claimant or by a representative of a claimant, that complies with the Plan's reasonable procedure for filing Claims and making Benefit Claims determinations. A Claim does not include a request for a determination of an individual's eligibility to participate in the Plan.

1.13 Claims Administrator

The person or entity duly authorized by the Board, as contracted from time to time, to process Claims.

1.14 Claims Timely Filing

Claims Timely Filing is the time period allowed for filing a Claim for medical services in order for the services to be Covered under the Plan as follows:

(1) Preferred Provider/Participating Provider/In-Network Provider: The time period outlined in their contract with the Claims Administrator. The Participant is not held responsible for the Claim costs if the Provider does not file the Claim timely; or

(2) Non-Preferred Provider/Non-Participating Provider/Non-Network Provider: The time period is one (1) year from the date of service and the Participant may be held responsible for the Claim costs if the Claim is not filed timely.

1.15 Clinical Psychologist

A person who provides clinical psychological services in connection with the diagnosis or treatment of mental, psychoneurotic or personality disorders, and who is duly licensed as a Psychologist.

1.16 COBRA (Consolidated Omnibus Budget Reconciliation Act of 1985) Participant

A Participant who is eligible for continuation of Coverage as a qualified beneficiary when he would otherwise lose his group health Coverage. Refer to Article 11.

1.17 Coinsurance

Participants' share of the costs of a Covered Health Care Service, calculated as a percentage (for example, 10% for In-Network services) of the Allowed Amount for the service. Participants pay Coinsurance plus any Deductibles you owed. For example, if the Plan's Allowed Amount for a Covered service is $100 and the Participant has met his or her Deductible, the Participant's Coinsurance payment of 10% would be $10. The Plan pays the rest of the Allowed Amount. Refer to Appendices A and B of Article 4 for non-Medicare Participants and Appendix D of Article 8 for Medicare Participants.

1.18 Common-Law Spouse

A Spouse in a common-law Marriage, which occurs prior to the parties residing in Missouri, in a state that recognizes common-law Marriage. The Plan will permit the Common-Law Spouse

of the Participant to be a Dependent as defined in Article 1.25(1) as a lawful Spouse. Proof of common-law Marriage will be required by the Board.

1.19 Complications of Pregnancy

Conditions due to pregnancy, labor and delivery that require medical care to prevent serious harm to the health of the mother or the fetus. Morning sickness and a non-emergency caesarean section are not Complications of Pregnancy.

1.20 Copayment

A fixed amount (for example, $25) Participants pay for a Covered Health Care Service, usually when they receive the service. The amount can vary by the type of Covered Health Care Service.

1.21 Coverage Date

The date on which participation begins under the Plan provided all requirements and conditions for participation have been satisfied and performed.

1.22 Covered (or Coverage)

A service or supply specified in Article 5 for which Benefits will be furnished, subject to the Deductible(s) and other requirements for payment by the Plan, when rendered by a Provider. Refer to the definition of Provider in Article 1.93. A charge for a Covered service will be considered to have been incurred on the date the service or supply was provided to the Participant. Eligibility for payment of Benefits, including obstetrical Benefits without limitations, will be determined on the date the service is rendered.

1.23 Custodial Care

Care provided primarily for the convenience of the Participant or his family, maintenance of the Participant, or which is designed essentially to assist the Participant in meeting his activities of daily living and which is not primarily provided for its therapeutic value in the treatment of an Illness, disease, bodily Injury, or condition. Custodial Care includes, but is not limited to:

(1) help in walking, bathing, dressing, feeding;

(2) preparation of special diets;

(3) supervision over self-administration of medications not requiring constant attention of trained medical personnel; or

(4) acting as a companion or sitter.

Unless a Participant is receiving medical, surgical, or psychiatric treatment that is intended or designed to permit him to live outside a Hospital or Skilled Nursing Facility, the care being provided will be deemed Custodial Care.

1.24 Deductible(s)

The amount Participants owe for Health Care Services the Plan Covers before the Plan begins to pay. For example, if the Participant's Deductible is $450, the Plan will not pay anything until the Participant has met the $450 Deductible for Covered Health Care Services subject to the Deductible. (The Deductible may not apply to all services.) Deductibles are shown in

Appendices A and B of Article 4 for non-Medicare Participants and Appendix D of Article 8 for Medicare Participants.

Family Maximum: When the maximum amount shown in Appendices A and B of Article 4 for non-Medicare Participants and Appendix D of Article 8 for Medicare Participants has been incurred by Participants of a family toward their calendar year Deductibles, the Deductibles of all Participants of that family will be considered satisfied for that calendar year.

1.25 Dependent

(Dependents, for the purpose of this Plan, must meet the eligibility requirements and be enrolled in the Plan)

(1) Subscriber's lawful Spouse or Common-Law Spouse. Refer to Article 1.18 for the definition of Common-Law Spouse and to Article 1.104 for the definition of Spouse;

(2) Subscriber's child(ren) through the end of the month they turn twenty-six (26) years of age; except those children who are also subscribers in their own right employed with MoDOT, MSHP or MPERS as they cannot be enrolled as both a dependent and a subscriber. Child(ren) includes:

a) biological child(ren) (legal documentation required);

b) legally adopted child(ren) (legal documentation required);

c) grandchild(ren) if the Subscriber has legal guardianship (guardianship papers required);

d) stepchild(ren) if the legal or biological parent is enrolled in the Plan and proof of parent status is provided;

e) other children who qualify due to the Subscriber's legal guardianship of the child (guardianship papers required);

f) child(ren) for whom you are required to provide Coverage under a Qualified Medical Child Support Order (QMCSO).

(3) Unemancipated Dependents of a Subscriber enrolled in the Plan will continue to meet the eligibility requirements stated above, regardless of age, if they are mentally incapacitated and/or physically disabled, and incapable of self-support, during the continuance of such disability and incapacity. Periodic proof of disability status may be required by the Board.

1.26 Developmental Delay

The absence or delay of a skill or developmental milestone that has not been achieved by the Participant. Developmental Delay does not include a delay of a skill or developmental milestone if the Participant has a medical diagnosis such as, but not limited to, cerebral palsy, anoxic birth Injury, or chromosomal abnormalities.

1.27 Diagnostic Admission

An Inpatient admission that occurs even though the Participant's condition does not require the constant availability of medical supervision or Skilled Nursing Care and could reasonably be

diagnosed on an Outpatient basis. The primary purpose of such an admission is to arrive at a diagnosis through the use of x-ray and laboratory tests, consultations, and evaluation, whether or not treatment is provided during the admission. The Board may rely on the Hospital's medical records, among other evidence, to assist in determining the primary purpose of the admission.

1.28 Diagnostic Service

A test or procedure that is rendered because of specific symptoms and is directed toward the determination of a definite condition or disease and its subsequent treatment. A Diagnostic Service must be ordered by a Physician. Diagnostic Services may include:

(1) x-ray and other radiology services;

(2) laboratory and pathology services; or

(3) cardiographic, encephalographic, and radioisotope tests.

1.29 Durable Medical Equipment (DME)

Equipment and supplies ordered by a health care Provider for everyday or extended use. Coverage for DME may include, but is not limited to: oxygen equipment, wheelchairs, crutches or blood testing strips for diabetes.

1.30 Election Period

The period of time allowed per the qualifying event to enroll in the Plan.

1.31 Emergency Medical Condition

An Illness, Injury, symptom or condition so serious that a reasonable person would seek Health Care Services right away to avoid severe harm.

1.32 Emergency Medical Transportation

Ambulance services for an Emergency Medical Condition.

1.33 Emergency Room Care

Emergency services Participants get in an emergency room.

1.34 Emergency Services

Evaluation of an Emergency Medical Condition and treatment to keep the condition from getting worse.

1.35 Employee

An individual in active employment status with MoDOT, MSHP, or MoDOT and Patrol Employees' Retirement System (MPERS), and is a member of MPERS as defined by law.

1.36 Employer

MoDOT, MSHP, and MPERS.

1.37 Employer Contribution

The contribution authorized by the State of Missouri and paid out of operating funds of the Employer to fund the Benefits provided under the Plan as defined in Article 13.2.

1.38 Exam/Examination

Inspection or investigation, especially as a means of diagnosing a disease.

1.39 Excluded Services

Health care services that the Plan does not Cover.

1.40 Experimental/Investigational

The use of any treatment, procedure, facility, equipment, drug, device, or supply not accepted by the Claims Administrator as standard medical treatment of the condition being treated, or any of such items requiring federal or other government agency approval not granted at the time services were rendered.

1.41 Freestanding Renal Dialysis Facility

A Provider, other than a Hospital, that is primarily engaged in providing Renal Dialysis Treatment, maintenance, or training to Participants on an Outpatient or home health care basis.

1.42 Grievance

A complaint that a Participant communicates to the Plan.

1.43 Habilitation Services

Health Care Services that help a person keep, learn, or improve skills and functioning for daily living. Examples include therapy for a child who is not walking or talking at the expected age. These services may include physical and Occupational Therapy, speech-language pathology, and other services for people with disabilities in a variety of Inpatient and/or Outpatient settings.

1.44 Health Care Services

The services and supplies Covered under the medical and/or Prescription Drug agreements, except to the extent such Health Care Services and supplies are limited or excluded under the Plan.

1.45 Health Insurance

A contract that requires the health insurer to pay some or all of Participants' health care costs in exchange for a Premium.

1.46 Health Savings Account (HSA)

A tax-advantaged savings account that may be used to pay current or future qualified medical expenses. Enrollment in the plan's qualified High Deductible Health Plan is required for participation in the HSA.

1.47 High Deductible Health Plan (HDHP)

A HDHP has higher deductibles than a traditional health plan. When combined with an HSA, a HDHP provides a tax-advantaged way to help save for future medical expenses.

1.48 Home Health Care

Health Care Services a person receives at home.

1.49 Hospice Services

Services to provide comfort and support for persons in the last stages of a terminal Illness and their families.

1.50 Hospital

(1) An institution that is operated pursuant to law and is primarily engaged in providing for compensation, on an Inpatient basis, for the medical care and treatment of sick and Injured persons through medical, diagnostic and surgical facilities, all of which facilities must be provided on its premises, under the supervision of a staff of one (1) or more Physicians and with twenty four (24) hour-a-day nursing service by a registered nurse (RN) on duty; or

(2) An institution accredited as a Hospital by the Joint Commission on Accreditation of Hospitals.

In no event will the term “Hospital” include a convalescent nursing home or any institution or part thereof that is used principally as a convalescent facility, rest facility, nursing facility or facility for the aged.

1.51 Hospitalization

Care in a Hospital that requires admission as an Inpatient and usually requires an overnight stay. An overnight stay for observation could be Outpatient care.

1.52 Hospital Outpatient Care

Care in a Hospital that usually does not require an overnight stay.

1.53 Illness

Physical ailment, disease, or pregnancy. For the purpose of this definition, the term Illness does not apply to Mental Health, which includes substance abuse.

1.54 Injury

Bodily damage, other than Illness, including all related conditions and recurrent symptoms.

1.55 In-Network

An arrangement that has been made with a Health Care Service Provider for cost containment. Refer to Article 1.71 for the definition of Out-of-Network.

1.56 In-Network Coinsurance

The percentage Participants pay of the Allowed Amount for Covered Health Care Services to Providers who contract with the Plan. In-Network Coinsurance usually costs less than Out-of-Network Coinsurance.

1.57 In-Network Copayment

A fixed amount (for example, $25) Participants pay for Covered Health Care Services to Providers who contract with the Plan. In-Network Copayments usually are less than Out-of-Network Copayments.

1.58 Inpatient

A Participant who receives treatment as a registered bed patient in a Hospital and for whom a room and board charge is made.

1.59 Intensive Care Unit

A section, ward or wing within a Hospital that meets all of the following requirements:

(1) is solely for the treatment of patients who are in critical condition;

(2) provides, within such area, special nursing care and observation of a continuous and constant nature not available in the regular rooms and wards of the Hospital;

(3) provides a concentration of special life-saving equipment immediately available at all times for the treatment of patients confined within such area;

(4) contains at least two (2) beds for the accommodation of critically ill patients; and

(5) provides at least one (1) RN who continuously and constantly attends the patients confined in such area on a twenty-four (24) hour-a-day basis.

1.60 Invisible/HAIRPEN Providers

Represents a category of non-par specialist providers who are typically Hospital based, which include, but not limited to, the following specialties: Hospitalist (full-time in-hospital physician), Anesthesiologist, Intensivists (includes cardiology, pulmonology and others who staff ICU), Radiologist, Pathologist, Emergency Room Physicians, and Neonatologist.

1.61 Long-Term Disability Recipient

A Subscriber who has been determined to be disabled and eligible to receive long-term disability Benefits through the disability insurance carrier contracted through MPERS.

1.62 Marriage

State of being lawfully married.

1.63 Medically Necessary (or Medical Necessity)

Health care services or supplies needed to prevent, diagnose or treat an Illness, Injury, condition, disease or its symptoms and that meet accepted standards of medicine.

1.64 Medicare Participant

An individual who is a Participant under the Plan and eligible for Coverage under Title XVIII of the Social Security Act of 1965, as amended (Medicare). Medicare Participant does not include an Employee or his Dependent (except when Medicare eligibility is for a kidney transplant or renal dialysis).

1.65 Mental Health

A disturbance of the mental processes of the human mind manifested in a psychotic or neurotic condition or reaction including but not limited to bipolar disorder, autism, and other such conditions. Alcoholism, drug addiction and overdose, for the purposes of the Plan and in determining any Benefit due hereunder, are included.

1.66 Nanometrics

Nanometric-based therapeutics are products that use ultra-small (Nanometric/molecular-sized) electronic or mechanical devices.

1.67 Network

The facilities, Providers and suppliers the Plan has contracted with to provide Health Care Services.

1.68 Non-Preferred Provider/Non-Participating Provider/Out-of-Network Provider

A Provider who does not have a contract with the Plan to provide Covered Health Care Services to Participants. Participants will pay more to see a Non-Preferred Provider. Refer to Article 1.83 for the definition of Preferred Provider/Participating Provider/In-Network Provider.

1.69 Nutritional Counseling

An interactive helping process focusing on the need for diet modification.

1.70 Orthotic Appliances and Prosthetic Devices

Orthotic Appliances correct a defect of a body form or function, whereas Prosthetic Devices aid body functioning or replace a limb or body part.

1.71 Out-of-Network

No arrangement has been made with a Health Care Service Provider for cost containment. If the cost of a Covered service exceeds the Out-of-Network Rate, the Subscriber will be responsible for such excess, with the exception of those services received from an Invisible Provider as defined in Article 1.60, providing services at an In-Network facility or emergency situations. Refer to Article 1.55 for the definition of In-Network.

1.72 Out-of-Network Coinsurance

The percentage Participants pay of the Allowed Amount for Covered Health Care Services to Providers who do not contract with the Plan. Out-of-Network Coinsurance usually costs more than In-Network Coinsurance.

1.73 Out-of-Network Rate

The charge for Out-of-Network Covered services obtained from a Non-Participating Provider for which Benefits may be payable, as determined reasonable by the Plan. When a Participant utilizes an Out-of-Network Physician or other professional Non-Participating Provider, the Out-of-Network Rate (Allowed Amount) is the negotiated rate or the Medicare rate allowed for such services. If the Medicare payment methodology is not applicable due to Provider type, the Out-of-Network rate is sixty-five percent (65%) of billed charges, after the Deductible. Costs exceeding the Out-of-Network Rate is the responsibility of the Participant. Refer to Article 1.3 for the definition of Allowed Amount.

In most cases, the Out-of-Network Rate is equivalent to the current Medicare fee schedule for the services and supplies rendered. In other cases, the Out-of-Network Rate will be determined by the Claims Administrator. Please feel free to contact the Claims Administrator regarding the Out-of-Network Rate in such cases.

1.74 Out-of-Pocket Maximum

The most Participants pay during a calendar year before the Plan begins to pay 100% of the Allowed Amount. This maximum does not include:

(1) Participants' Premium;

(2) balance-billed charges;

(3) Health Care Services and prescription drugs the Plan does not Cover; and

(4) amounts resulting from reductions in Benefits due to the Participant's (or Provider's) failure to comply with the cost containment provisions.

1.75 Outpatient

A Participant who receives services while not an Inpatient.

1.76 Over-the-Counter (OTC) Drugs

Medications and oral nutritional supplements that do not require a prescription under federal law even if a Physician prescribes them or if a prescription is required under State or local law.

1.77 Participant

An individual who is lawfully present in the United States with proof of citizenship, permanent residency, or lawful immigration status enrolled in the Plan, including an Employee, Retiree, Vested Participant, Work-Related Disability Recipient, Long-Term Disability Recipient, surviving lawful Spouse, any of their Dependents, or such persons who are entitled to continued Coverage under other provisions of the Plan.

1.78 Participating Pharmacy/In-Network Pharmacy

A Pharmacy that has a contract with the Prescription Drug administrator to provide services to Participants at a discount.

1.79 Physician

A licensed practitioner of the healing arts, acting within the scope of his license, limited to a doctor of medicine, doctor of osteopathy, podiatrist, doctor of dental medicine, and doctor of dental surgery.

1.80 Physician Services

Health Care Services a licensed medical Physician (M.D. – Medical Doctor or D.O. – Doctor of Osteopathic Medicine) provides or coordinates.

1.81 Plan

A Benefit the Missouri Department of Transportation and Missouri State Highway Patrol Medical and Life Insurance Plan provides Participants to pay for the Participants' Health Care Services.

1.82 Plan Sponsor

The Commission.

1.83 Preferred Provider/Participating Provider/In-Network Provider

A Provider who has a contract with the Plan to provide services to Participants at a discount. Refer to Article 1.68 for the definition of Non-Preferred Provider/Non-Participating Provider/Out-of-Network Provider.

1.84 Preferred Provider Organization (PPO)

An arrangement has been made with Providers where reimbursements for Health Care Services are furnished at discounted rates. Under this arrangement the Subscriber is not responsible for charges above the Allowed Amount. The Provider will file all Claims for you and should not ask for payment at the time of service. You may encounter Invisible Providers while obtaining services from Providers within the PPO. In this case, the Invisible Providers, if Non-Participating, will be reimbursed at the negotiated rate. If a negotiated rate is not applicable, the services will be paid at the In-Network level of Benefits based on billed charges. You may have additional responsibilities like filing Claims, and obtaining Prior Authorization for services.

1.85 Premium

The monthly amount that Participants and the Plan must pay for the Plan.

1.86 Prescription Drug Coverage

Plan that helps pay for Prescription Drugs and medications.

1.87 Prescription Drug

Drugs and medications that, by law, require a prescription.

1.88 Preventive Care

Those procedures intended for avoidance or early detection of an Illness. Examples of such services may include, but are not limited to, the following:

(1) blood pressure, diabetes, and cholesterol tests;

(2) certain cancer screenings, including mammograms and colonoscopies;

(3) routine vaccinations;

(4) regular well-child and well-baby visits, from birth to twenty-one (21) years of age; and

(5) women's Preventive Care service as defined by the Affordable Care Act.

Certain procedures may not be Covered as Preventive Care even if the Physician recommends them for preventive measures. For instance, if the Preventive Care service is not the primary purpose of an office visit, or if the Physician bills the Preventive Care service and the office visit separately, additional costs may occur.

1.89 Prior Authorization/Preauthorization

A decision by the Plan that a Health Care Service, treatment plan, Prescription Drug or Durable Medical Equipment is Medically Necessary. Sometimes called prior approval or precertification. The Plan may require Prior Authorization for certain services before Participants receive them, except in an emergency. Prior Authorization is not a promise that

the Plan will Cover the cost. Refer to Article 9.2 for additional information and services requiring Prior Authorization.

1.90 Primary Care Physician

A Physician (M.D. – Medical Director or D.O. – Doctor of Osteopathic Medicine) who directly provides or coordinates a range of Health Care Services for a patient.

1.91 Primary Care Provider

A Physician (M.D. – Medical Director or D.O. – Doctor of Osteopathic Medicine), nurse practitioner, clinical nurse Specialist or Physician assistant, as allowed under state law, who provides, coordinates or helps a patient access a range of Health Care Services.

1.92 Prosthetic Devices and Orthotic Appliances

Orthotic Appliances correct a defect of a body form or function, whereas Prosthetic Devices aid body functioning or replace a limb or body part.

1.93 Provider

A Physician (M.D. – Medical Director or D.O. – Doctor of Osteopathic Medicine), health care professional or health care facility licensed, certified, or accredited as required by state law.

1.94 Psychiatric Facility

A Provider that, for compensation from its patients, is primarily engaged in providing diagnostic and therapeutic services for the treatment of nervous or mental disorders.

1.95 Reconstructive Surgery

Surgery and follow-up treatment needed to correct or improve a part of the body because of birth defects, accidents, Injuries or medical conditions.

1.96 Rehabilitation Services

Health care services that help a person keep, get back, or improve skills and functioning for daily living that have been lost or impaired because a person was sick, hurt or disabled. These services may include physical and Occupational Therapy, speech-language pathology and psychiatric Rehabilitation Services in a variety of Inpatient and/or Outpatient settings.

1.97 Retiree

(1) An individual who has retired from MoDOT, MSHP, or MPERS under the provisions of RSMo. Chapter 104, provided such retired individual was, on the day preceding the effective date of retirement, Covered under the Plan that provided medical care Benefits exclusively for Employees who are members of MPERS; or

(2) A former Employee of MoDOT, MSHP, or MPERS retiring after the effective date of the Plan under the provisions of RSMo. Chapter 104 provided such former Employee was in the Plan from the date of last employment until the date of retirement (Vested Participant).

1.98 Screening

A preliminary procedure, such as a test or examination, to detect the most characteristic sign or signs of a disorder that may require further investigation.

1.99 Semi-Private Accommodations

A room with two (2) or more beds in a Hospital. The difference in cost between Semi-Private Accommodations and private accommodations is Covered only when private accommodations are Medically Necessary or when Semi-Private Accommodations are not available and when an exception has been made by the medical director in advance of the admission.

1.100 Skilled Nursing Care

Services from licensed nurses in Participants' own home or in a nursing home. Skilled care services are from technicians and therapists in your own home or in a nursing home.

1.101 Skilled Nursing Facility

A Provider that is primarily engaged in providing twenty-four (24) hour-a-day skilled nursing and related services at the facility to patients requiring convalescent and rehabilitative care. Such care is rendered by or under the supervision of Physicians and eligibility for payment is based on care rendered in compliance with the Medicare-established guidelines. A Skilled Nursing Facility is not, other than incidentally, a place that provides:

(1) minimal care, Custodial Care, ambulatory care, or part-time care services; or

(2) care or treatment of a nervous or mental disorder, alcoholism, drug abuse, or pulmonary tuberculosis.

1.102 Special Enrollment Period

Enrollment for the following reasons and as referenced in Article 3.2:

(1) life events including Marriage, birth, adoption;

(2) loss of eligibility under other insurance Coverage;

(3) total loss of Employer Contribution to lawful Spouse's plan;

(4) enrolling Dependents under court order;

(5) enrolling Dependents due to U.S. Citizenship status;

(6) COBRA Coverage with previous employer ends;

(7) loss of Medicaid or State Children's Health Insurance Program (CHIP) Coverage;

(8) loss of TRICARE For Life (military Coverage for Medicare Participants);

(9) loss of eligibility during or after your authorized FMLA leave, (refer to Article 3.2 (10)); or

(10) gain eligibility for Premium assistance to purchase Coverage under Plan through Medicaid or CHIP plan.

The Special Enrollment Period does not apply to a Retiree, Vested Participant, Long-Term Disability Recipient, or surviving lawful Spouse not enrolled in the Plan; or if their Coverage under the Plan terminates for any reason, **except if they lose Coverage under Medicaid, TRICARE for Life, or their Coverage terminates due to active military duty.** Upon loss of

Medicaid, TRICARE for Life, or their return from active military duty, the Participant can be reinstated in the Plan. Refer to Articles 2.6 and 3.2.

1.103 Specialist

A Physician Specialist focuses on a specific area of medicine or a group of patients to diagnose, manage, prevent or treat certain types of symptoms and conditions. A non-Physician Specialist is a Provider who has more training in a specific area of health care.

1.104 Spouse

A partner in Marriage. Refer to Article 1.18 for the definition of Common-Law Spouse and to Article 1.62 for the definition of Marriage. (Spouse, for the purpose of this Plan document, means one enrolled in the Plan.)

1.105 State

The State of Missouri.

1.106 Subscriber

The principal eligible individual from whom Coverage under the Plan for Dependents emanates and who is a member of MPERS.

1.107 Subscriber Contribution

The periodic contribution required from the Subscriber for Coverage under the Plan.

1.108 Survivor Participant

An individual who was a lawful Spouse or a Dependent of a Subscriber and enrolled in the Plan at the time of death of the Subscriber and meets the eligibility requirements of the Plan.

1.109 Telemedicine Services

The practice by a duly licensed Physician or other health care Provider acting within the scope of such Provider's practice, of health care delivery, diagnosis, consultation, treatment, or transfer of medical data by means of interactive audio, and/or video telecommunications that permit real time communications.

1.110 Therapy Service

Services or supplies used to promote the recovery of the Participant. Therapy Services are limited to the following:

(1) Radiation Therapy

The treatment of disease by x-ray, radium, or radioactive isotopes.

(2) Chemotherapy

The treatment of malignant disease by chemical or biological antineoplastic agents.

(3) Renal Dialysis Treatment

The treatment of an Acute or chronic kidney ailment that may include the supportive use of an artificial kidney machine.

(4) Physical Therapy

The treatment by physical means includes:

a) hydrotherapy, or similar modalities;

b) bio-mechanical and neurophysiological principles;

c) devices to relieve pain, restore maximum function, and prevent disability following disease, Injury, or loss of body part; or

d) massage therapy conducted by a Physician (excluding chiropractors), or conducted by a licensed massage therapist under the direction of a Physician and the bill is submitted by and payable to the Physician.

This Benefit is limited to a combined total of sixty (60) Physical, Occupational, and Speech Therapy visits per calendar year and is subject to applicable Deductible(s) and Coinsurance.

(5) Cardiac Rehabilitation

Cardiac Rehabilitation treatment is deemed Medically Necessary if services are rendered:

a) under the supervision of a Physician;

b) in connection with a myocardial infarction, coronary occlusion (blockage) or coronary bypass surgery;

c) initiated within twelve (12) weeks after other treatment for the medical condition ends; and

d) provided by a Provider as defined by this Plan.

(6) Respiratory Therapy/Pulmonary Rehabilitation

Introduction of dry or moist gases into the lungs for treatment purposes.

(7) Occupational Therapy

Treatment of a physically disabled Participant by means of constructive activities designed and adapted to promote the restoration of the Participant's ability to satisfactorily accomplish the ordinary tasks of daily living and those tasks required by the Participant's particular occupational role.

This Benefit is limited to a combined total of sixty (60) Physical, Occupational, and Speech Therapy visits per calendar year and is subject to applicable Deductible(s) and Coinsurance.

(8) Speech Therapy

Treatment by a qualified speech therapist for the correction of a speech impairment resulting from disease, surgery, Injury, congenital and developmental anomalies, or previous therapeutic processes.

This Benefit is limited to a combined total of sixty (60) Physical, Occupational, and Speech Therapy visits per calendar year and is subject to applicable Deductible(s) and Coinsurance.

1.111 Treatment for Autism Spectrum Disorders

Care prescribed or ordered for an individual diagnosed with an Autism Spectrum Disorder by a licensed Physician or licensed psychologist, including equipment Medically Necessary for such care, pursuant to the powers granted under such licensed Physician's or licensed psychologist's license, including, but not limited to:

(1) Psychiatric care – direct or consultative services provided by a psychiatrist licensed in the state in which the psychiatrist practices;

(2) Psychological care – direct or consultative services provided by a psychologist licensed in the state in which the psychologist practices;

(3) Habilitative or rehabilitative care – professional, counseling, and guidance services and treatment programs, including ABA therapy, that are necessary to develop the functioning of an individual;

(4) Therapeutic care – services provided by licensed speech therapists, occupational therapists, or physical therapists;

(5) Pharmacy care – medications used to address symptoms of an Autism Spectrum Disorder prescribed by a licensed Physician, and any health-related services deemed Medically Necessary to determine the need or effectiveness of the medications only to the extent that such medications are included in the insured’s health Benefit Plan.

1.112 Urgent Care

Care for an Illness, Injury and condition serious enough that a reasonable person would seek care right away, but not so severe as to require Emergency Room Care.

1.113 Usual, Customary and Reasonable (UCR)

The amount paid for a medical service in a geographic area based on what Providers in the area usually charge for the same or similar medical service. The UCR amount sometimes is used to determine the Allowed Amount.

1.114 Utilization Review Organization

A company, or division within a company, that employs qualified health care professionals and specializes in the business of evaluating medical records for prospective or retrospective determination of appropriateness of treatment.

1.115 Vested Participant

An individual who, between April 1, 1984 and August 13, 1988, or after June 14, 1989, terminated employment with MoDOT, MSHP, or MPERS while participating in the Plan and after becoming vested in his right to a Benefit at retirement from MPERS.

1.116 Work-Related Disability Recipient

A Subscriber who has been determined to be disabled and eligible to receive work-related disability Benefits through the disability insurance carrier contracted through MPERS.

ARTICLE 2

ELIGIBILITY

2.1 Eligibility

Persons who meet the definition of a Participant, located in Article 1.77, are eligible as follows:

(1) Employee Eligibility

Any new Employee will be eligible to become a Participant effective on the first day of the next calendar month following date of employment. Eligibility is subject to submission of proper application and payment of any required contribution as outlined in Article 3.

(2) Dependent Eligibility

Dependents of a Subscriber who meet the definition of a Dependent as stated in Article 1.25 will be eligible for Coverage as follows:

a) During the same period of time the Subscriber remains Covered, unless age limitations apply.

b) Eligible Dependents not enrolled at the time of Subscriber's enrollment are eligible to enroll at a later date with a qualifying event as outlined in Article 3.2, except Coverage will not be extended to any Dependents not enrolled in the Plan at the time of the Subscriber's death.

c) Surviving Dependents enrolled at the time of Subscriber's death may continue Coverage as follows:

i. A surviving Spouse. However, Coverage will not be extended to a qualifying Spouse's new Spouse or new Dependent children not enrolled prior to the Subscriber's death.

ii. Surviving Dependent children through the end of the month they turn twenty-six (26) years of age, excluding any child who is a member of the armed forces of any country and eligible for military insurance Coverage. Coverage will not be extended to a Spouse or child of the surviving Dependent.

(3) Retiree Eligibility

Employees retiring after the effective date of the Plan and their Dependents may, at their option and under the eligibility provision stated herein, remain in the Plan.

(4) Vested Eligibility

An Employee, whose employment with the State terminates and is a Vested Participant of MPERS, is eligible to continue the medical insurance Coverage. To continue the Coverage, you must make an election by filing an application to be received by the Risk and Benefits Management Division located in Jefferson City, MO within sixty (60) days from the last day of the month in which your employment terminates.

2.2 Application for Coverage

Any Employee who is eligible to participate in the Plan must, during the Election Period, complete an enrollment form furnished by the Plan.

If application includes request for Spouse/Dependent Coverage, Employee must furnish social security number(s) and one (1) copy of lawful presence documentation for each. Acceptable lawful presence documents include; but are not limited to:

(1) U.S. Birth Certificate

(2) U.S. Passport (valid or expired)

(3) U.S. Passport Card (valid or expired)

(4) Certificate of Citizenship

(5) Certificate of Birth Abroad

(6) Certificate of Naturalization

(7) Valid Lawful Permanent Resident Card

(8) Valid Employment Authorization Card

(9) Valid Missouri Driver's License

An affidavit furnished by the Board must be completed for each Spouse/ Dependent whose documentation is not submitted at the time of enrollment. The affidavit allows a ninety (90) day extension for submission of required documentation. If documentation is not received within ninety (90) days, the Spouse/Dependent(s) will no longer be eligible for Coverage under the Plan.

2.3 Change of Employment Status

Subject to the continuation of Coverage provisions of the Plan, a Participant who ceases to be an eligible Employee because of a change in employment status will cease to be a Participant at the end of the month in which the change occurred; except if the Participant is a Vested Participant as defined in Article 1.115 and elects to continue Coverage in the Plan.

If an Employee who is not eligible as a Participant becomes eligible, the Employee's effective date of Coverage will be on the first day of the next calendar month following date of employment.

2.4 Employee Leave of Absence Without Pay

An Employee taking leave of absence without pay authorized by the Employer for purposes of military, education, maternity, Illness, Injury, Emergency, etc., may continue the Coverage by paying the required contribution without Employer participation. Employees whose paid or unpaid leave is designated as leave under the Family and Medical Leave Act will receive the Employer Contribution during that leave. If the Employee terminates Coverage at the time of or during a leave of absence, reinstatement of Coverage will not be permitted without a qualifying event as stated in Article 3.2, except for Employees on an authorized military leave of absence as referenced in Article 3.2.

2.5 Medicare Eligibility

Medicare eligibility will apply as follows:

(1) an Employee who is eligible for Medicare will continue to be a Participant under the Plan unless:

a) he elects in writing to terminate Plan Coverage and select Medicare, at which time his Dependent Coverage will also end; or

b) he does not pay the Plan Premium, which the Plan will notify him in writing he has sixty (60) days to pay the Premium before his membership is termed.

(2) an Employee's Spouse who reaches age sixty-five (65) years may choose between continuing as a Participant or electing Medicare in lieu of the Plan; however, the Spouse will continue to be a Participant under the Plan unless the written election is received by the Board;

(3) all Participants, except Employees and their Dependents, will be transferred to Medicare Participant status under the Plan when they become eligible for Coverage under Medicare;

(4) an Employee and/or his Dependents who become Medicare eligible for reasons of kidney transplant or renal dialysis, Medicare will be primary payer in accordance with the Medicare guidelines; or

(5) a Medicare eligible individual, not previously enrolled in the MoDOT/MSHP/MPERS Part D Prescription Drug program, becomes eligible for enrollment due to Marriage or other event that meets the Plan's eligibility requirements. That individual will be required to provide proof they have maintained creditable Prescription Drug Coverage since the end of their Initial Enrollment Period (IEP) for Part D. The IEP for Part D is concurrent with the individual's IEP for Medicare Part B which is the seven (7) month period that begins three (3) months before the month an individual first meets the eligibility requirements for Parts A & B and ends three (3) months after the month of first eligibility. **Otherwise, the individual may be subject to the late enrollment penalty, which could increase their monthly Premium.** Proof of creditable Prescription Drug Coverage can include, but is not limited to: copies of any disclosure notices provided to them by any entity(s) that provided Prescription Drug Coverage.

2.6 Termination of Coverage

The Plan has the right to rescind any Coverage of the Subscriber and/or Dependents for cause, making a fraudulent claim or an intentional material misrepresentation in applying for or obtaining Coverage, or obtaining Benefits under the Plan. The Plan may void Coverage for the Subscriber and/or Covered Dependents for the period of time Coverage was in effect; terminate Coverage as of a date to be determined at the Plan's discretion; or immediately terminate Coverage. If Coverage is to be terminated or voided retroactively for fraud or misrepresentation, the Plan will provide at least thirty (30) days' advance written notice of such

action. The Employer may refund contributions paid for any Coverage rescinded; however, Claims paid will be offset from this amount. The Plan reserves the right to collect additional monies if Claims are paid in excess of the Subscriber's and/or Dependent's paid contributions.

A Subscriber may terminate medical Coverage at any time during the year for himself or his Dependents if he has opted not to participate in the cafeteria plan or is not eligible to participate in the cafeteria plan. However, if the Subscriber participates in the cafeteria plan, he will not be allowed to terminate medical Coverage for himself or his Dependents unless he has a Change in Status event approved by the cafeteria plan administrator. If a subscriber terminates Coverage, he cannot re-enroll in the Plan without a qualifying event as stated in Article 3.2.

(1) Termination of Coverage for Subscribers

Subject to the continuation of Coverage provisions, Coverage by the Plan will terminate on the earliest of the following:

a) at the end of the month in which active employment ends, unless the individual immediately qualifies and continues to participate as a Subscriber under the Plan;

b) at the end of the month in which a change in employment status no longer qualifies the Employee for Coverage as a Subscriber;

c) as of the date of the Participant's death;

d) non-payment of any required contributions; or

e) the termination of the Plan.

(2) Termination of Coverage for Retirees, Vested Participants, Long-Term Disability Recipients, Surviving Spouse, or COBRA Participants

Should a Retiree's, Vested Participant's, Long-Term Disability Recipient's, surviving Spouse's or COBRA Participant's Coverage terminate for any reason other than death, such Retiree, Vested Participant, Long-Term Disability Recipient, surviving Spouse or such COBRA Participant and his Dependents shall not be eligible for re-enrollment, except for Participants eligible for Coverage when returning from active military duty and losing Coverage through the military, or Participants losing coverage through Medicaid or TRICARE for Life (Refer to Article 3.2).

(3) Termination of Coverage for Dependents

Subject to the continuation of Coverage provisions in this article and Article 11, all Dependent Coverage will terminate when the Subscriber's Coverage terminates. If a Subscriber's Coverage terminates because of death, Dependents of a deceased Subscriber may continue Coverage under the Plan, providing the Subscriber was enrolled in the Plan at the time of death and such Dependents were Covered and are eligible for Coverage under the Plan. In the event the surviving Spouse of a Retiree does not receive a MPERS Benefit, Coverage can be continued contingent upon payment of the Premium.

Also, if an Employee is over age sixty-five (65) years and elects to terminate the Plan and select Medicare, his Dependent Coverage will also terminate, subject to the continuation of Coverage provisions in Article 11.

Further, any Dependent will cease to be Covered at the earliest of:

a) the end of the month in which their dependent status terminates;

b) non-payment of any required contributions for such Coverage;

c) the effective date of an approved election or change of election which requests that the individual no longer be Covered;

d) Plan termination; or

e) death.

ARTICLE 3

ELECTION AND EFFECTIVE DATE OF COVERAGE

3.1 Election of Coverage

(1) New Employees shall have an Election Period of thirty-one (31) days after their effective date of employment in which they may enroll themselves and their Dependents. However, this period will be extended for each day during this period the Employee was incapacitated and unable to apply for Coverage.

(2) If an Employee makes application for enrollment or re-enrollment more than thirty-one (31) days after his effective date of employment, he can only be enrolled if he has a qualifying event as stated in Article 3.2 or during open enrollment as stated in Article 3.1(4).

(3) If an Employee enrolls during his Election Period and elects not to enroll all eligible Dependents at that time, and at a later date wishes to enroll such Dependents, the Dependents can only be enrolled if they have a qualifying event as stated in Article 3.2 or during an open enrollment period offered every October in odd-numbered years, with Coverage to be effective January 1 of even-numbered years.

(4) Employees not currently enrolled will have the option to enroll themselves and eligible Dependents during an open enrollment period offered every October in odd numbered years, with Coverage to be effective January 1 of even numbered years.

(5) Subscribers and dependents currently enrolled in either the PPO Plan or the HDHP/HSA Plan can switch between Plans annually during the month of October for January 1 coverage. However, new dependents cannot be enrolled unless the dependents have a qualifying event as stated in Article 3.2 or during the bi-annual open enrollment period as stated in Article 3.1(4).

(6) All Subscribers may continue their Coverage while on active military duty and pay the COBRA rate. If they elect to cancel Coverage during active military duty, they must complete and file an enrollment/change/cancellation form along with active-duty orders. They may reinstate their Coverage as noted in Article 3.2(4).

(7) Plan groups - The following Plan groups are established to provide Coverage for eligible Participants.

a) Subscriber Only – A non-Medicare Subscriber

b) Subscriber/Spouse – A non-Medicare Subscriber and Spouse

c) Subscriber/Family – Subscriber with Spouse and one (1) or more child Dependents or Subscriber with three (3) or more child Dependents

d) Subscriber/Child – Subscriber and one (1) child

e) Subscriber/Two (2) Children – Subscriber and two (2) children

f) Medicare Participant – An individual as defined in Article 1.64.

(8) Each Subscriber will be entitled to elect one (1) of the Plan groups provided the required Subscriber Contributions are paid. At the time the Subscriber elects such Coverage, he will specify the number of Dependents Covered, their name, date of birth, social security number, relationship and whether they are Medicare eligible.

(9) Special Situations -

Two Employees of either MoDOT, MSHP, or MPERS who are married may choose to be enrolled separately, each taking Subscriber Coverage, Subscriber child(ren), etc., or enrolled jointly under Subscriber/Spouse or Subscriber/family Coverage. It will be the responsibility of the Subscribers to notify their insurance representatives of their Marriage or the employment of their Spouse and what type of Coverage they desire for themselves and any Dependents. The open enrollment period to enroll in this category is within thirty-one (31) days of date of Marriage or date of hire. The Subscribers will have the option of changing their enrollment category either in October of each calendar year for Coverage effective January 1 of the following year; or in the event of a change in employment status or Plan category. However, new Dependents must be enrolled during the open enrollment period as stated in Article 3.1(4) or during a qualifying event as stated in Article 3.2.

3.2 Special Enrollment Period

A Special Enrollment Period will be allowed for the following qualifying events (late enrollments will be subject to Board approval):

(1) A Dependent of a Subscriber is born, adopted, or granted U.S. Citizenship, provided the Subscriber makes application to enroll the child within thirty-one (31) days after the date of such event.

(2) A child of the Subscriber is enrolled in the Subscriber/family Plan prior to a new birth, adoption, or receiving U.S. Citizenship, and the Subscriber makes application within thirty-one (31) days after the date of such event.

