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 Brandon Denkler, Assistant to the Chief Administrative Officer, 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 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 ratemaking; 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:** Anthem 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.

[i] 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, 2025, 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.

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 8.2. 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 Out-of-Pocket Maximum Benefit. Nor will this penalty apply if admitted as In-patient from the Emergency Room. 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
Second Edition - January 1,1997
Third Edition – May 1,1999
Fourth Edition – January 1, 2001
Fifth Edition – January 1, 2003
Sixth Edition – January 1, 2005
Seventh Edition – January 1, 2007
Eighth Edition – January 1, 2008
Ninth Edition – January 1, 2009
Tenth Edition – January 1, 2010
Eleventh Edition – May 1, 2010
Twelfth Edition – January 1, 2011
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
Twenty-First Edition – January 1, 2018
Twenty-second Edition – February 2019
Twenty-third Edition – January 29, 2020
Twenty-Fourth Edition – January 1, 2021
Twenty-Fifth Edition – January 1, 2022
Twenty-Sixth Edition – January 1, 2023
Twenty-Seventh Edition – January 1, 2024
Twenty-Eighth Edition – January 1, 2025

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) 522-1294

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) 607-2140
Central District - Jefferson City	(573) 522-5168
St. Louis District - St. Louis	(314) 453-1717 or (314) 453-1709
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 Spring	(636) 300-2800, ext. 3341
Troop D – Springfield	(417) 895-6868, ext. 3452
Troop E – Poplar Bluff	(573) 840-9500, ext. 3519
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:

Anthem – Claims and Network Administrator

Participant Services Phone..... (833)290-2481
Prior Authorization Phone..... (800)992-5498
Live Health Online..……..... (866)647-6117
Mental Health or Chemical Dependency:
Anthem Behavioral Health... ..... (800)788-4003

Wellness Coordinator……(314)923-8662
Web Address..... www.anthem.com

Medical Claims Mailing Address:

Anthem Blue Cross Blue Shield
P. O. Box 105187
Atlanta, GA 30348-5187

CarelonRx/Anthem. - Prescription Drug Program Administrator

Non-Medicare Participants
Retail/Mail Order Prescription Drug Questions ..... (833)267-2133

Web Address …….....www.anthem.com

United Health Care- Medicare Advantage Prescription Drug Plan Administrator
Coverage and Benefit Information:
Customer Service Number…….(844)465-2406
Web Address…… retiree.uhc.com/MoDOT-MSHP

MetLife Insurance Company – Optional and Basic Life Insurance
Customer Service Number……..... (800)638-6420

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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

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.

Employees with religious beliefs or moral convictions contrary to this coverage can contact the Employee Benefits Office at (877) 863-9406 to see what options may be available.

1.11 Board of Trustees (Board)

The body established by the Commission to provide for the general management 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 10.

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 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.

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 (Cover 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 their family, maintenance of the Participant, or which is designed essentially to assist the Participant in meeting their 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 $600, the Plan will not pay anything until the Participant has met the $600 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.

Family Maximum: When the maximum amount shown in Appendices A and B of Article 4 for non-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 the Subscriber is required to provide Coverage under a Qualified Medical Child Support Order (QMCSO) (legal documentation required).

(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 should have 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) cardiograph, 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 12.2.

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 such item 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 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 are made.

1.59 Intensive Care Unit

A section, ward or wing within a Hospital that meets all 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 Providers

Represents a category of non-par specialist providers who are typically Hospital based, which include, but are 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 Nanometric

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, except for 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 with Providers where reimbursements for Health Care Services are furnished at discounted rates. Under this arrangement the Participant is not responsible for charges above the Allowed Amount. The Provider will file all Claims for the Participant and should not ask for payment at the time of service. The Participant 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. The Participant 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 8.2 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 RS Mo. 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 RS Mo. 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 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.

(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 time period 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 children.

(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, the Employee must make an election by filing an application to be received by

the Employee Health and Wellness 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 the application includes a request for Spouse/Dependent Coverage, the 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 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) they elect in writing to terminate Plan Coverage and select Medicare; at which time his Dependent Coverage will also end; or

b) they do 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 terminated.

(2) an Employee's Spouse who reaches age sixty-five (65) 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 UHC Medicare Advantage Prescription Drug Plan, 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, including making a fraudulent claim or an intentional material misrepresentation in applying for or obtaining Coverage or Benefits under the Plan. The Plan may void Coverage for the Subscriber and/or Covered Dependents for the time period 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 themselves or their Dependents if they have 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, they will not be allowed to terminate medical Coverage for themselves or their Dependents unless they have a Change in Status event approved by the cafeteria plan administrator. If a subscriber terminates Coverage, they 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:

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

c) 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 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 10, 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) and elects to terminate the Plan and select Medicare, his Dependent Coverage will also terminate, subject to the continuation of Coverage provisions in Article 10.

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) the termination of the Plan; or

e) the date of the Dependent's 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 their effective date of employment, they can only be enrolled if they have a qualifying event as stated in Article 3.2 or during open enrollment as stated in Article 3.1(3).

(3) If an Employee enrolls during their 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 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) An employee who marries after their first initial eligibility period as stated in Article 3.1(1), may enroll themselves and new eligible dependents within 31 days of date of marriage.

(2) 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.

(3) An employee who gains a dependent through birth or adoption after their first eligibility period as stated in Article 3.1(1), may enroll themselves, their spouse, and any eligible dependents within 31 days of the dependents birth or adoption.

(4) 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.

(5) 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.

(6) 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.)

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

(8) 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.

(9) 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) Dependent's COBRA eligibility period expires, and they meet the eligibility requirements of the Plan;

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

f) They are no longer eligible for military Coverage.

(Loss of Coverage or total loss of employer contribution towards the Spouse's plan cannot be the result of gaining Medicare eligibility.)

(10) 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.

(11) 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.

(12) 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.

(13) 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(13), application must be received within sixty (60) days after other Coverage ends. If the qualifying event is loss of military Coverage, refer to section 3.2(6) 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; and

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

4.2 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.

4.3 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.

4.4 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.

4.5 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.

4.6 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 1/1/2025

This Schedule of Benefits summarizes obligations 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.

PPO 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 $600 Family Maximum $1,800 (Defined as three (3) or more family members)	Individual $600 Family Maximum $1,800 (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.	Individual $100	Not Covered

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

PPO 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 $1,950 Family Maximum $5,850 (Defined as three (3) or more family members)	Individual $2,955 Family Maximum $8,865 (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	Individual $5,000 Family $8,400	Not Covered

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

PPO BENEFITS AND SERVICES		PARTICIPANT'S RESPONSIBILITY	
		IN-NETWORK	OUT-OF-NETWORK
	* Medical Copayments * 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 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	*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.

PPO BENEFITS AND SERVICES		PARTICIPANT'S RESPONSIBILITY	
		IN-NETWORK	OUT-OF-NETWORK
	Cancer Screenings (continued) 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.		
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

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

PPO BENEFITS AND SERVICES		PARTICIPANT'S RESPONSIBILITY	
		IN-NETWORK	OUT-OF-NETWORK
10.	**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
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, accidental Injury, or the Calendar Year Out-Of-Packet Maximum has been met.**	$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 Services** ***Prior Authorization required.***	10% Coinsurance after medical Deductible	Not Covered

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

PPO BENEFITS AND SERVICES		PARTICIPANT'S RESPONSIBILITY	
		IN-NETWORK	OUT-OF-NETWORK
		(1) Hearing aids/screening for dependent children with Developmental Delays up to twenty-six (26) years of age a) Limited to one (1) hearing aid per ear every twenty-four (24) months. b) Limited to one (1) diagnostic hearing screening and/or audiogram every twelve (12) months. (2) Cochlear Implants – if deemed medically necessary	
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	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.