(3) New eligible Dependents of a Subscriber who marry after the Election Period and make application prior to or no later than thirty-one (31) days after such event.

(4) Subscribers and eligible Dependents enrolled in the Plan who cancelled their Coverage in effect immediately prior to the Subscriber's authorized military leave as follows:

a) Active Employee/Subscribers must submit a completed enrollment form within thirty-one (31) days of their return to work to be reinstated for the same level of Coverage in force prior to their military leave. (Reference Article 3.3 for effective dates of Coverage.)

b) Retired/Vested Subscribers must submit a completed enrollment form and an official document indicating the separation date from the military within thirty-one (31) days of discharge to be reinstated for the same level of Coverage in force prior to their military leave. If they fail to reinstate their Coverage within thirty-one (31) days,

they cannot enroll at a later date. (Reference Article 3.3 for effective dates of Coverage.)

(5) Dependent children when a Subscriber is ordered by a court to provide Coverage and upon receipt of a copy of the court order.

(6) Dependent children of a divorced Subscriber and the divorce decree stipulates the Subscriber must provide Coverage, and application is made within thirty-one (31) days of the signed divorce decree. A copy of the divorce decree must be received by the medical Plan.

(7) Employees, Work-Related Disability Recipients and Dependents who lose eligibility under other insurance because:

a) They are no longer eligible for Coverage under Spouse's plan;

b) Spouse's employer-sponsored medical plan terminates;

c) The Spouse's Employer's total contribution toward the Spouse's plan ceases;

d) Dependents have a qualifying event, and meet the eligibility requirements of a Dependent;

e) Dependent's COBRA Coverage ends and they meet the eligibility requirements of the Plan;

f) They are no longer eligible for Medicaid or CHIP Coverage; or

g) They are no longer eligible for military Coverage.

(8) Loss of Medicaid or TRICARE for Life applies to all Subscribers and Dependents enrolled in the Plan immediately prior to their enrollment in Medicaid or TRICARE for Life.

(9) Dependents of Employees, Retirees, Vested Participants, Work-Related Disability Recipients, Long-Term Disability Recipients, and COBRA Participants enrolled in the Plan, if the Dependents meet the eligibility requirements of the Plan, make application, and have a qualifying event as stated in this article.

(10) Subscribers and eligible Dependents enrolled in the Plan immediately prior to the Subscriber's authorized FMLA leave, if application is made within thirty-one (31) days of return to work.

(11) Participants become eligible for Premium assistance to purchase Coverage in the Plan under applicable Medicaid or CHIP plan.

Under these provisions, application is required. If the qualifying event is due to loss of eligibility as stated in Article 3.2, or if the Employee becomes eligible for Premium assistance as stated in Article 3.2(11), application must be received within sixty (60) days after other Coverage ends. If the qualifying event is loss of military Coverage, reference 3.2(4) of this

Article. Documentation will be required from the previous insurance carrier or former employer as follows:

(1) Coverage has been terminated;

(2) the reason for Coverage termination;

(3) list of Dependents Covered;

(4) the date Coverage was terminated; and

(5) discharge papers (required for military only).

3.3 Effective Date of Coverage

(1) The effective date of Coverage for a new Employee and any eligible Dependents will be on the first day of the next calendar month following date of employment. Effective date of Coverage is subject to submission of proper application and payment of any required contribution.

(2) Child(ren) of the Subscriber born, adopted, or granted U.S. Citizenship after the effective date of the Subscriber's Coverage under the Plan shall be Covered automatically on the date of birth, adoption or on the date of physical placement, if the petition for adoption is filed, or the date granted U.S. Citizenship is provided, if:

a) the Subscriber enrolls the child(ren) in the appropriate Plan category within thirty-one (31) days of such event; and

b) payment of required contributions is received.

If application is made more than thirty-one (31) days from the date of such event, the child(ren) must have a qualifying event as stated in Article 3.2 to be eligible for Coverage. The effective date will be the first day following the date of the qualifying event. Additional documentation, as stated in Article 3.2, will be required as well as receipt of payment of any required contributions.

If the Subscriber is currently enrolled in a Subscriber/family Plan and submits a late enrollment application, Coverage will be subject to Board Approval.

(3) If a Subscriber marries after the effective date of his Coverage, the Spouse and/or Spouse's Dependents are eligible for Coverage, if:

a) they meet the eligibility requirements of the Plan;

b) application is made prior to or within thirty-one (31) days after the date of Marriage; and

c) required contributions are received.

The effective date of Coverage will be the date of Marriage.

If application is made more than thirty-one (31) days from date of Marriage, Spouse and/or Spouse's Dependents must have a qualifying event as stated in Article 3.2, to be eligible for Coverage. If Spouse and/or Spouse's Dependents have a qualifying event, Coverage will be effective on the first day following the date of the qualifying event. Additional documentation, as stated in Article 3.2, and receipt of payment of any additional contributions will be required.

(4) The effective date of Coverage for a Subscriber returning from authorized FMLA leave will be the return to work date.

(5) The effective dates of Coverage for Subscribers returning from authorized military leave, who have a qualifying event as stated in Article 3.2 (4) and have submitted the required paperwork, are as follows:

a) Active Employees' Coverage may be reinstated the first day of the month in which they return to employment, the first day of the following month after their return to employment, or the first day of the month following their loss of military coverage.

b) Retired/Vested Subscribers' Coverage may be reinstated the first day of the month in which they return from active duty, the first day of the following month after their return from active duty, or the first day of the month following their loss of military coverage.

No change in a Subscriber's Plan group or change in status of a person who may be Covered under the Plan shall take effect until the first day following the date of the qualifying event, except as noted in this article.

ARTICLE 4

SCHEDULE OF BENEFITS

4.1 Plan Schedule of Benefits

For a Schedule of Benefits please reference the following appendices:

(1) Appendix A of this article for non-Medicare PPO Plan Participants;

(2) Appendix B of this article for non-Medicare HDHP/HSA Plan Participants;

(3) Appendix C of Article 5 for a schedule of immunizations; and

(4) Appendix D of Article 8 for Medicare PPO Participants.

4.2 Medicare Participant Benefits

Medicare Participants will be eligible for Benefits described in Article 8.

4.3 Copayment

Copayments for medical services (such as office visit copays):

(1) do not apply to the Deductible(s) for the PPO Plan but do apply to the Out-of-Pocket Maximum; and

(2) do not apply to the HDHP/HSA Plan.

4.4 Coverage for Out-of-Country Services

Claims for services received from Non-Participating Providers, that are Covered under the Plan will be Covered at the Out-of-Network Benefit level, and must be submitted in accordance with the procedure set forth in this section.

The Plan shall make Claim forms available to the Participant for filing Claims for medical services and supplies performed or received outside of the country.

The following documentation must be filed with the Claims Administrator within one (1) year of the date of service as proof of service for reimbursement:

(1) Completed Claim form; and

(2) Proof of service (i.e., itemized billing statement of services and/or supplies from Provider).

Reimbursement for Covered services will be paid at the exchange rate as of the date of service and will be paid to the Participant.

If the Plan determines that a Participant has not incurred a Covered expense or that the Benefit is not Covered under the Plan or if the Participant fails to furnish the requested proof, no reimbursement shall be made to the Participant.

4.5 Coverage for Out-of-Network Services

When receiving Out-of-Network services, present your identification card to the Provider of care.

If using a Non-Participating Provider, you may be required to file the Claim with the Claims Administrator. These Benefits are paid at the Out-of-Network Benefit level based on a negotiated rate or based on the Medicare payment schedule. If a negotiated rate or Medicare payment schedule is not available, the Out-of-Network Rate is based on sixty-five percent (65%) of billed charges after the Deductible is applied. The Participant is also responsible for any amount that exceeds the Out-of-Network Rate for services rendered.

4.6 Coverage for Veterans Administration (VA) Facilities

If a Participant (non-Medicare) is confined in a VA Hospital, the Plan will pay at the In-Network Benefit level on eligible charges after the Plan's yearly Deductible(s) has been met. Only non-military service related medical expenses, or services and supplies, are eligible and only if Benefits are not available under any governmental health plan (except Medicaid), except to the extent required under existing State or federal laws and regulations. Payment will be made to the VA facility only.

4.7 Prescription Drug Program

Refer to Article 6 for a detailed explanation of the Prescription Drug program.

APPENDIX A

PPO PLAN

Schedule of Benefits for Non-Medicare Participants

Effective 1/1/2017

This Schedule of Benefits summarizes your obligation towards the cost of certain Covered services for all non-Medicare Participants of the Plan. **Refer to Article 5 for a detailed description of medical Covered services, Article 6 for a detailed description of Prescription Drug Coverage and to Article 7 for a detailed description of limitations or exclusions.**

To receive In-Network Benefits, all Covered services must be performed by a Participating Provider, except as stated in this section under "Emergency Ambulance Services," "Emergency Services" and Article 1.60, "Invisible Providers."

Out-of-Network Provider service insurance payments are subject to Out-of-Network Rates only. Some In-Network Providers utilize Out-of-Network Providers to perform certain services and the Participant will be responsible for the Out-of-Network Rate except as stated in Article 1.60, "Invisible Providers."

*****The Participant will be responsible one hundred percent (100%) for amounts above Out-of-Network Rates.

All services must be Medically Necessary as a condition of Coverage and not otherwise limited or excluded.

BENEFITS AND SERVICES		PARTICIPANT'S RESPONSIBILITY	
		IN-NETWORK	OUT-OF-NETWORK
1.	**Deductible (Medical)** Total amount a Participant is required to pay each calendar year before applicable Coinsurance is applied to Covered services. The Deductible need only be met once per Participant per calendar year.	Individual $450 Family Maximum $1,350 (Defined as three (3) or more family members)	Individual $450 Family Maximum $1,350 (Defined as three (3) or more family members)
2.	**Deductible (Prescription Drug)** Total amount a Participant is required to pay each calendar year before applicable Coinsurance is applied to Covered services. The Deductible need only be met once per Participant per calendar year (except for new Medicare members).	Individual $100	Not Covered

*The Participant will be responsible one hundred percent (100%) for amounts above Out-of-Network Rates.

BENEFITS AND SERVICES		PARTICIPANT'S RESPONSIBILITY	
		IN-NETWORK	OUT-OF-NETWORK
3.	**Out-of-Pocket Maximum (Medical)** The Out-of-Pocket Maximum need only be met once per Participant per calendar year. The following applies to the Out-of-Pocket Maximum: • Medical Coinsurance for Covered services and supplies • Medical Deductible • Medical Copayments The following do not apply to the Out-of-Pocket Maximum: • Prescription Drug Deductible • Prescription Drug Copayments • Prescription Drug Coinsurance • Costs above the Out-of-Network Rate • Non-Covered services and supplies • Utilization review penalties Refer to Article 1.74 for the complete definition of Out-of-Pocket Maximum.	Individual $1,600 Family Maximum $4,800 (Defined as three (3) or more family members)	Individual $2,425 Family Maximum $7,275 (Defined as three (3) or more family members)
4.	**Out-of-Pocket Maximum (Prescription Drug)** The Out-of-Pocket Maximum need only be met once per Participant per calendar year. The following applies to the Out-of-Pocket Maximum: • Pharmacy Coinsurance for Covered services and supplies • Pharmacy Deductible • Pharmacy Copayments The following do not apply to the Out-of-Pocket Maximum: • Medical Deductible • Medical Copayments	Individual $5,000 Family $8,400	Not Covered

*The Participant will be responsible one hundred percent (100%) for amounts above Out-of-Network Rates.

BENEFITS AND SERVICES		PARTICIPANT'S RESPONSIBILITY	
		IN-NETWORK	OUT-OF-NETWORK
	• Medical Coinsurance • Costs above the Out-of-Network Rate • Non-Covered services and supplies • Utilization review penalties • Pharmacy drugs that are not Covered.		
5.	**Maximum Lifetime Benefit** Combined total of all Covered Benefits.	Unlimited	Unlimited
6.	**Allergy Injections**	10% Coinsurance after medical Deductible	20% Coinsurance of Out-of-Network Rate after medical Deductible*
7.	**Cancer Screenings** Cancer screenings shall include the following: a. pelvic exam and pap smear every calendar year for any non-symptomatic woman age eighteen (18) years and over; b. mammograms (refer to the "Mammograms" section of Article 5 for additional information on Coverage); c. a prostate exam and prostate specific antigen (PSA) blood test every calendar year for any non-symptomatic man over the age of fifty (50) years or for younger men who are at high risk and/or have a family history of prostate cancer; or d. colorectal screening for men and women age fifty (50) years or older; or if a doctor prescribes at a younger age because of high risk or family history: fecal occult blood test every calendar year and	*If processed as medical Benefit:* $25 Copayment per visit for office visit only All other Covered services applied to medical Deductible(s) and 10% Coinsurance *If processed as Preventive Care service:* Covered Services will be paid at 100%	*If processed as medical Benefit:* 20% Coinsurance of Out-of-Network Rate after medical Deductible * *If processed as Preventive Care service:* Not Covered

*The Participant will be responsible one hundred percent (100%) for amounts above Out-of-Network Rates.

BENEFITS AND SERVICES		PARTICIPANT'S RESPONSIBILITY	
		IN-NETWORK	OUT-OF-NETWORK
	Cancer Screenings (continued) sigmoidoscopy every five (5) years; – a colonoscopy every ten (10) years; or – a digital rectal exam, sigmoidoscopy, colonoscopy or barium test.		
8.	**Chiropractic Services** Coverage is provided only for manual manipulation and spinal x-ray services. **Office visits and other services are not Covered.**	10% Coinsurance after medical Deductible Limited to thirty (30) treatments per calendar year for manual manipulations of the spine and one (1) spinal x-ray per calendar year.	20% Coinsurance of Out-of-Network Rate after medical Deductible* Limited to thirty (30) treatments per calendar year for manual manipulations of the spine and one (1) spinal x-ray per calendar year.
9.	**Contraceptives (Oral)** Certain services may be Covered under the Preventive Care Benefit. Refer to the "Preventive Care" section of Article 5. Refer to the "Birth Control" section of Article 5.	(1) Generics - 0% Coinsurance (2) Brand (no generic equivalent available) - 30% Coinsurance (3) Brand (generic available) – 30% Coinsurance of brand drug's cost plus the difference between the brand and generic Items 2 and 3 are subject to the Prescription Drug Deductible and have a minimum copayment of $5.	Not Covered
10.	**Contraceptives (Other)** Coverage for non-oral Contraceptive methods, including but not limited to devices and injectibles. Refer to the "Birth Control" section of Article 5.	0% Coinsurance	Not Covered

*The Participant will be responsible one hundred percent (100%) for amounts above Out-of-Network Rates.

BENEFITS AND SERVICES		PARTICIPANT'S RESPONSIBILITY	
		IN-NETWORK	OUT-OF-NETWORK
11.	**Durable Medical Equipment** Certain services may be Covered under the Preventive Care Benefit. Refer to the "Preventive Care" section of Article 5. ***Prior Authorization required on certain DME devices.***	10% Coinsurance of Covered expenses after medical Deductible	20% Coinsurance of Out-of-Network Rate after medical Deductible*
12.	**Emergency Ambulance Services** Coverage is provided for emergency ambulance services as defined under Emergency Services in Article 1.34 and excluded as defined in Article 7.4.	10% Coinsurance after medical Deductible	10% Coinsurance after medical Deductible
13.	**Emergency Services** Coverage is provided for worldwide Emergency Services as defined in Article 1.34 and as deemed an emergency by the Claims Administrator. **Copayment waived if admitted or accidental Injury.**	$75 Copayment per visit then 10% Coinsurance after medical Deductible	*If deemed Emergency Services:* $75 Copayment per visit then 10% Coinsurance of negotiated rate or billed charges after medical Deductible* *If not deemed Emergency Services:* $75 Copayment per visit then 20% Coinsurance of Out-of-Network Rate after medical Deductible*
14.	**Hearing Aids and Screenings** for Dependent children with Developmental Delays up to twenty-six (26) years of age, including Cochlear Implants and Bone Anchored Hearing Aids (BAHA). ***Prior Authorization required.***	10% Coinsurance after medical Deductible Limited to one (1) hearing aid per ear every twenty-four (24) months. Limited to one (1) diagnostic hearing screening and/or audiogram every twelve (12) months.	Not Covered

*The Participant will be responsible one hundred percent (100%) for amounts above Out-of-Network Rates.

BENEFITS AND SERVICES		PARTICIPANT'S RESPONSIBILITY	
		IN-NETWORK	OUT-OF-NETWORK
15.	**Home Health Care and Hospice** ***Prior Authorization required for Home Health related services.***	10% Coinsurance after medical Deductible	20% Coinsurance of Out-of-Network Rate after medical Deductible*
16.	**Immunizations** Coverage is provided in accordance with the recommended schedules in Appendix C of Article 5. The Plan will Cover the Zoster (shingles) vaccine and administration for Participants fifty (50) years of age and older.	$0 Copayment or 0% Coinsurance of eligible expenses	Not Covered
17.	**Inpatient Hospital Services** Unlimited Coverage is provided for Medically Necessary Physician and surgeon services, Semi-Private Accommodations (unless a private room is the only room available or is required for medical reasons), operating rooms and related facilities, intensive and coronary care units, laboratory, x-rays, radiology services and procedures, medications and biologicals, anesthesia, special duty nursing as prescribed, short-term Rehabilitation Services, nursing care, meals and special diets. ***Prior Authorization required.***	10% Coinsurance after medical Deductible	20% Coinsurance of Out-of-Network Rate after medical Deductible* 20% penalty up to $1,000 for failure to Prior Authorize

*The Participant will be responsible one hundred percent (100%) for amounts above Out-of-Network Rates.

BENEFITS AND SERVICES		PARTICIPANT'S RESPONSIBILITY	
		IN-NETWORK	OUT-OF-NETWORK
18.	**Maternity Care - Inpatient Hospital** *Coverage for Subscriber or Dependent.* Covered services include all Physician Services for mother and newborn(s), delivery, newborn nursery services, and Semi-Private Accommodations (unless a private room is the only room available or is required for medical reasons). (Refer to Article 5, "Maternity Services" for information on Coverage.) Certain services may be Covered under the Preventive Care Benefit. Refer to the "Preventive Care" section of Article 5. ***Prior Authorization required***	10% Coinsurance after medical Deductible	20% Coinsurance of Out-of-Network Rate after medical Deductible* 20% penalty up to $1,000 for failure to Prior Authorize
19.	**Maternity Care - Office Visits** *Coverage for Subscriber or Dependent.* Covered services include pre-natal and post-natal care, examinations, tests and educational services. (Infertility testing, office visit treatments and surgery are not Covered.) Certain services may be Covered under the Preventive Care Benefit. Refer to the "Preventive Care" section of Article 5.	$25 Copayment initial office visit only 10% Coinsurance after medical Deductible	20% Coinsurance of Out-of-Network Rate after medical Deductible*
20.	**Mental Health/Substance Abuse - Inpatient** ***Prior Authorization required for all Inpatient Mental Health/ substance abuse admissions.***	10% Coinsurance after medical Deductible	20% Coinsurance of Out-of-Network Rate after medical Deductible* 20% penalty up to $1,000 for failure to Prior Authorize

*The Participant will be responsible one hundred percent (100%) for amounts above Out-of-Network Rates.

BENEFITS AND SERVICES		PARTICIPANT'S RESPONSIBILITY	
		IN-NETWORK	OUT-OF-NETWORK
21.	**Mental Health/Substance Abuse - Outpatient** Coverage provided for Outpatient Mental Health/substance abuse services. Certain services may be Covered under the Preventive Care Benefit. Refer to the "Preventive Care" section of Article 5.	Outpatient office visit: $25 Copayment Outpatient Hospital: 10% Coinsurance after medical Deductible	20% Coinsurance of Out-of-Network Rate after medical Deductible*
22.	**Nutritional Counseling** Coverage is provided for Nutritional Counseling as referenced in "Nutritional Counseling" section of Article 5.	*If processed as medical Benefit:* $25 Copayment *If processed as Preventive Care service:* $0 Copayment or 0% Coinsurance of eligible expenses	20% Coinsurance of Out-of-Network Rate after Medical Deductible Not Covered
23.	**Office Visits** a. **Non-Preventive** Care including diagnosis and consultation performed at either a Primary Care Physician (PCP) or Specialist Physician office. b. **Telemedicine services** included with either PCP or Specialist Physician. Refer to Article 1.109 for the definition of Telemedicine Services. c. **Preventive Care Office Visits**	*If processed as medical Benefit:* $25 Copayment per visit for office visit only All other services applied to medical Deductible(s) and 10% Coinsurance. *If processed as Preventive Care service:* $0 Copayment or 0% Coinsurance of eligible expenses if the office visit is billed as part of the Preventive Care service. $25 Copayment if the office visit is billed separately from the Preventive Care service.	*If processed as medical Benefit:* 20% Coinsurance of Out-of-Network Rate after medical Deductible* *If processed as Preventive Care service:* Not Covered
25.	**Orthotic Appliances and Prosthetic Devices**	10% Coinsurance	20% Coinsurance

*The Participant will be responsible one hundred percent (100%) for amounts above Out-of-Network Rates.

BENEFITS AND SERVICES		PARTICIPANT'S RESPONSIBILITY	
		IN-NETWORK	OUT-OF-NETWORK
	Prior Authorization required on certain appliances and devices.	of Covered expenses after medical Deductible	of Out-of-Network Rate after medical Deductible*
26.	**Outpatient Services and Diagnostic Procedures and Tests** Coverage includes diagnostic procedures and tests, including but not limited to lab, radiology, and mammography. Certain procedures and tests are considered surgery, including but not limited to colonoscopy and endoscopy. Refer to the "Outpatient Surgery" section of this article. Certain services may be Covered under the Preventive Care Benefit. Refer to the "Preventive Care" section of Article 5.	10% Coinsurance after medical Deductible *If processed as a Preventive Care service* Covered at 100%	20% Coinsurance of Out-of-Network Rate after medical Deductible* *If processed as a Preventive Care service* Not Covered
27.	**Outpatient Surgery** Benefits are provided for Covered services rendered at an Outpatient Hospital or free standing surgery center.	10% Coinsurance after medical Deductible	20% Coinsurance of Out-of-Network Rate after medical Deductible* ***Prior Authorization required***
28.	**Prescription Drug Program** Prescription Drug Coverage is available through Participating pharmacies only. For Contraceptive Coverage, refer to the "Contraceptives (Oral)" and "Contraceptives (Other)" sections of this Appendix. **For additional information on Prescription Drug Coverage, refer to Article 6 "Prescription Drug Program".**	30% Coinsurance of costs after pharmacy Deductible. A minimum $5 Copayment is required.	Not Covered

*The Participant will be responsible one hundred percent (100%) for amounts above Out-of-Network Rates.

BENEFITS AND SERVICES		PARTICIPANT'S RESPONSIBILITY	
		IN-NETWORK	OUT-OF-NETWORK
29.	**Preventive Care** Services include immunizations as referenced in Appendix C of Article 5 and anything coded as Preventive Care, including but not limited to routine health assessments, well-child care, and child health supervision services, Covered under the Plan. **Refer to "Office Visits" of this article.** Refer to Appendix C in Article 5 of this summary Plan document.	Covered at 100% for Preventive Care service	Not Covered
30.	**Prosthetic Devices and Orthotic Appliances**	Refer to the "Orthotic Appliances and Prosthetic Devices" section of this article.	
31.	**Skilled Nursing Facility** Coverage is provided in lieu of an Inpatient Hospital admission when approved by the Plan. Coverage is provided for a Semi-Private Accommodations (unless a private room is the only room available or is required for medical reasons). ***Prior Authorization required.***	10% Coinsurance per admission after medical Deductible	20% Coinsurance of Out-of-Network Rate per admission after medical Deductible*
32.	**Therapy/Rehabilitation Services and Supplies** Coverage is provided for Medically Necessary Therapy Services as defined in Article 1.110. Physical, Occupational, and Speech Therapies are limited to a combined total of sixty (60) visits per calendar year for both In-Network and Out-of-Network and is subject to applicable Deductibles(s) and Coinsurance.	10% Coinsurance after medical Deductible	20% Coinsurance of Out-of-Network Rate after medical Deductible*

*The Participant will be responsible one hundred percent (100%) for amounts above Out-of-Network Rates.

BENEFITS AND SERVICES		PARTICIPANT'S RESPONSIBILITY	
		IN-NETWORK	OUT-OF-NETWORK
33.	**Transplant (Human Organ)** Contact the Claims Administrator's Transplant Case Manager for Transplant Benefits and Covered services. **Donor Expenses** are limited to $20,000 per Covered Transplant Procedure. **Travel Expenses** are limited to $10,000 per Covered Transplant Procedure. **Prior Authorization required.**	0% Coinsurance after medical Deductible $15,000 for solid organs $30,000 maximum benefit for Allogeneic Bone Marrow Donor Search Contact the Claims Administrator's Transplant Case Manager for additional Transplant Benefits and Covered services.	20% Coinsurance of Out-of-Network Rate after medical Deductible $15,000 for solid organs $30,000 maximum benefit for Allogeneic Bone Marrow Donor Search Contact the Claims Administrator's Transplant Case Manager for additional Transplant Benefits and Covered services.
34.	**Urgent Care** Urgent Care services (as deemed Urgent Care by the Claims Administrator) that are received at participating alternate facilities both in and out of the service area are Covered.	$25 Copayment for office visit only. Other services applied toward medical Deductible and 10% Coinsurance	*If deemed Urgent Care:* 10% Coinsurance of negotiated rate or billed charges after medical Deductible* *If not deemed Urgent Care:* 20% Coinsurance of the Out-of-Network Rate after medical Deductible*
35.	**Vision Services** **Refer to the "Vision Services" section of Article 5 for Covered services.**	$25 Copayment for office visit only. Other services applied toward medical Deductible and 10% Coinsurance	20% Coinsurance of the Out-of-Network Rate after medical Deductible
Refer to Article 5 for a detailed description of Covered services and to Article 7 for a detailed description of limitations or exclusions.			

*The Participant will be responsible one hundred percent (100%) for amounts above Out-of-Network Rates.

APPENDIX B

HDHP/HSA PLAN

Schedule of Benefits for Non-Medicare Participants
Effective 1/1/2017

This Schedule of Benefits summarizes your obligation towards the cost of certain Covered services for non-Medicare Participants enrolled in the HDHP/HSA Plan. **Refer to Article 5 for a detailed description of medical Covered services, Article 6 for a detailed description of Prescription Drug Coverage and to Article 7 for a detailed description of limitations or exclusions.**

To receive In-Network Benefits, all Covered services must be performed by a Participating Provider, except as stated in this section under "Emergency Ambulance Services," "Emergency Services" and Article 1.60, "Invisible Providers."

Out-of-Network Provider service insurance payments are subject to Out-of-Network Rates only. Some In-Network Providers utilize Out-of-Network Providers to perform certain services and the Participant will be responsible for the Out-of-Network Rate except as stated in Article 1.60, "Invisible Providers."

*****The Participant will be responsible one hundred percent (100%) for amounts above Out-of-Network Rates.

All services must be Medically Necessary as a condition of Coverage and not otherwise limited or excluded.

BENEFITS AND SERVICES		PARTICIPANT'S RESPONSIBILITY	
		IN-NETWORK	OUT-OF-NETWORK
1.	**Deductible (Medical & Prescription Drugs)** Total amount a Participant is required to pay each calendar year before applicable Coinsurance is applied to Covered services. The family maximum of $3,500 must be met for a dependent(s) deductible to be met for the calendar year.	Individual $1,700 Family Maximum $3,500	Individual $3,500 Family Maximum $7,000

*The Participant will be responsible one hundred percent (100%) for amounts above Out-of-Network Rates.

BENEFITS AND SERVICES		PARTICIPANT'S RESPONSIBILITY	
		IN-NETWORK	OUT-OF-NETWORK
2.	**Out-of-Pocket Maximum (Medical and Prescription Drugs)** The Out-of-Pocket Maximum need only be met once per calendar year. The family maximum of $6,600 must be met for a dependent(s) Out-of-Pocket Maximum to be met for the calendar year. The following applies to the Out-of-Pocket Maximum: • Deductible • Medical Coinsurance for Covered services and supplies • Medical Copayments • Prescription Drug Copayments • Prescription Drug Coinsurance The following does not apply to the Out-of-Pocket Maximum: • Costs above the Out-of-Network Rate • Non-Covered medical services, supplies, and non-covered prescription drugs • Utilization review penalties. Refer to Article 1.74 for the complete definition of Out-of-Pocket Maximum	Individual $3,300 Family Maximum $6,600	Individual $5,000 Family Maximum $10,000
3.	**Maximum Lifetime Benefit** Combined total of all Covered Benefits.	Unlimited	Unlimited
4.	**Allergy Injections**	30% Coinsurance after Deductible	50% Coinsurance of Out-of-Network Rate after Deductible*

*The Participant will be responsible one hundred percent (100%) for amounts above Out-of-Network Rates.

BENEFITS AND SERVICES		PARTICIPANT'S RESPONSIBILITY	
		IN-NETWORK	OUT-OF-NETWORK
5.	**Cancer Screenings** Cancer screenings shall include the following: a. pelvic exam and pap smear every calendar year for any non-symptomatic woman age eighteen (18) and over; b. mammograms (refer to the "Mammograms" section of Article 5 for additional information on Coverage); c. a prostate exam and prostate specific antigen (PSA) blood test every calendar year for any non-symptomatic man over the age of fifty (50) or for younger men who are at high risk and/or have a family history of prostate cancer; or d. colorectal screening for men and women age fifty (50) or older; or if a doctor prescribes at a younger age because of high risk or family history: fecal occult blood test every calendar year and sigmoidoscopy every five (5) years; – a colonoscopy every ten (10) years; or – a digital rectal exam, sigmoidoscopy, colonoscopy or barium test.	*If processed as medical Benefit:* 30% Coinsurance after Deductible *If processed as Preventive Care service:* Covered Services will be paid at 100%	*If processed as medical Benefit:* 50% Coinsurance of Out-of-Network Rate after Deductible * *If processed as Preventive Care service:* Not Covered
6.	**Chiropractic Services** Coverage is provided only for manual manipulation and spinal x-ray services. **Office visits and other services are not Covered.**	30% Coinsurance after Deductible Limited to thirty (30) treatments per calendar year for manual manipulations of the spine and one (1) spinal x-ray per calendar year.	50% Coinsurance of Out-of-Network Rate after Deductible* Limited to thirty (30) treatments per calendar year for manual manipulations of the spine and one (1) spinal x-ray per calendar year.

*The Participant will be responsible one hundred percent (100%) for amounts above Out-of-Network Rates.

BENEFITS AND SERVICES		PARTICIPANT'S RESPONSIBILITY	
		IN-NETWORK	OUT-OF-NETWORK
7.	**Contraceptives (Oral)** Certain services may be Covered under the Preventive Care Benefit. Refer to the "Preventive Care" section of Article 5. Refer to the "Birth Control" section of Article 5.	(1) Generics -0% Coinsurance (2) Brand (no generic) - 30% Coinsurance after Deductible (3) Brand (generic available) – 30% Coinsurance of brand drug's cost plus the difference between the brand and generic after Deductible Items 2 and 3 have a minimum copayment of $5.	Not Covered
8.	**Contraceptives (Other)** Coverage for non-oral Contraceptive methods, including but not limited to devices and injectables. Refer to the "Birth Control" section of Article 5.	0% Coinsurance	Not Covered
9.	**Durable Medical Equipment** Certain services may be Covered under the Preventive Care Benefit. Refer to the "Preventive Care" section of Article 5. ***Prior Authorization required on certain DME services.***	30% Coinsurance of Covered expenses after Deductible	50% Coinsurance of Out-of-Network Rate after Deductible*
10.	**Emergency Ambulance Services** Coverage is provided for emergency ambulance services as defined under Emergency Services in Article 1.34 and excluded as defined in Article 7.4.	30% Coinsurance after Deductible	30% Coinsurance after Deductible

*The Participant will be responsible one hundred percent (100%) for amounts above Out-of-Network Rates.

BENEFITS AND SERVICES		PARTICIPANT'S RESPONSIBILITY	
		IN-NETWORK	OUT-OF-NETWORK
11.	**Emergency Services** Coverage is provided for worldwide Emergency Services as defined in Article 1.34 and as deemed an emergency by the Claims Administrator.	30% Coinsurance after Deductible	*If deemed Emergency Services:* 30% Coinsurance of negotiated rate or billed charges after Deductible* *If not deemed Emergency Services:* 50% Coinsurance of Out-of-Network Rate after Deductible*
12.	**Hearing Aids and Screenings** for Dependent children with Developmental Delays up to twenty-six (26) years of age, including Cochlear Implants and Bone Anchored Hearing Aids (BAHA). ***Prior Authorization required.***	30% Coinsurance after Deductible Limited to one (1) hearing aid per ear every twenty-four (24) months. Limited to one (1) diagnostic hearing screening and/or audiogram every twelve (12) months.	Not Covered
13.	**Home Health Care and Hospice** ***Prior Authorization required for Home Health care related services.***	30% Coinsurance after Deductible	50% Coinsurance of Out-of-Network Rate after Deductible*
14.	**Immunizations** Coverage is provided in accordance with the recommended schedules in Appendix C of Article 5. The Plan will Cover the Zoster (shingles) vaccine and administration for Participants fifty (50) years of age and older.	0% Coinsurance of eligible expenses	Not Covered

*The Participant will be responsible one hundred percent (100%) for amounts above Out-of-Network Rates.

BENEFITS AND SERVICES		PARTICIPANT'S RESPONSIBILITY	
		IN-NETWORK	OUT-OF-NETWORK
15.	**Inpatient Hospital Services** Unlimited Coverage is provided for Medically Necessary Physician and surgeon services, Semi-Private Accommodations (unless a private room is the only room available or is required for medical reasons), operating rooms and related facilities, intensive and coronary care units, laboratory, x-rays, radiology services and procedures, medications and biologicals, anesthesia, special duty nursing as prescribed, short-term Rehabilitation Services, nursing care, meals and special diets. ***Prior Authorization required.***	30% Coinsurance after Deductible	50% Coinsurance of Out-of-Network Rate after Deductible* 20% penalty up to $1,000 for failure to Prior Authorize
16.	**Maternity Care, Inpatient Hospital** *Coverage for Subscriber or Dependent.* Covered services include all Physician Services for mother and newborn(s), delivery, newborn nursery services, and Semi-Private Accommodations (unless a private room is the only room available or is required for medical reasons). (Refer to Article 5, "Maternity Services" for information on Coverage.) Certain services may be Covered under the Preventive Care Benefit. Refer to the "Preventive Care" section of Article 5. ***Prior Authorization required.***	30% Coinsurance after Deductible	50% Coinsurance of Out-of-Network Rate after Deductible* 20% penalty up to $1,000 for failure to Prior Authorize

*The Participant will be responsible one hundred percent (100%) for amounts above Out-of-Network Rates.

BENEFITS AND SERVICES		PARTICIPANT'S RESPONSIBILITY	
		IN-NETWORK	OUT-OF-NETWORK
17.	**Maternity Care Office Visits** *Coverage for Subscriber or Dependent.* Covered services include pre-natal and post-natal care, examinations, tests and educational services. (Infertility testing, office visit treatments and surgery are not Covered.) Certain services may be Covered under the Preventive Care Benefit. Refer to the "Preventive Care" section of Article 5.	30% Coinsurance after Deductible	50% Coinsurance of Out-of-Network Rate after Deductible*
18.	**Mental Health/Substance Abuse - Inpatient** ***Prior Authorization required for all Inpatient Mental Health/substance abuse admissions.***	30% Coinsurance after Deductible	50% Coinsurance of Out-of-Network Rate after Deductible* 20% penalty up to $1,000 for failure to Prior Authorize
19.	**Mental Health/Substance Abuse - Outpatient** Coverage provided for Outpatient Mental Health/substance abuse services. Certain services may be Covered under the Preventive Care Benefit. Refer to the "Preventive Care" section of Article 5.	30% Coinsurance after Deductible	50% Coinsurance of Out-of-Network Rate after Deductible*
20.	**Nutritional Counseling** Coverage is provided for nutritional counseling provided by an in network provider.	*If processed as medical Benefit* 30% Coinsurance after Deductible *If processed as Preventive Care service* $0 copayment or 0% Coinsurance of eligible expenses	*If processed as medical Benefit* 50% Coinsurance of Out-of-Network Rate after Deductible* *If processed as Preventive Care service* Not Covered

*The Participant will be responsible one hundred percent (100%) for amounts above Out-of-Network Rates.

BENEFITS AND SERVICES		PARTICIPANT'S RESPONSIBILITY	
		IN-NETWORK	OUT-OF-NETWORK
21.	**Office Visits** a) **Non-Preventive** Care including diagnosis and consultation performed at either a Primary Care Physician (PCP) or Specialist Physician office. b) **Preventive Care Office Visits.** c) **Telemedicine services** included with either PCP or Specialist Physician. Refer to Article 1.109 for the definition of Telemedicine Services.	*If processed as medical Benefit:* 30% coinsurance after Deductible *If processed as Preventive Care service*: $0 copayment or 0% Coinsurance if Office Visit is billed as part of the Preventive Care service. 30% coinsurance after deductible if Office Visit is billed separately from the Preventive Care service	*If processed as medical Benefit:* 50% Coinsurance of Out-of-Network Rate after Deductible* *If processed as Preventive Care service:* Not Covered
22.	**Orthotic Appliances and Prosthetic Devices** ***Prior Authorization required for certain appliances and devices.***	30% Coinsurance of Covered expenses after Deductible	50% Coinsurance of Out-of-Network Rate after Deductible*
23.	**Outpatient Services and Diagnostic Procedures and Tests** Coverage includes diagnostic procedures and tests, including but not limited to lab, radiology, and mammography. Certain procedures and tests are considered surgery, including but not limited to colonoscopy and endoscopy. Refer to the "Outpatient Surgery" section of this article. Certain services may be Covered under the Preventive Care Benefit. Refer to the "Preventive Care" section of Article 5.	30% Coinsurance after Deductible *If processed as a Preventive Care service* Covered at 100%	50% Coinsurance of Out-of-Network Rate after Deductible* *If processed as Preventive Care service* Not Covered

*The Participant will be responsible one hundred percent (100%) for amounts above Out-of-Network Rates.

BENEFITS AND SERVICES		PARTICIPANT'S RESPONSIBILITY	
		IN-NETWORK	OUT-OF-NETWORK
24.	**Outpatient Surgery** Benefits are provided for Covered services rendered at an Outpatient Hospital or free standing surgery center.	30% Coinsurance after Deductible	50% Coinsurance of Out-of-Network Rate after Deductible* ***Prior Authorization required***
25.	**Prescription Drug Program** Prescription Drug Coverage is available through Participating pharmacies only. For Contraceptive Coverage, refer to the "Contraceptives (Oral)" and "Contraceptives (Other)" sections of this Appendix. **For additional information on Prescription Drug Coverage, refer to Article 6 "Prescription Drug Program".**	30% Coinsurance of cost after Deductible. A minimum $5 Copayment is required.	Not Covered
26.	**Preventive Care** Services include immunizations as referenced in Appendix C of Article 5 and anything coded as Preventive Care, including but not limited to routine health assessments, well-child care, and child health supervision services, Covered under the Plan. **Refer to "Office Visits" of this article.** Refer to Appendix C in Article 5 of this summary Plan document.	Covered at 100% for Preventive Care service	Not Covered
27.	**Prosthetic Devices and Orthotic Appliances**	Refer to the "Orthotic Appliances and Prosthetic Devices" section of this article.	
28.	**Skilled Nursing Facility** Coverage is provided in lieu of an Inpatient Hospital admission when approved by the Plan. Coverage is provided for a Semi-Private Accommodations (unless a private room is the only room available or is required for medical reasons). ***Prior Authorization required.***	30% Coinsurance per admission after Deductible	50% Coinsurance of Out-of-Network Rate per admission after Deductible*

*The Participant will be responsible one hundred percent (100%) for amounts above Out-of-Network Rates.

BENEFITS AND SERVICES		PARTICIPANT'S RESPONSIBILITY	
		IN-NETWORK	OUT-OF-NETWORK
29.	**Therapy/Rehabilitation Services and Supplies** Coverage is provided for Medically Necessary Therapy Services as defined in Article 1.110. Physical, Occupational, and Speech Therapies are limited to a combined total of sixty (60) visits per calendar year for both In-Network and Out-of-Network and is subject to applicable Deductibles(s) and Coinsurance.	30% Coinsurance after Deductible	50% Coinsurance of Out-of-Network Rate after Deductible*
30.	**Transplant (Human Organ)** Contact the Claims Administrator's Transplant Case Manager for Transplant Benefits and Covered services. **Donor Expenses** are limited to $20,000 per Covered Transplant Procedure. **Travel Expenses** are limited to $10,000 per Covered Transplant Procedure. ***Prior Authorization required.***	0% Coinsurance after Deductible $15,000 for solid organs $30,000 maximum benefit for Allogeneic Bone Marrow Donor Search Contact the Claims Administrator's Transplant Case Manager for additional Transplant Benefits and Covered services.	50% Coinsurance of Out-of-Network Rate after Deductible $15,000 for solid organs $30,000 maximum benefit for Allogeneic Bone Marrow Donor Search Contact the Claims Administrator's Transplant Case Manager for additional Transplant Benefits and Covered services.

*The Participant will be responsible one hundred percent (100%) for amounts above Out-of-Network Rates.

BENEFITS AND SERVICES		PARTICIPANT'S RESPONSIBILITY	
		IN-NETWORK	OUT-OF-NETWORK
31.	**Urgent Care** Urgent Care services (as deemed Urgent Care by the Claims Administrator) that are received at participating alternate facilities both in and out of the service area are Covered.	30% Coinsurance after Deductible.	*If deemed Urgent Care:* 30% Coinsurance of negotiated rate or billed charges after Deductible* *If not deemed Urgent Care:* 50% Coinsurance of the Out-of-Network Rate after Deductible*
32.	**Vision Services** Refer to the "Vision Services" section of Article 5 for Covered services.	30% Coinsurance after Deductible	50% Coinsurance of the Out-of-Network Rate after Deductible
Refer to Article 5 for a detailed description of Covered services and to Article 7 for a detailed description of limitations or exclusions.			

*The Participant will be responsible one hundred percent (100%) for amounts above Out-of-Network Rates.

ARTICLE 5

COVERED SERVICES AND SUPPLIES

The Plan Covers only those Health Care Services and supplies that are:

(1) deemed Medically Necessary,

(2) Prior Authorized, if Prior Authorization is required, and

(3) not excluded under the exclusions and limitations set forth in Article 7.

The following section, "**Schedule of Covered Services**,**"** provides the Health Care Services and supplies Covered by the Plan. The schedule is provided to assist the Participant with determining the level of Coverage and Prior Authorization procedures, limitations, and exclusions that apply for Covered services that are deemed Medically Necessary, subject to the exclusions and limitations set forth in Article 7. All Prior Authorizations and determinations referenced in the Schedule of Covered Services are made by the Plan. If a service is Medically Necessary but not specifically listed and not otherwise excluded, please contact the Claims Administrator to confirm whether the service is a Covered service.

The Copayment and/or Coinsurance amount the Participant is required to pay for each Covered health service is stated in Appendices A and B of Article 4 for non-Medicare Participants and Appendix D of Article 8 for Medicare Participants. The Emergency Services Copayment for the PPO Plan will be waived if the Emergency Services visit is necessitated by an accident or Injury or if the patient is admitted as a Hospital Inpatient directly from the emergency room.

The Network of Participating Providers is available to the Participant upon request and is available on the Claims Administrator's website. Listing a particular Provider on the Claims Administrator's website is not a guarantee that the particular Provider will be Participating at the time the Participant seeks health services. The Participant must verify the participation status of Providers with the Plan before obtaining health services.

Except where noted, these health services are Covered when rendered by either Participating or Non-Participating Providers. Please remember that health services rendered by Non-Participating Providers will be Covered at the lower Out-of-Network level of Benefits and the Participant will be responsible one hundred percent (100%) for amounts above Out-of-Network Rates. An exception to this rule is when Participating Providers utilize Non-Participating Providers, referred to as Invisible Providers in Article 1.60, or when Invisible Providers are utilized in emergency situations. Also reference Article 1.84, "Preferred Provider Organization" for payment information.

Please note that the Covered services in the Schedule of Benefits are subject to all applicable exclusions of this summary Plan document.

Medical Benefits apply when Covered charges are incurred by a Participant for care of an Injury, Illness, or Mental Health service and while the Participant is Covered for these Benefits under the Plan. Certain services may require Prior Authorization from the Claims Administrator. Please refer to Article 9.2 for a listing of services requiring Prior Authorization.

Important Notice for Mastectomy Patients

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

(1) reconstruction of the breast on which the mastectomy was performed;

(2) surgery and reconstruction of the other breast to produce a symmetrical appearance; and

(3) Prosthesis and treatment of physical complications at all stages of the mastectomy, including lymphedemas.

Such services will be performed in a manner determined in consultation with the attending Physician and the Participant. See the “Breast Reconstruction” section of this article for further detail regarding this Coverage.

Prior Authorization is required.

COVERAGE FOR SERVICES OR SUPPLIES WHEN DETERMINED BY THE PLAN TO BE MEDICALLY NECESSARY		
SERVICE OR SUPPLY	**CRITERIA AND COVERAGE PROVIDED**	**AUTHORIZATION REQUIREMENTS, LIMITATIONS, AND EXCLUSIONS**
Abortion	Refer to the "Birth Control" section of this article.	**Exclusions:** Refer to the "Birth Control" section of this article
Allergy	Covered service for allergy testing, diagnosis, treatment, allergy serum, and the administration of injections. Coverage is provided for allergy and dermatology services and supplies ordered by and provided by or under the direction of a Physician in the Provider's office.	**Limitations:** Self-injectables are Covered under the Prescription Drug program. **Exclusions:** (1) Those non-Physician allergy services or associated expenses relating to an allergic condition including, but not limited to, installation of air filters, air purifiers, or air ventilation system cleaning (2) Non-prescription allergy medications Prescription strength non-sedating anti-histamines for non-Medicare Participants
Ambulance/ Transportation Services	Ambulance/transportation services providing Emergency air or land transportation by means of a specially designed and equipped vehicle used only for transporting the sick and Injured. These services will be Covered at the In-Network level of Benefits provided by the Plan as follows: (1) from a Participant's home or scene of injury/accident to a Hospital when Emergency Services are necessary; (2) between Hospitals; or (3) to or from a medical clinic. Benefits will be paid for air ambulance services to the nearest Hospital capable of providing Medically Necessary treatment when ground transportation would endanger the safety of the Participant. In no event will ambulance/ transportation services include any service rendered for convenience of the patient.	**Limitations:** Air or ground ambulance /transportation transfers between facilities require Prior Authorization. **Exclusions:** (1) Ambulance/transportation due to the absence of other transportation on the part of the Participant (2) Non-medical Emergency ambulance/transportation services regardless of who requested the ambulance /transportation service (3) Ambulance/transportation charges, except as provided in the "Ambulance/ Transportation Services" and "Transplant (Human Organ)" sections of this article (4) Air ambulance transportation for transplants, unless approved by the medical director

COVERAGE FOR SERVICES OR SUPPLIES WHEN DETERMINED BY THE PLAN TO BE MEDICALLY NECESSARY		
SERVICE OR SUPPLY	**CRITERIA AND COVERAGE PROVIDED**	**AUTHORIZATION REQUIREMENTS, LIMITATIONS, AND EXCLUSIONS**
Autism Spectrum Disorders	Notwithstanding any other provision of the Plan, Coverage is provided for the diagnosis and Medically Necessary Treatment for Autism Spectrum Disorders when ordered by your treating Physician or licensed psychologist in accordance with a treatment plan. Except for Inpatient services, the Plan has the right to review the treatment plan of a Participant receiving Treatment for Autism Spectrum Disorder not more than once every six (6) months unless the treating Physician or psychologist and the Plan agree that a more frequent review is necessary. The cost of obtaining the review or treatment plan will be borne by the Plan. Coverage provided for ABA shall be for Participants up to nineteen (19) years of age and limited as allowed by law.	Prior Authorization for services may be required. Treatment plans may be required. **Exclusions:** (1) Services and supplies for conditions related to milieu therapy, learning disabilities, mental retardation, or for Inpatient admission for environmental change; (2) Treatment for disorders relating to learning, motor skills, and communication
Birth Control **Refer to "Contraceptives Oral" and "Contraceptives Other" as outlined in Appendices A and B of Article 4 for non-Medicare Participants and in Appendix D of Article 8 for Medicare Participants.**	Coverage of Birth Control is provided, including Medically Necessary Abortions, Contraceptive methods and counseling, and Sterilization for both Medicare and non-Medicare Participants. (1) Abortion a) Coverage is provided for Medically Necessary Abortions and includes services in connection with a Medically Necessary Abortion; and b) Coverage includes treatment of the complications of any Abortion. (2) Contraceptives a) Oral Contraceptives, NuvaRing, and;	Prior Authorization may be required, except for a vasectomy performed in a Physician's office. **Exclusions:** (1) Abortions other than Medically Necessary (2) Services in connection with an Abortion, except a Medically Necessary Abortion as defined in Article 1.1 (3) Contraceptives when utilizing Out-of-Network Providers and Out-of-Network pharmacies (4) Reversal of Sterilization

COVERAGE FOR SERVICES OR SUPPLIES WHEN DETERMINED BY THE PLAN TO BE MEDICALLY NECESSARY		
SERVICE OR SUPPLY	**CRITERIA AND COVERAGE PROVIDED**	**AUTHORIZATION REQUIREMENTS, LIMITATIONS, AND EXCLUSIONS**
Birth Control (continued)	b) implantation of Contraceptive devices and injectables not Covered under the Prescription Drug program will be Covered through the medical Benefit program as outlined in Appendices A and B of Article 4 for non-Medicare Participants and in Appendix D of Article 8 for Medicare Participants. Out-of-Pocket Limit will not be applicable with regard to these services. (3) Sterilizations Coverage is provided for tubal ligation and vasectomy. Certain services may be Covered under the Preventive Care Benefit. Refer to "Preventive Care" in Appendices A and B of Article 4 for non-Medicare Participants and in Appendix D of Article 8 for Medicare Participants.	
Blood and Blood Products	Covered service for administration and processing of blood and blood products in connection with services Covered. For Medicare eligible Participants, the first three (3) pints of blood, which are not Covered by Medicare Parts A and B, are Covered.	**Exclusions:** (1) Those services and associated expenses related to personal blood storage, unless associated with a scheduled surgery (2) Fetal cord blood harvesting and storage (3) Donor expenses for obtaining blood from a blood bank or supplier

COVERAGE FOR SERVICES OR SUPPLIES WHEN DETERMINED BY THE PLAN TO BE MEDICALLY NECESSARY		
SERVICE OR SUPPLY	**CRITERIA AND COVERAGE PROVIDED**	**AUTHORIZATION REQUIREMENTS, LIMITATIONS, AND EXCLUSIONS**
Breast Reconstruction	Coverage is provided for breast Reconstructive Surgery as follows: (1) Medically Necessary breast reductions; (2) As required by the Women's Health and Cancer Rights Act (WHCRA), if the Participant elects breast reconstruction after a Covered mastectomy, Benefits will be provided for: a) augmentation and reduction of the affected breast; b) augmentation or reduction on the opposite breast to restore symmetry; c) prosthesis; treatment of physical complications at all stages of the mastectomy, including lymphedema; d) nipple reconstruction; In lieu of surgery, Coverage is provided for external Prosthetic Devices.	*Prior Authorization required.* **Exclusions:** (1) Reduction, including for male gynecomastia, and augmentation mammoplasty unless Medically Necessary or associated with Reconstructive Surgery following a Medically Necessary mastectomy
Cardiac Rehabilitation Therapy	Refer to the "Therapy/Rehabilitation Services and Supplies" section of this article.	
Chemotherapy and Radiation Therapy	Refer to the "Therapy/Rehabilitation Services and Supplies" section of this article.	**Exclusions:** (1) Experimental or Investigational Chemotherapy or Radiation Therapy. (2) Refer to the "Therapy/Rehabilitation Services and Supplies" section of this article.
Chiropractic Services	The manual manipulation of the spine by a licensed chiropractor to correct a subluxation. The Plan allows Coverage for one (1) spinal x-ray by a chiropractor per calendar year. Covered services for manual manipulations will be limited to thirty (30) treatments per calendar year.	**Exclusions:** Chiropractic services, except as provided in this article

COVERAGE FOR SERVICES OR SUPPLIES WHEN DETERMINED BY THE PLAN TO BE MEDICALLY NECESSARY		
SERVICE OR SUPPLY	**CRITERIA AND COVERAGE PROVIDED**	**AUTHORIZATION REQUIREMENTS, LIMITATIONS, AND EXCLUSIONS**
Clinical Trials	Coverage is provided for routine patient care costs of a qualified individual, as defined under the Affordable Care Act, incurred as a result of Phase I, II, III or IV clinical trials undertaken for the purposes of the prevention, early detection, or treatment of cancer and approved or funded by one (1) of the following entities: (1) National Institute of Health (NIH); (2) an NIH cooperative group or center; (3) the FDA in the form of an Investigational new drug application; (4) the federal Departments of Veterans' Affairs or Defense; (5) a qualified research entity that meets the criteria for NIH Center support grant eligibility; or (6) an institutional review board that has an appropriate assurance approved by the Department of Health and Human Services. Routine patient care costs will be Covered for Phase I,II, III or IV clinical trials undertaken for the purposes of the prevention, early detection or treatment of cancer if the trial: (1) is sanctioned by the NIH or the National Cancer Institute (NCI); (2) conducted at an academic or NCI Center; and (3) the Participant is enrolled in the clinical trial, not merely following the Phase II protocol. Coverage includes routine patient care costs incurred for drugs and devices that have been approved for sale by the FDA. In the case of treatment under a clinical trial, the treating facility and personnel must have the expertise and training to provide the treatment and treat a sufficient volume of patients.	*Prior Authorization is required.* **Limitations:** Coverage is limited to Participating Providers. **Exclusions:** (1) Routine patient care for any clinical trial that does not meet the criteria

COVERAGE FOR SERVICES OR SUPPLIES WHEN DETERMINED BY THE PLAN TO BE MEDICALLY NECESSARY		
SERVICE OR SUPPLY	**CRITERIA AND COVERAGE PROVIDED**	**AUTHORIZATION REQUIREMENTS, LIMITATIONS, AND EXCLUSIONS**
Colorectal Cancer Screening	(1) In accordance with the current American Cancer Society guidelines, Coverage is provided as follows for any Participant age fifty (50) years or older or if a doctor prescribes at a younger age because of high risk or family history: a) a fecal occult blood test every calendar year and sigmoidoscopy every five (5) years; b) a colonoscopy every ten (10) years; or c) a digital rectal exam, sigmoidoscopy, colonoscopy or barium test. (2) Colorectal cancer exams for symptomatic Participants will be Covered as needed. Services for symptomatic conditions are subject to Deductible(s), Copayment(s) and Coinsurance if processed under regular medical Benefits; however, non-symptomatic screenings may also be processed under "Preventive Care" in Appendices A and B of Article 4 for non-Medicare Participants and in Appendix D of Article 8 for Medicare Participants.	**Exclusions:** (1) Non-symptomatic colorectal cancer screenings processed as Preventive Care when utilizing Out-of-Network Providers
Contraceptives	Refer to the "Birth Control" section of this article.	**Exclusions:** Refer to the "Birth Control" section of this article
Cosmetic, Plastic and Related Reconstructive Surgery	Services are limited to the surgical correction of congenital birth defects or the effects of disease or Injury, which cause anatomical functional impairment, when such surgery is reasonably expected to correct the functional impairment. For purposes of this Benefit agreement, psychological or emotional conditions do not constitute Medical Necessity. Reconstructive surgery, while a Participant in the Plan, is Covered under	*Prior Authorization required.* **Exclusions:** (1) Implants for cosmetic or psychological reasons (2) Elective or voluntary enhancement procedures, services, and medications (growth hormone and testosterone) including, but not limited to: a) weight loss;

COVERAGE FOR SERVICES OR SUPPLIES WHEN DETERMINED BY THE PLAN TO BE MEDICALLY NECESSARY		
SERVICE OR SUPPLY	**CRITERIA AND COVERAGE PROVIDED**	**AUTHORIZATION REQUIREMENTS, LIMITATIONS, AND EXCLUSIONS**
Cosmetic, Plastic and Related Reconstructive Surgery (continued)	the following scenarios: (1) a disfiguration of the face or hands; (2) Reconstructive Surgery of a diseased breast upon which surgery was performed; (3) surgery and reconstruction of the non-diseased breast to produce a symmetrical appearance, with no time limit imposed on Reconstructive Surgery; or (4) for the grafting of skin to any other part of the body.	b) hair growth; c) sexual performance; d) athletic performance; e) cosmetic purposes; f) anti-aging; g) mental performance; h) salabrasion; i) chemosurgery; (3) laser surgery or other skin abrasion procedures associated with the removal of scars; tattoos; and actinic changes. (4) Reduction, including for male gynecomastia, and augmentation mammoplasty unless Medically Necessary or associated with Reconstructive Surgery following a Medically Necessary mastectomy (5) Cosmetic procedures including, but not limited to, pharmacological regimens, plastic surgery, and non-Medically Necessary dermatological procedures and Reconstructive Surgery. (6) Cosmetic procedures are those procedures that improve physical appearance, but do not correct or materially improve a physiological function and are not Medically Necessary except when the procedure is needed for prompt repair of accidental Injury or to improve the function of a congenital anomaly.

COVERAGE FOR SERVICES OR SUPPLIES WHEN DETERMINED BY THE PLAN TO BE MEDICALLY NECESSARY		
SERVICE OR SUPPLY	**CRITERIA AND COVERAGE PROVIDED**	**AUTHORIZATION REQUIREMENTS, LIMITATIONS, AND EXCLUSIONS**
Dental Services	(1) A dental examination prescribed by a Physician prior to joint replacement, valve replacement or transplant surgery to verify an infection/bacteria is not present, which could jeopardize the success of the surgery. The Coverage will not include any dental services required as a result of the check-up. Proof of surgery will be required from your Physician. (2) Repair due to Injury to sound natural teeth; initial care must be rendered within ninety (90) days of Injury (3) The administration of general anesthesia and Hospital charges is provided as follows: a) a child under the age of five (5) years; b) a Participant who is severely disabled; or c) a Participant who has a medical or behavioral condition that requires Hospitalization or general anesthesia. The general anesthesia will also apply whether in a Hospital or surgical center. <u>Actual dental work affiliated with these services will not be Covered.</u> (4) Dental Benefit services include evaluations and office visits when associated with Covered dental services. Refer to the "Oral Surgery and Diseases of the Mouth" section of this article.	Limited Benefit. Prior Authorization required. **<u>Exclusions:</u>** (1) Services or supplies provided for dental services as follows: a) routine care and treatment for filling, removal, replacement, repair, or artificial restoration of the teeth (either natural or artificial), root canal, surgery involving structures directly supporting the teeth, or orthodontia b) preparation of the mouth for the fitting or the continued use of dentures, except as provided in this article c) Injuries to the teeth while eating are not considered accidental Injuries d) other services not provided in this article (2) Dental x-rays, supplies and appliances (including occlusal splints and guards and orthodontia) (3) Those dental services provided by a Doctor of Dental Surgery, "D.D.S.," a Doctor of Medical Dentistry "D.M.D." or a Physician licensed to perform dental related oral surgical procedures (including services for overbite or underbite and services related to surgery for cutting through the lower or upper jaw bone) whether the services are considered to be medical or dental in nature except as provided in this section. Refer to the "Oral Surgery and Diseases of the Mouth" section of this article.

COVERAGE FOR SERVICES OR SUPPLIES WHEN DETERMINED BY THE PLAN TO BE MEDICALLY NECESSARY		
SERVICE OR SUPPLY	**CRITERIA AND COVERAGE PROVIDED**	**AUTHORIZATION REQUIREMENTS, LIMITATIONS, AND EXCLUSIONS**
Dermatological Services	Covered service when necessary to remove a skin lesion that interferes with normal body functions or is suspected to be malignant.	Prior Authorization may be required. Contact the Claims Administrator for predetermination of Benefits.
Diabetic Services and Supplies	Coverage shall include Participants with gestational Type I or Type II diabetes and will be subject to applicable Deductible(s), Copayment(s) and Coinsurance as follows: (1) related office visit; (2) equipment and supplies not Covered under the Prescription Drug program, including insulin pumps and related supplies and continuous glucose monitors and related supplies; (3) self-management training used in the management and treatment of diabetes; (4) diabetic testing supplies for Medicare Participants, including glucose testing monitors, blood glucose testing strips, lancet devices and lancets, will not be Covered under the Prescription Drug program. These supplies will be Covered under Medicare Part B Plan. Insulin and syringes will continue to be Covered under the Prescription Drug program of the Plan; (5) diabetic foot care is provided as follows: a) one (1) pair of therapeutic shoes, including fitting of shoes and inserts, per calendar year for diabetic foot disease or peripheral neuropathy; and b) services in connection with the treatment of corns, calluses, toenails, and complete removal of nail roots or for services for metabolic peripheral vascular disease or diabetes; and (6) diabetic eye examination per	Prior Authorization required for insulin pumps and cartridges. **<u>Limitations:</u>** (1) Glucose monitors, glucose strips, and lancets are Covered under the Prescription Drug program except for Medicare Participants (2) Insulin and syringes will be Covered under the Prescription Drug program of the Plan for both Medicare and non-Medicare Participants (3) More than one (1) pair of therapeutic shoes and one (1) shoe insert per calendar year **<u>Exclusions:</u>** (1) Diabetic services processed as Preventive Care when utilizing Out-of-Network Providers

COVERAGE FOR SERVICES OR SUPPLIES WHEN DETERMINED BY THE PLAN TO BE MEDICALLY NECESSARY		
SERVICE OR SUPPLY	**CRITERIA AND COVERAGE PROVIDED**	**AUTHORIZATION REQUIREMENTS, LIMITATIONS, AND EXCLUSIONS**
Diabetic Services and Supplies (continued)	calendar year. Certain services may be Covered under the Preventive Care Benefit. Refer to "Preventive Care" in Appendices A and B of Article 4 for non-Medicare Participants and in Appendix D of Article 8 for Medicare Participants.	

COVERAGE FOR SERVICES OR SUPPLIES WHEN DETERMINED BY THE PLAN TO BE MEDICALLY NECESSARY		
SERVICE OR SUPPLY	**CRITERIA AND COVERAGE PROVIDED**	**AUTHORIZATION REQUIREMENTS, LIMITATIONS, AND EXCLUSIONS**
Durable Medical Equipment (DME)	(1) Covered service when determined to be necessary and reasonable for the treatment of an Illness or Injury, or to improve the functioning of a malformed body part, and when all of the following circumstances apply: a) it can withstand repeated use; b) it is primarily and customarily used to serve a medical purpose c) it is generally not useful to a Participant in the absence of an Illness or Injury; and d) it is appropriate for use in the home. (2) There is Coverage for the initial rental and purchase of DME when Prior Authorized by the Plan, and ordered by or provided by a Physician for use outside a Hospital or Skilled Nursing Facility. Coverage is provided for DME that meets the minimum specifications that are Medically Necessary. (3) Coverage includes, but is not limited to the following: a) trusses, crutches, and braces; b) equipment for the administration of oxygen; c) custom wheelchair; d) electric wheelchair or electric scooter (with approved predetermination of Medical Necessity); e) Hospital-type bed; f) insulin pumps and related supplies; g) continuous glucose monitors and related supplies;	Prior Authorization may be required on certain DME devices. Upgrades to DME are the responsibility of the Participant. **<u>Exclusions:</u>** (1) DME that does not serve a medical purpose or cannot be used in a Participant's home and equipment that is generally not useful to a Participant without Illness, Injury or diseases (2) The purchase or rental of services or supplies of common household use or for personal hygiene and convenience including, but not limited to: a) physical fitness equipment b) air purifiers c) central or unit air conditioners d) allergenic pillows e) mattresses or beds f) humidifiers g) hot tubs and saunas and h) personal items such as: i. a TV ii. telephone iii. cots iv. visitors' meals v. barber or beauty service vi. guest services vii. similar incidental services and supplies (3) Over-the-counter devices and/or supplies (such as ACE wraps, disposable medical supplies, elastic supports after the initial placement, finger splints, and Jobst and TEDS stockings over two (2) pairs per year)

COVERAGE FOR SERVICES OR SUPPLIES WHEN DETERMINED BY THE PLAN TO BE MEDICALLY NECESSARY		
SERVICE OR SUPPLY	**CRITERIA AND COVERAGE PROVIDED**	**AUTHORIZATION REQUIREMENTS, LIMITATIONS, AND EXCLUSIONS**
Durable Medical Equipment (DME) (continued)	h) one (1) pair of therapeutic shoes, including fitting of shoes and inserts, per calendar year for diabetic foot disease or peripheral neuropathy; and i) TENS unit. For information on Coverage for glucose monitors, refer to the "Diabetic Services and Supplies" section of this article. (4) Participants with DME that is Covered under a manufacturer's warranty should address any repairs and replacements with the manufacturer before contacting the Plan. If it is determined that the issue is not Covered under the manufacturer's warranty, Coverage may be provided for replacement of DME which has become non-functional and non-repairable due to normal, routine wear and tear. (5) Services for repair and replacement of DME will be Covered under the Plan if deemed Medically Necessary. A letter of Medical Necessity will be required from the Provider for review prior to Coverage. The Participant must seek repair of the equipment prior to replacement, unless the repair cost is greater than the replacement cost. The Plan will not Cover replacement batteries or routine maintenance or maintenance agreements. (6) Certain services may be Covered under the Preventive Care Benefit. Refer to "Preventive Care" in Appendices A and B of Article 4 for non-Medicare Participants and in Appendix D of Article 8 for Medicare Participants.	(4) Repairs, replacement, or maintenance costs for any otherwise Covered DME unless there is sufficient change in Participant's physical condition to make the original device no longer functional (5) Maintenance due to normal wear and tear of items owned by the Participant (6) Exclusions 5 and 6 also apply to disposable medical supplies, including but not limited to, feeding bags, and feeding syringes (7) Services and supplies processed as Preventive Care when utilizing Out-of-Network Provider For information on Coverage for glucose monitors, refer to the "Diabetic Services and Supplies" section of this article.

COVERAGE FOR SERVICES OR SUPPLIES WHEN DETERMINED BY THE PLAN TO BE MEDICALLY NECESSARY		
SERVICE OR SUPPLY	**CRITERIA AND COVERAGE PROVIDED**	**AUTHORIZATION REQUIREMENTS, LIMITATIONS, AND EXCLUSIONS**
Emergency Services	Services and supplies furnished or required to screen and stabilize an Emergency medical condition provided on an Outpatient basis at either a Hospital or alternate facility are Covered. An Emergency Services Copayment must be satisfied each time a Covered individual receives Emergency Services, and must be satisfied in addition to the Plan's calendar year Deductible(s) and Coinsurance. The Emergency Services Copayment will be waived if the Emergency Services visit is necessitated by an accident or Injury or if the patient is admitted as a Hospital Inpatient directly from the Emergency room. See Appendices A and B of Article 4 for non-Medicare Participants and Appendix D of Article 8 for Medicare Participants.	

COVERAGE FOR SERVICES OR SUPPLIES WHEN DETERMINED BY THE PLAN TO BE MEDICALLY NECESSARY		
SERVICE OR SUPPLY	**CRITERIA AND COVERAGE PROVIDED**	**AUTHORIZATION REQUIREMENTS, LIMITATIONS, AND EXCLUSIONS**
Eyeglasses and Corrective Lenses	Not a Covered service, except when necessary for the first pair of eyeglasses or corrective lenses following cataract surgery performed while the Participant is enrolled with the Plan or when new cataract lenses are needed because of a prescription change. Prosthetic lenses following initial intraocular cataract surgery.	**Limitations:** Implant of a Crystalens or any lens classified as a deluxe accommodating intraocular lens following initial cataract surgery is considered to be a deluxe Prosthetic Device and reimbursement will not exceed the cost of traditional intraocular lenses following initial or replacement cataract surgery. **Exclusions:** (1) Eyeglasses, contact lenses, and examinations, whether or not prescribed (2) Replacement of cataract lenses except as provided in this article (3) Those health services and associated expenses for orthoptics, eye exercises, blepharoplasty, radial keratotomy, LASIK, and other refractive eye surgery
Family Planning and Fertility Services	For Birth Control Coverage, refer to the "Birth Control" sections in this article.	Prior Authorization may be required. **Exclusions:** (1) Services in connection with the treatment and diagnosis of fertility or infertility including, but not limited to: a) artificial insemination b) intracytoplasmic sperm injection (ICSI) c) in vitro or in vivo fertilization d) gamete intrafallopian transfer (GIFT) procedures e) zygote intrafallopian transfer (ZIFT) procedures f) embryo transport g) reversal of voluntary Sterilization h) surrogate parenting i) selective reduction j) cryo preservation

COVERAGE FOR SERVICES OR SUPPLIES WHEN DETERMINED BY THE PLAN TO BE MEDICALLY NECESSARY		
SERVICE OR SUPPLY	**CRITERIA AND COVERAGE PROVIDED**	**AUTHORIZATION REQUIREMENTS, LIMITATIONS, AND EXCLUSIONS**
Family Planning and Fertility Services (continued)		k) travel costs l) donor eggs or semen and related costs including collection and preparation m) non-Medically Necessary amniocentesis n) any infertility treatment deemed Experimental or Investigational (2) Additionally, pharmaceutical agents used for the purpose of treating infertility are not Covered, except as provided in Article 6 (3) Services and supplies, including but not limited to Contraceptives (oral and others), processed as Preventive Care when utilizing Out-of-Network Provider
Genetic Testing	Genetic Testing is a Covered service if it meets Medical Necessity as determined by the Claims Administrator.	*Prior Authorization required.*
Growth Hormone	Growth hormone therapy: (1) for children less than eighteen (18) years of age who have been appropriately diagnosed to have an actual growth hormone deficiency; and (2) for the treatment of Turner's Syndrome or to HIV wasting syndrome.	**Exclusions:** Growth hormone therapy for any condition except as specifically listed as Covered.

COVERAGE FOR SERVICES OR SUPPLIES WHEN DETERMINED BY THE PLAN TO BE MEDICALLY NECESSARY		
SERVICE OR SUPPLY	**CRITERIA AND COVERAGE PROVIDED**	**AUTHORIZATION REQUIREMENTS, LIMITATIONS, AND EXCLUSIONS**
Gynecological Services	Coverage is provided for: (1) well-woman services per calendar year for non-symptomatic conditions, in accordance with the current American Cancer Society guidelines; and (2) services for symptomatic conditions. Services for symptomatic conditions are subject to Deductible(s), Copayment(s) and Coinsurance if processed under regular medical Benefits. Non-symptomatic screenings will be processed under "Preventive Care" in Appendices A and B of Article 4 for non-Medicare Participants and Appendix D of Article 8 for Medicare Participants.	**Exclusions:** Non-symptomatic gynecological services processed as Preventive Care service when utilizing Out-of-Network Providers.
Hearing Aids and Screenings	Hearing aids and screenings will be Covered for Dependent children with Developmental Delays up to twenty-six (26) years of age as follows: (1) once every twenty-four (24) months per ear; (2) for In-Network Benefit services only and will be applied to the Participant's applicable Deductible and Coinsurance amounts; (3) one hearing screening and/or audiogram to determine hearing loss per twelve (12) month period; and (4) for the following types of hearing aids: a) conventional b) programmable c) digital d) BAHAs e) cochlear implants. For newborn hearing screening, refer to the "Newborn Care" section of this article.	The purchase of hearing aids will require a Prior Authorization with the Claims Administrator. **Exclusions:** (1) Routine hearing tests, audiograms, and hearing aids except as stated under Covered services. (2) Adjustments, batteries, and other services related to hearing aids. (3) Hearing aids and related services if received Out-of-Network. (4) Exam for prescribing and fitting hearing aids, hearing therapy and any related diagnostic hearing tests, except as provided in this article.

COVERAGE FOR SERVICES OR SUPPLIES WHEN DETERMINED BY THE PLAN TO BE MEDICALLY NECESSARY		
SERVICE OR SUPPLY	**CRITERIA AND COVERAGE PROVIDED**	**AUTHORIZATION REQUIREMENTS, LIMITATIONS, AND EXCLUSIONS**
Home Health Care Services	Covered service when all of the following requirements are met: (1) the service is ordered by a Physician; (2) services required are of a type which can only be performed by a licensed nurse, physical therapist, speech therapist, or occupational therapist; (3) the services are a substitute or alternative to Hospitalization; (4) part-time intermittent services are required; (5) a treatment plan has been established and periodically reviewed by the ordering Physician; and (6) the agency rendering services is Medicare certified and licensed by the state of location.	*Prior Authorization required.* **Exclusions:** Home services to help meet personal, family, or domestic needs.
Hospice Care	Coverage is provided for Hospice Care for treatment of a terminally ill Participant. Skilled care through a Hospice program includes: (1) supportive care involving the evaluation of the emotional, social and environmental circumstances related to or resulting from the Illness; and (2) guidance and assistance during the Illness for the purpose of preparing the Participant and the Participant's family for imminent death when the Participant has a prognosis of six (6) months or less to live.	
Immunizations	Immunizations are Covered for Participants pursuant to the Plan's criteria, which uses national standards approved by the Advisory Committee on Immunization Practices, the American Academy of Pediatrics, the American Academy of Family Physicians, the Guide to Clinical Preventative Services, and the	**Limitations:** For Medicare Participants, shingles vaccines and administration must be received at a Participating Pharmacy.

COVERAGE FOR SERVICES OR SUPPLIES WHEN DETERMINED BY THE PLAN TO BE MEDICALLY NECESSARY		
SERVICE OR SUPPLY	**CRITERIA AND COVERAGE PROVIDED**	**AUTHORIZATION REQUIREMENTS, LIMITATIONS, AND EXCLUSIONS**
Immunizations (continued)	Report of the United States Preventative Services Task Force to establish eligibility guidelines. (1) For Dependent children zero (0) through six (6) years of age: Covered at one hundred percent (100%) for In-Network Provider services according to the "Recommended Immunization Schedule for Persons Aged 0 Through 6 Years" referenced in Appendix C of this article. (2) For Dependent children seven (7) through eighteen (18) years of age: Covered at one hundred percent (100%) for In-Network Provider services, according to the "Recommended Immunization Schedule for Persons Aged 7 Through 18 Years" referenced in Appendix C of this article. (3) Participants nineteen (19) years of age or older Covered at one hundred percent (100%) for In-Network Provider Services, in accordance with the "Vaccinations for Adults" immunization schedule located in Appendix C of this article, except the Plan will Cover the Zoster (shingles) vaccine and administration at fifty (50) years of age and older.	**Exclusions:** Immunizations utilizing Out-of-Network Providers or Out-of-Network pharmacies for all Plan Participants, or immunizations not listed on the schedules in Appendix C, Article 5

COVERAGE FOR SERVICES OR SUPPLIES WHEN DETERMINED BY THE PLAN TO BE MEDICALLY NECESSARY		
SERVICE OR SUPPLY	**CRITERIA AND COVERAGE PROVIDED**	**AUTHORIZATION REQUIREMENTS, LIMITATIONS, AND EXCLUSIONS**
Implants and Related Health Services	Implant devices and related implantation health services are Covered when provided by or under the direction of a Physician, in accordance with the Plan's guidelines and approved in advance by the medical director as follows: (1) penile implants except as listed under Exclusions; (2) implants for the purpose of contraception; and (3) implants for the delivery of medication.	*Prior Authorization may be required.* **Exclusions:** (1) Dental, oral, or Nanometric implants (2) Cochlear implants (including services related to cochlear implants), except as provided in the "Hearing Aids and Screenings" section of this article (3) Penile implants when prescribed to treat impotence that is psychological in origin (4) Implants for cosmetic or psychological reasons
Impotence	For Coverage for Impotence, refer to the "Implants and Related Health Services" section of this article.	*Prior Authorization may be required.* **Exclusions:** (1) Treatment for male psychogenic impotence unless subject only to the provisions of the Mental Health Covered Benefits (2) Penile implants when prescribed to treat impotence that is psychological in origin (3) Prescriptions and injectable medication for the treatment of sexual dysfunction, including impotence
Injectable Medications	Medically Necessary Injectable and self-Injectable medications are Covered when FDA-approved and medically appropriate. Injectable and self-injectable medication may be limited by Prior Authorization and substitute Coverage by therapeutically interchangeable drugs, according to clinical guidelines used by the Plan.	*Prior Authorization may be required.* **Limitations:** Some self-injectable medications are excluded by the medical Benefit but may be Covered under the Prescription Drug program. For injectable Contraceptives, refer to the "Birth Control" section of this article.

COVERAGE FOR SERVICES OR SUPPLIES WHEN DETERMINED BY THE PLAN TO BE MEDICALLY NECESSARY		
SERVICE OR SUPPLY	**CRITERIA AND COVERAGE PROVIDED**	**AUTHORIZATION REQUIREMENTS, LIMITATIONS, AND EXCLUSIONS**
Inpatient Hospital Care	(1) Coverage includes: a) general nursing care; b) use of operating room, surgical and anesthesia services and supplies; c) blood and blood products; d) Therapy Services; e) ordinary casts, splints and dressings; f) all drugs and oxygen used in Hospital; g) laboratory and x-ray examinations; h) electrocardiograms; i) Semi-Private Accommodations (unless a private room is the only room available or is required for medical reasons); j) Intensive Care Unit; and k) Coronary Care Unit. (2) Single Surgical Services. The allowance for a single surgical service will be the Allowed Amount (for In-Network services) or the Out-of-Network Rate (for Out-of-Network services). When surgical services are concurrently rendered by two (2) or more Physicians, the payment will be in accordance with the Claims Administrator's Provider contract or the Non-Participating Provider payment schedule in effect at the time of service. (3) Multiple Surgical Services. Payment for multiple surgeries will be in accordance with the Claims Administrator's Provider contracts or the Non-Participating Provider payment schedule in effect at the time of service for the Allowed Amount (for In-Network services) and for the Out-of-Network Rate (for Out-of-Network services).	*Prior Authorization required.* **<u>Limitations:</u>** Payment for a private room is an allowance equal to the definition of Semi-Private Accommodations. **<u>Exclusions:</u>** (1) Diagnostic Admissions (2) Those personal comfort and convenience items or services such as: a) TV b) telephone c) barber or beauty service d) cots (3) visitors' expenses guest services (4) similar incidental services and supplies (5) Additional elective, not Medically Necessary surgical procedures

COVERAGE FOR SERVICES OR SUPPLIES WHEN DETERMINED BY THE PLAN TO BE MEDICALLY NECESSARY		
SERVICE OR SUPPLY	**CRITERIA AND COVERAGE PROVIDED**	**AUTHORIZATION REQUIREMENTS, LIMITATIONS, AND EXCLUSIONS**
Inpatient Hospital Care (continued)	(4) Special Surgery. Special surgeries are limited to Reconstructive Surgery, while a Participant in the Plan, to correct: a) a disfiguration of the face or the hand(s); b) Reconstructive Surgery of a diseased breast upon which surgery was performed; c) surgery and reconstruction of the non-diseased breast to produce a symmetrical appearance, with no time limit imposed on Reconstructive Surgery; d) for the grafting of skin to any other part of the body; or e) elective Sterilizations will be a Covered service for Subscribers and their Spouse. Refer to the "Birth Control" section of this article. (5) Human Organ and Tissue Transplants refer to the "Transplant (Human Organ)" section of this article. (6) Anesthesia. Administration of anesthesia Inpatient Medical Services ordered by the attending Physician and rendered by a Physician or other professional Provider. (7) Inpatient Medical Services. Care rendered by a Physician or other professional Provider to a Participant who is a Hospital Inpatient for a condition not related to surgery or an obstetrical procedure.	

COVERAGE FOR SERVICES OR SUPPLIES WHEN DETERMINED BY THE PLAN TO BE MEDICALLY NECESSARY		
SERVICE OR SUPPLY	**CRITERIA AND COVERAGE PROVIDED**	**AUTHORIZATION REQUIREMENTS, LIMITATIONS, AND EXCLUSIONS**
Inpatient Hospital Care (continued)	(8) Concurrent Care. Care rendered concurrently with surgery during a Hospital stay by a Physician other than the operating surgeon for treatment of a medical condition separate from the condition for which surgery was performed. Care rendered by two (2) or more Physicians concurrently during a Hospital stay for separate medical conditions when the nature or severity of the Participant's condition requires the skills of separate Physicians. (9) Consultation services rendered to a Participant by another Physician at the request of the attending Physician. Consultation does not include staff consultations that may be required by Hospital rules and regulations Consistent with the Plan's utilization management policy, all Acute care Hospital admissions and continued stays are reviewed for Medical Necessity during the Inpatient stay. Coverage is dependent on the establishment of Medical Necessity for the care. If the Hospital stay or portion thereof is determined not to be Medically Necessary, the Provider will be notified that Coverage will cease. Certain health services rendered during a Participant's confinement are subject to separate Benefit restrictions and/or Copayments as provided in Appendices A and B of Article 4 for non-Medicare Participants, Appendix D of Article 8 for Medicare Participants, and the Plan exclusions in Article 7.	