PPO BENEFITS AND SERVICES		PARTICIPANT'S RESPONSIBILITY	
		IN-NETWORK	OUT-OF-NETWORK
	biologicals, anesthesia, special duty nursing as prescribed, short-term Rehabilitation Services, nursing care, meals, and special diets. ***Prior Authorization required.***		
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*

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

PPO BENEFITS AND SERVICES		PARTICIPANT'S RESPONSIBILITY	
		IN-NETWORK	**OUT-OF-NETWORK**
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
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*	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.

PPO BENEFITS AND SERVICES		PARTICIPANT'S RESPONSIBILITY	
		IN-NETWORK	**OUT-OF-NETWORK**
		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.*	
24.	**Orthotic Appliances and Prosthetic Devices** ***Prior Authorization required on certain appliances and devices.***	10% Coinsurance of Covered expenses after medical Deductible	20% Coinsurance of Out-of-Network Rate after medical Deductible*
25.	**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
26.	**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***
27.	**Prescription Drug Program** Prescription Drug Coverage is available through Participating pharmacies only.	30% Coinsurance of costs after pharmacy Deductible. A minimum $5 Copayment	Not Covered

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

PPO BENEFITS AND SERVICES		PARTICIPANT'S RESPONSIBILITY	
		IN-NETWORK	OUT-OF-NETWORK
	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".**	is required.	
28.	**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-childcare, and child health supervision services, Covered under the Plan. **Refer to the "Office Visits" section of this article.** Refer to Appendix C in Article 5.	Covered at 100% for Preventive Care service.	Not Covered
29.	**Prosthetic Devices and Orthotic Appliances**	Refer to the "Orthotic Appliances and Prosthetic Devices" section of this article.	
30.	**Skilled Nursing Facility** Coverage is provided in lieu of an Inpatient Hospital admission when approved by the Plan. Coverage is provided for 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*
31.	**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	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.

PPO BENEFITS AND SERVICES		PARTICIPANT'S RESPONSIBILITY	
		IN-NETWORK	OUT-OF-NETWORK
	per calendar year for both In-Network and Out-of-Network and is subject to applicable Deductibles(s) and Coinsurance.		
32.	**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.
33.	**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	$25 Copayment for office visit only. 20% Coinsurance of the Out-of-Network Rate after medical Deductible for other services*
34.	**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 1/1/2025

This Schedule of Benefits summarizes obligations 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.

HDHP/HSA 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. If you have dependents on the plan, the family maximum of $3,500 must be met before the Plan begins to pay.	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.

HDHP/HSA 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. If you have dependents on the plan, the family maximum of $6,600 must be met before the Plan pays 100%. 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*
5.	**Cancer Screenings** Cancer screenings shall include the following:	*If processed as medical Benefit:* 30% Coinsurance	*If processed as medical Benefit:* 50% Coinsurance of

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

HDHP/HSA BENEFITS AND SERVICES		PARTICIPANT'S RESPONSIBILITY	
		IN-NETWORK	**OUT-OF-NETWORK**
	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.	after Deductible *If processed as Preventive Care service:* Covered Services will be paid at 100%	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.

HDHP/HSA 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
11.	**Emergency Services** Coverage is provided for worldwide Emergency Services as defined in Article 1.34 and as deemed an	30% Coinsurance after Deductible	*If deemed Emergency Services:*

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

HDHP/HSA BENEFITS AND SERVICES		PARTICIPANT'S RESPONSIBILITY	
		IN-NETWORK	OUT-OF-NETWORK
	emergency by the Claims Administrator.		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 Services** ***Prior Authorization required.***	30% Coinsurance after Deductible (1) Hearing aids/ screening for dependent children with Developmental Delays up to twenty-six (26) years of age. a) Limited to one (1) hearing aid per ear every twenty-four (24) months. b) Limited to one (1) diagnostic hearing screening and/or audiogram every twelve (12) months. (2) Cochlear Implants when deemed medically necessary	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.