COVERAGE FOR SERVICES OR SUPPLIES WHEN DETERMINED BY THE PLAN TO BE MEDICALLY NECESSARY		
SERVICE OR SUPPLY	**CRITERIA AND COVERAGE PROVIDED**	**AUTHORIZATION REQUIREMENTS, LIMITATIONS, AND EXCLUSIONS**
Laboratory Services/ Outpatient Services and Diagnostic Procedures and Tests	Covered service. Refer to the "Outpatient Services and Diagnostic Procedures and Tests" and "Preventive Care" sections in Appendices A and B of Article 4 for non-Medicare Participants and Appendix D of Article 8 for Medicare Participants.	Prior Authorization may be required for some genetic testing. **Exclusions:** Preventive Care service when utilizing Out-of-Network Providers
Lead Poisoning Testing	Lead poisoning testing shall include: (1) testing of pregnant women for lead poisoning; (2) testing of all children, enrolled in the Plan, less than six (6) years of age; and (3) related office visit. Coverage for testing shall be in accordance with the provisions of the Department of Health's Childhood Lead Testing Program.	
Long-term Care Services	The services Covered under this provision include, but are not limited to, Skilled Nursing Care, rehabilitative and other Therapy Services, and post-Acute care, as needed. If the Participant is a resident of a long-term care facility licensed by Missouri or a continuing care retirement community, such Participant has the option of receiving Medically Necessary services Covered by this provision in the long-term care facility that serves as the Participant's primary residence if the following conditions apply: (1) the facility is willing and able to provide the Covered service to the Participant; (2) the facility and its Providers meet the requisite licensing and training standards required under Missouri law; (3) the facility is certified through Medicare; and	*Prior Authorization required.* **Exclusions:** (1) Services and supplies in rest homes, health resorts, homes for the aged, or places primarily for domiciliary or Custodial Care, except as otherwise specifically provided; (2) Services for or in connection with Custodial Care, education or training of the Participant, whether or not prescribed by a Physician, except as otherwise specifically provided

COVERAGE FOR SERVICES OR SUPPLIES WHEN DETERMINED BY THE PLAN TO BE MEDICALLY NECESSARY		
SERVICE OR SUPPLY	**CRITERIA AND COVERAGE PROVIDED**	**AUTHORIZATION REQUIREMENTS, LIMITATIONS, AND EXCLUSIONS**
Long-term Care Services (continued)	(4) the facility and its Providers agree to abide by the terms and conditions of the Claims Administrator's contracts with similar Providers, abide by the Affordable Care Act standards and requirements imposed by State and federal law, and meet the quality standards of the Plan for similar Providers.	
Mammograms	(1) In accordance with the current American Cancer Society guidelines, Coverage for any non-symptomatic woman is provided as follows: a) a baseline mammogram for women thirty-five (35) years of age to thirty-nine (39) years of age, inclusive; b) a mammogram every calendar year for women forty (40) years of age and over; c) a mammogram for any woman, upon the recommendation of a Physician, where such woman, her mother or her sister has a prior history of breast cancer; and d) office visit related to mammogram. Also refer to the "Preventive Care" section of this article and to Appendices A and B of Article 4 for non-Medicare Participants and Appendix D of Article 8 for Medicare Participants. (2) Mammogram is Covered for any symptomatic woman as needed. (3) Symptomatic mammograms are subject to Deductible(s), Copayment(s) and Coinsurance if processed under regular medical Benefits; however, non-symptomatic mammograms will also be processed under "Preventive Care" in Appendices A and B of Article 4 for	**Exclusions:** (1) Non-symptomatic mammograms processed as Preventive Care when utilizing Out-of-Network Providers; (2) Digital tomosynthesis breast imaging including three-dimensional (3D) digital tomosynthesis (i.e., 3D mammography).

COVERAGE FOR SERVICES OR SUPPLIES WHEN DETERMINED BY THE PLAN TO BE MEDICALLY NECESSARY		
SERVICE OR SUPPLY	**CRITERIA AND COVERAGE PROVIDED**	**AUTHORIZATION REQUIREMENTS, LIMITATIONS, AND EXCLUSIONS**
Mammograms (continued)	non-Medicare Participants and Appendix D of Article 8 for Medicare Participants.	
Mastectomy	Medically Necessary mastectomies are Covered. If a Participant elects breast reconstruction following a Medically Necessary mastectomy, the following Benefits are also Covered: (1) Reconstructive Surgery of a diseased breast upon which surgery was performed; (2) surgery and reconstruction of the non-diseased breast to produce a symmetrical appearance, with no time limit imposed on Reconstructive Surgery; (3) prostheses; and (4) treatment of physical complications at all stages of the mastectomy, including lymphedemas. A time limit cannot be imposed for Prosthetic Devices received for a mastectomy; and if the mastectomy was not performed while a Participant was enrolled in the Plan, the Prosthetic Device must be provided. Refer to the "Breast Reconstruction" section of this article.	*Prior Authorization required.* **Limitations:** Two (2) mastectomy bras per Calendar Year **Exclusions:** Reduction, including for male gynecomastia, and augmentation mammoplasty unless Medically Necessary or associated with Reconstructive Surgery following a Medically Necessary mastectomy
Maternity Services	Obstetrical care and care for conditions of pregnancy for the Subscriber or Dependents of a Subscriber. Maternity-related medical, Hospital and other Covered health services are treated as any other Illness. Coverage for the mother and her newborn child includes forty-eight (48) hours of post-natal maternity care for vaginal delivery and ninety-six (96) hours of post-natal maternity care for cesarean delivery. Refer to the "Office Visits, Diagnostic and	*Prior Authorization is required.* **Exclusions:** (1) Services for obstetrical care and care for conditions of pregnancy for any Participant other than the Subscriber or the Dependent of the Subscriber. (2) Services in connection with the treatment and diagnosis of fertility or infertility including but not limited to: a) artificial insemination b) intracytoplasmic sperm

COVERAGE FOR SERVICES OR SUPPLIES WHEN DETERMINED BY THE PLAN TO BE MEDICALLY NECESSARY		
SERVICE OR SUPPLY	**CRITERIA AND COVERAGE PROVIDED**	**AUTHORIZATION REQUIREMENTS, LIMITATIONS, AND EXCLUSIONS**
Maternity Services (continued)	Treatment Services Received in a Physician's Office" section of this article for additional prenatal and post-partum Coverage. Testing for lead poisoning for pregnant women is a Covered Benefit. Certain services may be Covered under the Preventive Care Benefit. Refer to "Preventive Care" in Appendices A and B of Article 4 for non-Medicare Participants and in Appendix D of Article 8 for Medicare Participants.	injection (ICSI) c) in vitro or in vivo fertilization d) gamete intrafallopian transfer (GIFT) procedures e) zygote intrafallopian transfer (ZIFT) procedures f) embryo transport g) reversal of voluntary Sterilization h) surrogate parenting i) selective reduction j) cryo preservation k) travel costs l) donor eggs or semen and related costs including collection and preparation; non-Medically Necessary amniocentesis m) any infertility treatment deemed Experimental or Investigational (3) Newborn home delivery and mid-wives (4) Surrogate motherhood services and supplies, including, but not limited to, all services and supplies relating to the conception and Pregnancy of a Participant acting as a surrogate mother (5) Maternity services processed as Preventive Care when utilizing Out-of-Network Providers
Medical Complications	Medically Necessary treatment of complications, even if arising from non-Covered services or services received prior to Participant's effective date.	

COVERAGE FOR SERVICES OR SUPPLIES WHEN DETERMINED BY THE PLAN TO BE MEDICALLY NECESSARY		
SERVICE OR SUPPLY	**CRITERIA AND COVERAGE PROVIDED**	**AUTHORIZATION REQUIREMENTS, LIMITATIONS, AND EXCLUSIONS**
Mental Health Conditions and Chemical Dependency Services	Coverage is provided for Medically Necessary treatment of chemical dependency (including detoxification) and Mental Health conditions through the following: (1) partial or full day Outpatient programs; (2) Acute Inpatient admissions; or (3) residential treatment. Services for the treatment for Mental Health rendered by an appropriate Provider will be provided on the same basis as the services and medical care for physical conditions. (Refer to Article 1.65 for the definition of Mental Health.) Certain services may be Covered under the Preventive Care Benefit. Refer to "Preventive Care" in Appendices A and B of Article 4 for non-Medicare Participants and in Appendix D of Article 8 for Medicare Participants.	Prior Authorization from the Plan's Mental Health and substance abuse designee is required for the following: (1) Acute Inpatient admissions; and (2) residential treatment services. **<u>Exclusions:</u>** (1) Services rendered or billed by a school or halfway house (2) Care that is custodial in nature (3) Services and supplies that are not immediately nor clinically appropriate (4) Treatments that are considered Experimental, Investigational, controversial or unproven services, treatments, devices, or pharmacological regimens including, but not limited to, Methadone treatment (5) Non-Emergency or non-urgent transportation to another facility (6) Services and supplies for conditions related to milieu therapy, learning disabilities, mental retardation, or for Inpatient admission for environmental change (7) Treatment for disorders relating to learning, motor skills, and communication (8) Biofeedback therapies (9) Hypnotherapy (10) Services and treatment related to sex transformation, sexual therapy or counseling, sexual dysfunctions or inadequacies except conditions resulting from Injury or organic disease

COVERAGE FOR SERVICES OR SUPPLIES WHEN DETERMINED BY THE PLAN TO BE MEDICALLY NECESSARY		
SERVICE OR SUPPLY	**CRITERIA AND COVERAGE PROVIDED**	**AUTHORIZATION REQUIREMENTS, LIMITATIONS, AND EXCLUSIONS**
Mental Health Conditions and Chemical Dependency Services (continued)		(11) Services and treatment related to religious counseling, marital/ relationship counseling (12) Services and treatment related to vocational or employment counseling (13) Services and supplies processed as Preventive Care when utilizing Out-of-Network Provider
Newborn Care	The Covered services for eligible newborn children shall consist of: (1) Coverage for Injury or Illness, including Medically Necessary care or treatment of medically diagnosed congenital defects, birth abnormalities, or prematurity, and transportation costs of the newborn to and from the nearest facility that is appropriately staffed and equipped to treat the newborn's condition. (2) Coverage is provided for all newborns to be tested or screened for phenylketonuria (PKU) and such other common metabolic or genetic diseases. Refer to the "Phenylketonuria (PKU) or any other Amino and Organic Acid Inherited Disease Formula/Food" section of this article for Coverage of formula and food treatments. (3) Coverage is also provided for newborn hearing screening, necessary rescreening, audiological assessment and follow-up, and initial amplification. If delivered in an ambulatory surgical center or Hospital, the newborn must be screened prior to discharge. If delivered in a place other than an ambulatory surgical center or Hospital, the screening must be performed within three (3) months of the date of birth.	**Exclusions:** (1) Newborn home delivery and mid-wives (2) Newborn care processed as Preventive Care when utilizing Out-of-Network Providers

COVERAGE FOR SERVICES OR SUPPLIES WHEN DETERMINED BY THE PLAN TO BE MEDICALLY NECESSARY		
SERVICE OR SUPPLY	**CRITERIA AND COVERAGE PROVIDED**	**AUTHORIZATION REQUIREMENTS, LIMITATIONS, AND EXCLUSIONS**
Newborn Care (continued)	(4) Covered physiological technologies are: automated or diagnostic auditory brainstem response (ABR); otoacoustic emissions (OAE) or other technologies approved by the Department of Health. Certain services may be Covered under the Preventive Care Benefit. Refer to "Preventive Care" in Appendices A and B of Article 4 for non-Medicare Participants and in Appendix D of Article 8 for Medicare Participants.	
Nutritional Counseling	Covered service only when: (1) provided by a Registered Dietician or a Physician; and (2) in connection with diabetes; morbid obesity; coronary artery disease; hyperlipidemia. Coverage includes self-management training used in the management and treatment of diabetes.	**Exclusions:** (1) Food or food supplements. (2) Nutritional counseling processed as preventive care when utilizing out of network providers.
Occupational Therapy	Refer to the "Therapy/Rehabilitation Services and Supplies" section of this article.	
Office Visits, Diagnostic and Treatment Services Received in a Physician's Office	(1) Covered services include: a) Preventive Care (refer to the "Preventive Care" section of this article), including well-baby care and periodic check-ups according to the Preventive Care guidelines adopted by the Plan. The Plan's guidelines are available on the Claims Administrator's website or from the Claims Administrator upon request; b) diagnosis and treatment of Illness or Injury; c) injectables normally rendered in a Physician's office; d) laboratory tests; e) consultations with Specialists;	**Limitations:** Office visits for Excluded Services may not be Covered. **Exclusions:** Preventive Care service when utilizing Out-of-Network Providers.

COVERAGE FOR SERVICES OR SUPPLIES WHEN DETERMINED BY THE PLAN TO BE MEDICALLY NECESSARY		
SERVICE OR SUPPLY	**CRITERIA AND COVERAGE PROVIDED**	**AUTHORIZATION REQUIREMENTS, LIMITATIONS, AND EXCLUSIONS**
Office Visits, Diagnostic and Treatment Services Received in a Physician's Office (continued)	f) obstetrical care, including prenatal care, postpartum care, and a home visit in accordance with the medical criteria. Criteria is outlined in the "Guidelines for Perinatal Care" prepared by the American Academy of Pediatrics and the American College of Obstetricians and Gynecologists or the "Standards for Obstetric-Gynecologic Services" prepared by the American College of Obstetricians and Gynecologists. Refer to the "Maternity Services" section of this article. (2) Certain health services, including but not limited to diagnostic, x-ray, and laboratory services, provided in a Physician's office are subject to separate Benefit restrictions and/or Coinsurance, Copayments, and Deductible as described in Appendices A and B of Article 4 for non-Medicare Participants and Appendix D of Article 8 for Medicare Participants.	

COVERAGE FOR SERVICES OR SUPPLIES WHEN DETERMINED BY THE PLAN TO BE MEDICALLY NECESSARY		
SERVICE OR SUPPLY	**CRITERIA AND COVERAGE PROVIDED**	**AUTHORIZATION REQUIREMENTS, LIMITATIONS, AND EXCLUSIONS**
Oral Surgery and Diseases of the Mouth	(1) Charges for Injury to or care of the mouth, teeth, gums and alveolar processes will be Covered charges under medical Benefits if that care is for the following oral surgical procedures (including anesthesia): a) repair due to Injury to sound natural teeth; initial care must be rendered within ninety (90) days of the Injury b) surgery needed to correct accidental Injuries to the jaws, cheeks, lips, tongue, floor and roof of the mouth. Accidental Injury is defined as an Injury caused by an external force or element such as a blow or fall; c) excision of tumors and cysts of the jaws, cheeks, lips, tongue, roof and floor of the mouth when pathological examination is necessary; d) removal of impacted teeth; e) excision of benign bony growths of the jaw and hard plate; f) external incision of and drainage of cellulitis; g) incision of sensory sinuses, salivary glands or ducts; h) reduction of dislocations and surgical repair of TMJ; i) removal of teeth as a complication of radionecrosis.	*Prior Authorization may be required.* **Exclusions:** (1) Oral implants and transplants except for Medically Necessary treatment of Acute traumatic Injury or cleft palate showing continued functional impairment (2) Oral surgery supplies that are required as part of an orthodontic treatment program or that are required for correction of an occlusal defect (3) Surgical procedures that involve the teeth or their supporting structures (such as the periodontal membrane, gingival, and alveolar bone), except as provided in this article (4) Surgical procedures involving orthodontic care, dental implants, or preparation of the mouth for the fitting or the continued use of dentures, except as provided in this article (5) Injuries to the teeth while eating are not considered accidental Injuries (6) Other services not provided in this article Refer to the “Dental Services” section of this article.

COVERAGE FOR SERVICES OR SUPPLIES WHEN DETERMINED BY THE PLAN TO BE MEDICALLY NECESSARY		
SERVICE OR SUPPLY	**CRITERIA AND COVERAGE PROVIDED**	**AUTHORIZATION REQUIREMENTS, LIMITATIONS, AND EXCLUSIONS**
Oral Surgery and Diseases of the Mouth (continued)	(2) A dental examination prescribed by a Physician prior to joint replacement, valve replacement or transplant surgery to verify an infection/bacteria is not present, which could jeopardize the success of the surgery. The Coverage will not include any dental services required as a result of the check-up. Proof of surgery will be required from your Physician. (3) The administration of general anesthesia and Hospital charges for dental care to children under five (5) years of age, the severely disabled, or a Participant with a medical or behavioral condition that requires Hospitalization. The general anesthesia will also apply whether in a Hospital or surgical center. Actual dental work affiliated with these services will not be Covered. Refer to the “Dental Services” section of this article.	

COVERAGE FOR SERVICES OR SUPPLIES WHEN DETERMINED BY THE PLAN TO BE MEDICALLY NECESSARY		
SERVICE OR SUPPLY	**CRITERIA AND COVERAGE PROVIDED**	**AUTHORIZATION REQUIREMENTS, LIMITATIONS, AND EXCLUSIONS**
Orthotic Appliances and Prosthetic Devices	Refer to the "Prosthetic Devices and Orthotic Appliances" section of this article.	
Osteoporosis	Coverage includes services (including office visits) related to diagnosis, treatment and appropriate management for enrollees with a condition or medical history for which bone mass measurement is medically indicated.	
Outpatient Diagnostic Tests and Therapeutic Treatments	Coverage includes services and supplies for prescheduled diagnostic tests and therapeutic treatments provided under the direction of a Physician at a Hospital or alternate facility.	*Prior Authorization may be required.* **Exclusions:** Services processed as Preventive Care service when utilizing Out-of-Network Providers
Outpatient Services, Surgeries, and Supplies	Coverage is provided for services and supplies for Prior Authorized and prescheduled Outpatient surgery provided under the direction of a Physician at a Hospital or alternate facility. (1) Ancillary Hospital services and supplies including, but not restricted to: (a) use of operating, delivery, and treatment rooms and equipment; (b) pharmacy services and supplies; (c) administration of blood and blood processing (including the cost of blood, plasma, or fractionalized blood products); (d) anesthesia, anesthesia supplies and services rendered by an Employee of the Hospital or through approved contractual arrangements; (e) medical and surgical dressings, supplies, casts, and splints; (f) Diagnostic Services; or (g) Therapy Services.	*Prior Authorization may be required.* **Exclusions:** (1) Non-Covered services, surgeries, and supplies under the Plan as provided in Article 7 (2) Services processed as Preventive Care service when utilizing Out-of-Network Providers

COVERAGE FOR SERVICES OR SUPPLIES WHEN DETERMINED BY THE PLAN TO BE MEDICALLY NECESSARY		
SERVICE OR SUPPLY	**CRITERIA AND COVERAGE PROVIDED**	**AUTHORIZATION REQUIREMENTS, LIMITATIONS, AND EXCLUSIONS**
Outpatient Services, Surgeries, and Supplies (continued)	(2) Surgery performed by a Physician, including normal pre-operative and post-operative care. a) Single Surgical Services The allowance for a single surgical service will be the Allowed Amount (for In-Network services) and the Out-of-Network Rate (for Out-of-Network services). When surgical services are concurrently rendered by two (2) or more Physicians, the payment will be in accordance with the Claims Administrator's Provider contract or the Non-Participating Provider payment schedule in effect at the time of service. (3) Multiple Surgical Services. The allowance for a multiple surgical service will be the Allowed Amount (for In-Network services) and the Out-of-Network Rate (for Out-of-Network services). When surgical services are concurrently rendered by two (2) or more physicians, the payment will be in accordance with the Claims Administrator's Provider contract or the Non-Participating Provider payment schedule in effect at the time of service. a) Special surgeries are limited to Reconstructive Surgery, while a Participant in the Plan, to correct: – a disfiguration of the face or hand(s); – Reconstructive Surgery of a diseased breast upon which surgery was performed;	

COVERAGE FOR SERVICES OR SUPPLIES WHEN DETERMINED BY THE PLAN TO BE MEDICALLY NECESSARY		
SERVICE OR SUPPLY	**CRITERIA AND COVERAGE PROVIDED**	**AUTHORIZATION REQUIREMENTS, LIMITATIONS, AND EXCLUSIONS**
Outpatient Services, Surgeries, and Supplies (continued)	– surgery and reconstruction of the non-diseased breast to produce a symmetrical appearance, with no time limit imposed on Reconstructive Surgery; or – for the grafting of skin to any other part of the body; b) elective surgery and related medical treatment provided such surgery or treatment is necessary to reduce or eliminate a physical endangerment to the Participant's health and is not an exclusion under the Plan as noted in Article 7; c) elective Sterilizations (Refer to the "Birth Control" section of this article); or d) implantation of Contraceptive devices and injectables not Covered under the Prescription Drug program will be Covered at the Coinsurance Benefit level outlined in the Prescription Drug program. (Refer to the "Birth Control" section of this article, Appendices A and B of Article 4 for non-Medicare Participants and Appendix D of Article 8 for Medicare Participants.) Out-of-Pocket Limit will not be applicable with regard to these services. (4) Administration of anesthesia ordered by the attending Physician and rendered by a Physician or other professional Provider is Covered. (5) Care rendered by a Physician or other professional Provider to a Participant who is an Outpatient for a condition not related to surgery or an obstetrical procedure is Covered.	

COVERAGE FOR SERVICES OR SUPPLIES WHEN DETERMINED BY THE PLAN TO BE MEDICALLY NECESSARY		
SERVICE OR SUPPLY	**CRITERIA AND COVERAGE PROVIDED**	**AUTHORIZATION REQUIREMENTS, LIMITATIONS, AND EXCLUSIONS**
Pelvic Examinations and Pap Smears	(1) In accordance with the American Cancer Society guidelines, Coverage is provided for a pelvic exam and pap smear every calendar year for any non-symptomatic women as follows: a) age eighteen (18) years and over; or b) under age eighteen (18) years if needed. Also refer to the "Preventive Care" section of this article. (2) Coverage is provided for a pelvic exam and pap smear for any symptomatic women as needed. Services for symptomatic conditions are subject to Deductible(s), Copayment(s) and Coinsurance if processed under regular medical Benefits; however, non-symptomatic screenings will be processed under "Preventive Care" in Appendices A and B of Article 4 for non-Medicare Participants and Appendix D of Article 8 for Medicare Participants.	**Exclusions:** Non-symptomatic pelvic exams and pap smears processed as Preventive Care service when utilizing Out-of-Network Providers
Phenylketonuria (PKU) or any other Amino and Organic Acid Inherited Disease Formula/Food	Coverage is provided for formula and low protein modified food products used for PKU and such other metabolic or genetic disease as well as inherited diseases of amino acids and organic acids for Dependents less than six (6) years of age recommended by a Physician as determined by the Plan to be Medically Necessary as follows: (1) Special dietary products for treatment of metabolic and genetic (2) diseases for Dependents less than six (6) years of age are Covered. (3) Coverage is provided for all potentially treatable or manageable disorders, including cystic fibrosis, galactosemia, biotinidase deficiency, congenital adrenal hyperplasia, maple syrup urine disease (MSUD)	*Prior Authorization required.* **Exclusions:** (1) Outpatient enteral tube feedings or formula and supplies, except as defined as a Covered service in this article, including, but not limited to use for PKU or any other amino and organic acid inherited disease (2) Nutritional-based therapies, except for treatment of PKU and for nutritional deficiencies due to short bowel syndrome and HIV (3) Oral supplements and/or enteral feedings, either by mouth or by tube

COVERAGE FOR SERVICES OR SUPPLIES WHEN DETERMINED BY THE PLAN TO BE MEDICALLY NECESSARY		
SERVICE OR SUPPLY	**CRITERIA AND COVERAGE PROVIDED**	**AUTHORIZATION REQUIREMENTS, LIMITATIONS, AND EXCLUSIONS**
	and other amino acid disorders, glucose-6-phosphate degydrogenase deficiency (G-6-PD), MCAD and other fatty acid oxidation disorders, methylmalonic academia, propionic academia, isovaleric academia and glutaric academia Type 1. (4) Formula for the treatment of inherited diseases of amino acids and organic acids are Covered.	
Physical Therapy	Refer to the "Therapy/Rehabilitation Services and Supplies" section of this article.	
Podiatry	Covered service when determined to be Medically Necessary. Coverage is provided for one (1) pair of therapeutic shoes, including fitting of shoes and inserts, per calendar year for diabetic foot disease or peripheral neuropathy.	*Prior Authorization may be required.* **<u>Exclusions:</u>** (1) Services in connection with the following: a) the treatment of weak, strained, flat, unstable or unbalanced feet b) fallen arches c) metatarsalgia or bunions (except for open cutting operations or laser surgery) d) corns e) calluses f) toenails (except for the partial or complete removal of nail roots or for services for metabolic peripheral vascular disease or diabetes)

COVERAGE FOR SERVICES OR SUPPLIES WHEN DETERMINED BY THE PLAN TO BE MEDICALLY NECESSARY		
SERVICE OR SUPPLY	**CRITERIA AND COVERAGE PROVIDED**	**AUTHORIZATION REQUIREMENTS, LIMITATIONS, AND EXCLUSIONS**
		(2) Shoe inserts unless the Participant has diabetes with demonstrated peripheral neuropathy or the insert is needed for a shoe that is part of a brace. If all necessary criteria are present, one (1) shoe insert will be Covered per calendar year
Preventive Care	(1) Preventive Care service (including office visits, x-rays, laboratory tests and routine preventive immunizations) are Covered as provided under "Preventive Care" and "Immunizations" in Appendices A and B of Article 4 for non-Medicare Participants and Appendix D of Article 8 for Medicare Participants. (2) In accordance with the American Cancer Society guidelines, cancer screenings shall include the following screenings and office visits related to the screening: a) pelvic exam and pap smear every calendar year for any non-symptomatic woman as follows: i. age eighteen (18) years and over; or ii. under age eighteen (18) years if needed; b) mammogram Coverage for any non-symptomatic woman Covered under the Plan is provided as follows: i. a baseline mammogram for women age thirty-five (35) years to thirty-nine (39) years, inclusive; ii. a mammogram every calendar year for women forty (40) years of age and over; iii. office visit related to mammogram; and	**Limitations:** Breast pumps are limited to one (1) per pregnancy. **Exclusions:** (1)Preventive Care service when utilizing Out-of-Network Providers and Out-of-Network pharmacies; (2) Digital tomosynthesis breast imaging including three-dimensional (3D) digital tomosynthesis (i.e., 3D mammography).

COVERAGE FOR SERVICES OR SUPPLIES WHEN DETERMINED BY THE PLAN TO BE MEDICALLY NECESSARY		
SERVICE OR SUPPLY	**CRITERIA AND COVERAGE PROVIDED**	**AUTHORIZATION REQUIREMENTS, LIMITATIONS, AND EXCLUSIONS**
	iv. a mammogram for any woman, upon the recommendation of a Physician, where such woman, her mother or her sister has a prior history of breast cancer. c) a prostate exam and PSA blood test; d) colorectal screenings for men and women fifty (50) years of age or older or if a doctor prescribes at a younger age because of high risk or family history; e) a fecal occult blood test every calendar year and sigmoidoscopy every five (5) years; f) a colonoscopy every ten (10) years; or g) a digital rectal exam, sigmoidoscopy, colonoscopy or barium test. (3) In accordance with the women's Preventive Care guidelines in the Affordable Care Act the following services will be Covered under Preventive Care: a) Well-woman visits b) Screening for gestational diabetes c) Human papillomavirus (HPV) DNA testing for women 30 years and older d) Sexually transmitted infection counseling e) Human immunodeficiency virus (HIV) screening and counseling	

COVERAGE FOR SERVICES OR SUPPLIES WHEN DETERMINED BY THE PLAN TO BE MEDICALLY NECESSARY		
SERVICE OR SUPPLY	**CRITERIA AND COVERAGE PROVIDED**	**AUTHORIZATION REQUIREMENTS, LIMITATIONS, AND EXCLUSIONS**
	f) FDA-approved contraception methods and Contraceptive counseling (subject to standard medical management and formulary restrictions) as stated in the "Birth Control" section of this article g) Electric and manual breast pumps, supplies and counseling. h) Domestic violence screening and counseling Non-symptomatic screenings will be processed under "Preventive Care" in Appendices A and B of Article 4 for non-Medicare Participants and Appendix D of Article 8 for Medicare Participants.	
Private Duty Nursing	Coverage includes private duty nursing services performed by an actively practicing private duty nurse when prescribed by a Physician and limited to the time such services are deemed Medically Necessary.	*Prior Authorization required.*
Prostate Screening and Exams	(1) Coverage is provided for a prostate exam and PSA blood test for any non-symptomatic man. Also refer to the "Preventive Care" section of this article. (2) Coverage is provided for a prostate exam and PSA blood test for any symptomatic man as needed.	**Exclusions:** Non-symptomatic prostate screenings, processed under Preventive Care service, when utilizing Out-of-Network Providers

COVERAGE FOR SERVICES OR SUPPLIES WHEN DETERMINED BY THE PLAN TO BE MEDICALLY NECESSARY		
SERVICE OR SUPPLY	**CRITERIA AND COVERAGE PROVIDED**	**AUTHORIZATION REQUIREMENTS, LIMITATIONS, AND EXCLUSIONS**
Prostate Screening and Exams (continued)	Services for symptomatic conditions are subject to Deductible(s), Copayment(s) and Coinsurance if processed under regular medical Benefits; however, non-symptomatic screenings will be processed under the "Preventive Care" section in Appendices A and B of Article 4 for non-Medicare Participants and Appendix D of Article 8 for Medicare Participants.	
Prosthetic Devices and Orthotic Appliances	Coverage for Prosthetic Devices and Orthotic Appliances will be provided in accordance with the DME Benefit. (1) Coverage is provided for the initial purchase, fitting, and necessary adjustments of Prosthetic Devices and supplies that replace all or part of an absent body organ or limb, (including contiguous tissue) or replace all or part of the function of a permanently inoperative or malfunctioning body organ or limb. A time limit cannot be imposed for Prosthetic Devices received for a mastectomy; and if the mastectomy was not performed while a Participant was enrolled in the Plan, the Prosthetic Devices must be provided. (2) Services for repair and replacement of DME will be Covered under the Plan if deemed Medically Necessary. A letter of Medical Necessity will be required from the Provider for review prior to Coverage. The Participant must seek repair of the equipment prior to replacement, unless the repair cost is greater than the replacement cost. The Plan will not Cover replacement batteries or routine maintenance or maintenance agreements.	*Prior Authorization required on certain appliances and devices* If Participant requires refitting and a replacement due to structural change in anatomy, the replacement must be Prior Authorized. **Exclusions:** (1) Repair, replacement or maintenance of DME, Prosthetic Devices or braces unless there is sufficient change in the Participant's physical condition to make the original device no longer functional (2) Maintenance due to normal wear and tear of items owned by the Participant (3) Services relating to hearing aids as follows: a) routine hearing tests, audiograms, and hearing aids except as provided in the "Hearing Aids and Screenings" section of this article b) adjustments, batteries, and other services related to hearing aids c) all Out-of-Network services

COVERAGE FOR SERVICES OR SUPPLIES WHEN DETERMINED BY THE PLAN TO BE MEDICALLY NECESSARY		
SERVICE OR SUPPLY	**CRITERIA AND COVERAGE PROVIDED**	**AUTHORIZATION REQUIREMENTS, LIMITATIONS, AND EXCLUSIONS**
	(3) The initial purchase and fitting of Orthotic Appliances such as braces, splints or other appliances which are required for support of an Injured or deformed part of the body as a result of a disabling congenital condition or an Injury or sickness. (4) For Coverage of therapeutic shoes, refer to the "Podiatry" section of this article (5) For Coverage of Hearing Aids, Cochlear Implants, and BAHA devices, refer to the "Hearing Aids and Screenings" section of this article. (6) For Coverage of Cataract lenses, refer to the "Eyeglasses and Corrective Lenses" section of this article. (7) For Coverage of Penile Prosthesis, refer to the "Implants and Related Health Services" section of this article.	(4) More than one (1) pair of therapeutic shoes, including fitting of shoes and inserts, per calendar year for diabetic foot disease or peripheral neuropathy (5) Shoe inserts unless the Participant has diabetes with demonstrated peripheral neuropathy or the insert is needed for a shoe that is part of a brace. If all necessary criteria are present, one (1) shoe insert will be Covered per calendar year (6) Electrical continence aids, either anal or urethral (7) Implants for cosmetic or psychological reasons (8) Replacement batteries or routine maintenance or maintenance agreements (9) Penile prostheses for psychogenic impotence (10) Dental appliances (11) Orthopedic shoes (12) Replacement of cataract lenses except when new cataract lenses are needed because of prescription change not to exceed the cost of traditional intraocular lenses (13) Devices employing robotics (14) All mechanical organs (15) Arch supports and other foot support devices (16) Elastic stockings (17) Remote control devices (18) Garter belts (19) Special braces

COVERAGE FOR SERVICES OR SUPPLIES WHEN DETERMINED BY THE PLAN TO BE MEDICALLY NECESSARY		
SERVICE OR SUPPLY	**CRITERIA AND COVERAGE PROVIDED**	**AUTHORIZATION REQUIREMENTS, LIMITATIONS, AND EXCLUSIONS**
Prosthetic Devices and Orthotic Appliances (continued)		**Exclusions (continued):** For exclusions related to therapeutic shoes, refer to the "Podiatry" section of this article. For exclusions related to Hearing Aids, Cochlear Implants, and BAHA devices, refer to the "Hearing Aids and Screenings" section of this article. For exclusions related to Cataract lenses, refer to the "Eyeglasses and Corrective Lenses" section of this article. For exclusions related to Penile Prosthesis, refer to the "Implants and Related Health Services" section of this article.
Pulmonary Rehabilitation (Respiratory Therapy)	Refer to the "Therapy/Rehabilitation Services and Supplies" section of this article.	
Radiology	Coverage provided if related to Medically Necessary services.	*Prior Authorization may be required.* **Limitations:** One (1) spinal x-ray for chiropractic services per calendar year **Exclusions:** X-ray services for non-Covered services
Reconstructive Surgery	Covered Service for repair of: (1) disfigurement resulting from an Injury that occurred while a Participant; or (2) surgery that substantially improves function of any malformed body part. Coverage also includes breast reconstruction following a mastectomy. Refer to the "Mastectomy", "Breast Reconstruction" and "Reduction Mammoplasty" sections of this article.	*Prior Authorization required.* **Exclusions:** Refer to the "Cosmetic, Plastic and Related Reconstructive Surgery" section of this article.

COVERAGE FOR SERVICES OR SUPPLIES WHEN DETERMINED BY THE PLAN TO BE MEDICALLY NECESSARY		
SERVICE OR SUPPLY	**CRITERIA AND COVERAGE PROVIDED**	**AUTHORIZATION REQUIREMENTS, LIMITATIONS, AND EXCLUSIONS**
Reduction Mammoplasty	Coverage is provided for Medically Necessary breast reduction, including for male gynecomastia, and augmentation mammoplasty or if it is associated with Reconstructive Surgery following a Medically Necessary mastectomy.	*Prior Authorization is required.* **Exclusions:** Reduction, including for male gynecomastia, and augmentation mammoplasty that is not Medically Necessary or is not associated with Reconstructive Surgery following a Medically Necessary mastectomy
Renal Dialysis Treatment	Refer to the "Therapy/Rehabilitation Services and Supplies" section of this article.	
Respiratory Therapy (Pulmonary Rehabilitation)	Refer to the "Therapy/Rehabilitation Services and Supplies" section of this article.	
Second Opinion	Covered service.	
Skilled Nursing Facility Service	Coverage is provided for confinement (on a Semi-Private Accommodations basis unless a private room is the only room available or is required for medical reasons) and medical services and supplies provided under the direction of a Physician in a Skilled Nursing Facility. Facilities are Covered only for the care and treatment of an Injury or Illness which cannot be safely provided in an Outpatient setting, as determined by the Plan.	*Prior Authorization required.* **Limitations:** Coverage in a Skilled Nursing Facility is subject to Medical Necessity. Certain health services (e.g. lab, x-ray, Physical Therapy, etc.) rendered during a Participant's confinement are subject to separate Benefit restrictions, Deductible, Coinsurance and/or Copayments described in Appendices A and B of Article 4 for non-Medicare Participants and Appendix D of Article 8 for Medicare Participants.
Sleep Studies	Covered service.	*Prior authorization required.*
Speech Therapy	Refer to the "Therapy/Rehabilitation Services and Supplies" section of this article.	
Sterilization	Refer to the "Birth Control" section of this article.	**Exclusions:** Refer to the "Birth Control" section of this article

COVERAGE FOR SERVICES OR SUPPLIES WHEN DETERMINED BY THE PLAN TO BE MEDICALLY NECESSARY		
SERVICE OR SUPPLY	**CRITERIA AND COVERAGE PROVIDED**	**AUTHORIZATION REQUIREMENTS, LIMITATIONS, AND EXCLUSIONS**
Surgical Services	Surgical services and other related medical care ordered by and provided by or under the direction of a Physician in a Hospital, Skilled Nursing Facility or alternate facility are Covered. Refer to the following sections of this article: (1) "Inpatient Hospital Care" (2) "Outpatient Services, Surgeries, and Supplies" (3) "Oral Surgery and Diseases of the Mouth"	*Prior Authorization may be required.* **Exclusions:** Refer to the following sections of this article: (1) "Inpatient Hospital Care" (2) "Outpatient Services, Surgeries, and Supplies" (3) "Oral Surgery and Diseases of the Mouth"
Telemedicine Services	Coverage is provided for telemedicine services that are appropriately provided in accordance with applicable laws and generally accepted health care practices and standards. Coverage includes diagnosis, consultation or treatment of the Member through electronic-based communications and is subject to correct coding and reimbursement on the same basis as a face-to-face consultation between a Provider and the Member. Member's cost-sharing responsibilities will not be greater than the same service received in person with the same Provider, and will be consistent with the type of service received.	**Exclusions:** (1) Site-origination fees for the telemedicine provider (2) Standard telephone, facsimile transmissions, unsecured electronic mail, or a combination thereof, does not constitute telemedicine services.
Temporomandibular Joints (TMJ)	Coverage includes reduction of dislocations and surgical repair of TMJ.	**Exclusions:** Non-surgical services, including appliances such as braces, splints, other orthodontia, etc.
Termination of Pregnancy	Refer to the "Birth Control" section of this article.	**Exclusions:** Refer to the "Birth Control" section of this article
Therapy/ Rehabilitation Services and Supplies	Therapy Services means services or supplies used to promote the recovery of the Participant. Coverage is provided for short-term Inpatient or Outpatient (whichever is Medically Necessary) Rehabilitation Services which are	*Prior Authorization may be required.* **Limitations:** Limited to treatment for conditions that in the judgment of the Participant's Physician and the Claims Administrator's medical

COVERAGE FOR SERVICES OR SUPPLIES WHEN DETERMINED BY THE PLAN TO BE MEDICALLY NECESSARY		
SERVICE OR SUPPLY	**CRITERIA AND COVERAGE PROVIDED**	**AUTHORIZATION REQUIREMENTS, LIMITATIONS, AND EXCLUSIONS**
	expected to result in significant functional improvement of the Participant's condition. Outpatient Rehabilitation Services include Medically Necessary Covered services, supplies, and related Physician and facility charges and must be provided under the direction of a Physician and Prior Authorized by the Plan. Physical Therapy, Occupational Therapy, and Speech Therapy are limited to a combined total of sixty (60) Outpatient visits per calendar year. For visit limitations of your Benefit Plan, refer to the "Physical, Occupational, and Speech Therapy" section in Appendices A and B of Article 4 for non-Medicare Participants and Appendix D of Article 8 for Medicare Participants. (1) Radiation Therapy Coverage includes the services or supplies for the treatment of disease radioactive isotopes. (2) Chemotherapy Coverage includes the services or supplies for the treatment of malignant disease by chemical or biological (3) Renal Dialysis Treatment Covered service for the treatment of an Acute or chronic kidney ailment that may include the supportive use of an artificial kidney machine. Also includes hemodialysis and peritoneal services provided by Outpatient or Inpatient facilities or at home. Home dialysis, including equipment, supplies, and maintenance, is a Covered service (4) Physical Therapy Coverage consists of treatment by physical means including: a) hydrotherapy, or similar	director are subject to significant improvement of the condition through relatively short-term therapy. **<u>Exclusions:</u>** (1) Rehabilitative services provided for long-term, chronic medical conditions. Long-term Physical Therapy and rehabilitation or other Physical Therapy or rehabilitation when no significant improvement has occurred or is likely to occur (2) Rehabilitative services whose primary goal is to maintain the Participant's current level of function, as opposed to improving the functional status (3) Rehabilitative services whose primary goal is to return the Participant to a specific occupation or job, such as work-hardening or work-conditioning programs (4) Educational or vocational therapy, schools or services designed to retrain the Participant for employment (5) Physical and occupational rehabilitative services whose purpose is to treat or improve a developmental/learning disability or delay. Refer to definition of Developmental Delay in Article 1.26 (6) Rebalance Billings that are Experimental or have not been shown to be clinically effective for the medical condition being treated, including Experimental or Investigational Chemotherapy or Radiation Therapy (7) Alternative Rehabilitation Services (e.g., acupuncture,

COVERAGE FOR SERVICES OR SUPPLIES WHEN DETERMINED BY THE PLAN TO BE MEDICALLY NECESSARY		
SERVICE OR SUPPLY	**CRITERIA AND COVERAGE PROVIDED**	**AUTHORIZATION REQUIREMENTS, LIMITATIONS, AND EXCLUSIONS**
	modalities; b) bio-mechanical and neurophysiological principles; c) devices to relieve pain, restore maximum function, and prevent disability following disease, Injury, or loss of body part; or d) massage therapy conducted by a Physician (excluding chiropractors), or conducted by a licensed massage therapist under the direction of a Physician and the bill is submitted by and payable to the Physician. (5) Cardiac Rehabilitation Covered service, but limited to treatment for therapy conditions, in the judgment of the treating Provider and the Claims Administrator's medical director, subject to significant improvement of the condition through relatively short-term therapy. Cardiac Rehabilitation is deemed Medically Necessary if the services are: a) rendered under the supervision of a Physician; b) rendered in connection with a myocardial infarction, coronary occlusion (blockage) or coronary bypass surgery; c) initiated within twelve (12) weeks after other treatment for the medical condition ends; and d) rendered by a provider as defined by this Plan. (6) Respiratory Therapy/Pulmonary Rehabilitation Coverage consists of the introduction of dry or moist gases into the lungs for treatment purposes. (7) Occupational Therapy Coverage consists of treatment of a physically disabled Participant by means of constructive activities designed and	acupressure) (8) Fees or costs associated with services that are primarily exercise. Examples include, but are not limited to, membership fees for health clubs, fitness centers, weight loss centers or clinics, or home exercise equipment (9) Physical, Occupational, and Speech Therapy visits over sixty (60) combined Outpatient visits per calendar year (10) Therapy or services related to Developmental Delay

COVERAGE FOR SERVICES OR SUPPLIES WHEN DETERMINED BY THE PLAN TO BE MEDICALLY NECESSARY		
SERVICE OR SUPPLY	**CRITERIA AND COVERAGE PROVIDED**	**AUTHORIZATION REQUIREMENTS, LIMITATIONS, AND EXCLUSIONS**
	adapted to promote the restoration of the Participant's ability to satisfactorily accomplish the ordinary tasks of daily living and those tasks required by the Participant's particular occupational role. (8) Speech Therapy Coverage consists of treatment by a licensed speech therapist for the correction of a speech impairment resulting from disease, surgery, Injury, congenital and developmental anomalies, or previous therapeutic processes.	
Tobacco Cessation	Coverage is provided for Tobacco Abuse Counseling as recommended by the U.S. Preventive Services Task Force. This includes eight (8) visits per twelve (12) month period of tobacco cessation counseling sessions, and ninety (90) days supply of FDA approved tobacco cessation medications up to two (2) times per year.	**Limitations:** Coverage provided for over-the-counter products through Aetna's Tobacco Cessation program only. Exclusion: No out-of-network coverage
Transplants (Human Organ)	Contact the Claims Administrator's Transplant Case Manager for additional Transplant Benefits and Covered services.	Contact the Claims Administrator's Transplant Case Manager for Transplant Benefits and Covered services. **Exclusions:** (1) Transplant Health Care Services for the donor under this Plan if the recipient is not a Participant. (2) Any transplant service deemed Experimental or Investigational. (3) Any transplant service deemed cosmetic. (4) Any service received or supplies furnished outside the United States or Canada. (5) Treatment while the Participant is not under the regular care of a Physician or for a service or

COVERAGE FOR SERVICES OR SUPPLIES WHEN DETERMINED BY THE PLAN TO BE MEDICALLY NECESSARY		
SERVICE OR SUPPLY	**CRITERIA AND COVERAGE PROVIDED**	**AUTHORIZATION REQUIREMENTS, LIMITATIONS, AND EXCLUSIONS**
		supply which is not Prior Authorized by the Claims Administrator. (6) Treatment arising out of or in the course of a Participant's employment with an employer or self-employment. (7) Air ambulance transportation, unless approved by the medical director. (8) Travel time and related expenses charged by a Provider of service. (9) Services and supplies, which are not Medically Necessary. (10) A Covered transplant procedure using fetal tissue. (11) Expenses for other than human-to-human organ transplants. (12) Oral implants/transplants. (13) Services or supplies for which there would be no payment required if the Plan did not provide a Benefit; or Benefits are available through any governmental program which provides or pays for health services, whether or not such Benefits are applied for, except Benefits received from Medicaid.

COVERAGE FOR SERVICES OR SUPPLIES WHEN DETERMINED BY THE PLAN TO BE MEDICALLY NECESSARY		
SERVICE OR SUPPLY	**CRITERIA AND COVERAGE PROVIDED**	**AUTHORIZATION REQUIREMENTS, LIMITATIONS, AND EXCLUSIONS**
Transplant Travel Benefit	Coverage is provided for the transportation, and lodging for the transplant member plus one other person for travel to and from the transplant center. If the patient is a minor, transportation and reasonable and necessary lodging costs for two persons who travel with the minor are included. Expenses for lodging are reimbursed at the per diem rates established by the Internal Revenue Service. Coverage is also provided for reasonable expenses for parking, taxi, or shuttle buses. For those with primary coverage by Medicare Parts A and B, the Plan does not provide benefits for organ or tissue transplants for which Medicare denies transplant benefits. Copies of <u>all</u> receipts, including airline ticket and hotel receipts must be submitted in order to be reimbursed. Forward all original receipts to your *TRANSPLANT CASE MANAGER* at Aetna. Standard turnaround time for transplant travel claim reimbursement is between 4-6 weeks. All claims for travel expense reimbursement must be filed within 180 days following the 12 month period from date of discharge from the facility post-transplant.	**<u>Limitations:</u>** (1) Maximum allowance of $10,000 per covered transplant to be used by the member for all travel related expenses (mileage, airfare, and lodging, regardless of the number of trips related to transplant services. (2) Lodging is reimbursed at a total of $200 per day for the transplant member plus one other person. If two people accompany a minor, the limitation remains a total of $200 per day. **<u>Exclusions:</u>** (1) Car rental (2) Meals (3) Entertainment costs (4) Purchase of alcohol or tobacco products (5) Telephone calls (6) Personal care services

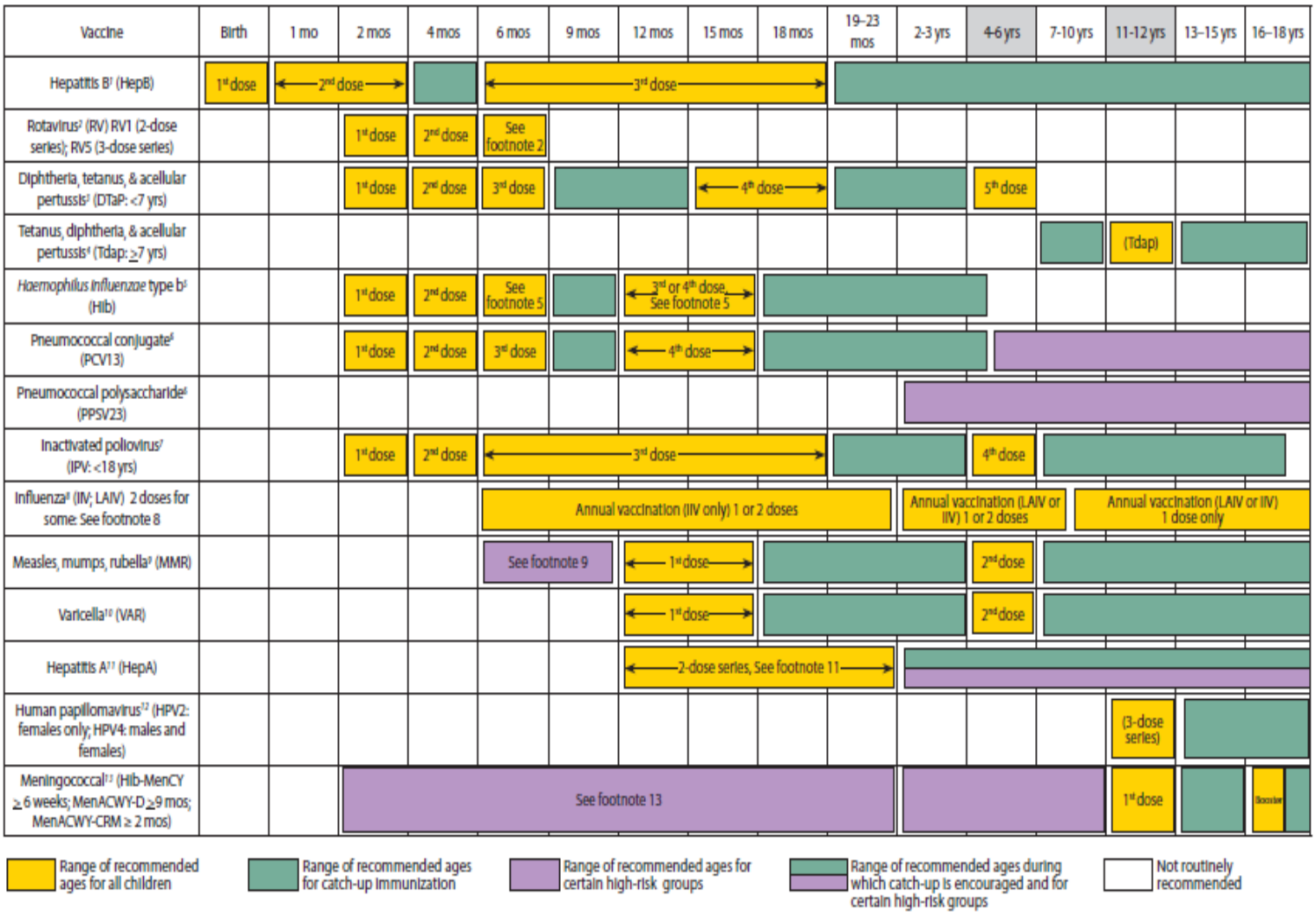
COVERAGE FOR SERVICES OR SUPPLIES WHEN DETERMINED BY THE PLAN TO BE MEDICALLY NECESSARY		
SERVICE OR SUPPLY	**CRITERIA AND COVERAGE PROVIDED**	**AUTHORIZATION REQUIREMENTS, LIMITATIONS, AND EXCLUSIONS**
Urgent Care Services	Urgent Care services provided at an alternate facility such as an Urgent Care center or after-hours facility is Covered.	**Limitations:** Benefits are subject to Deductibles, Copayments, Coinsurances, and other restrictions as described in Appendices A and B in Article 4 for non-Medicare Participants and Appendix D of Article 8 for Medicare Participants.
Vision Services (Reference "Eyeglasses And Corrective Lenses" of this article).	Coverage Includes: (1) Services to treat Injuries to the eye (2) Services to treat disease of the eye (3) Diabetic eye exam, per calendar year	**Exclusions:** (1) Routine eye care services (2) Orthoptics (3) Eye exercises (4) Radial Keratotomy (5) LASIK (6) Other refractive eye surgery (7) Other services not relative to Injury or disease
Well Child Care	Includes normal, periodic examinations through six (6) years of age. This service is Covered at one hundred percent (100%) and is not subject to Deductible(s). For children over six (6) years of age, refer to the "Preventive Care" section in Appendices A and B of Article 4 for non-Medicare Participants and Appendix D of Article 8 for Medicare Participants. For newborn Coverage, refer to the "Newborn Care" section of this article. For child immunizations Coverage, refer to the "Immunizations" section of Appendix C of this article. For lead poisoning Coverage, refer to the "Lead Poisoning Testing" section of this article.	**Limitations:** Preventive Care service are Covered as provided in Appendices A and B of Article 4 for non-Medicare Participants and Appendix D of Article 8 for Medicare Participants. **Exclusions:** Preventive Care service when utilizing Out-of-Network Providers

Appendix C Immunization Schedules

Figure 1. Recommended immunization schedule for persons aged 0 through 18 years – United States, 2015.

(FOR THOSE WHO FALL BEHIND OR START LATE, SEE THE CATCH-UP SCHEDULE [FIGURE 2]).

These recommendations must be read with the footnotes that follow. For those who fall behind or start late, provide catch-up vaccination at the earliest opportunity as indicated by the green bars in Figure 1. To determine minimum intervals between doses, see the catch-up schedule (Figure 2). School entry and adolescent vaccine age groups are shaded.



This schedule includes recommendations in effect as of January 1, 2015. Any dose not administered at the recommended age should be administered at a subsequent visit, when indicated and feasible. The use of a combination vaccine generally is preferred over separate injections of its equivalent component vaccines. Vaccination providers should consult the relevant Advisory Committee on Immunization Practices (ACIP) statement for detailed recommendations, available online at http://www.cdc.gov/vaccines/hcp/acip-recs/index.html. Clinically significant adverse events that follow vaccination should be reported to the Vaccine Adverse Event Reporting System (VAERS) online (http://www.vaers.hhs.gov) or by telephone (800-822-7967). Suspected cases of vaccine-preventable diseases should be reported to the state or local health department. Additional information, including precautions and contraindications for vaccination, is available from CDC online (http://www.cdc.gov/vaccines/recs/vac-admin/contraindications.htm) or by telephone (800-CDC-INFO [800-232-4636]).

This schedule is approved by the Advisory Committee on Immunization Practices (http//www.cdc.gov/vaccines/acip), the American Academy of Pediatrics (http://www.aap.org), the American Academy of Family Physicians (http://www.aafp.org), and the American College of Obstetricians and Gynecologists (http://www.acog.org).

NOTE: The above recommendations must be read along with the footnotes of this schedule.

Appendix C Immunization Schedules

(Continued)

FIGURE 2. Catch-up immunization schedule for persons aged 4 months through 18 years who start late or who are more than 1 month behind —United States, 2015.

The figure below provides catch-up schedules and minimum intervals between doses for children whose vaccinations have been delayed. A vaccine series does not need to be restarted, regardless of the time that has elapsed between doses. Use the section appropriate for the child's age. Always use this table in conjunction with Figure 1 and the footnotes that follow.

Vaccine	Minimum Age for Dose 1	Minimum Interval Between Doses			
		Dose 1 to Dose 2	Dose 2 to Dose 3	Dose 3 to Dose 4	Dose 4 to Dose 5
Children age 4 months through 6 years					
Hepatitis B[1]	Birth	4 weeks	8 weeks *and* at least 16 weeks after first dose. Minimum age for the final dose is 24 weeks.		
Rotavirus[2]	6 weeks	4 weeks	4 weeks[2]		
Diphtheria, tetanus, and acellular pertussis[3]	6 weeks	4 weeks	4 weeks	6 months	6 months[3]
Haemophilus influenzae type b[5]	6 weeks	4 weeks if first dose was administered before the 1st birthday. 8 weeks (as final dose) if first dose was administered at age 12 through 14 months. No further doses needed if first dose was administered at age 15 months or older.	4 weeks[5] if current age is younger than 12 months **and** first dose was administered at younger than age 7 months, **and** at least 1 previous dose was PRP-T (ActHib, Pentacel) or unknown. 8 weeks *and* age 12 through 59 months (as final dose)[5] • if current age is younger than 12 months **and** first dose was administered at age 7 through 11 months; OR • if current age is 12 through 59 months **and** first dose was administered before the 1st birthday, **and** second dose administered at younger than 15 months; OR • if both doses were PRP-OMP (PedvaxHIB; Comvax) **and** were administered before the 1st birthday. No further doses needed if previous dose was administered at age 15 months or older.	8 weeks (as final dose) This dose only necessary for children age 12 through 59 months who received 3 doses before the 1st birthday.	
Pneumococcal[6]	6 weeks	4 weeks if first dose administered before the 1st birthday. 8 weeks (as final dose for healthy children) if first dose was administered at the 1st birthday or after. No further doses needed for healthy children if first dose administered at age 24 months or older.	4 weeks if current age is younger than 12 months and previous dose given at <7months old. 8 weeks (as final dose for healthy children) if previous dose given between 7-11 months (wait until at least 12 months old); OR if current age is 12 months or older and at least 1 dose was given before age 12 months. No further doses needed for healthy children if previous dose administered at age 24 months or older.	8 weeks (as final dose) This dose only necessary for children aged 12 through 59 months who received 3 doses before age 12 months or for children at high risk who received 3 doses at any age.	
Inactivated poliovirus[7]	6 weeks	4 weeks[7]	4 weeks[7]	6 months[7] (minimum age 4 years for final dose).	
Meningococcal[13]	6 weeks	8 weeks[13]	See footnote 13	See footnote 13	
Measles, mumps, rubella[9]	12 months	4 weeks			
Varicella[10]	12 months	3 months			
Hepatitis A[11]	12 months	6 months			
Children and adolescents age 7 through 18 years					
Tetanus, diphtheria; tetanus, diphtheria, and acellular pertussis[4]	7 years[4]	4 weeks	4 weeks if first dose of DTaP/DT was administered before the 1st birthday. 6 months (as final dose) if first dose of DTaP/DT was administered at or after the 1st birthday.	6 months if first dose of DTaP/DT was administered before the 1st birthday.	
Human papillomavirus[12]	9 years	Routine dosing intervals are recommended.[12]			
Hepatitis A[11]	Not applicable (N/A)	6 months			
Hepatitis B[1]	N/A	4 weeks	8 weeks **and** at least 16 weeks after first dose.		
Inactivated poliovirus[7]	N/A	4 weeks	4 weeks[7]	6 months[7]	
Meningococcal[13]	N/A	8 weeks[13]			
Measles, mumps, rubella[9]	N/A	4 weeks			
Varicella[10]	N/A	3 months if younger than age 13 years. 4 weeks if age 13 years or older.			

NOTE: The above recommendations must be read along with the footnotes of this schedule.

Appendix C Immunization Schedules

(Continued)

2015 Recommended Immunizations for Adults: By Age

If you are this age, talk to your healthcare professional about these vaccines →

	Flu *Influenza*	Td/Tdap Tetanus, diphtheria, pertussis	Shingles *Zoster*	Pneumococcal PCV13	Pneumococcal PPSV23	Meningococcal	MMR Measles, mumps, rubella	HPV *Human papillomavirus* for women	HPV *Human papillomavirus* for men	Chickenpox *Varicella*	Hepatitis A	Hepatitis B	Hib *Haemophilus influenzae* type b
19 - 21 years	Flu vaccine every year	1 dose of Tdap* Td booster every 10 years		1 dose	1 or 2 doses	1 or more doses	1 or 2 doses	3 doses	3 doses	2 doses	2 doses	3 doses	1 or 3 doses
22 - 26 years									3 doses				
27 - 49 years													
50 - 59 years													
60 - 64 years			1 dose										
65+ year				1 dose	1 dose								

More Information:

There are several flu vaccines available. Talk to your healthcare professional about which flu vaccines is right for you.

* If you are pregnant, you should get a Tdap vaccine during the **3rd trimester of every pregnancy** to help protect your babies from pertussis (whooping cough).

You should get zoster vaccine even if you've had shingles before.

There are two different types of pneumococcal vaccine: PCV13 (conjugate) and PPSV23 (polysaccharide). Talk with your healthcare professional to find out if one or both pneumococcal vaccines are recommended for you.

Your healthcare professional will let you know how many doses you need.

Recommended for you if you did not get it when you were a child.

If you were born in 1957 or after, and don't have a record of being vaccinated or having had measles, mumps and rubella, talk to your healthcare professional about how many doses you may need.

There are two HPV vaccines but only one HPV vaccine (Gardasil®) should be given to men.

If you are a male 22 through 26 years old and have sex with men you should complete the HPV vaccine series if you have not already done so.

Your healthcare professional will let you know how many doses you need.

For more information, call 1-800-CDC-INFO (1-800-232-4636) or visit www.cdc.gov/vaccines

Recommended For You: This vaccine is recommended for you **unless** your healthcare professional tells you that you cannot safely receive it or that you do not need it.

May Be Recommended For You: This vaccine is recommended for you if you have certain risk factors due to your health, job, or lifestyle that are not listed here. Talk to your healthcare professional to see if you need this vaccine.

If you are traveling outside the United States, you may need additional vaccines.
Ask your healthcare professional about which vaccines you may need at least 6 weeks prior to your travel.

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2015 Recommended Immunizations for Adults: **By Health Condition**

If you have this health condition, talk to your healthcare professional about these vaccines →

	Flu *Influenza*	Td/Tdap Tetanus, diphtheria, pertussis	Shingles *Zoster*	Pneumococcal PCV13	Pneumococcal PPSV23	Meningococcal	MMR Measles, mumps, rubella	HPV *Human papillomavirus* for women	HPV *Human papillomavirus* for men	Chickenpox *Varicella*	Hepatitis A	Hepatitis B	Hib *Haemophilus influenzae* type b
Pregnancy	Flu vaccine every year	*see below			1 - 2 doses								
Weakened Immune System			SHOULD NOT GET VACCINE				SHOULD NOT GET VACCINE		3 doses through age 26 years	SHOULD NOT GET VACCINE		3 doses	post-HSCT* recipients only
HIV: **CD4 count less than 200**						1 or more doses							
HIV: **CD4 count 200 or greater**		1 dose of Tdap		1 dose							2 doses	3 doses	1 or 3 doses
Kidney disease or poor kidney function		followed by Td booster every 10 years			1 - 2 doses			3 doses through age 26 years	3 doses through age 21 years	2 doses			
Asplenia (If you do not have a spleen or if it does not work well)			1 dose for those 60 years or older			1 or more doses	1 or 2 doses					3 doses	1 or 3 doses
Heart disease Chronic lung disease Chronic alcoholism						1 or more doses							1 or 3 doses
Diabetes (Type 1 or Type 2)				1 dose								3 doses	
Chronic Liver Disease											2 doses		

More Information:

There are several flu vaccines available. Talk to your healthcare professional about which flu vaccines is right for you.

* If you are pregnant, you should get a Tdap vaccine during the **3rd trimester of every pregnancy** to help protect your babies from pertussis (whooping cough).

You should get zoster vaccine even if you've had shingles before.

There are two different types of pneumococcal vaccine: PCV13 (conjugate) and PPSV23 (polysaccharide). Talk with your healthcare professional to find out if one or both pneumococcal vaccines are recommended for you.

Your healthcare professional will let you know how many doses you need.

Recommended for you if you did not get it when you were a child.

If you were born in 1957 or after, and don't have a record of being vaccinated or having had measles, mumps and rubella, talk to your healthcare professional about how many doses you may need.

There are two HPV vaccines but only one HPV vaccine (Gardasil®) should be given to men.

If you are a male 22 through 26 years old and have sex with men you should complete the HPV vaccine series if you have not already done so.

Your healthcare professional will let you know how many doses you need.

*Hematopoietic stem cell transplant

Recommended For You: This vaccine is recommended for you ***unless*** your healthcare professional tells you that you cannot safely receive it or that you do not need it.

May Be Recommended For You: This vaccine is recommended for you if you have certain other risk factors due to your age, health, job, or lifestyle that are not listed here. Talk to your healthcare professional to see if you need this vaccine.

YOU SHOULD NOT GET THIS VACCINE

If you are traveling outside the United States, you may need additional vaccines.
Ask your healthcare professional about which vaccines you may need at least 6 weeks prior to your travel.

For more information, call 1-800-CDC-INFO (1-800-232-4636) or visit www.cdc.gov/vaccines

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CS251118

ARTICLE 6

PRESCRIPTION DRUG PROGRAM

A Prescription Drug program for the benefit of non-Medicare and Medicare Participants is provided under the Plan. By using the Prescription Drug program, the Participant implicitly consents to the Prescription Drug program administrator having access, as needed, to the medical records of the Participant. Restrictions, Prior Authorizations, step therapy and exclusions do apply for some prescriptions.

6.1 Medicare and Non-Medicare Participants

The following applies to both Medicare and non-Medicare Participants of the Plan. (Refer to Appendices A and B of Article 4 for non-Medicare Participants and Appendix D of Article 8 for Medicare Participants.)

(1) A Network pharmacy must be utilized for prescriptions to be Covered, both in-State or out-of-State.

(2) Prescription Drug card must be presented to the retail pharmacy at the time of purchase.

(3) Participants may obtain up to a 90-day supply of maintenance medications at either retail or mail order pharmacies after they have filled a starter quantity of the medication. A starter quantity is required if the medication is new, has not been filled in the past six months or if the dose form or strength of the medication changes.

(4) Coinsurance on Prescription Drugs purchased at retail pharmacies and the mail pharmacy will apply with a minimum Copayment. Refer to Appendices A and B of Article 4 for non-Medicare Participants and Appendix D of Article 8 for Medicare Participants.

(5) The Board may limit the Coinsurance payable by the Participant to a maximum level if it is deemed that a specific Covered Prescription Drug that is a special treatment medication would pose a significant financial burden to the Participant. This limit will be applicable to each thirty (30) day supply. These are special treatment(s) where there are little or no options for treatment, other treatment options have been exhausted, and/or the Participant needs the drug to treat a potentially catastrophic or life threatening condition (i.e., organ transplant, cancer, AIDS, etc.). The drugs available under this Benefit may change as new drugs become available or as drugs become available in generic formulation. Selection of special treatment drugs is at the sole discretion of the Board. Neither the Board nor the Plan will incur liability to a Participant/Subscriber if a drug is not selected by the Board to be a special treatment medication.

(6) Specific Drugs paid at one-hundred percent (100%):

The following are specific drugs which will be Covered at one hundred percent (100%), with no Deductible, Coinsurance or Copayment applied. For Coverage, these specific drugs require a prescription from your Physician and must be filled at a MedImpact Participating Pharmacy except as noted in e) below:

a) aspirin (OTC) – Dose: 81 mg and 325 mg, men forty-five (45) to seventy-nine (79) years of age and women fifty-five (55) to seventy-nine (79) years of age;

b) low-dose aspirin (81 mg/d) as preventive medication after 12 weeks of gestation in pregnant women at high risk for preeclampsia.

c) iron (OTC) – children six (6) to twelve (12) months of age who are at risk for iron deficiency anemia, drops only;

d) folic Acid (OTC) – Dose: 0.4 to 0.8 mg (400 to 800 mg) women planning or capable of pregnancy;

e) fluoride – children under six (6) years of age: drops and chewable tablets only;

f) tobacco cessation, OTC products available through Aetna's Tobacco Cessation Program;

g) tobacco cessation Prescription Drugs, (generics only when available), and limited to two treatment cycles of ninety (90) days supply per lifetime;

h) shingles vaccine, for Participants fifty (50) years of age and older;

i) flu vaccine;

j) generic Contraceptives (oral and others) purchased at an In-Network Pharmacy;

k) Prescription Vitamin D for members over sixty-five (65) years of age; and

l) preventive breast cancer prescription drugs for women thirty-five (35) years of age or older. The medications in this class must meet the step therapy requirements of the Prescription Drug Plan.

(7) The fact that a Physician prescribes a specific drug does not make the drug a Covered Benefit. **The following is a list of standard excluded drugs, which is not all inclusive:**

a) any drug that is utilized to terminate a pregnancy is excluded. This includes, but is not limited to RU-486;

b) OTC products or OTC equivalents and State restricted drugs (unless specifically included). Refer to definition of Over-the-Counter (OTC) Drugs in Article 1.76;

c) therapeutic devices or appliances such as pulmo-aid pumps, mini-med pumps, etc. (check with the medical Plan Claims Administrator);

d) implantable time-released medication unless otherwise noted as stated in Article 5;

e) Experimental or Investigational drugs; or drugs prescribed for Experimental (non-FDA approved/unlabeled) indications;

f) FDA approved drugs for cosmetic use only;

g) nutritional supplements, unless otherwise noted;

h) erectile dysfunction drugs;

i) fertility drugs;

j) weight loss medications;

k) immunization agents, biological serum, vaccines (except those vaccines that are specifically included in Article 6.1), and biologicals;

l) extemporaneously prepared combinations of raw bulk chemical ingredients (i.e. progesterone, testosterone, or estrogen powders) or combinations of federal legend drugs in a non-FDA approved dosage form (i.e. capsules or suppositories made from DHEA, progesterone, testosterone or estrogen powders);

m) natural compounded hormones;

n) homeopathic legend products;

o) lost, spilled, dropped, stolen etc. medications;

p) influenza treatments (except those treatments Covered for Medicare Participants);

q) prescription strength non-sedating anti-histamines for non-Medicare Participants;

r) prescription strength vitamins, except prenatal vitamins, B-12 injections and fluoride treatments; and

s) Solodyn, which is an extended release form of Minocycline, a tetracycline.

(8) Some medications also require step therapy or an approved Prior Authorization before they are Covered under the Plan. If your prescription fails to process, have your pharmacist contact the Prescription Drug program administrator to check why the Claim did not process.

(9) The Plan will coordinate Benefits on Prescription Drugs purchased through another plan if the pharmacy is a participating provider.

6.2 Non-Medicare Participants (PPO & HDHP)

The following applies to non-Medicare Participants of the Plan. (Refer to Appendices A and B of Article 4). A minimum Copayment or Coinsurance is required to be paid as follows:

(1) Single source brand medications (No Generic Equivalent Available)

Non-Medicare Participants will pay the greater of thirty percent (30%) Coinsurance or the minimum Copayment after the Deductible is met.

(2) Brand Medications (Generic Equivalents Available)

a) The Plan requires filling generic medications when available or a penalty may apply. When a brand medication that has a generic equivalent available is dispensed, the Participant will pay the thirty (30%) Coinsurance based on the cost of the brand medication after the Deductible plus the difference between the brand and generic costs of the drug, not to exceed the Plan's contracted discount rate.

b) If a brand medication that has a generic equivalent is deemed to be Medically Necessary, the prescribing Physician must submit a FDA MedWatch form (describing the failure of the generic medication) to the Prescription Drug program administrator for review. If approved, no penalty will apply and the Participant will pay thirty (30%) Coinsurance after the Deductible based on the total cost of the brand medication.

(3) An Out-of-Pocket Maximum per calendar year for Prescription Drug costs will be applicable to non-Medicare participants of the PPO plan. This will include Deductible, Copayments, and Coinsurance amounts, but will not include costs for excluded drugs or drugs filled at a Non-Participating pharmacy. Reference Appendix A of Article 4 for additional information.

(4) For the HDHP, the cost of Prescription Drugs is included with medical service expenses, which applies to Deductible and Coinsurance amounts, but will not include costs for excluded drugs or drugs filled at a Non-Participating pharmacy. Reference Appendix B of Article 4 for additional information.

6.3 Medicare Participants only

The following applies to Medicare Participants only. (Refer to the Medicare prescription Benefit located in Appendix D of Article 8.)

(1) Single source brand medications (no generic equivalent available), Participant will pay the greater of a minimum Copayment or thirty percent (30%) Coinsurance of the total cost of the brand medication after the Deductible is met. For 2017, the Coverage gap begins when the total cost for Prescription Drugs for the year reaches three thousand seven hundred dollars ($3,700).

(2) If a brand medication, included in the Medicare Part D Drug List as governed by the Centers for Medicare and Medicaid Services (CMS), is dispensed and a generic equivalent medication is available, the Medicare Participant will pay the greater of a five dollar ($5.00) minimum Copayment after the Deductible is met or as follows:

a) Fifty percent (50%) Coinsurance of the brand medication after the Deductible, if they are not in the Coverage gap. For 2017, the Coverage gap begins when the total cost for Prescription Drugs for the year reaches three thousand seven hundred dollars ($3,700).

b) Fifty percent (50%) of the total cost of the brand medication in the Coverage gap.

(3) For generic medications, Participant will pay the greater of a five dollar ($5.00) minimum Copayment or thirty percent (30%) Coinsurance after the Deductible is met.

(4) Enhanced medications Covered under the Plan, but not included in the Part D formulary regulated by CMS, the Medicare Participant will pay the greater of a minimum Copayment or as follows:

a) Thirty percent (30%) Coinsurance for single source brand medications both in and out of Part D Coverage gap; or

b) Fifty percent (50%) Coinsurance for multi-source brand medications, both in and out of Part D Coverage gap.

(5) Once the Medicare Participant reaches four thousand nine hundred and fifty dollars ($4,950) in out-of-pocket expenses, the cost sharing will be reduced to the greater of a five percent (5%) Coinsurance or three dollars and thirty cents ($3.30) Copayment for generics and eight dollars and twenty-five cents ($8.25) Copayment for brands.

(6) The Prescription Drug Deductible applied to a non-Medicare Participant does not apply towards the Prescription Drug Deductible of a Medicare Participant in the year they become Medicare eligible.

(7) Diabetic testing supplies for Medicare Participants, including glucose testing monitors, blood glucose testing strips, lancet devices and lancets, are not Covered under the Prescription Drug program. These supplies are Covered under Medicare Part B Plan. Insulin and syringes are Covered under the Prescription Drug program of the Plan.

ARTICLE 7

PLAN EXCLUSIONS

The services and supplies specified in this section will **not** be considered Covered services.

7.1 Abortion (termination of pregnancy)

Refer to Article 7.5.

7.2 Allergy

(1) Those non-Physician allergy services or associated expenses relating to an allergic condition including, but not limited to, installation of air filters, air purifiers, or air ventilation system cleaning.

(2) Non-prescription allergy medications.

(3) Prescription strength non-sedating antihistamines for non-Medicare Participants.

7.3 Alternative Therapies

Non-traditional medical services, treatments and supplies, which are not specified as Covered Services under the Plan. These services, treatments and supplies, etc. include, but are not limited to the following:

(1) acupuncture, acupressure, hypnosis;

(2) biofeedback therapy;

(3) blood pressure cuff;

(4) donor expenses for obtaining blood from a blood bank or supplier; or

(5) massage therapy (except as provided under Article 1.110).

7.4 Ambulance/Transportation Services

(1) Ambulance/transportation due to the absence of other transportation on the part of the Participant.

(2) Non-medical Emergency ambulance/transportation services regardless of who requested the ambulance/transportation service.

(3) Ambulance/transportation charges, except as provided for in the “Ambulance/ Transportation Services” and “Transplant (Human Organ)” sections of Article 5.

(4) Air ambulance transportation for transplants, unless approved by the medical director.

7.5 Birth Control

(1) Abortions or Services in connection with an Abortion, except a Medically Necessary Abortion as defined in Article 1.1.

(2) Contraceptives when utilizing Out-of-Network Providers and Out-of-Network pharmacies.

(3) Reversal of Sterilization.

7.6 Blood and Blood Products

(1) Those services and associated expenses related to personal blood storage, unless associated with a scheduled surgery.

(2) Fetal cord blood harvesting and storage.

(3) Donor expenses for obtaining blood from a blood bank or supplier.

7.7 Breast Reconstruction

Reduction, including for male gynecomastia, and augmentation mammoplasty unless Medically Necessary or associated with Reconstructive Surgery following a Medically Necessary mastectomy.

7.8 Chemotherapy and Radiation Therapy

(1) Experimental or Investigational Chemotherapy or Radiation Therapy.

(2) Refer to the “Therapy/Rehabilitation Services and Supplies” section of this article.

7.9 Chiropractic Services

Chiropractic services, except as provided in Article 5.

7.10 Christian Science Services

Services and supplies rendered by a Christian Science facility accredited by the Department of Care of the First Church of Christ, Scientist, Boston, Massachusetts, or an institution of substantially similar nature to that operated by the First Church of Christ, Scientist; or comparable spiritual organizations.

7.11 Circumcision

Circumcision if not performed within thirty (30) days of birth except when Medically Necessary.

7.12 Clinical Trials

Refer to the “Clinical Trials” section in Article 5.

(1) Routine patient care for any clinical trial that does not meet the criteria.

(2) The cost of any non-Health Care Services that a Participant may require in conjunction with the clinical trial (e.g. transportation, lodging, Custodial Care) and the administrative costs associated with managing the clinical trial.

(3) Coverage for the cost of Investigational drug(s) and/or device(s).

(4) Services not Covered under the Participant's Plan for non-Investigational treatment (e.g. cosmetic surgery, Custodial Care) or costs in conjunction with the clinical trial.

(5) Items and services solely to satisfy data collection and analysis needs, not used in the direct clinical management of the patient.

(6) Items and services customarily provided by the research sponsors free of charge for any enrollee in the trial.

7.13 Colorectal Cancer Screening

Non-symptomatic colorectal cancer screenings processed as Preventive Care when utilizing Out-of-Network Providers.

7.14 Cosmetic, Plastic and Related Reconstructive Surgery

(1) Implants for cosmetic or psychological reasons.

(2) Elective or voluntary enhancement procedures, services, and medications (growth hormone and testosterone) including, but not limited to:

a) weight loss;

b) hair growth;

c) sexual performance;

d) athletic performance;

e) Cosmetic purposes;

f) anti-aging;

g) mental performance;

h) salabrasion;

i) chemosurgery;

j) laser surgery or other skin abrasion procedures associated with the removal of scars;

k) tattoos; and

l) actinic changes.

(3) Cosmetic procedures including, but not limited to, pharmacological regimens, plastic surgery, and non-Medically Necessary dermatological procedures and Reconstructive Surgery. Cosmetic procedures are those procedures that improve physical appearance, but do not correct or materially improve a physiological function and are not Medically Necessary except when the procedure is needed for prompt repair of accidental Injury or to improve the function of a congenital anomaly.

(4) Reduction, including for male gynecomastia, and augmentation mammoplasty unless Medically Necessary or associated with Reconstructive Surgery following a Medically Necessary mastectomy.

7.15 Coverage Term

(1) Services or supplies provided before the Participant's Coverage Date begins or after the Participant's Coverage date ends under the Plan.

(2) Services and supplies rendered prior to the effective date of the Plan or after the termination date of the Plan.

7.16 Custodial Care Services

Services and supplies in rest homes, health resorts, homes for the aged or places primarily for domiciliary or Custodial Care, except as otherwise specifically provided. Services for or in connection with Custodial Care, education or training of the Participant whether or not prescribed by the Physician, except as otherwise specifically provided.

7.17 Dental Services

(1) Services or supplies provided for dental services as follows:

a) Routine care and treatment for filling, removal, replacement, repair, or artificial restoration of the teeth (either natural or artificial), root canal, surgery involving structures directly supporting the teeth, or orthodontia;

b) Preparation of the mouth for the fitting or the continued use of dentures, except as provided in Article 5;

c) Injuries to the teeth while eating are not considered accidental Injuries;

d) other services not provided in Article 5.

(2) Those dental services provided by a Doctor of Dental Surgery, "D.D.S.," a Doctor of Medical Dentistry "D.M.D." or a Physician licensed to perform dental related oral surgical procedures (including services for overbite or underbite and services related to surgery for cutting through the lower or upper jaw bone) whether the services are considered to be medical or dental in nature except as provided in Article 5.

(3) Dental x-rays, supplies and appliances (including occlusal splints and guards and orthodontia).

(4) Refer to the “Oral Surgery and Diseases of the Mouth” sections of Article 5 and this article.

7.18 Developmental Delay

(1) Services and supplies for conditions related to milieu therapy, learning disabilities, mental retardation, or for Inpatient admission for environmental change.

(2) Treatment for disorders relating to learning, motor skills, and communication.

7.19 Diabetic Services and Supplies

(1) More than one (1) pair of therapeutic shoes and one (1) shoe insert per calendar year.

(2) Diabetic services processed as Preventive Care when utilizing Out-of-Network Providers.

7.20 Durable Medical Equipment (DME)

(1) DME that does not serve a medical purpose or cannot be used in a Participant’s home and equipment that is generally not useful to a Participant without Illness, Injury or diseases.

(2) The purchase or rental of services or supplies of common household use or for personal hygiene and convenience including, but not limited to:

a) physical fitness equipment;

b) air purifiers;

c) central or unit air conditioners;

d) allergenic pillows;

e) mattresses or beds;

f) humidifiers;

g) hot tubs and saunas; and

h) personal items such as:

i. a TV;

ii. telephone;

iii. cots;

iv. visitors’ meals;

v. barber or beauty service;

vi. guest services; or

vii. similar incidental services and supplies.

(3) Over-the-counter devices and/or supplies (such as ACE wraps, disposable medical supplies, elastic supports after the initial placement, finger splints, and Jobst and TEDS stockings over two (2) pairs per year).

(4) Those repairs, replacement, or maintenance costs for any otherwise Covered DME unless there is sufficient change in Participant's physical condition to make the original device no longer functional.

(5) Maintenance due to normal wear and tear of items owned by the Participant.

(6) Exclusions (4) and (5) also apply to disposable medical supplies, including but not limited to, feeding bags, and feeding syringes.

(7) Services and supplies processed as Preventive Care when utilizing Out-of-Network Providers.

For information on Coverage for glucose monitors, refer to the "Diabetic Services and Supplies" sections of Article 5 and this article.

7.21 Experimental/Investigational Services

Expenses incurred for and in connection with procedures, drugs, or devices that are considered by the Claims Administrator to be Experimental or Investigational.

7.22 Eyeglasses and Corrective Lenses

(1) Eyeglasses, contact lenses, and examinations, whether or not prescribed.

(2) Replacement of cataract lenses unless specifically Covered in Article 5.

(3) Those health services and associated expenses for orthoptics, eye exercises, blepharoplasty, radial keratotomy, LASIK, and other refractive eye surgery.

7.23 Family Member as Provider

The services of a Provider who ordinarily resides in the Participant's home or is a member of the Participant's immediate family.

7.24 Family Planning and Fertility Services

(1) Services in connection with the treatment and diagnosis of fertility or infertility, including, but not limited to:

(a) artificial insemination;

(b) intracytoplasmic sperm injection (ICSI);

(c) in vitro or in vivo fertilization;

(d) gamete intrafallopian transfer (GIFT) procedures;

(e) zygote intrafallopian transfer (ZIFT) procedures;

(f) embryo transport;

(g) reversal of voluntary Sterilization;

(h) surrogate parenting;

(i) selective reduction;

(j) cryo preservation;

(k) travel costs;

(l) donor eggs or semen and related costs including collection and preparation;

(m) non-Medically Necessary amniocentesis; and

(n) any infertility treatment deemed Experimental or Investigational.

(2) Pharmaceutical agents used for the purpose of treating infertility, except as provided for in Article 6.

7.25 Felony

Injuries or Illnesses resulting from taking part in the commission of a felony.

7.26 Growth Hormone

Growth hormone therapy for any condition, except as specifically listed as Covered.

7.27 Gynecological Services

Non-symptomatic gynecological services processed as Preventive Care service when utilizing Out-of-Network Providers.

7.28 Hearing Aids and Screenings

(1) Routine hearing tests, audiograms, and hearing aids except as provided in Article 5.

(2) Adjustments, batteries, and other services related to hearing aids.

(3) Hearing aids and related services received Out-of-Network.

(4) Exam for prescribing and fitting hearing aids, hearing therapy and any related diagnostic hearing tests except as provided in Article 5.

7.29 Home Health Care Services

Home services to help meet personal, family or domestic needs.

7.30 Hormone Replacement

Hormone replacement therapies, including natural compounded hormones, except as may be Covered under the Prescription Drug program.

7.31 Immunizations

Immunizations when utilizing Out-of-Network Providers and Out-of-Network pharmacies, or immunizations not listed on the schedules in Appendix C, Article 5.

7.32 Implants and Related Health Services

(1) Dental, oral, or Nanometric implants.

(2) Cochlear implants (including services related to cochlear implants), except as provided in the “Hearing Aids and Screenings” section of Article 5.

(3) Penile implants when prescribed to treat impotence that is psychological in origin.

(4) Implants for cosmetic or psychological reasons.

7.33 Impotence

(1) Treatment for male psychogenic impotence except as provided in the Mental Health Covered Benefits.

(2) Penile implants when prescribed to treat impotence that is psychological in origin.

(3) Prescriptions and injectable medication for the treatment of sexual dysfunction, including impotence.

7.34 Inpatient Hospital Care

(1) Diagnostic Admissions.

(2) Those personal comfort and convenience items or services such as TV, telephone, barber or beauty service, cots, visitors’ expenses, guest services and similar incidental services and supplies.

(3) Additional elective, not Medically Necessary surgical procedures.

7.35 Laboratory Services/Outpatient Services and Diagnostic Procedures and Tests

Routine laboratory services utilizing Out-of-Network Providers processed as Preventive Care.

7.36 Long-term Care Services

(1) Services and supplies in rest homes, health resorts, homes for the aged, or places primarily for domiciliary or Custodial Care, except as otherwise specifically provided.

(2) Services for or in connection with Custodial Care, education or training of the Participant, whether or not prescribed by a Physician, except as otherwise specifically provided.

7.37 Mammograms

(1) Non-symptomatic mammograms (preventive) when utilizing Out-of-Network Providers.

(2) Digital tomosynthesis breast imaging including three-dimensional (3D) digital tomosynthesis (i.e., 3D mammography).

7.38 Mastectomy

Reduction, including for male gynecomastia, and augmentation mammoplasty unless Medically Necessary or associated with Reconstructive Surgery following a Medically Necessary mastectomy.

7.39 Maternity Services

(1) Services for obstetrical care and care for conditions of pregnancy for any Participant other than the Subscriber or the Dependent of the Subscriber.

(2) Services in connection with the treatment and diagnosis of fertility or infertility, including but not limited to:

a) artificial insemination;

b) intracytoplasmic sperm injection (ICSI);

c) in vitro or in vivo fertilization;

d) gamete intrafallopian transfer (GIFT) procedures;

e) zygote intrafallopian transfer (ZIFT) procedures;

f) embryo transport;

g) reversal of voluntary Sterilization;

h) surrogate parenting;

i) selective reduction;

j) cryo preservation;

k) travel costs;

l) donor eggs or semen and related costs including collection and preparation;

m) non-Medically Necessary amniocentesis; and

n) any infertility treatment deemed Experimental or Investigational.

(3) Newborn home delivery and mid-wives.

(4) Surrogate motherhood services and supplies, including, but not limited to, all services and supplies relating to the conception and Pregnancy of a Participant acting as a surrogate mother.

(5) Maternity services processed as Preventive Care when utilizing Out-of-Network Providers.

7.40 Medically Necessary

Services, supplies, and days of care that are not Medically Necessary for the diagnosis or treatment of an Injury, Illness, or symptomatic complaint. The fact that a Physician may prescribe, order, recommend, or approve a service or supply does not, of itself, make it Medically Necessary or make the charge a Covered service, even though the service or supply is not specifically listed as an exclusion. The authority for determining whether services, supplies, or days of care are Medically Necessary lies with the Claims Administrator.

7.41 Mental Health Conditions and Chemical Dependency Services

(1) Services rendered or billed by a school or halfway house.

(2) Care that is custodial in nature.

(3) Services and supplies that are not immediately, nor clinically, appropriate.

(4) Treatments, services, devices, or pharmacological regimens that are considered Experimental, Investigational, controversial or unproven including, but not limited to, Methadone treatment.

(5) Non-Emergency or non-urgent transportation to another facility.

(6) Services and supplies for conditions related to milieu therapy, learning disabilities, mental retardation, or for Inpatient admission for environmental change.

(7) Treatment for disorders relating to learning, motor skills, and communication.

(8) Biofeedback therapies.

(9) Hypnotherapy.

(10) Services and treatment related to sex transformation, sexual therapy or counseling, sexual dysfunctions or inadequacies except conditions resulting from Injury or organic disease.

(11) Services and treatment related to religious counseling or marital/relationship counseling.

(12) Services and treatment related to vocational or employment counseling.

(13) Services and supplies processed as Preventive Care when utilizing Out-of-Network Provider.

7.42 Military/Governmental Health Services

(1) Treatment in any State or federal institution or facility, including any Veterans Administration Hospital, for military service-related medical expenses, or services and supplies for which the Participant is eligible or for which Benefits are available under any governmental health plan besides Medicaid, except to the extent required under existing State or federal laws and regulations.

(2) Services and supplies for diseases contracted or injuries sustained as a result of war, declared or undeclared, or any act of war, for military personnel or others while participating in the armed forces and Covered under other medical insurance.

7.43 Newborn Care

(1) Newborn home delivery and mid-wives.

(2) Newborn care processed as Preventive Care when utilizing Out-of-Network Providers.

7.44 No Obligation to Pay

Services and supplies for which the Participant has no legal obligation to pay.

7.45 Non-Covered Providers

Services rendered by non-Covered Providers, including, but not limited to, the following Providers and facilities:

(1) naturopaths;

(2) licensed counselors (except as provided in Article 1.91);

(3) mid-wives;

(4) marital counselors; or

(5) sanatoriums.

7.46 Nutritional Counseling

Food or food supplements. Counseling services outside of diabetes, hyperlipidemia, coronary artery disease, and morbid obesity.

7.47 Obesity and Weight Control Services

Care and treatment for obesity, weight loss or dietary control, regardless of Medical Necessity, including, but not limited to:

(1) bariatric, gastric bypass, or related surgeries;

(2) removal of excess fat or skin following weight loss;

(3) services at a health spa or similar facility; or

(4) Prescription Drugs prescribed for weight loss.

7.48 Occupational Injury

Services and supplies for any condition, disease, ailment or accidental Injury arising out of and in the course of employment if Benefits or compensation is available, in whole or in part, under any worker's compensation or occupational disease statutes or other similar law (the "Statutes"). This exclusion applies whether or not the Participant Claims the Benefits or compensation and whether or not the Participant recovers compensation from any third party. However, if a dispute arises between the Participant and the insurance carrier for any Coverage under one (1) of these Statutes, the Plan may pay the Covered services, pending settlement of the workers' compensation claims, and if the insurance carrier for Benefits or compensation under these Statutes should later be held responsible, the Participant or carrier would be required to reimburse the Plan.

7.49 Office Visits, Diagnostic and Treatment Services Received in a Physician's Office

(1) Preventive Care service when utilizing Out-of-Network Providers.

(2) Office visits for Excluded Services may not be Covered.

7.50 Oral Surgery and Diseases of the Mouth

(1) Oral implants and transplants except for Medically Necessary treatment of Acute traumatic Injury or cleft palate showing continued functional impairment.

(2) Oral surgery supplies that are required as part of an orthodontic treatment program or that are required for correction of an occlusal defect.

(3) Surgical procedures that involve the teeth or their supporting structures (such as the periodontal membrane, gingival, and alveolar bone), except as provided in Article 5.

(4) Surgical procedures involving orthodontic care, dental implants, or preparation of the mouth for the fitting or the continued use of dentures, except as provided in Article 5.

(5) Injuries to the teeth while eating are not considered accidental Injuries.

(6) Other services not provided in Article 5.

Refer to the "Dental Services" section of Article 5 and this article.

7.51 Orthotic Appliances and Prosthetic Devices

Refer to the "Prosthetic Devices and Orthotic Appliances" section of this article.

7.52 Out-of-Network Rate

Charges in excess of the Out-of-Network Rate, or in excess of the value of the service or supply as determined by the Claims Administrator.

7.53 Outpatient Diagnostic Tests and Therapeutic Treatments

Service processed as Preventive Care service when utilizing Out-of-Network Providers.

7.54 Outpatient Services, Surgeries, and Supplies

(1) Non-Covered services, surgeries, and supplies under the Plan as provided in this article.

(2) Service processed as Preventive Care service when utilizing Out-of-Network Providers.

7.55 Outside the Scope of a Provider

Services or supplies rendered or prescribed by a Provider outside the scope of his license.

7.56 Over-the-Counter Drugs

Medication and oral nutritional supplements that do not require a prescription under federal law even if your doctor prescribes them or if a prescription is required under your State or local law.

7.57 Pelvic Examinations and Pap Smears

Non-symptomatic pelvic exams and pap smears when utilizing Out-of-Network Providers.

7.58 Personal Hygiene and Convenience Items

Refer to the “Durable Medical Equipment (DME)” section of this article.

7.59 Phenylketonuria (PKU) (or any other amino and organic acid inherited disease formula/food)

(1) Outpatient enteral tube feedings or formula and supplies, except as provided in Article 5, including, but not limited to use for PKU or any other amino and organic acid inherited disease.

(2) Nutritional-based therapies, except for treatment of PKU and for nutritional deficiencies due to short bowel syndrome and HIV.

(3) Oral supplements and/or enteral feedings, either by mouth or by tube.

7.60 Podiatry

(1) Services in connection with the following:

a) the treatment of weak, strained, flat, unstable or unbalanced feet;

b) fallen arches;

c) metatarsalgia or bunions (except for open cutting operations or laser surgery);

d) corns;

e) calluses ;and

f) toenails (except for the partial or complete removal of nail roots or for services for metabolic peripheral vascular disease or diabetes).

(2) Shoe inserts unless the Participant has diabetes with demonstrated peripheral neuropathy or the insert is needed for a shoe that is part of a brace. If all necessary criteria are present, one (1) pair of shoe inserts will be Covered per calendar year.

7.61 Prescription Drugs

Services and supplies when utilizing Out-of-Network Providers and Out-of-Network pharmacies.

7.62 Preventive Care

Preventive Care service when utilizing Out-of-Network Providers and Out-of-Network pharmacies.

7.63 Prostate Screenings and Exams

Non-symptomatic prostate screenings when utilizing Out-of-Network Providers.

7.64 Prosthetic Devices and Orthotic Appliances

(1) Repair, replacement or maintenance of DME, Prosthetic Devices or braces unless there is sufficient change in the Participant's physical condition to make the original device no longer functional.

(2) Maintenance due to normal wear and tear of items owned by the Participant.

(3) Services relating to hearing aids as follows:

a) Routine hearing tests, audiograms, and hearing aids except as stated in the "Hearing Aids and Screenings" section of Article 5;

b) Adjustments, batteries, and other services related to hearing aids; and

c) All Out-of-Network services.

(4) More than one (1) pair of therapeutic shoes, including fitting of shoes and inserts, per calendar year for diabetic foot disease or peripheral neuropathy.

(5) Electrical continence aids, either anal or urethral.

(6) Implants for cosmetic or psychological reasons.

(7) Replacement batteries or routine maintenance or maintenance agreements.

(8) Penile prostheses for psychogenic impotence.

(9) Dental appliances.

(10) Orthopedic shoes.

(11) Replacement of cataract lenses except when new cataract lenses are needed because of prescription change not to exceed the cost of traditional intraocular lenses.

(12) Devices employing robotics.

(13) All mechanical organs.

(14) Arch supports and other foot support devices.

(15) Elastic stockings.

(16) Remote control devices.

(17) Garter belts.

(18) Special braces.

(19) Shoe inserts unless the Participant has diabetes with demonstrated peripheral neuropathy or the insert is needed for a shoe that is part of a brace. If all necessary criteria are present, one (1) shoe insert will be Covered per calendar year.

For exclusions related to therapeutic shoes, refer to the “Podiatry” section of Article 5 and this article.

For exclusions related to Hearing Aids, Cochlear Implants, and BAHA devices, refer to the “Hearing Aids and Screenings” section of Article 5 and this article.

For exclusions related to Cataract lenses, refer to the “Eyeglasses and Corrective Lenses” section of Article 5 and this article.

For exclusions related to Penile Prosthesis, refer to the “Implants and Related Health Services” section of Article 5 and this article.

7.65 Radiology

X-ray services for non-Covered services.

7.66 Reconstructive Surgery

Refer to the “Cosmetic, Plastic and Related Reconstructive Surgery” section of Article 5 and this article.

7.67 Reduction Mammoplasty

Reduction, including for male gynecomastia, and augmentation mammoplasty that is not Medically Necessary or is not associated with Reconstructive Surgery following a Medically Necessary mastectomy.

7.68 Services not Listed as Covered

(1) Services or supplies not specifically listed as Covered.

(2) Services not specified as Covered.

7.69 Services not ordered by a Physician

Any Hospital service or supply not ordered by a Physician.

7.70 Sexual Related Services and Supplies

Services or supplies related to sex transformation, sexual therapy or counseling, or sexual dysfunctions or inadequacies except conditions resulting from Injury or organic disease.

7.71 Standards of Medicine

Services and supplies for treatment not rendered in accordance with standards of medical practice, as determined by the Claims Administrator.

7.72 Surgical Services

Refer to the following sections of Article 5 and this article:

(1) “Inpatient Hospital Care;”

(2) “Outpatient Services, Surgeries, and Supplies”; and

(3) “Oral Surgery and Diseases of the Mouth.”

7.73 Taxes on Purchases

Taxes on Covered expenses such as crutches, braces, etc., that the Participant purchases.

7.74 Telemedicine Services

(1) Site-origination fees for the telemedicine provider.

(2) Standard telephone, facsimile transmissions, unsecured electronic mail, or a combination thereof, does not constitute telemedicine services.

7.75 Temporomandibular Joints (TMJ)

Non-surgical services, including appliances such as braces, splints, other orthodontia, etc.

7.76 Termination of Pregnancy (Abortion)

Refer to the “Birth Control” section of Article 5 and this article.

7.77 Therapy/Rebalance Billings and Supplies

(1) Rehabilitative services provided for long-term, chronic medical conditions. Long-term Physical Therapy and rehabilitation or other Physical Therapy or rehabilitation when no significant improvement has occurred or is likely to occur.

(2) Rehabilitative services whose primary goal is to maintain the Participant's current level of function, as opposed to improving the functional status.

(3) Rehabilitative services whose primary goal is to return the Participant to a specific occupation or job, such as work-hardening or work-conditioning programs.

(4) Educational or vocational therapy, schools or services designed to retrain the Participant for employment.

(5) Physical and occupational rehabilitative services whose purpose is to treat or improve a developmental/learning disability or delay. Refer to definition of Developmental Delay in Article 1.26.

(6) Balance Billings that are Experimental or have not been shown to be clinically effective for the medical condition being treated.

(7) Alternative Rehabilitation Services (e.g., acupuncture, acupressure).

(8) Fees or costs associated with services that are primarily exercise. Examples include, but are not limited to, membership fees for health clubs, fitness centers, weight loss centers or clinics, or home exercise equipment.

(9) Physical, Occupational, and Speech Therapy visits over sixty (60) combined Outpatient visits per calendar year.

(10) Therapy or services related to Developmental Delays.

7.78 Transplants (human organ)

Contact the Claims Administrator's Transplant Case Manager for Transplant Benefits and Covered services.

(1) Transplantation health services for the donor under this Plan if the recipient is not a Participant.

(2) Any transplant service deemed Experimental or Investigational.

(3) Any transplant service deemed cosmetic.

(4) Any services received or supplies furnished outside the United States or Canada.

(5) Treatment while the Participant is not under the regular care of a Physician or for a service or supply which is not Prior Authorized by the Claims Administrator.

(6) Treatment arising out of or in the course of a Participant's employment with an employer or self-employment.

(7) Air ambulance transportation, unless approved by the medical director.

(8) Travel time and related expenses charged by a Provider of service.

(9) Services and supplies, which are not Medically Necessary.

(10) A Covered transplant procedure using fetal tissue.

(11) Expenses for other than human-to-human organ transplants.

(12) Oral implants/transplants.

(13) Services or supplies for which there would be no payment required if the Plan did not provide a Benefit; or Benefits are available through any governmental program which provides or pays for health services, whether or not such Benefits are applied for, except Benefits received from Medicaid.

7.79 Transportation/Ambulance Services

(1) Ambulance/transportation due to the absence of other transportation on the part of the Participant.

(2) Non-medical Emergency ambulance/transportation services regardless of who requested the ambulance/transportation service.

(3) Ambulance/transportation charges, except as provided in the "Ambulance/Transportation Services" and "Transplant (Human Organ)" sections of Article 5.

(4) Air ambulance transportation for transplants, unless approved by the medical director.

7.80 Well Child Care

Preventive Care service when utilizing Out-of-Network Providers.

7.81 Vision Services

(1) Routine Eye care services and exams
(2) Orthoptics
(3) Eye exercise
(4) Radial Keratotomy
(5) LASIK
(6) Other refractive eye surgery
(7) Other services not relative to Injury or disease

ARTICLE 8

MEDICARE PARTICIPANT PROVISIONS

8.1 Eligibility

The Medicare Participant provisions of the Plan as stated in Article 2.5 apply to the following Participant classes:

(1) Retirees and their Dependents;

(2) Vested Participants and their Dependents;

(3) surviving Spouses and their Dependents; and

(4) Long-Term, and Work-Related Disability Recipients and their Dependents.

Medicare Participant provisions do not apply to Employees and their Dependents.

Plan Benefits for Covered services received on and after the date Medicare Participant status begins will be paid according to the terms of this article.

8.2 Deductible(s)

The Deductibles are as follows:

(1) Four hundred fifty dollars ($450) per calendar year per Medicare Participant applied to all Covered medical services rendered to the Medicare Participant;

(2) Fifty dollars ($50) for Private Duty Nursing Services; and

(3) One hundred dollars ($100) calendar year Deductible per Medicare Participant for the Prescription Drug program, unless the Participant qualifies for low income subsidy and is not subject to the Deductible.

<u>Prescription Drug amounts credited to a Participant's non-Medicare Prescription Drug Deductible in the calendar year a Participant becomes eligible for Medicare Part D will not be credited toward the Medicare Participant's annual Prescription Drug Deductible.</u>

8.3 Benefits

The Medicare Participant Benefits of the Plan are designed to supplement the Benefits of Parts A and B of Medicare. For purposes of calculating Medicare Participant Benefits under the Plan, each Medicare Participant will be deemed to be enrolled in both Part A and Part B of Medicare. No Plan Benefits will be paid for services Covered by Medicare Part A and/or Part B if the Medicare Participant is not enrolled in both Medicare Parts A and B.

Once the Medicare Allowed Amount has been determined, the Claim is reduced by the amount payable by Medicare. On Medicare assigned Claims, Benefits are paid up to the Medicare Allowed Amounts. On Medicare non-assigned Claims, Benefits are paid up to the lesser of the

Provider's actual fee or up to fifteen percent (15%) over the Medicare Allowed Amount for the type of services rendered.

Prescription Drug Benefits, which are not Covered by Medicare Parts A or B, will be Covered under the Plan's Part D Prescription Drug program, as stated in the guidelines of the summary Plan document. Refer to Article 6 for additional information.

Other specific Benefits the Plan will Cover include the first three (3) pints of blood, which are not Covered by Medicare Parts A and B; and one (1) x-ray of the spine by a chiropractor per calendar year subject to your Deductible(s) and Coinsurance requirements under the Plan.

8.4 Coordination of Benefits

If a Medicare Participant receives Benefits from any other group health plan that is intended to supplement Medicare, the Plan will coordinate its Benefits with those of the other health plan as described in Article 10; however, the Plan will always calculate its Medicare Participant Benefits after Medicare has paid.

In all cases, Medicare Prescription Drug Coverage under a Medicare Part D Plan is always the secondary payer if other non Part D Prescription Drug Coverage exists, with few exceptions. It is the Medicare Participant's responsibility to notify the Plan if other Prescription Drug Coverage exists.

The Plan will coordinate Benefits on Prescription Drugs purchased through another plan if the pharmacy is a participating provider.

8.5 Services by Non-Medicare Provider

If a Medicare Participant is confined in a Hospital or treated by a Provider that does not participate in Medicare, and if Medicare Benefits are not recoverable by individual filing, Plan Benefits for such confinement or treatment will be calculated under the regular non-Medicare Participant provisions of the Plan. If Medicare Benefits are recoverable by individual filing, Plan Benefits for such confinement or treatment will be calculated according to these Medicare Participant provisions. The responsibility for filing the forms necessary for Medicare reimbursement will be with the Medicare Participant.

8.6 Coverage for Out-of-Country Services

Benefits are payable as stated in Article 8.5.

8.7 Coverage for Veterans Administration (VA) Facilities

(1) If a Medicare Participant is confined in a VA Hospital, the Plan will consider the equivalent of the current Medicare Part A Deductible(s) as an eligible expense, which will be paid to the VA Hospital at one hundred percent (100%) after the Plan's yearly Deductible(s) has been met; and

(2) Services received from a VA doctor or facility will be Covered at either the patient responsibility based on Medicare equivalent remittance advice (if provided) or twenty percent (20%) of the billed eligible expense. This Coverage will be provided after the

Plan's yearly Deductible(s) has been met. Payment will be made to the doctor or facility only. This Coverage is equivalent to eligible expenses Covered by the Plan for Medicare Part B; and

(3) The Plan will not coordinate Benefits on Prescription Drugs purchased through another plan or a VA facility.

8.8 Coverage for Medicare Denied Claims

If Medicare denies a Claim for services considered a Covered service under the Plan for non-Medicare Participants, the services will be paid in accordance with the Plan's usual Deductible and Coinsurance.

8.9 Diabetic Testing Supplies

Diabetic testing supplies, including glucose testing monitor, blood glucose testing strips, lancet devices and lancets will be Covered under Medicare Part B, and will no longer be Covered under your Prescription Drug program. Insulin and syringes will continue to be Covered under your Part D Prescription Drug program.

8.10 Reinstatement of Coverage

A Medicare recipient and eligible Dependents will be allowed to reenroll in the Plan if they were enrolled in the Plan immediately prior to enrollment in Medicaid or TRICARE for Life (military Coverage) and lose their coverage under Medicaid or TRICARE for Life.

APPENDIX D

Schedule of Benefits for Medicare Participants Effective 1/1/2017

This Schedule of Benefits summarizes your obligation towards the cost of certain Covered services for all Medicare Participants of the Plan. Refer to Article 5 for a detailed description of Covered services, Article 6 for Prescription Drug Coverage, and Article 7 for a detailed description of limitations or exclusions.

*The Participant will be responsible 100% for amounts above the Out-of-Network Rate.

All services must be Medically Necessary as a condition of Coverage and not otherwise limited or excluded.

Once the Medicare Allowed Amount has been determined, the Claim is reduced by the amount payable by Medicare. On Medicare assigned Claims, Benefits are paid up to the Medicare Allowed Amounts. On Medicare non-assigned Claims, Participants may have no additional responsibility after Deductible and the Medicare payment.

BENEFITS AND SERVICES		PARTICIPANT RESPONSIBILITY			
		MEDICARE ASSIGNED CLAIMS	MEDICARE NON-ASSIGNED CLAIMS	MEDICARE NON-COVERED CLAIMS FOR SERVICES THAT THE PLAN COVERS	
				IN-NETWORK	OUT-OF-NETWORK
1.	**Deductible (Medical)** Total amount a Participant is required to pay each calendar year before applicable Coinsurance is applied to Covered services. The Deductible need only be met once per Participant per calendar year and does not apply to the Out-of-Pocket Limit or the Prescription Drug Deductible.	Individual Medical $450 Private Duty Nursing $50	Individual Medical $450 Private Duty Nursing $50	Individual Medical $450 Private Duty Nursing $50	

BENEFITS AND SERVICES		PARTICIPANT RESPONSIBILITY			
		MEDICARE ASSIGNED CLAIMS	MEDICARE NON-ASSIGNED CLAIMS	MEDICARE NON-COVERED CLAIMS FOR SERVICES THAT THE PLAN COVERS	
				IN-NETWORK	OUT-OF-NETWORK
2.	**Deductible (Prescription Drug)** Total amount a Medicare Participant is required to pay each calendar year before applicable Coinsurance is applied to Covered services. The Deductible need only be met once per Medicare Participant per calendar year and does not apply to the Out-of-Pocket Limit or the medical Deductible.	Individual $100	Individual $100	Individual $100	Not Covered
3.	**Out-of-Pocket Maximum:** Need only be met once per Participant per calendar year. The following applies to the Out-of-Pocket Maximum: • Medical Deductible • Medical Coinsurance for Covered Services and Supplies • Medical Copayments The following do not apply to the Out-of-Pocket Maximum • Prescription Drug Deductible • Prescription Drug Copayments	$0	$0	$1,600	$2,425

BENEFITS AND SERVICES		PARTICIPANT RESPONSIBILITY			
		MEDICARE ASSIGNED CLAIMS	MEDICARE NON-ASSIGNED CLAIMS	MEDICARE NON-COVERED CLAIMS FOR SERVICES THAT THE PLAN COVERS	
				IN-NETWORK	OUT-OF-NETWORK
	• Prescription Drug Coinsurance				
	• Costs above the Allowed Amount (for In-Network services) or the Out-of-Network Rate (for Out-of-Network services) • Non-Covered services and supplies Utilization review penalties Refer to Article 1.74 for the complete definition of Out-of-Pocket Maximum.				
4.	**Maximum Lifetime Benefit** Combined total of all Covered Benefits.	Unlimited	Unlimited	Unlimited	
5.	**Allergy Injections**	0% Coinsurance of Medicare Allowed Amount after Deductible	0% Coinsurance after Deductible Participants may have no additional responsibility after Deductible and the Medicare payment.	10% Coinsurance after Deductible	20% Coinsurance of Out-of-Network Rate after Deductible*
6.	**Blood and blood products** The first three (3) pints of blood, which are not Covered by Medicare Parts A	0% Coinsurance of Medicare Allowed Amount after	0% Coinsurance after Deductible Participants may have no	10% Coinsurance after Deductible	20% Coinsurance of Out-of-Network Rate after Deductible*

BENEFITS AND SERVICES		PARTICIPANT RESPONSIBILITY			
		MEDICARE ASSIGNED CLAIMS	MEDICARE NON-ASSIGNED CLAIMS	MEDICARE NON-COVERED CLAIMS FOR SERVICES THAT THE PLAN COVERS	
				IN-NETWORK	OUT-OF-NETWORK
	and B, are Covered under this Plan.	Deductible	additional responsibility after Deductible and the Medicare payment.		
7.	**Cancer screenings** Cancer screenings shall include the following screenings and office visits related to the screening: a. pelvic exam and pap smear every calendar year for any non-symptomatic woman age eighteen (18) and over; b. mammograms (Refer to the "Mammograms" section of Article 5). c. a prostate exam and PSA blood test every calendar year for any non-symptomatic man over the age of fifty (50) years or for younger men who are at high risk and/or have a family history of prostate cancer; or	If processed as medical Benefit: 0% Coinsurance of Medicare Allowed Amount after Deductible If processed as Preventive Care service: 0% Coinsurance of Medicare Allowed Amount	If processed as medical Benefit: 0% Coinsurance after Deductible Participants may have no additional responsibility after Deductible and the Medicare payment. If processed as Preventive Care service: 0% Coinsurance	If processed as medical Benefit: 10% Coinsurance after Deductible If processed as Preventive Care service: 0% Coinsurance	If processed as medical Benefit: 20% Coinsurance of Out-of-Network Rate after Deductible* If processed as Preventive Care service: Not Covered

BENEFITS AND SERVICES		PARTICIPANT RESPONSIBILITY			
		MEDICARE ASSIGNED CLAIMS	MEDICARE NON-ASSIGNED CLAIMS	MEDICARE NON-COVERED CLAIMS FOR SERVICES THAT THE PLAN COVERS	
				IN-NETWORK	OUT-OF-NETWORK
7.	**Cancer screenings (continued)** d. colorectal cancer screening for men and women age fifty (50) years or older or if a doctor prescribes at a younger age because of high risk or family history; fecal occult blood test every calendar year; and sigmoidoscopy every five (5) years. • a colonoscopy every ten (10) years; or • a digital rectal exam, sigmoidoscopy, colonoscopy or barium test. Certain services may be Covered under the Preventive Care Benefit. Refer to the "Preventive Care" section of Article 5.				

BENEFITS AND SERVICES		PARTICIPANT RESPONSIBILITY			
		MEDICARE ASSIGNED CLAIMS	MEDICARE NON-ASSIGNED CLAIMS	MEDICARE NON-COVERED CLAIMS FOR SERVICES THAT THE PLAN COVERS	
				IN-NETWORK	OUT-OF-NETWORK
8.	**Chiropractic Services** Coverage is provided for manipulation and spinal x-ray services. Office visit not Covered.	0% Coinsurance of Medicare Allowed Amount after Deductible	0% Coinsurance after Deductible Participants may have no additional responsibility after Deductible and the Medicare payment.	10% Coinsurance after Deductible Limited to thirty (30) manual manipulation of the spine treatments per calendar year and one (1) spinal x-ray per calendar year.	20% Coinsurance of Out-of-Network Rate after Deductible* Limited to thirty (30) manual manipulation of the spine treatments per calendar year and one (1) spinal x-ray per calendar year.
9.	**Contraceptives (Oral)** Contraceptive Coverage will not apply to the annual Out-of-Pocket Maximum. Certain services may be Covered under the Preventive Care Benefit. Refer to the "Preventive Care" section of Article 5.	If processed as medical Benefit: 0% Coinsurance of Medicare Allowed Amount after Deductible If processed as Preventive Care service: 0% Coinsurance of Medicare Allowed Amount	If processed as medical Benefit: 0% Coinsurance after Deductible Participants may have no additional responsibility after Deductible and the Medicare payment. If processed as Preventive Care service: 0% Coinsurance	(1) Generics - 0% Coinsurance (2) Brand (no generic equivalent available) - 30% Coinsurance (3) Brand (generic available) – 50% Coinsurance Items 2 and 3 are subject to the Prescription Drug Deductible and have a minimum copayment of $5.	Not Covered
10.	**Contraceptives (Other)** Coverage for non-oral Contraceptive methods, including but not limited to	If processed as medical Benefit: 0% Coinsurance of Medicare Allowed	If processed as medical Benefit: 0% Coinsurance after	0% Coinsurance	Not Covered

BENEFITS AND SERVICES		PARTICIPANT RESPONSIBILITY			
		MEDICARE ASSIGNED CLAIMS	MEDICARE NON-ASSIGNED CLAIMS	MEDICARE NON-COVERED CLAIMS FOR SERVICES THAT THE PLAN COVERS	
				IN-NETWORK	OUT-OF-NETWORK
	Contraceptives (Other) (continued) devices and injectables. Certain services may be Covered under the Preventive Care Benefit. Refer to the "Preventive Care" section of Article 5.	Amount after Deductible If processed as Preventive Care service: 0% Coinsurance of Medicare Allowed Amount	Deductible Participants may have no additional responsibility after Deductible and the Medicare payment. If processed as Preventive Care service: 0% Coinsurance		
11.	**Durable Medical Equipment and Diabetic Supplies** Covered diabetic supplies include glucose monitors, test strips and lancets. Certain services may be Covered under the Preventive Care Benefit. Refer to the "Preventive Care"	If processed as medical Benefit: 0% Coinsurance of Medicare Allowed Amount after Deductible If processed as Preventive Care service: 0% Coinsurance of Medicare Allowed Amount	If processed as medical Benefit: 0% Coinsurance after Deductible Participants may have no additional responsibility after Deductible and the Medicare payment. If processed as Preventive Care service: 0% Coinsurance	If processed as medical Benefit: 10% Coinsurance after Deductible If processed as Preventive Care service: 0% Coinsurance	If processed as medical Benefit: 20% Coinsurance of Out-of-Network Rate after Deductible* If processed as Preventive Care service: Not Covered

BENEFITS AND SERVICES		PARTICIPANT RESPONSIBILITY			
		MEDICARE ASSIGNED CLAIMS	MEDICARE NON-ASSIGNED CLAIMS	MEDICARE NON-COVERED CLAIMS FOR SERVICES THAT THE PLAN COVERS	
				IN-NETWORK	OUT-OF-NETWORK
12.	**Emergency Ambulance Services** Coverage is provided for emergency ambulance services as defined under Emergency Services in Article 1.34 and excluded as defined in Article 7.4.	0% Coinsurance of Medicare Allowed Amount after Deductible	0% Coinsurance after Deductible Participants may have no additional responsibility after Deductible and the Medicare payment.	10% Coinsurance after Deductible	10% Coinsurance after Deductible
13.	**Emergency Services** Coverage is provided for worldwide Emergency Services as defined in Article 1.34.	0% Coinsurance of Medicare Allowed Amount after Deductible	0% Coinsurance after Deductible Participants may have no additional responsibility after Deductible and the Medicare payment.	$75 Copayment then 10% Coinsurance after Deductible	If deemed Emergency Services: $75 Copayment then 10% Coinsurance of negotiated rate or billed charges after Deductible* If not deemed Emergency Services: $75 Copayment then 20% Coinsurance of Out-of-Network Rate after Deductible*

BENEFITS AND SERVICES		PARTICIPANT RESPONSIBILITY			
		MEDICARE ASSIGNED CLAIMS	MEDICARE NON-ASSIGNED CLAIMS	MEDICARE NON-COVERED CLAIMS FOR SERVICES THAT THE PLAN COVERS	
				IN-NETWORK	OUT-OF-NETWORK
14.	**Hearing Aids and Screenings for Dependent children with Developmental Delays up to twenty-six (26) years of age (including cochlear implants and Bone Anchored Hearing Aids)**	0% Coinsurance of Medicare Allowed Amount after Deductible	0% Coinsurance after Deductible Participants may have no additional responsibility after Deductible and the Medicare payment.	10% Coinsurance after Deductible Limited to one (1) hearing aid per ear every twenty-four (24) months. Limited to one (1) diagnostic hearing screening and/or audiogram every twelve (12) months.	Not Covered
15.	**Home Health Care and Hospice**	0% Coinsurance of Medicare Allowed Amount after Deductible	0% Coinsurance after Deductible Participants may have no additional responsibility after Deductible and the Medicare payment.	10% Coinsurance after Deductible	20% Coinsurance of Out-of-Network Rate after Deductible*
16.	**Immunizations** Covered according to the recommended immunization schedules in Appendix C of Article 5. The Plan will Cover the Zoster (shingles) vaccine and administration for Participants fifty (50) years of age and older.	0% Coinsurance of Medicare Allowed Amount	0% Coinsurance Participants may have no additional responsibility after the Medicare payment.	0% Coinsurance of eligible expenses	Not Covered

BENEFITS AND SERVICES		PARTICIPANT RESPONSIBILITY			
		MEDICARE ASSIGNED CLAIMS	MEDICARE NON-ASSIGNED CLAIMS	MEDICARE NON-COVERED CLAIMS FOR SERVICES THAT THE PLAN COVERS	
				IN-NETWORK	OUT-OF-NETWORK
	Immunizations (continued) Shingles vaccine and administration is only Covered when received from a Participating Pharmacy.				
17.	**Inpatient Hospital Services** Unlimited Coverage is provided for the following Medically Necessary services: a. Physician and surgeon services; b. semi-private rooms (unless a private room is the only room available or is required for medical reasons); c. operating rooms and related facilities; d. intensive and coronary care units; e. laboratory, x-rays, radiology services and procedures; f. medications and biologicals; g. anesthesia; h. special duty nursing as prescribed; i. short-term Rehabilitation Services; j. nursing care; and l. meals and special diets.	0% Coinsurance of Medicare Allowed Amount after Deductible	0% Coinsurance after Deductible Participants may have no additional responsibility after Deductible and the Medicare payment.	10% Coinsurance after Deductible	20% Coinsurance of Out-of-Network Rate after Deductible*

BENEFITS AND SERVICES		PARTICIPANT RESPONSIBILITY			
		MEDICARE ASSIGNED CLAIMS	MEDICARE NON-ASSIGNED CLAIMS	MEDICARE NON-COVERED CLAIMS FOR SERVICES THAT THE PLAN COVERS	
				IN-NETWORK	OUT-OF-NETWORK
18.	**Maternity Care, Inpatient Hospital** *Coverage for Subscriber and Dependents.* Covered services include all Physician Services for mother and newborn delivery, newborn nursery services and semi-private room (unless a private room is the only room available or is required for medical reasons). Certain services may be Covered under the Preventive Care Benefit. Refer to the "Preventive Care" section of Article 5.	If processed as medical Benefit: 0% Coinsurance of Medicare Allowed Amount after Deductible If processed as Preventive Care service: 0% Coinsurance of Medicare Allowed Amount	If processed as medical Benefit: 0% Coinsurance after Deductible Participants may have no additional responsibility after Deductible and the Medicare payment. If processed as Preventive Care service: 0% Coinsurance	If processed as medical Benefit: 10% Coinsurance after Deductible If processed as Preventive Care service: 0% Coinsurance	If processed as medical Benefit: 20% Coinsurance of Out-of-Network Rate after Deductible* If processed as Preventive Care service: Not Covered

BENEFITS AND SERVICES		PARTICIPANT RESPONSIBILITY			
		MEDICARE ASSIGNED CLAIMS	MEDICARE NON-ASSIGNED CLAIMS	MEDICARE NON-COVERED CLAIMS FOR SERVICES THAT THE PLAN COVERS	
				IN-NETWORK	OUT-OF-NETWORK
19.	**Maternity Care Office Visits** *Coverage for Subscriber and Dependents.* Covered services include pre-natal and post-natal care, examinations, tests and educational services. (Infertility testing, office visit treatments and surgery are not Covered.) Certain services may be Covered under the Preventive Care Benefit. Refer to the "Preventive Care" section of Article 5.	If processed as medical Benefit: 0% Coinsurance of Medicare Allowed Amount after Deductible If processed as Preventive Care service: 0% Coinsurance of Medicare Allowed Amount	If processed as medical Benefit: 0% Coinsurance after Deductible Participants may have no additional responsibility after Deductible and the Medicare payment. If processed as Preventive Care service: 0% Coinsurance	If processed as medical Benefit: 10% Coinsurance after Deductible If processed as Preventive Care service: 0% Coinsurance	If processed as medical Benefit: 20% Coinsurance of Out-of-Network Rate after Deductible* If processed as Preventive Care service: Not Covered
20.	**Mental Health/ Substance Abuse - Inpatient**	0% Coinsurance of Medicare Allowed Amount after Deductible	0% Coinsurance after Deductible Participants may have no additional responsibility after Deductible and the Medicare payment.	10% Coinsurance after Deductible	20% Coinsurance of Out-of-Network Rate after Deductible*

BENEFITS AND SERVICES		PARTICIPANT RESPONSIBILITY			
		MEDICARE ASSIGNED CLAIMS	MEDICARE NON-ASSIGNED CLAIMS	MEDICARE NON-COVERED CLAIMS FOR SERVICES THAT THE PLAN COVERS	
				IN-NETWORK	OUT-OF-NETWORK
21.	**Mental Health/ Substance Abuse - Outpatient** Certain services may be Covered under the Preventive Care Benefit. Refer to the "Preventive Care" section of Article 5.	If processed as medical Benefit: 0% Coinsurance of Medicare Allowed Amount after Deductible If processed as Preventive Care service: 0% Coinsurance of Medicare Allowed Amount	If processed as medical Benefit: 0% Coinsurance after Deductible Participants may have no additional responsibility after Deductible and the Medicare payment. If processed as Preventive Care service: 0% Coinsurance	If processed as medical Benefit: 10% Coinsurance after Deductible If processed as Preventive Care service: 0% Coinsurance	If processed as medical Benefit: 20% Coinsurance of Out-of-Network Rate after Deductible* If processed as Preventive Care service: 0% Coinsurance
22.	**Office Visits** a. Non-Preventive Care including diagnosis and consultation. b. Telemedicine services included with either PCP or Specialist Physician. Refer to Article 1.109 for the definition of Telemedicine Services. Preventive Care Office Visits.	0% Coinsurance of Medicare Allowed Amount after Deductible	0% Coinsurance after Deductible Participants may have no additional responsibility after Deductible and the Medicare payment. If processed as Preventive Care 0% Coinsurance	10% Coinsurance after Deductible If processed as Preventive Care 0% Coinsurance	20% Coinsurance of Out-of-Network Rate after Deductible* Preventive Care office visits not Covered.

BENEFITS AND SERVICES		PARTICIPANT RESPONSIBILITY			
		MEDICARE ASSIGNED CLAIMS	MEDICARE NON-ASSIGNED CLAIMS	MEDICARE NON-COVERED CLAIMS FOR SERVICES THAT THE PLAN COVERS	
				IN-NETWORK	OUT-OF-NETWORK
23.	**Orthotic Appliances and Prosthetic Devices**	0% Coinsurance of Medicare Allowed Amount after Deductible	0% Coinsurance after Deductible Participants may have no additional responsibility after Deductible and the Medicare payment.	10% Coinsurance after Deductible	20% Coinsurance of Out-of-Network Rate after Deductible*
24.	**Outpatient Services and Diagnostic Procedures and Tests** Coverage includes diagnostic procedures and tests, including but not limited to lab, radiology, and mammography. Certain procedures and tests are considered surgery, including but not limited to colonoscopy and endoscopy. Refer to the "Outpatient Services, Surgeries, and Supplies" section of Article 5. Certain services may be Covered under the Preventive Care Benefit. Refer to the "Preventive Care" section of Article 5.	If processed as medical Benefit: 0% Coinsurance of Medicare Allowed Amount after Deductible If processed as Preventive Care service: 0% Coinsurance of Medicare Allowed Amount	If processed as medical Benefit: 0% Coinsurance after Deductible Participants may have no additional responsibility after Deductible and the Medicare payment. If processed as Preventive Care service: 0% Coinsurance	If processed as medical Benefit: 10% Coinsurance after Deductible If processed as Preventive Care service: 0% Coinsurance	If processed as medical Benefit: 20% Coinsurance of Out-of-Network Rate after Deductible* If processed as Preventive Care service: Not Covered

BENEFITS AND SERVICES		PARTICIPANT RESPONSIBILITY			
		MEDICARE ASSIGNED CLAIMS	MEDICARE NON-ASSIGNED CLAIMS	MEDICARE NON-COVERED CLAIMS FOR SERVICES THAT THE PLAN COVERS	
				IN-NETWORK	OUT-OF-NETWORK
25.	**Outpatient Surgery** Benefits are provided for Covered services rendered at an Outpatient Hospital or free standing surgery center.	0% Coinsurance of Medicare Allowed Amount after Deductible	0% Coinsurance after Deductible Participants may have no additional responsibility after Deductible and the Medicare payment.	10% Coinsurance after Deductible	20% Coinsurance of Out-of-Network Rate after Deductible*
26.	**Prescription Drug Program** Prescription Drug program is available through Participating pharmacies only.	Refer to the Prescription Drug program at the end of this table and in Article 6 for additional information on Coverage.			
27.	**Preventive Care** Services include immunizations as outlined in Appendix C of Article 5 and anything coded as Preventive Care, including but not limited to routine health assessments, well-child care and child health supervision services, Covered under the Plan.	If Covered by Medicare, 0% Coinsurance of Medicare Allowed Amount	If Covered by Medicare, 0% Coinsurance Participants may have no additional responsibility after the Medicare payment.	0% Coinsurance	Not Covered
28.	**Prosthetic Devices and Orthotic Appliances**	Refer to the “Orthotic Appliances and Prosthetic Devices” section of this article.			

BENEFITS AND SERVICES		PARTICIPANT RESPONSIBILITY			
		MEDICARE ASSIGNED CLAIMS	MEDICARE NON-ASSIGNED CLAIMS	MEDICARE NON-COVERED CLAIMS FOR SERVICES THAT THE PLAN COVERS	
				IN-NETWORK	OUT-OF-NETWORK
29.	**Skilled Nursing Facility** Coverage is provided in lieu of an Inpatient Hospital admission. Coverage is provided for a semi-private room (unless a private room is the only room available or is required for medical reasons).	0% Coinsurance of Medicare Allowed Amount after Deductible	0% Coinsurance after Deductible Participants may have no additional responsibility after Deductible and the Medicare payment.	10% Coinsurance after Deductible	20% Coinsurance of Out-of-Network Rate after Deductible*
30.	**Therapy/ Rehabilitation Services and Supplies** Coverage is provided for Medically Necessary Therapy Services as defined in Article 1.110.	0% Coinsurance of Medicare Allowed Amount after Deductible	0% Coinsurance after Deductible Participants may have no additional responsibility after Deductible and the Medicare payment.	10% Coinsurance after Deductible Limited to a combined total of sixty (60) Physical, Occupational, and Speech Therapy visits per calendar year for both In-Network and Out-Of-Network and is subject to applicable Deductibles(s) and Coinsurance	20% Coinsurance of Out-of-Network Rate after Deductible* Limited to a combined total of sixty (60) Physical, Occupational, and Speech Therapy visits per calendar year for both In-Network and Out-Of-Network and is subject to applicable Deductibles(s) and Coinsurance
31.	**Transplant (Human Organ); Prior Authorization required.**	Contact the Claims Administrator's Transplant Case Manager for Transplant Benefits and Covered services.	Contact the Claims Administrator's Transplant Case Manager for Transplant Benefits and Covered services.	Contact the Claims Administrator's Transplant Case Manager for Transplant Benefits and Covered services.	Contact the Claims Administrator's Transplant Case Manager for Transplant Benefits and Covered services.

BENEFITS AND SERVICES		PARTICIPANT RESPONSIBILITY			
		MEDICARE ASSIGNED CLAIMS	MEDICARE NON-ASSIGNED CLAIMS	MEDICARE NON-COVERED CLAIMS FOR SERVICES THAT THE PLAN COVERS	
				IN-NETWORK	OUT-OF-NETWORK
32.	**Urgent Care** Urgent Care services (as deemed Urgent Care by the Claims Administrator) that are received at participating alternate facilities both in and out of the service area are Covered.	0% Coinsurance of Medicare Allowed Amount after Deductible	0% Coinsurance after Deductible Participants may have no additional responsibility after Deductible and the Medicare payment.	10% Coinsurance after Deductible	If deemed Urgent Care: 10% Coinsurance of negotiated rate or billed charges after Deductible If not deemed Urgent Care: 20% Coinsurance of the Out-of-Network Rate after Deductible*
33.	**Vision Services** Refer to the “Vision Services” section of Article 5 for Covered services.	0% Coinsurance of Medicare Allowed Amount after Deductible	0% Coinsurance after Deductible Participants may have no additional responsibility after Deductible and the Medicare payment	10% Coinsurance after Deductible	20% Coinsurance of the Out-of-Network Rate after Deductible*

2017 Medicare Member Share				
	Annual Individual Deductible	$100		
Initial Coverage Phase Member Share up to $3,700 Total Drug Spend				
Tier	**Drug Type**	**Minimum Copay**	**Copay**	**Maximum Copay**
Tier 1	Generics	$5	30%	N/A
Tier 2	Brand - No Generic Available	$5	30%	N/A
Tier 3	Brand with Generic Equivalents	$5	50%	N/A
Tier 4	Brand - No Generic Available	$5	30%	$50
Tier 5	Brand with Generic Equivalents	$5	50%	$50
Coverage Gap Phase Member Share up to $4,950 Total Cost Drug Spend				
Tier	**Drug Type**	**Minimum Copay**	**Copay**	**Maximum Copay**
Tier 1	Generics	$5	30%	N/A
Tier 2	Brand - No Generic Available	$5	30%	N/A
Tier 3	Brand with Generic Equivalents	$5	50%	N/A
Tier 4	Brand - No Generic Available	$5	30%	$50
Tier 5	Brand with Generic Equivalents	$5	50%	$50
Catastrophic Member Share				
	Drug Type	**Minimum Copay**	**Copay**	
	Generic Drugs	$3.30	5%	
	Brand Drugs	$8.25	5%	
Exception List				
Critical Care Medications				
Tier	**Drug Type**	**Minimum Copay**	**Copay**	**Maximum OOP**
	Brand - No Generic Available	$5	30%	$50
	Brand with Generic Equivalents	$5	30%	$50
Enhanced Drug Coverage -Non Covered Medicare Medications				
Tier	**Drug Type**	**Minimum Copay**	**Copay**	**Deductible OOP**
	Generics	$5	30%	N/A
	Brand - No Generic Available	$5	30%	N/A
	Brand with Generic Equivalents	$5	30%	N/A

*The Participant will be responsible one hundred percent (100%) for the amounts above the Out-of-Network Rate for medical Coverage.

**For 2017, the Part D Coverage gap begins when the total cost for prescription drugs for the calendar year reaches three thousand seven hundred dollars ($3,700) and ends when eligible TrOOP expenses have reached four thousand nine hundred and fifty dollars ($4,950). Participants exceeding four thousand nine hundred and fifty dollars ($4,950) in TrOOP eligible expenses will enter the catastrophic phase, where out-of-pocket cost shares will be greater of five percent (5%) or three dollars and thirty cents ($3.30) for a generic or preferred drug that is a multi-source drug, and the greater of five percent (5%) or eight dollars and twenty-five cents ($8.25) for all other drugs.

Notice For Medicare Eligible Participants

Important Notice About Your

Prescription Drug Coverage and Medicare

Please read this article carefully and keep this document where you can find it. This article has information about current Prescription Drug Coverage for people with Medicare. It also tells you where to find more information to help you make decisions about your Prescription Drug Coverage.

Starting January 1, 2006, new Medicare Prescription Drug Coverage became available to everyone with Medicare. The Claims Administrator has determined that the Prescription Drug Coverage offered under this Plan is, on average for all Participants, expected to pay out as much as the standard Medicare Prescription Drug Coverage will pay. Read this article carefully – it explains the options you have under the Medicare Prescription Drug Coverage, and can help you decide whether or not you want to enroll in the Medicare Prescription Drug Coverage.

Because your Coverage under this Plan is on average at least as good as standard Medicare Prescription Drug Coverage, you can keep this Coverage and not pay extra if you later decide to enroll in Medicare Prescription Drug Coverage. When people become eligible for Medicare Part D, the initial enrollment period is three (3) months before the month in which the Participant first meets the Medicare eligibility requirements for Part D and ends three (3) months after the month of first eligibility. However, because you have existing Prescription Drug Coverage that, on average, is as good as Medicare Coverage, you can choose to join a Medicare Prescription Drug plan later. Each year after the initial enrollment period, you will have the opportunity to enroll in a Medicare Prescription Drug plan from November 15th through December 31st.

If you decide to enroll in a Medicare Prescription Drug plan and drop your Coverage under this Plan, be aware that you may not be able to get Coverage under this Plan back. You should compare your Coverage under this Plan, including which drugs are Covered, with the Coverage and cost of the Plans offering Medicare Prescription Drug Coverage in your area. **In addition, your Coverage under this Plan pays for other health expenses, in addition to Prescription Drugs, and if you choose to drop this Plan and enroll in Medicare Prescription Drug Coverage, you will also lose all of those health Benefits under this Plan as well as your current Prescription Drug program.**

You should also know that if you drop or lose your Coverage with the Plan and do not enroll in Medicare Prescription Drug Coverage after your Coverage under this Plan ends, you may pay more to enroll in Medicare Prescription Drug Coverage later. If after your initial enrollment period, you go sixty-three (63) days or longer without Prescription Drug Coverage that is at least as good as Medicare's Prescription Drug Coverage; your monthly Premium will go up at least one percent (1%) per month for every month after your initial enrollment that you did not have that Coverage. For example, if you go nineteen (19) months without Coverage, your Premium will always be at least nineteen percent (19%) higher than what most people pay. You will have to pay this higher Premium as long as you have Medicare Coverage. In addition, you may have to wait until the next November to enroll.

You may receive this notice at other times in the future, such as before the next period you can enroll in Medicare Prescription Drug Coverage, and if this Coverage changes. You may also request a copy. Contact the Plan for further information.

More detailed information about the Medicare plans that offer Prescription Drug Coverage is available in the "Medicare & You" handbook published by the Centers for Medicare and Medicaid Services (CMS), the federal agency responsible for the Medicare program. You can get more information about the Medicare Prescription Drug plans from these places:

(1) Visit www.Medicare.gov for personalized help.

(2) Call your State Health Insurance Assistance Program (see your copy of the "Medicare & You" handbook for their telephone number).

(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. Information about this extra help is available from the Social Security Administration (SSA). For more information about this extra help, visit SSA online at www.socialsecurity.gov, or call them at 1-800-772-1213 (TTY 1-800-325-0778).

ARTICLE 9

UTILIZATION MANAGEMENT SERVICES

9.1 General Information

The requirements listed in this article are incorporated into the Plan to reduce or eliminate costs for services and supplies not provided in a cost-effective manner.

Coverage for certain health services requires Prior Authorization through the Claims Administrator. Refer to Article 9.2. Prior Authorization is the utilization review process to determine whether the requested service, procedure, prescription drug or medical device meets the Plan's clinical criteria for coverage. Your Participating Provider is responsible for obtaining Prior Authorization from the Claims Administrator for In-Network services; however, Non-Participating Providers are not obligated to request Prior Authorization. Participants are responsible for verifying whether the health service received Out-of-Network is Covered under the Plan and the required Prior Authorization has been granted before receiving the health service. To verify Coverage or Prior Authorization, you may call the Participant Services number on the back of your identification card. Prior Authorization needs to be requested at least fourteen (14) business days prior to receiving the non-emergency service.

Failure to obtain Prior Authorization for Inpatient Hospitalization received Out-of-Network will result in a twenty percent (20%) penalty (not to exceed one thousand dollars ($1,000)) of the total Out-of-Network Rate before Plan Benefits are determined. The penalty will be assessed on each Inpatient occurrence where Prior Authorization is required but not obtained and will not apply to the Participant's Deductible or maximum out-of-pocket Benefit. Plan guidelines for Benefit determination will apply to all Claims including those requiring Prior Authorization. One hundred percent (100%) of costs incurred for services not Covered by the Plan for any reason will be deducted before Plan payment is determined.

The Board and Claims Administrator are only providing Benefits in accordance with the Plan and their determinations as to Benefits are not intended to control the decisions of the Participant's Provider. Accordingly, they are not responsible for the quality or availability of services or supplies received by Participants.

9.2 Services Requiring Prior Authorization

Prior Authorization is the process for authorizing the non-Emergency use of facilities, diagnostic testing, and other health services before care is provided. Refer to Article 1.89. The following services require Prior Authorization:

(1) Inpatient confinements (with exception of hospice)
(2) Observation stays more than 24 hours
(3) Ambulance – elective transportation by fixed-wing aircraft (plane)
(4) Autologous chondrocyte implantation, Carticel®
(5) Cochlear device and/or implantation
(6) Dental implants
(7) Dialysis Visits
(8) Dorsal column (lumbar) neurostimulators: trial or implantation
(9) Electric or motorized wheelchairs and scooters

(10) Gastrointestinal (GI) tract imaging through capsule endoscopy
(11) Hip surgery to repair impingement syndrome
(12) Home Health care related services (private duty nursing)
(13) Lower limb prosthetics
(14) Nonparticipating freestanding ambulatory surgical facility services
(15) Orthognathic surgery procedures, bone grafts, osteotomies and surgical management of the temporomandibular joint
(16) Osseointegrated implant
(17) Osteochondral allograft/knee
(18) Power morcellation with uterine myomectomy, with hysterectomy or for the removal of uterine fibroids
(19) Proton beam radiotherapy
(20) Reconstructive or other procedures that may be cosmetic:
    a. Blepharoplasty/canthoplasty
    b. Breast reconstruction
    c. Breast reduction/mammoplasty
    d. Cervicoplasty
    e. Surgery for varicose veins, except stab phlebectomy
(21) Spinal Procedures
    a. Artificial intervertebral disc surgery
    b. Cervical, lumbar and thoracis laminectomy/laminotomy procedures
    c. Spinal fusion surgery
    d. Uvulopalatopharyngoplasty, including laser-assisted procedures
    e. Ventricular assist devices
    f. Drugs and medical injectables – see Aetna list at www.aetna.com
(22) Special Programs:
    a. BRCA genetic testing
    b. Cardiac rhythm implantable devices
    c. Hip and Knee arthroplasties
    d. Mental health or substance abuse services precertification*
    e. Transplants
    f. Oncology pathway solutions 9chemotherapy for cancel diagnosis)
    g. Pain Management
    h. Pre-implantation genetic testing
    i. Pediatric Congenital Heart Surgery Program
    j. Polysomnography (attended sleep studies)
    k. Radiation Oncology
    l. Radiology imaging
    m. Transthoracis echocardiogram

*** Mental Health and Substance abuse managed by Aetna Behavioral Health.***

9.3 Pre-Admission Certification and Concurrent Review Requirements

(1) Elective Hospital admissions, except those for obstetrical care, must be approved by the Claims Administrator in advance. Elective admissions are defined as admissions that do not involve Emergency Services.

(2) Elective Hospital admissions will not be approved for any Saturday, Sunday, or nationally recognized legal holiday that occurs on Friday or Monday unless, on the day of admission, the Participant receives Medically Necessary services that can only be rendered in a Hospital and cannot be postponed.

(3) Further, admission will not be approved for the day before a surgical procedure is scheduled to be performed unless, on the day of admission, the Participant receives Medically Necessary services that can only be rendered in a Hospital.

(4) When an admission is approved, the Claims Administrator will determine a length of stay appropriate to the nature and severity of the Participant's condition.

(5) During the confinement, the Claims Administrator will monitor the Participant's medical chart for appropriateness of treatment. Toward the end of the assigned length of stay, the Claims Administrator will contact Hospital personnel to ensure discharge is scheduled to occur as planned. If the attending Physician believes additional days of confinement are necessary, he may request an extension on the number of days, and will be required to submit medical data to substantiate the request.

9.4 Admission Review

Hospital admissions for obstetrical care and/or Emergency Services require admission review. In all cases, the Claims Administrator must be notified of the admission within forty-eight (48) hours or on the next working day, if later. The Claims Administrator will assign an appropriate length of stay and will monitor the Participant's care as outlined above.

9.5 Case Management

The Claims Administrator strives for the early identification and effective management of selected Participants for whom intensive management can be expected to improve the quality of care and reduce overall medical expenses. The complex case management program offers special assistance to Participants with serious and complex, long-term medical needs and promotes quality of care to reduce the likelihood of extended, more costly health care. The Claims Administrator identifies serious and complex medical conditions as ones that are persistent and substantially disabling or life-threatening and that require treatments and services across a variety of domains of care to ensure the best possible outcome for each unique Participant. Long-term medical needs are those that are more chronic than Acute and can be expected to require extended use of health care resources.

Complex case management is a collaborative process which assesses, plans, implements, coordinates, monitors, and evaluates options and services to meet an individual Participant's health care needs through communication and available resources to promote quality, cost-effective outcomes.

Note: Participation in case management is voluntary. There are no reductions of Benefits or penalties if the patient and family choose not to participate.

9.6 Disease Management

The Claims Administrator offers disease management programs designed to assist patients with the management of chronic Illnesses. The disease management programs are based on nationally recognized clinical practice guidelines and designed to provide education on disease processes, treatment goals and self-management skills. The disease management programs include disease-specific educational packets, target reminders for recommended services, and support from a disease management call center staffed with RNs and health coaches.

Note: Participation in disease management programs is voluntary. There are no reductions of Benefits or penalties if the patient chooses not to participate.

ARTICLE 10

COORDINATION OF BENEFITS

10.1 Applicability

(1) The Coordination of Benefits (COB) provision applies to the Plan when a Participant has health care Coverage under more than one (1) health plan. Health plan, for purposes of this article, is defined in Article 10.2.

(2) If this COB provision applies, Article 10.3 should be examined. Those rules determine whether the Benefits of the Plan are determined before or after those of another health plan. The Benefits of the Plan:

a) shall not be reduced when, under Article 10.3, the Plan determines its Benefits before another health plan; but

b) may be reduced when, under Article 10.3, another health plan determines its Benefits first. This reduction is described in Article 10.4.

(3) Other insurance Coverage on Dependents will be verified annually by the Claims Administrator.

10.2 Definitions

(1) Health plan means any of the following that provide Benefits or services for, or because of, medical or dental care or treatment:

a) Group insurance or group-type Coverage, whether insured or uninsured. This includes prepayment, group practice or individual practice Coverage. This provision does not include individual contracts, Hospital indemnity-type Coverages that are written on a non-expense incurred basis, student accident Coverages, or automobile medical insurance plans.

b) Coverage under a governmental plan required or provided by law. This does not include a State plan under Medicaid (Title XIX, Grants to States for Medical Assistance Programs, of the United States Social Security Act as amended from time to time). It also does not include any plan when, by law, its Benefits exceed those of any private insurance program or other non-governmental program.

Each contract or other arrangement for Coverage under this section is a separate health plan. Also, if an arrangement has two (2) parts and COB rules apply to only one (1) of the two (2), each of the parts is a separate health plan.

(2) Primary Plan/Secondary Plan

Article 10.3, “Order of Benefit Determination Rules”, states whether the Plan is a primary plan or secondary plan as to another health plan Covering the person.

When the Plan is a primary plan, its Benefits are determined before those of the other health plan and without considering the other health plan’s benefits.

When the Plan is a secondary plan, its Benefits are determined after those of the other health plan and may be reduced because of the other health plan's benefits.

When there are more than two (2) health plans Covering the person, the Plan may be a primary plan as to one (1) or more other health plans, and may be a secondary plan as to a different health plan.

In all cases, Medicare Prescription Drug Coverage under a Medicare Part D Plan is always the secondary payer if other Prescription Drug Coverage exists, with few exceptions. It is the Medicare Participant's responsibility to notify the Plan if other Prescription Drug Coverage exists.

(3) Allowable Expense means a necessary, reasonable, and customary item of expense for health care, when the item of expense is Covered at least in part by one (1) or more plans Covering the person for whom the Claim is made.

The difference between the cost of a private Hospital room and the cost of a semi-private Hospital room is not considered an allowable expense under the above definition unless a private Hospital room is the only room available or is Medically Necessary either in terms of generally accepted medical practice or as specifically defined in the health Plan.

When a health plan provides Benefits in the form of services, the reasonable cash value of each service rendered will be considered both an allowable expense and a Benefit paid.

(4) Claim Determination Period means a calendar year. However, it does not include any part of a year during which a person has no Coverage under the Plan, or any part of a year before the date this COB provision or a similar provision takes effect.

10.3 Order of Benefit Determination Rules

(1) General - When there is a basis for a Claim under the Plan and another health plan, the secondary plan is one whose benefits are determined after those of the other health plan, unless:

a) the other health plan has rules coordinating its benefits with those of the Plan; and

b) both those rules and the Plan's rules, in the subparagraph below, require that the Plan's Benefits be determined before those of the other health plan.

(2) Rules - The Plan determines its order of Benefits using the first of the following rules that applies:

a) Subscriber - The benefits of the health plan that Covers the person as a Subscriber (that is, other than as a Dependent) are determined before those of the health plan that Covers the person as a Dependent.

b) Dependent Child (Parents not Separated or Divorced) - Except as stated in the subparagraph below, when the Plan and another health plan Cover the same child as a Dependent of different persons, called parents:

i. the benefits of the health plan of the parent whose birthday falls earlier in a year are determined before those of the health plan of the parent whose birthday falls later in that year; but

ii. if both parents have the same birthday, the benefits of the health plan that Covered the parent longer are determined before those of the health plan that Covered the other parent for a shorter period of time.

c) Dependent Child (Separated or Divorced Parents) - If two (2) or more health plans Cover a person as a Dependent child of divorced or separated parents, benefits for the child are determined in this order:

i. first, the health plan of the parent with custody of the child;

ii. then, the health plan of the Spouse of the parent with custody of the child; and

iii. finally, the health plan of the parent not having custody of the child.

However, if the specific terms of a court decree state that one (1) of the parents is responsible for the health care expenses of the child, and the entity obligated to pay or provide the benefits of the health plan of that parent has actual knowledge of those terms, the benefits of that health plan are determined first. This paragraph does not apply with respect to any Claim determination period or calendar year during which any benefits are actually paid or provided before the entity has that actual knowledge.

d) Active/Inactive Employee - The benefits of a health plan that Covers a person as an Employee who is neither laid off, terminated, on long-term disability, nor retired (or as that Employee's Dependent) are determined before those of a health plan that Covers that person as a laid-off, terminated, disabled, or retired Employee (or as that Employee's Dependent). If the other health plan does not have this rule, and if, as a result, the health plans do not agree on the order of benefits, this rule is ignored.

e) Longer/Shorter Length of Coverage - If none of the above rules determine the order of benefits, the benefits of the health plan that Covered a Subscriber/dependents longer are determined before those of the health plan that Covered that person for the shorter time.

10.4 Effect on the Benefits of the Plan

This section applies when, in accordance with Article 10.3, "Order of Benefit Determination Rules", the Plan is a secondary plan as to one (1) or more other health plans. In that event, the Benefits of the Plan may be reduced under this section. Such other health plans are referred to as "the other health plans" in Article 10.4(1).

(1) Reduction in the Plan's Benefits -The Benefits of the Plan will be reduced when the sum of:

a) the Benefits that would be payable for the allowable expenses under the Plan in the absence of this COB provision; and

b) the benefits that would be payable for the allowable expenses under the other health plans, in the absence of provisions with a purpose like that of this COB provision, whether or not Claim is made, exceeds those allowable expenses in a Claim determination period. In that case, the Benefits of the Plan will be reduced so that they and the benefits payable under the other health plans do not total more than those allowable expenses. When the Benefits of the Plan are reduced as described above, each Benefit is reduced in proportion. It is then charged against any applicable Benefit limit of the Plan.

10.5 Right to Receive and Release Needed Information

Certain facts are needed to apply these COB rules. The Claims Administrator has the right to decide which facts are needed, and may get needed facts from or give them to any other organization or person. The Claims Administrator need not tell, or get the consent of, any person to do this. Each person claiming Benefits under the Plan must give the Claims Administrator any facts needed to pay the Claim.

10.6 Facility of Payment

A payment made under another health plan may include an amount that should have been paid under the Plan. If that occurs, the Claims Administrator may pay that amount to the organization that made that payment. That amount will then be treated as though it were a Benefit paid under the Plan. The Claims Administrator will not have to pay that amount again. The term “payment made” includes providing Benefits in the form of services, in which case “payment made” means reasonable cash value of the Benefits provided in the form of services.

10.7 Right of Recovery

If the amount of the payments made by the Claims Administrator is more than should have been paid under this COB provision, recovery of the excess may be made from one (1) or more of:

(1) the persons paid or for whom paid;

(2) insurance companies; or

(3) other organizations.

The “amount of the payments made” includes the reasonable cash value of any Benefits provided in the form of services.

ARTICLE 11

COBRA CONTINUATION COVERAGE RIGHTS

11.1 General Information

The right to COBRA continuation Coverage was created by a federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA). COBRA continuation of Coverage can become available to a participant when the participant would otherwise lose their group health Coverage. It can also become available to other members of a participant's family who are Covered under the Plan when they would otherwise lose their group health Coverage. As a State sponsored Plan, this Plan is subject to COBRA provisions.

COBRA continuation Coverage is a continuation of Plan Coverage when Coverage would otherwise end because of a life event known as a "qualifying event." Specific qualifying events are listed later in this summary Plan document. After a qualifying event, COBRA continuation Coverage must be offered to each Participant who is a "qualified beneficiary." A participant, a participant's spouse, and a participant's Dependent children could become qualified beneficiaries if Coverage under the Plan is lost because of the qualifying event. Under the Plan, qualified beneficiaries who elect COBRA continuation Coverage must pay for the Coverage.

11.2 Qualified Beneficiary

For purposes of this article, the term "qualified beneficiary" means any individual who, on the day of or the day before the qualifying event, is a Participant under the Plan as:

(1) the non-Medicare or Medicare Subscriber;

(2) the non-Medicare or Medicare Spouse of the Subscriber; or

(3) the non-Medicare or Medicare Dependent child of the Subscriber.

11.3 Qualifying Event

(1) If a participant is the Employee, the participant will become a qualified beneficiary if the participant loses their Coverage under the Plan because either of the following events happens:

a) hours of employment are reduced, or

b) employment ends for any reason other than gross misconduct and the participant does not qualify as a Vested Participant under MPERS.

(2) If the participant is the Spouse of the Employee, the participant will become a qualified beneficiary if they lose Coverage under the Plan because one (1) of the following qualifying events happens:

a) the Spouse's hours of employment are reduced;

b) the Spouse's employment ends for any reason other than gross misconduct; or

c) if the Spouse becomes divorced or legally separated from the Employee.

(3) If the participant is a Dependent child, they will become a qualified beneficiary if they lose Coverage under the Plan because one (1) of the following qualifying events happens:

a) the parent-Employee's hours of employment are reduced;

b) the parent-Employee's employment ends for any reason other than his gross misconduct;

c) loss of Dependent status under the Plan.

11.4 Non-Qualifying Events

The following are non-qualifying events for which the Plan is not required to offer COBRA Coverage:

(1) Participants eligible for continuation of Coverage as Vested Participants of MPERS;

(2) Participants electively cancelling their medical insurance Coverage;

(3) Participant's loss of Coverage is due to gross misconduct; or

(4) Dependent children age twenty-five (25) years of age who fail to submit an "Attestation for Dependent Child" form to the Employee Benefits' office attesting they do not have medical insurance Coverage through their employer and they are not eligible for Coverage through active military. These guidelines are in accordance with the Affordable Care Act effective January 1, 2011.

11.5 Vested Status vs. COBRA

Terminated Employees with vested status can continue medical Coverage under the Plan, including any eligible Dependents as long as Premiums are paid and, for Dependents, as long as they are eligible.

11.6 Applicable Premium

For purposes of this article, the term "applicable Premium" means the cost of the Coverage as determined pursuant to the law.

11.7 COBRA Election Period

For purposes of this article, the term "COBRA Election Period" means the sixty (60) day period beginning on the later of the date on which Coverage terminates under the Plan by reason of a qualifying event or the date notice is given to a Participant pursuant to Article 11.12.

If a qualified beneficiary waives continuation Coverage during the Election Period, he must be permitted to later revoke the waiver of Coverage and elect continuation Coverage, as long as the revocation is submitted before the end of the Election Period. If a waiver is later revoked, the Plan is permitted to make continuation Coverage effective on the date the waiver was revoked.

11.8 Maximum Coverage Period

In the case of a qualifying event specified in Article 11.3, Coverage may be continued, pursuant to this article:

(1) for a maximum period of eighteen (18) months when the qualifying event is the end of employment or reduction of the Employee's hours of employment and the Employee is no longer eligible for Benefits;

(2) if the qualifying event is the end of employment or reduction of the Employee's hours, and the Employee became entitled to Medicare less than eighteen (18) months before the qualifying event, COBRA Coverage for the Employee's Spouse and Dependents can last up to thirty-six (36) months after the date the Employee becomes entitled to Medicare. For example, if a Covered Employee became entitled to Medicare eight (8) months before the date his/her employment ends, COBRA Coverage for his/her Spouse and children would last for twenty-eight (28) months (thirty-six (36) months minus eight (8) months);

(3) if the qualified beneficiary is determined to have been disabled, under Title II or Title XVI of the Social Security Act, at the time of a qualifying event specified in Article 11.3, Coverage may be extended from eighteen (18) to twenty-nine (29) months and the disability would have to have started at some time before the sixtieth (60th) day of COBRA continuation Coverage and must last at least until the end of the eighteen (18) month period of continuation Coverage;

(4) if the participant's family experiences another qualifying event while receiving eighteen (18) months of COBRA continuation Coverage, the Spouse and Dependent children in the family can get up to eighteen (18) additional months of COBRA continuation Coverage, for a maximum of thirty-six (36) months, if notice of the second qualifying event is properly given to the Plan. This extension may be available to the Spouse and any Dependent children receiving continuation Coverage if the qualifying event is a divorce or legal separation, or if the Dependent child stops being eligible under the Plan as a Dependent child, but only if the event would have caused the Spouse or Dependent child to lose Coverage under the Plan had the first qualifying event not occurred;

(5) the maximum period of thirty-six (36) months applies to any qualifying event other than the termination of employment or reduction of Employee's hours so that the Employee is not eligible for Benefits.

11.9 Terminating Events

The eighteen (18), twenty-nine (29) and thirty-six (36) month periods specified in Article 11.8 are the maximum continuation periods required by law. The Plan may terminate continuation Coverage earlier than the end of the maximum period for any of the following reasons:

(1) the first day, after the qualified beneficiary elects to continue Coverage, on which the qualified beneficiary is Covered under another employer's medical plan provided the new plan does not contain any exclusion or limitation with respect to any pre-existing condition of such beneficiary;

(2) the day the qualified beneficiary is entitled to Medicare Coverage;

(3) the end of the last period for which timely Premium payments are made pursuant to the Article 11.11, “Premium Requirements”;

(4) the date the Employer ceases to maintain any group health plan; or

(5) a qualified beneficiary engages in conduct that would justify the Plan in terminating Coverage of a similarly situated Participant or beneficiary not receiving continuation Coverage (such as fraud).

11.10 Rights and Privileges during Continuation Period

During the continuation period, each qualified beneficiary will be afforded the same rights and privileges, with respect to bringing in new Dependents and choosing a Plan option as regular Subscribers; however, the only Dependents who will be considered qualified beneficiaries in their own right are those who were enrolled in the Plan on the day immediately preceding the initial qualifying event.

11.11 Premium Requirements

The applicable Premium for any continuation of Coverage pursuant to this article will be paid by the qualified beneficiary in a timely manner and in monthly installments. Continuation of Coverage will cease pursuant to this article upon the failure to make timely payment of any applicable Premium with respect to the Participant for whom Coverage has been continued. The initial payment will be deemed timely if received within forty-five (45) days of the date the election is made; subsequent payments will be due on the first day of the month for which they apply, with a grace period of thirty (30) days following such due date.

11.12 Notice Requirements

(1) The Board will provide, at the time of commencement of Coverage, written notice to each Employee Subscriber and to the Spouse (if any) of the Subscriber, of the rights provided under this article.

(2) The Board will provide, at the time of a qualifying event specified in Article 11.3 written notice to each Employee Subscriber and to the Spouse and eligible Dependents (if any) of the Subscriber, of the rights provided under this article.

(3) The Subscriber or the qualified beneficiary is responsible for notifying the Board of a divorce or legal separation, or cessation of Dependent eligibility within sixty (60) days after the date of such qualifying event. The qualified beneficiary who is determined to have been disabled, under Title II or Title XVI of the Social Security Act, at the time of a qualifying event specified in Article 11.3 is responsible for notifying the Board of such determination within sixty (60) days after the date of the determination and for notifying the Board within thirty (30) days of the date of any final determination under such titles that the qualified beneficiary is no longer disabled.

(4) The Board will notify any qualified beneficiary of such qualified beneficiary’s rights under this section within fourteen (14) days of receiving the notice pursuant to Article 11.12 or within fourteen (14) days of the qualifying event, whichever is applicable. Any notification

to an individual who is a qualified beneficiary as the Spouse of the Subscriber will be treated as notification to all other qualified beneficiaries residing with such Spouse at the time such notification is made.

ARTICLE 12

GRIEVANCE AND APPEALS PROCEDURES

12.1 Introduction

Following is a description of how the Plan processes Claims for Benefits and reviews the Appeal of any Claim that is denied. The terms used in this section are defined below.

A “Claim” is defined as any request for a Plan Benefit, made by a claimant, or by a representative of a claimant, that complies with the Plan’s reasonable procedure for filing Claims and making Benefit Claims determinations.

A "Claim" does not include a request for a determination of an individual's eligibility to participate in the Plan.

If a Claim is denied, in whole or in part, or if Plan Coverage is rescinded retroactively for fraud or intentional misrepresentation, the denial is known as an "Adverse Benefit Determination."

Adverse Benefit Determinations may be based on:

- The claimant’s eligibility for coverage, including a retrospective termination of coverage (whether or not there is an adverse effect on any particular benefit);
- Coverage determinations, including plan limitations or exclusions;
- The results of any Utilization Review activities;
- A decision that the service or supply is experimental or investigations; or
- A decision that the service or supply is not medically necessary.

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

A claimant must follow all Claims and Appeal procedures both internal and external, before he or she can file a lawsuit. If a lawsuit is brought, it must be filed within two years after the final determination of an Appeal.

Any of the authority and responsibilities of the Plan Administrator under the Claims and Appeal Procedures or the External Review Process, including the discretionary authority to interpret the terms of the Plan, may be delegated to a third party. Any questions regarding these procedures should be directed to the Plan Administrator.

There are different kinds of Claims and each one has a specific timetable (refer to Article 12.2). Upon receipt of the Claim, the Plan Administrator must decide whether to approve or deny the Claim. The Plan Administrator's notification to the claimant of its decision must be made as shown in the timetable. However, if the Claim has not been filed properly, if it is incomplete, or if there are other matters beyond the control of the Plan Administrator, the claimant may be notified that the period for providing the notification will need to be extended. If the period is extended because the Plan Administrator needs more information from the claimant, the

claimant must provide the requested information within the time shown on the timetable. Once the Claim is complete, the Plan Administrator must make its decision as shown in the timetable. If the Claim is denied, in whole or in part, the claimant has the right to file an Appeal. The claimant will have 180 days following receipt of an adverse Benefit Determination to appeal the determination to the Plan or its designee. The claimant will be notified of the decision of the Plan or its designee not later than 15 days (for pre-service claims) or 30 days (for post-service claims) after the appeal is received. The claimant may submit written comments, documents, records and any other information relating to the claim, whether or not the comments, documents, records or other information were submitted in connection with the initial claim. Decisions will be made within a reasonable period of time appropriate to the circumstances, but within the maximum time periods listed in the timetables below. Unless otherwise noted, "days" means calendar days.

12.2 Definitions

The definitions of the types of Claims are:

(1) Urgent Care Claim

An Urgent Care Claim is any Claim for medical care or treatment where the Plan conditions receipt of Benefits, in whole or in part, on approval of obtaining the care or treatment, and using the timetable for a non-Urgent Care determination could seriously jeopardize the life or health of the claimant; or the ability of the claimant to regain maximum function; or in the opinion of the attending or consulting Physician, would subject the claimant to severe pain that could not be adequately managed without the care or treatment that is the subject of the Claim.

A Physician with knowledge of the claimant’s medical condition may determine if a Claim is one involving Urgent Care. If there is no such Physician, an individual acting on behalf of the Plan applying the judgment of a prudent layperson who possesses an average knowledge of health and medicine may make the determination.

If the Plan Administrator requires advance approval of a service, supply or procedure before a benefit will be payable, and if the Plan Administrator or its designee, or the member’s physician, determines that it is an Urgent Care Claim, you will be notified of the decision, whether adverse or not, as soon as possible but not later than 72 hours after the claim is received

In the case of a Claim involving Urgent Care, the following timetable applies:

Insufficient information on the Claim, or failure to follow the Plan’s procedure for filing a Claim:	
Notification to claimant, orally or in writing	24 hours
Response by claimant, orally or in writing	48 hours
Benefit determination, orally or in writing	48 hours
Notification of Adverse Benefit Determination on Appeal	72 hours total for all Appeal levels

If there is an Adverse Benefit Determination on a Claim involving Urgent Care, a request for an expedited Appeal may be submitted orally or in writing by the claimant. All necessary information, including the Plan's Benefit determination on review, may be transmitted between the Plan and the claimant by telephone, facsimile, or other similarly expeditious method. Alternatively, the claimant may request an expedited review under the External Review Process (refer to Article 12.4).

If a claimant has received pre-authorization for an ongoing course of treatment, the claimant will be notified in advance if the previously authorized course of treatment is intended to be terminated or reduced so that the claimant will have an opportunity to appeal any decision by the Plan or its designee and receive a decision on that appeal before the termination or reduction takes effect. If the course of treatment involves urgent care, and you request an extension of the course of treatment at least 24 hours before its expiration, you will be notified of the decision within 24 hours after receipt of the request.

(2) Pre-Service Claim

A Pre-Service Claim means any Claim for a Benefit under this Plan where the Plan conditions receipt of the Benefit, in whole or in part, on approval in advance of obtaining medical care. These are, for example, Claims subject to pre-certification. Please see the Cost Management section of this booklet for further information about Pre-Service Claims.

For Pre-Service Claims which name a specific claimant, medical condition, and service or supply for which approval is requested, and which are submitted to a representative of the Plan or its designee responsible for handling benefit matters, but which fail to follow the Plan's procedures for filing pre-service claims, the claimant will be notified of the failure within 5 days (within 24 hours in the case of an urgent care claim) and of the proper procedures to be followed. The notice may be oral unless you request written notification.

In the case of a Pre-Service Claim, the following timetable applies:

Notification to claimant of Adverse Benefit Determination	15 days
Extension due to matters beyond the control of the Plan	15 days
Insufficient information on the Claim:	
Notification to claimant	15 days
Response by claimant	45 days
Notification, orally or in writing, of failure to follow the Plan's procedures for filing a Claim	15 days after end of additional period (or receipt of information)

(3) Post-Service Claim

A Post-Service Claim means any Claim for a Plan Benefit that is not a Claim involving Urgent Care or a Pre-Service Claim; in other words, a Claim that is a request for payment under the Plan for medical services already received by the claimant.

In the case of a Post-Service Claim, the following timetable applies:

Notification to claimant of Adverse Benefit Determination	30 days
Extension due to matters beyond the control of the Plan	15 days
Extension due to insufficient information on the Claim	15 days
Response by claimant following notice of insufficient information	45 days
Notification of Adverse Benefit Determination on Appeal	15 days after end of additional period (or receipt of information)

(4) Notice to claimant of Adverse Benefit Determinations

If a Claim is denied in whole or in part, the denial is considered to be an Adverse Benefit Determination. Except with Urgent Care Claims, when the notification may be oral followed by written or electronic notification within three (3) days of the oral notification, the Plan Administrator shall provide written or electronic notification of the Adverse Benefit Determination. The notice will state the following in a culturally and linguistically appropriate manner (for Plan years beginning July 1, 2011 and after) and in a manner calculated to be understood by the claimant:

a) Information sufficient to allow the claimant to identify the Claim involved (including date of service, the health care Provider, the Claim amount, if applicable, the diagnosis code and its corresponding meaning, and the treatment code and its corresponding meaning for Plan years beginning July 1, 2011 and after).

b) The specific reason or reasons for the adverse determination, including the denial code and its corresponding meaning, and a description of the Plan's standard, if any, that was used in denying the Claim.

c) Reference to the specific Plan provisions on which the determination was based.

d) A description of any additional material or information necessary for the claimant to perfect the Claim and an explanation of why such material or information is necessary.

e) A description of the Plan’s internal and external Appeal procedures. This description will include information on how to initiate the Appeal and the time limits applicable to such procedures. This will include a statement of the claimant’s right to bring a civil action under Section 502 of ERISA following a Final Adverse Benefit Determination.

f) If the Adverse Benefit Determination was based on an internal rule, guideline, protocol, or other similar criterion, the specific rule, guideline, protocol, or criterion will be provided free of charge. If this is not practical, a statement will be included that such a rule, guideline, protocol, or criterion was relied upon in making the Adverse Benefit Determination and a copy will be provided free of charge to the claimant upon request.

g) If the Adverse Benefit Determination is based on Medical Necessity, Experimental or Investigational treatment, or similar exclusion or limit, an explanation of the scientific or clinical judgment for the determination, applying the terms of the Plan to the claimant's medical circumstances, will be provided. If this is not practical, a statement will be included that such explanation will be provided free of charge, upon request.

h) Information about the availability of and contact information for, any applicable office of Health Insurance consumer assistance or ombudsman established under applicable federal law to assist individuals with the internal Claims and Appeals and external review process.

12.3 Appeals

When a claimant receives notification of an Adverse Benefit Determination, the claimant generally has one hundred eighty (180) days following receipt of the notification in which to file a written request for an Appeal of the decision. However, for Ongoing Course of Treatment, the Claimant must file the Appeal prior to the scheduled reduction or termination of treatment. For a Claim based on rescission of Coverage, the claimant must file the Appeal within thirty (30) days. A claimant may submit written comments, documents, records, and other information relating to the Claim.

If the claimant so requests, he or she will be provided, free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the Claim. The Plan Administrator shall provide the claimant any new or additional evidence that is relied upon, considered or generated by or at the direction of the Plan as soon as possible and sufficiently in advance of the time within which a final determination on Appeal is required to allow the claimant time to respond. This evidence shall be provided free of charge.

A document, record, or other information shall be considered relevant to a Claim if it:

(1) was relied upon in making the Benefit determination;

(2) was submitted, considered, or generated in the course of making the Benefit determination, without regard to whether it was relied upon in making the Benefit determination;

(3) demonstrated compliance with the administrative processes and safeguards designed to ensure and to verify that Benefit determinations are made in accordance with Plan documents and Plan provisions have been applied consistently with respect to all claimants; or

(4) constituted a statement of policy or guidance with respect to the Plan concerning the denied treatment option or Benefit.

The period of time within which a Benefit determination on Appeal is required to be made shall begin at the time an Appeal is filed in writing in accordance with the procedures of the Plan. This timing is without regard to whether all the necessary information accompanies the filing.

Before the Plan Administrator issues its Final Adverse Benefit Determination based on a new or additional rationale or new or additional information or records, the claimant must be provided, free of charge, a copy of the rationale or new or additional information or records.

The rationale or additional information or records must be provided as soon as possible and sufficiently in advance of the time within which a final determination on Appeal is required to allow the claimant time to respond.

The review shall take into account all comments, documents, records, and other information submitted by the claimant relating to the Claim, without regard to whether such information was submitted or considered in the initial Benefit determination. The review will not afford deference to the initial Adverse Benefit Determination and will be conducted by a fiduciary of the Plan who is neither the individual who made the Adverse Benefit Determination nor a subordinate of that individual.

If the determination was based on a medical judgment, including determinations with regard to whether a particular treatment, drug, or other item is Experimental, Investigational, or not Medically Necessary or appropriate, the fiduciary shall consult with a health care professional who was not involved in the original Benefit determination. This health care professional will have appropriate training and experience in the field of medicine involved in the medical judgment. Additionally, medical or vocational experts whose advice was obtained on behalf of the Plan in connection with the initial determination will be identified.

If the Appeal of a Claim is denied, in whole or in part, the Plan Administrator shall provide written notification of the Adverse Benefit Determination on Appeal. The notice will state the following, in a manner calculated to be understood by the claimant:

(1) Information sufficient to allow the claimant to identify the Claim involved (including date of service, the health care Provider, the Claim amount, if applicable, the diagnosis code and its corresponding meaning, and the treatment code and its corresponding meaning).

(2) The specific reason or reasons for the Adverse Benefit Determination, including the denial code and its corresponding meaning, and a description of the Plan's standard, if any, that was used in denying the Claim.

(3) Reference to the specific Plan provisions on which the determination was based.

(4) A description of any additional material or information necessary for the claimant to perfect the Claim and an explanation of why such material or information is necessary.

(5) A description of the Plan's internal and external review procedures and the time limits applicable to such procedures. This will include a statement of the claimant's right to bring a civil action under section 502 of ERISA following an Adverse Benefit Determination on review.

(6) A statement that the claimant is entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the Claim.

(7) If the Adverse Benefit Determination was based on an internal rule, guideline, protocol, or other similar criterion, the specific rule, guideline, protocol, or criterion will be provided free of charge. If this is not practical, a statement will be included that such a rule, guideline, protocol, or criterion was relied upon in making the Adverse Benefit Determination and a copy will be provided free of charge to the claimant upon request.

(8) If the Adverse Benefit Determination is based on Medical Necessity, Experimental or Investigational treatment, or similar exclusion or limit, an explanation of the scientific or clinical judgment for the determination, applying the terms of the Plan to the claimant's medical circumstances, will be provided. If this is not practical, a statement will be included that such explanation will be provided free of charge, upon request.

(9) Information about the availability of and contact information for, any applicable office of Health Insurance consumer assistance or ombudsman established under applicable federal law to assist individuals with the internal Claims and Appeals and external review process.

12.4 External Review Process

If a claimant receives a Final Adverse Benefit Determination under the Plan's internal Claims and Appeals Procedures due to a service that is considered not medically necessary or experimental or investigation in nature, he or she may request that the Claim be reviewed under the Plan's External Review process. An external review is a review by an independent clinical reviewer, selected by an External Review organization, who has expertise in the problem or question involved. This request must be filed in writing within 60 calendar days of the date he or she received the Final Adverse Benefit Determination and include a copy of the final claim denial letter and all other pertinent information that supports the claimants request

To request an external review, the following requirements must be met:

(1) The claimant is or was Covered under the Plan at the time the Claim was made or incurred; and

(2) The claimant has received notice of the denial of a claim by the Plan Administrator; and the claim was denied because the Plan Sponsor determined the service/care was not medical necessary or was experimental or investigation; and

(3) The cost of the service or treatment in question for which the claimant is responsible exceeds $500;

(4) The claimant has exhausted the Plan's internal Claims and Appeal Procedures; and

(5) The claimant has provided all the information required to process an External Review.

If upon the final standard level of appeal the Plan upholds the coverage denial and it is determined that the member is eligible for external review, the claimant will be informed in writing of the steps necessary to request an external review.

If the request for review is complete, but not eligible for External Review, the Plan Administrator will notify the claimant of the reasons for its ineligibility. The notice will include contact information for the Employee Benefits Security Administration at its toll free number (866-444-3272).

If the request is not complete, the notice will describe the information needed to complete it. The claimant will have forty-eight (48) hours or until the last day of the four (4) month filing period, whichever is later, to submit the additional information.

If the request is eligible for the External Review process, the Plan will assign it to a qualified Independent Review Organization (IRO). The IRO is responsible for notifying the claimant, in writing, that the request for External Review has been accepted. The notice should include a statement that the claimant may submit in writing, within ten (10) business days, additional information the IRO must consider when conducting the review. The IRO will share this information with the Plan. The Plan may consider this information and decide to reverse its denial of the Claim. If the denial is reversed, the Plan will notify the claimant in writing and the External Review process will end.

If the Plan does not reverse the denial, the IRO will make its decision on the basis of its review of all of the information in the record, as well as additional information where appropriate and available, such as:

(1) The claimant's medical records;

(2) The attending health care professional's recommendation;

(3) Reports from appropriate health care professionals and other documents submitted by the Plan or issuer, claimant, or the claimant's treating Provider;

(4) The terms of the Plan;

(5) Appropriate practice guidelines;

(6) Any applicable clinical review criteria developed and used by the Plan; and

(7) The opinion of the IRO's clinical reviewer.

The Plan will contact the External Review Organization that will conduct the review of the claim. The External Review Organization will select an independent clinical reviewer with appropriate expertise to perform the review. In making a decision, the external reviewer may consider any appropriate credible information that the claimant sends along with the Request for External Review, and will follow Aetna’s contractual documents and plan criteria governing the benefits. The claimant will be notified of the decision of the External Review Organziation usually within 30 calendar days of the Plan’s receipt of the claimant’s request form and all necessary information.

Generally, a claimant must exhaust the Plan's Claims and Procedures in order to be eligible for the External Review process. However, in some cases the Plan provides for an expedited External Review if the claimants physician certifies (by telephone or on a separate Request for External Review Form) that a delay in receiving the service would endanger the claimant’s health. Expediated reviews are decided within 3 to 5 calendar days after the Plan receives the request.

The claimant is responsible for the cost of compiling and sending the information that they wish to be reviewed by the External Review Organization to the Plan. The Plan is responsible for the cost of sending this information to the External Review Organization and for the cost of the external review.

12.5 Legal Action

No action at law or inequity shall be brought to recover a Claim under the Plan until the Grievance/Appeals process is complete after a Claim has been filed in accordance with the requirements of the Plan, nor shall such action be brought at all unless brought within three (3) years from expiration of time within which proof of loss is required by the Plan.

12.6 Misstatements

(1) Misstatements by a Participant(s) made at the time of enrollment or when a Claim is made may be grounds for denying enrollment, canceling enrollment or refusing Claim payment.

(2) Any misstatements involving this summary Plan document may be used in canceling enrollment or denying enrollment in the Basic (State Paid) Life Insurance Plan and/or Optional Life Insurance Plan.

(3) Failure to cooperate with the Board (or their designated representatives) and the Claims Administrator with regard to the investigation of a Claim may result in denial of that Claim and subsequent Claims.

12.7 Appeal to Board

If the claimant has exhausted both levels of the Plan Administrator's appeal process and is not satisfied with the final Adverse Benefit Determination, the claimant has the right to submit an Appeal to the Medical Board of Trustees for the Plan. The appeal request must be in writing addressed to the Chairman of the Board and submitted to the Employee Benefits Office by mail, fax, or email:

Address: Employee Benefits Office
P.O. Box 270
Jefferson City, MO 65102
Fax: (573)522-1482
E-mail: benefits@modot.mo.gov

Please note the decision is based only on whether or not benefits are available under the Plan for the proposed treatment or procedure. The determination as to whether the pending health service is necessary or appropriate is between the claimant and his/her physician.

ARTICLE 13

FUNDING POLICY

13.1 General Information

The Commission, acting through the Board, will control the Plan's funds, establish the Premium rates, implement necessary or desired policy revisions and provide general administrative control.

Amounts needed to pay Claims and expenses, and to fund the Plan's reserve liabilities, are determined periodically by an independent actuary subject to approval by the Board and the Commission.

13.2 Employer Contributions

(1) Employee Subscriber

a) The Employer will contribute a certain amount per month for each Employee, Long-Term and Work-Related Disability Recipient.

b) No Employer Contribution will be made for Employee Subscribers who are on leave of absence without pay (except as set out in d) below). Such Subscribers may continue Coverage by paying the required Premium without Employer Contribution.

c) Employees on active military leave who continue their medical Coverage will receive the Employer Contribution as long as they are on a paid leave status.

d) Employees whose paid or unpaid leave is designated as leave under the Family and Medical Leave Act will receive the Employer Contribution for that leave.

(2) Non-Subscriber Employees - In no event will a non-Subscriber Employee receive reimbursement of the Employer Contribution.

(3) Retiree Subscriber - The Employer will contribute a certain amount per month for each Retiree Subscriber, provided the Retiree has been retained as a special consultant as authorized in Chapter 104 RSMo.

(4) Surviving Spouse Subscriber - The Employer will contribute a certain amount per month for each surviving Spouse Subscriber.

(5) Vested and Continuation of Coverage (COBRA) Subscribers - These Subscribers will receive no Employer Contribution.

13.3 Subscriber Contribution Amount

The Subscriber Contribution will vary depending upon the type of Subscriber Coverage selected, the amount needed to fund the Plan, and the amount of contribution authorized by the Commission. Subscriber Contributions are due prior to the first day of each month of Coverage. If payment is not received, Coverage will end as of the first day of the month for which the Subscriber is delinquent.

13.4 Payment of Subscriber Contributions

Subscriber Contributions are due in advance of the Coverage Date.

All contributions will be collected by payroll deduction unless:

(1) the Subscriber is not eligible to receive a payroll or retirement payment or the payment is not sufficient to cover the required contribution, or

(2) the Employee is on an authorized leave of absence without pay.

If payroll deduction payments are not available, the Subscriber will be required to make payments in a manner prescribed by the Board.

13.5 Reimbursement of Contributions

(1) Reimbursement of excess contributions shall not be issued if the Subscriber is enrolled in the cafeteria plan and the administrator of the cafeteria plan does not approve a change in status. The Subscriber would continue in the same Premium category for the remainder of the calendar year.

(2) Except as outlined in (1) above, a Participant may be eligible for reimbursement of excess contribution as follows:

a) Reimbursement shall be issued for excess contributions received by the Plan for the Coverage period after the date proper documentation of a Plan change or termination of policy is received in the Employee Benefits' office located at the MoDOT Central Office in Jefferson City.

(Ex: A Premium has been collected for May's Coverage and the Employee Benefits' office receives proper documentation by the last business day in April to cancel Coverage effective May 1st)

b) Reimbursement of excess contributions shall be issued, as outlined herein, if excess contributions were paid due to error by the Board or its designated representatives or in reliance on misstatements of the Board or its designated representatives (with supporting documentation of said error or misrepresentation), but shall be limited to twelve (12) months of reimbursement. However, reimbursement of excess contributions will not be issued if the Plan has provided any Benefit that it would not otherwise have provided absent such error or misrepresentation during the twelve (12) month reimbursement period.

c) Reimbursement of excess contributions shall not be limited in the event of death of the Subscriber or a Participant of the Plan. However, Premiums are not prorated and reimbursement shall not be issued for the month of death.

Any medical and/or prescription Claims paid by the Plan for the Participant, whose Plan Coverage was terminated during the refund period, may be recovered by the Plan.

ARTICLE 14

SUBROGATION

14.1 Subrogation for Third Party Liability

Pursuant to Section 104.270 RSMo, and effective January 1, 2003, the Commission requires the Participant/Subscriber to reimburse the Plan for any medical Claims paid by the Plan for which there was third-party liability.

The Participant/Subscriber shall provide information requested by either the Board or the Claims Administrator regarding the existence of third-party liability. Failure to provide such information may result in the suspension of Benefits under the Plan for any and all services including services which are unrelated to the information requested.

Reimbursement to the Plan will be required whenever the Participant/Subscriber receives payments for physical or mental treatment from individuals, insurance companies, settlements or court verdicts. Any reimbursement shall not exceed the amount actually paid by the Plan.

Reimbursement to the Plan will not be required if the person Injured is:

(1) the policyholder of other liability Coverage; or

(2) is a Dependent of the policyholder of other liability Coverage, and it is such policy's other liability Coverage which pays. It is the responsibility of the Participant/Subscriber to provide, to the satisfaction of the Board, evidence of such insurance.

Failure of any Participant/Subscriber to provide reimbursement could, at the discretion of the Board, result in the nonpayment of services Covered by the Plan, including services which are not related to the reimbursement.

14.2 Subrogation Lien Approval

The Subrogation Vendor will notify the Plan of all recovery efforts when the total medical lien amount is greater than or equal to ten thousand dollars ($10,000). Once the Plan is notified:

(1) the Plan's Counsel (or designee) may approve any settlement in which the proposed recovery is ninety percent (90%) or more of the total medical lien or ninety percent (90%) or more of the amount the Plan would recover under section 208.215.11 RSMo; or

(2) the Board must approve all other proposed settlement amounts less than ninety percent (90%) of the total medical lien or less than ninety percent (90%) of the amount the plan would receive under section 208.215.11 RSMo,

ARTICLE 15

RESPONSIBILITIES FOR PLAN ADMINISTRATION

15.1 Plan Administration

The operation of the Plan will be under the supervision of the Board. It shall be a principal duty of the Board to ensure that the Plan is carried out in accordance with its terms, and for the exclusive Benefit of Employees and others entitled to participate in the Plan. The Board will have full authority to administer the Plan in all of its details, subject to the directives of the Commission and pertinent provisions of applicable law and regulations. The Board's authority includes, but is not limited to, the following:

(1) to enforce such rules and regulations as the Board deems necessary or proper for the efficient administration of the Plan;

(2) to interpret the Plan, with the Board's interpretations thereof in good faith to be final and conclusive on all persons claiming or administering Benefits under the Plan;

(3) to decide all questions concerning the Plan and the eligibility of any person to participate in the Plan and to receive Benefits provided under the Plan;

(4) to approve reimbursement requests and to authorize the payment of Benefits; and

(5) to select Claims Administrators, counsel, accountants, consultants and actuaries as may be required to assist in administering the Plan. Agent/Broker of Record letters will not be provided for any account.

15.2 Examination of Records

The Board will make available to each Participant records pertaining to the Participant for examination at reasonable times during normal business hours.

ARTICLE 16

AMENDMENT OR TERMINATION OF PLAN

16.1 Amendment

The Commission, at any time, may amend any or all of the provisions of the Plan without the consent of any Employee or Participant. However, such amendment will be without prejudice to any valid Claim with respect to Covered services rendered prior to the effective date of the amendment.

16.2 Termination

The Commission reserves the right to terminate the Plan, in whole or in part, at any time without the consent of any Employee or Participant. However, such termination will be without prejudice to any valid Claim with respect to Covered services rendered prior to the effective date of termination.

ARTICLE 17

MISCELLANEOUS

17.1 Plan Interpretation

The summary Plan document sets forth the provisions of the Plan. The Plan shall be read in its entirety and not severed except as provided below.

17.2 Conversion Privilege

There are no conversion privileges under the Plan.

17.3 Non-Alienation of Benefits

No Benefit, right or interest of any person hereunder shall be subject to anticipation, alienation, sale, transfer, assignment, pledge, encumbrance or charge, seizure, attachment or legal, equitable or other process or be liable for, or subject to, the debts, liabilities or other obligations of such person, except as otherwise required by law.

17.4 Limitation on Employee Rights

Nothing appearing in or done pursuant to the Plan shall be held or construed:

(1) to give any person any legal or equitable right against the Commission, the Employer, the Board, or the Claims Administrator, except as expressly provided herein or provided by law;

(2) to create a contract of employment with any Employee, to obligate the Employer to continue the service of any Employee or to affect or modify the terms of employment of any person in any way; or

(3) to create any vested rights to Benefits or the right to any Benefits or Coverage, except for Covered services rendered prior to the effective date of Plan amendments or Plan termination or the termination of Coverage.

17.5 Governing Law

To the extent not preempted by federal law, the provisions of the Plan shall be construed, enforced and administered according to the laws of the State of Missouri.

17.6 Severability

If any provision of the Plan is held invalid or unenforceable, its invalidity or unenforceability shall not affect any other provisions of the Plan, and the Plan shall be construed and enforced as if such provision had not been included herein.

17.7 Captions

The captions contained herein are inserted only as a matter of convenience and for reference, and in no way define, limit, enlarge or describe the scope or intent of the Plan, nor in any way will affect the Plan or the construction of any provision thereof.

17.8 Non-Gender Clause

Whenever used in the Plan, the masculine gender will include the feminine and the plural form will include the singular.

ARTICLE 18

BASIC (STATE PAID) LIFE INSURANCE PLAN

18.1 General Information

(1) The life insurance coverage outlined in this Plan is subject to every term, condition, exclusion, limitation, and provision of the current Minnesota Life Insurance group policy. In case of a conflict or inconsistency in the language of this Article and the language of the current Minnesota Life Insurance group policy, the language of the current Minnesota Life Insurance group policy shall govern.

(2) A copy of the current Minnesota Life Insurance group policy is available for review at: http://www.modot.org/newsandinfo/benefits.htmeneral Information.

18.2 Eligible Individuals

All Employees and individuals on Work-Related and Long-Term Disability Status with MoDOT, MSHP, and MPERS who are members of MPERS. (The eligibility date for Work-Related Disability Recipients was July 1, 2004.)

18.3 Effective Date of Coverage

The effective date for new Employees who enroll in Basic Life Insurance Coverage shall be the Employee's date of hire.

Application must be made within thirty-one (31) days after eligibility.

18.4 Amount of Life Insurance

(1) Beginning January 1, 2001, the maximum amount of insurance for which an Employee is eligible shall be one (1) times the annual Benefit base rate rounded to the next higher one thousand dollars ($1,000). MoDOT, MSHP, or MPERS provide this Benefit at no cost to the Employee, except as stated in Article 18.4. The amount of Coverage will be effective January 1st of each year based on the Employee's July 31st annual Benefit base rate of the preceding year.

(2) Long-Term Disability Recipients approved for Benefits prior to January 1, 2002, can continue with the amount they currently have in force. A Long-Term Disability Recipient approved for disability Benefits after January 1, 2002, can retain the amount of insurance Coverage in force on the date he ceased to be a full-time, permanent part-time or seasonal Employee eligible for Benefits.

(3) A Work-Related Disability Recipient approved for disability Benefits on July 1, 2004, or after, can retain the amount of insurance Coverage in force on the date he ceased to be a full-time, permanent part-time or seasonal Employee eligible for Benefits.

(4) This Coverage shall provide for triple indemnity if death is a result of Injury or disease occurring on or after the effective date of insurance and arising out of and in the course of actual performance of duty as an Employee.

18.5 Cost

There shall be no cost to the Employee for the life insurance provided, unless such Employee is on an authorized leave of absence without pay for the purpose of military, education, maternity, Illness, Emergency, family medical leave, etc. In such cases, the Employee may continue Coverage by paying the required Premium normally paid by the State for the amount of Coverage provided.

Evidence of insurability will not be required if an Employee's insurance was canceled while on an authorized leave of absence and he later returns to work. The Employee will qualify for Coverage as soon as he is paid on the payroll. Application should be completed at that time for re-enrollment.

Individuals on Work-Related Disability or Long-Term Disability who desire to continue Life Insurance Coverage, must pay the required Premium normally paid by the State for the amount of Coverage provided. The Premium payment is to be made through payroll deduction for those disability recipients approved prior to July 1, 2004. After July 1, 2004, the disability recipient will be required to make a manual payment or electronic transfer of funds.

18.6 Beneficiary

The Employee, Work-Related Disability Recipient, or Long-Term Disability Recipient must name the beneficiary(s) on the furnished form. The beneficiary(s) may be changed by completing and filing the required form.

18.7 Termination of Coverage

Coverage for terminating or retiring Employees terminates at the end of the month in which the Employee terminates or retires.

Coverage for individuals on Work-Related Disability or Long-Term Disability status will terminate in the event the individual retires or fails to make the Premium payment. If Coverage is canceled while on Work-Related Disability or Long-Term Disability, re-enrollment is not allowed unless and until the person returns to active work status.

If you are laid off, due to lack of work, your Coverage may be continued sixty (60) consecutive days following the month in which the lay-off commenced.

18.8 Portability and Conversion Privileges

If Basic Life Insurance, or any portion thereof, terminates, any individual Covered under the Policy may make application for portability or conversion with the current insurance carrier without providing Evidence of Good Health.

To apply for portability or conversion, the individual must, within thirty-one (31) days of the date group Coverage terminates, make written application to the insurance carrier and pay the Premium required for his age and class of risk.

ARTICLE 19

OPTIONAL GROUP LIFE INSURANCE PLAN

19.1 General Information

(1) The life insurance coverage outlined in this Plan is subject to every term, condition, exclusion, limitation, and provision of the current Minnesota Life Insurance group policy. In case of a conflict or inconsistency in the language of this Article and the language of the current Minnesota Life Insurance group policy, the language of the current Minnesota Life Insurance group policy shall govern.

(2) A copy of the current Minnesota Life Insurance group policy is available for review at: http://www.modot.org/newsandinfo/benefits.htmeneral Information.

19.1 Eligibility Provisions

(1) Employees, Long-Term and Work-Related Disability Recipients, and Retirees

All Employees and individuals on Work-Related Disability and Long-Term Disability status with MoDOT, MSHP, or MPERS who are members of MPERS and currently Covered under the Basic (State Paid) Life Insurance Plan are eligible.

Employees on an approved military leave of absence may elect to continue their Coverage as long as Premiums are paid and they have continued their Basic (State Paid) Life Coverage. If the Employee terminates his Coverage while on an approved military leave of absence, they may reinstate their Coverage upon return to active employment following an honorable discharge (provided the total military leave does not exceed five (5) years). The Coverage can be provided without Evidence of Good Health as long as they are rehired by the Employer and make application for reinstatement of Coverage within thirty-one (31) days from the date of their return to active employment. Coverage cannot go into effect before the person returns to active employment and cannot exceed the amount for which they are eligible.

Retirees may retain insurance Coverage as specified in Article 19.4, “Amount of Life Insurance” (3), (4), (5), and (6).

No Retiree or disability recipient may terminate Coverage and later re-enroll, except a Retiree who terminates their Coverage while on active military leave. Upon their return from military leave, they may reinstate their Coverage in the amount they had immediately prior to the leave (provided the leave does not exceed five (5) years). The Retiree must apply for reinstatement within thirty-one (31) days from the date of honorable discharge from the military.

(2) Dependents - Spouse and/or Child(ren) of Employees Enrolled in Optional Group Life Insurance

a) Spouse – Your lawful spouse who is not legally separated from you and is eligible to enroll for coverage if the Employee meets the active work provisions as stated in the current policy. The following requirements must be met:

i. the Employee is enrolled;

ii. the Employee applies for Spouse Coverage within thirty-one (31) days of date of Marriage or Employee's date of hire;

iii. if Evidence of Good Health is required, the application must be approved by the insurance carrier prior to the Employee's status change to Work-Related or Long-Term Disability Recipient or Retiree; or

iv. the Retiree, Work Related Disability or Long Term Disability Recipients elect to continue Spouse Coverage upon their status change from active employment.

b) Unmarried Dependent children (including natural born child(ren), legally adopted or granted U.S. Citizenship and/or child(ren), stepchild(ren), or any other child(ren) related to the Employee by blood or Marriage and who live with the Employee in a regular parent-child relationship), as follows:

i. If the Subscriber is enrolled in Dependent child Life Insurance Coverage, the Dependent child(ren) will be Covered from live birth, at the time of physical placement for an adopted child, or at the time granted U.S. Citizenship, up to the date the child turns twenty-six (26) years of age and continues to meet the eligibility requirements of the Plan.

ii. If you do not otherwise have Dependent Life Insurance Coverage in place for your child(ren), you must apply in writing within thirty-one (31) days from the date Dependent life insurance under this provision is effective.

iii. Unmarried Dependent children twenty-six (26) years of age or older if the child is disabled and primarily dependent upon the Employee for financial support, and if satisfactory proof of the dependence upon the Employee for financial support, and satisfactory proof of the Dependent child's disability is submitted within thirty-one (31) days of the date the Dependent child reaches such age. The insurance carrier will have the right to require satisfactory proof that the child continues to meet the required conditions as often as necessary during the first two (2) years of continuation, but not more than once a year after that.

Any Dependent who is full-time military, naval or air force service cannot be a Dependent.

19.2 Effective Date of Coverage

(1) Employees, Long-Term and Work-Related Disability Recipients, and Retirees

The effective date of Coverage of a new Employee will be on the first day of the calendar month following date of employment. For insurance Coverage to become effective:

a) the Employee must enroll for Coverage within thirty-one (31) days of date of hire;

b) pay the required Premiums; and

c) meet the active work provisions of the current policy. Employees who do not meet the active work provisions on the effective date will be eligible for Coverage when they return to their assigned duties as specified in the policy.

All Employees enrolled in Optional Group Life Insurance shall become insured on the effective date of their retirement or disability in accordance with Article 19.3, “Amount of Life Insurance”, if they apply for Retiree Coverage and continue to pay their Premiums.

(2) Dependents - Spouse and/or Child(ren)

a) Spouse and/or eligible Dependent child(ren) Coverage, as stated in Articles 19.4(7) and 19.4(8), may become effective on the first day of the next calendar month following the Employee’s date of hire. For insurance Coverage to become effective the Employee must:

i. enroll in Optional Group Life Insurance;

ii. enroll for Dependent Coverage;

iii. pay the required Premiums; and

iv. meet the active work provisions of the current policy. Coverage on Dependents of Employees who do not meet the active work provisions will become effective on the date the Employee returns to their assigned duties as specified in current policy.

b) Spouse is eligible for Coverage, as stated in Article 19.4(7) on the date of Marriage if:

i. the Employee is enrolled in Optional Life Insurance on that date;

ii. application is made within thirty-one (31) days of date of Marriage;

iii. Premiums are paid; and

iv. the Employee meets the active work provisions of the current policy.

c) Refer to Article 19.8, “Evidence of Insurability,” for additional Spouse Coverage and/or late enrollment requirements.

d) Dependent children born after the Employee hire date can enroll as follows:

i. effective on the date of birth if application is received within thirty-one (31) days of date of birth; or

ii. at any time as long as he/she continues to be an eligible Dependent, application is received, and payroll deduction is authorized to cover any additional Premium, with an effective date the first of the month following receipt of application. Evidence of Insurability is not required.

19.3 Amount of Life Insurance

(1) Employees

The maximum amount of insurance for which an Employee is eligible shall be six (6) times the annual Benefit base rate rounded to the next higher one thousand dollars ($1,000) and not to exceed eight hundred thousand dollars ($800,000).

New Employees can choose from the following elections when enrolling for Coverage:

a) Minimum of fifteen thousand dollars ($15,000).

b) A multiple of one (1) times to six (6) times their annual Benefit base rate with automatic annual increases effective January 1 of the year following an increase in their annual Benefit base rate reflected on July 31st of the preceding year.

c) A flat amount in a one thousand dollar ($1,000) increment equal to or greater than fifteen thousand dollars ($15,000) not to exceed six (6) times their annual Benefit base rate; with no automatic annual increase without evidence of insurability.

(2) Work-Related and Long-Term Disability Recipients

Long-Term Disability Recipients approved for Benefits prior to January 1, 2002, will continue with the amount they currently have in force. A Long-Term Disability Recipient approved for disability Benefits after January 1, 2002, can retain the amount of insurance Coverage in force on the date he ceased to be a full-time, permanent part-time or seasonal Employee eligible for Benefits.

Work-Related Disability Recipients approved for Benefits prior to July 1, 2004, will continue with the amount of Coverage they currently have in force. A Work-Related Disability Recipient approved for disability Benefits after July 1, 2004, can retain the amount of insurance Coverage in force on the date he ceased to be a full-time, permanent part-time or seasonal Employee eligible for Benefits.

Work-Related and Long-Term Disability Recipients can continue with the amount of Coverage (as stated above) they have in force at the time they are approved for disability. When they become eligible to retire, they can continue all or a portion of their Optional Life Insurance in accordance with the Plan guidelines stated in Article 19.4(3), 19.4(4), 19.4(5) and 19.4(6).

(3) Retirees (Retirement date prior to September 1, 1998.)

a) Employees retired prior to May 1, 1982, are not eligible for Coverage.

b) Employees retired between May 1, 1982, and May 1, 1984, may retain an amount no greater than two thousand five hundred dollars ($2,500) in multiples of five hundred dollars ($500).

c) Employees retired on or after May 1, 1984, may retain an amount no greater than five thousand dollars ($5,000) in multiples of five hundred dollars ($500).

d) Employees retired on or after September 1, 1988, may retain an amount no greater than ten thousand dollars ($10,000) in multiples of five hundred dollars ($500).

e) Employees retired on or after May 1, 1996, may retain an amount no greater than sixty thousand dollars ($60,000) in multiples of five hundred dollars ($500).

(4) Retirees under the "Closed Plan" (Retirement date September 1, 1998, or thereafter) may retain Optional Group Life Insurance into retirement as follows:

a) Maximum Coverage of sixty thousand dollars ($60,000)

b) Minimum Coverage of fifteen thousand dollars ($15,000)

c) Employees who carry Optional Group Life Insurance in an amount less than sixty thousand dollars ($60,000) may retain the amount of optional Coverage they carried as an Employee, plus the amount of their Basic (State Paid) Life Insurance Coverage, not to exceed sixty thousand dollars ($60,000).

d) Any Employee with less than sixty thousand dollars ($60,000) Coverage (Optional plus Basic (State Paid)) as an Employee must provide evidence of insurability to increase their Coverage (maximum sixty thousand dollars ($60,000)). Application for increased Coverage must be submitted and approved prior to retirement.

Example: An Employee carries fifteen thousand dollars ($15,000) Optional Group Life Insurance, plus thirty thousand dollars ($30,000) Basic (State Paid) Life Insurance, for a total of forty-five thousand dollars ($45,000) in Coverage. The maximum amount of Optional Group Life Insurance this Employee may carry into retirement (without evidence of insurability) is forty-five thousand dollars ($45,000).

e) Employees who carry only the Basic (State Paid) Life Insurance may elect Optional Group Life Insurance in an amount equal to their Basic (State Paid) Life Insurance, not to exceed sixty thousand dollars ($60,000), without evidence of insurability. If Basic (State Paid) Life Coverage is less than sixty thousand dollars ($60,000), they must provide evidence of insurability to increase their Coverage (maximum sixty thousand dollars ($60,000)). Application for increased Coverage must be made prior to retirement.

f) Employees who <u>did not carry the Basic (State Paid) Life Insurance</u> at the time of their retirement **<u>are ineligible</u>** to enroll in Optional Group Life Insurance.

(5) Retirees (Retirement date July 1, 2000, or thereafter) retiring under the "Year 2000 Plan" and receiving the temporary annuity of eight-tenths of a percentage point (.8%) may retain Optional Group Life Insurance as follows:

a) Minimum of fifteen thousand dollars ($15,000)

b) Employees who carry Optional Group Life Insurance can retain the amount of Coverage in effect the month prior to retirement. (Basic (State Paid) Coverage cannot be included in this amount).

c) Coverage will be reduced at age sixty-two (62) years to the maximum allowed of sixty thousand dollars ($60,000).

(6) Employees retiring January 1, 2007, will be eligible for the above Coverage amounts listed in Article 19.4(4) and 19.4(5), and Spouse Coverage listed in Article 19.4(7). The Coverage amounts must be in one thousand dollars ($1,000) increments.

(7) Spouse (Effective May 1, 2006)

Spouse insurance Coverage is as follows:

a) Guaranteed issue of fifteen thousand dollars ($15,000), if enrolled within thirty-one (31) days of Employee's date of hire or within thirty-one (31) days of date of Marriage and the Employee meets the active work provisions of the current policy;

b) Coverage greater than fifteen thousand dollars ($15,000) requires an approved application, and may be purchased in multiples of five thousand dollars ($5,000) up to one hundred thousand dollars ($100,000), not to exceed the amount of insurance carried by the Employee, Work-Related Disability Recipient or Long-Term Disability Recipient. If the application for increased Coverage is approved, to become effective the Employee must meet the active work provisions of the current policy. Increased Coverage cannot be approved for a Spouse of a Retiree, Work-Related Disability Recipient or Long-Term Disability Recipient;

c) Minimum of fifteen thousand dollars ($15,000);

d) Spouse Coverage can continue into retirement in five thousand dollars ($5,000) increments not to exceed Retiree's Coverage amount; however, upon the Retiree's death, Spouse Coverage terminates.

(8) Child(ren)

Child(ren) insurance is issued for a fixed amount of fifteen thousand dollars ($15,000) of Coverage per child.

19.4 Adjustments in the Amount of Coverage or Premium

(1) Employees, Long-Term and Work-Related Disability Recipients, and Retirees

a) If an Employee, Long-Term or Work-Related Disability Recipient, or Retiree's birthday causes him to be placed into an age bracket requiring a higher Premium, the payroll deduction Premium will be automatically increased the month following his date of birth. If the annual Benefit base rate of an Employee decreases and reduces the maximum amount of Coverage the Employee is entitled to, such reduction will automatically take effect on the first day of the month following the reduction in eligibility.

b) Retirees may reduce the amount of their Coverage in five hundred dollar ($500) increments at any time but may not increase the amount of their Coverage.

c) Work-Related Disability Recipients and Long-Term Disability Recipients may reduce the amount of their Coverage in one thousand dollar ($1,000) increments at any time but may not increase the amount of their Coverage. They also cannot discontinue Coverage and later re-enroll. When the Disability Recipients become eligible to retire,

they can continue all or a portion of their Optional Life Insurance as set out in Article 19.4(3), 19.4(4), 19.4(5) and 19.4(6) offered to Retirees. If a Work-Related Disability Recipient or Long-Term Disability Recipient had canceled his Optional Group Life Insurance and returns to active work status he can re-enroll with approved evidence of insurability.

d) Coverage for Employees participating in the Optional Group Life Insurance, who are enrolled in a multiple of one (1) times to six (6) times their annual Benefit base rate, will automatically increase on January 1, the year following any increase in the Employee's annual Benefit base rate reflected on July 31st of the preceding year.

(2) Spouse

a) The Premium for Spouse Coverage will automatically increase the month following the birthday of the Employee, Work-Related or Long-Term Disability Recipient, or Retiree, which causes the Spouse to be placed into an age bracket requiring a higher Premium. The Premium for Spouse Coverage is based on the Employee, Work-Related or Long-Term Disability Recipient, or Retiree's age.

b) If the annual Benefit base rate of an Employee decreases and reduces the amount of Optional Group Life Insurance for that Employee, the amount of Spouse insurance may be reduced. If the amount of Spouse insurance is reduced, the reduction will automatically take effect on the first day of the month following the reductions in wage or Benefit.

c) If the annual Benefit base rate of an Employee increases, the amount of Spouse insurance may be allowed to increase, subject to the limitations of the Plan with evidence of insurability. This increase must be initiated by the Employee.

19.5 Cost

(1) The cost of the insurance is based upon the amount of Coverage times the rate for their appropriate age bracket.

(2) The cost of insurance for a Spouse is based upon the amount of Coverage times the rate for the Employee, Work-Related or Long-Term Disability Recipient, or Retiree's appropriate age bracket.

(3) Rates are based on a contract bid by an insurance carrier and may change. Participants will be notified in advance of any such changes.

19.6 Beneficiary

(1) Employees, Long-Term and Work-Related Disability Recipients, and Retirees

The Employee, Long-Term or Work-Related Disability Recipient, or Retiree must designate a beneficiary or beneficiaries before insurance becomes effective. Such a designation must be stated on the furnished form. The beneficiary or beneficiaries may be changed by completing and filing the required form.

(2) Dependents - Spouse and/or Child(ren)

The Employee, Retiree, Work-Related or Long-Term Disability Recipient is the beneficiary of Dependents Optional Group Life Insurance.

19.7 Evidence of Insurability

(1) General Requirements

If evidence of insurability is required based on one (1) of the conditions listed below, you must complete and submit a Medical History Statement, along with the enrollment form, to your insurance representative. Any proposed insured may also be asked to have a health examination. If the insurance company approves Coverage, the insurance will become effective on the first day of the month following the date of approval if the Employee meets the active work provisions of the current policy.

a) Employees – Evidence of insurability required if:

i. enrollment is not made within thirty-one (31) days from the date of employment.

ii. the Employee elects to increase his Coverage for any reason other than an annual Benefit base rate increase.

iii. the Employees, Work-Related and Long-Term Disability Recipients planning to retire and wishing to retain their current level of Coverage after retirement will not be required to show evidence of insurability, except as set forth in Article 19.3.

b) Spouse – Evidence of insurability required:

i. if enrollment for Spouse Optional Group Life Insurance is not made within thirty-one (31) days of the date of eligibility.

ii. at any time when the desired amount of Spouse insurance exceeds fifteen thousand dollars ($15,000).

iii. at any time after the initial eligibility period if the Employee requests an increase in the amount of Spouse insurance and the Employee meets the active work provisions as stated in the current policy.

c) Dependent – Children

Evidence of Insurability will not be required for child(ren) Coverage at any time as long as they meet the eligibility guidelines for a Dependent.

19.8 Termination of Coverage

(1) Employees, Long-Term and Work-Related Disability Recipients, and Retirees will terminate as follows:

a) Upon termination of this policy;

b) For terminating Employees, at the end of the last month of employment;

c) Employees laid off due to lack of work may continue Coverage, including Dependent life Coverage, for sixty (60) consecutive days following the month in which the lay-off commenced.

d) For retiring Employees, coverage will terminate at the end of the last month of employment unless the Employee enrolls under the Retiree provisions;

e) Upon change of status from the long-term or work-related disability to Retiree, unless the disability Participant enrolls under the Retiree provisions; or

f) Upon failure to make required Premium payment; or

g) If termination is requested by the Participant, with cancellation to be effective the first day of the month following receipt of the cancellation form by the Employee Benefits Office located in Jefferson City, MO.

(2) Dependents - Spouse and/or Child(ren)

Spouse Coverage will terminate as follows:

a) Upon the date Coverage of the Employee, Long-Term or Work-Related Disability Recipient, or Retiree terminates due to non-payment of Premiums, cancellation of policy, or death;

b) In the event of a divorce; or

c) If the Employee, Long-Term and Work-Related Disability Recipient, or Retiree elects to terminate Spouse Coverage, with cancellation to be effective the first day of the month following receipt of the cancellation form by the Employee Benefits Office located in Jefferson City, MO.

Child Coverage will terminate as follows:

a) Upon the child's Marriage;

b) Upon the date the child attains twenty-six (26) years of age, unless the child qualifies for continued Coverage as a disabled child and the Employee reapplies for Coverage within thirty-one (31) days of the normal termination date of the child;

c) Upon the date Coverage of the Employee, Long-Term and Work-Related Disability Recipient terminates;

d) If the Employee, Long-Term and Work-Related Disability Recipient elects to terminate child Coverage, with cancellation to be effective the first day of the month following receipt of the cancellation form by the Employee Benefits Office located in Jefferson City, MO; or

e) Upon the Employee or Long-Term or Work-Related Disability Recipient's retirement.

19.9 Portability and Conversion Privileges

If Optional Life Insurance or any portion thereof, terminates, then any individual Covered under the Policy may make application with the insurance carrier for portability or without providing Evidence of Good Health.

To apply for portability or conversion of life insurance, the individual must, within thirty-one (31) days of the date group Coverage terminates, make written application to the insurance carrier and pay the Premium required for his age and class of risk.