HDHP/HSA 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
17.	**Maternity Care Office Visits** *Coverage for Subscriber or Dependent.* Covered services include pre-natal	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.

HDHP/HSA BENEFITS AND SERVICES		PARTICIPANT'S RESPONSIBILITY	
		IN-NETWORK	OUT-OF-NETWORK
	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.		
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
21.	**Office Visits** a) **Non-Preventive** Care including diagnosis and consultation performed at either a Primary Care Physician (PCP) or	*If processed as medical Benefit:* 30% coinsurance	*If processed as medical Benefit:* 50% Coinsurance of Out-of-Network Rate

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

HDHP/HSA BENEFITS AND SERVICES		PARTICIPANT'S RESPONSIBILITY	
		IN-NETWORK	**OUT-OF-NETWORK**
	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.	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	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
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***

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

HDHP/HSA BENEFITS AND SERVICES		PARTICIPANT'S RESPONSIBILITY	
		IN-NETWORK	OUT-OF-NETWORK
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-childcare, and child health supervision services, Covered under the Plan. **Refer to the "Office Visits" section of this article.** Refer to Appendix C in Article 5.	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.

HDHP/HSA 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.
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.	30% Coinsurance for office visit only after deductible 50% Coinsurance of the Out-of-Network Rate after Deductible* for all other services provided.

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

HDHP/HSA BENEFITS AND SERVICES		PARTICIPANT'S RESPONSIBILITY	
		IN-NETWORK	OUT-OF-NETWORK
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:

(1) are deemed Medically Necessary,

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

(3) are 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. 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 a Participating Provider 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 8.2 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 antihistamines 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**
Birth Control* **Refer to "Contraceptives Oral" and "Contraceptives Other" as outlined in Appendices A and B of Article 4 for non-Medicare.** * Employees with religious beliefs or moral convictions contrary to this coverage can contact the Employee Benefits Office at (877) 863-9406 to see what options may be available.	Coverage of Birth Control is provided, including Medically Necessary Abortions, Contraceptive methods and counseling, and Sterilization for 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; 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. 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.	Prior Authorization may be required, except for a vasectomy performed in a Physician's office. **Exclusions:** (1) Abortions other than Medically Necessary Abortions (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**
Blood and Blood Products	Covered service for administration and processing of blood and blood products in connection with services 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
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.

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**
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
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.	Prior Authorization is required. **Limitations:** Coverage is limited to Participating Providers. **Exclusions:** Routine patient care for any clinical trial that does not meet the criteria of Covered 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**
Clinical Trials (continued)	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.	
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. Colorectal cancer exams for symptomatic Participants will be Covered as needed.	**Exclusions:** 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.	
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. Reconstructive surgery is Covered under 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	Prior Authorization required. **Limitations:** Psychological or emotional conditions that do not constitute Medical Necessity **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; b) hair growth; c) sexual performance; d) athletic performance;

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)	(4) for the grafting of skin to any other part of the body;	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.
Dental Services	(1) A dental examination prescribed by a Physician prior to joint replacement, valve replacement or transplant surgery to verify an infection or 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.	Limited Benefit. Prior Authorization required. **Exclusions:** (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

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 (continued)	(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. Actual dental work affiliated with these services will not be Covered. (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.	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 jawbone) 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.
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;	Prior Authorization required for insulin pumps and cartridges. **Limitations:** (1) Glucose monitors, glucose strips, and lancets are Covered under the Prescription Drug program

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SERVICE OR SUPPLY	**CRITERIA AND COVERAGE PROVIDED**	**AUTHORIZATION REQUIREMENTS, LIMITATIONS, AND EXCLUSIONS**
Diabetic Services and Supplies (continued)	(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 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 (5) diabetic eye examination per 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.	(2) Insulin and syringes will be Covered under the Prescription Drug program of the Plan for non-Medicare Participants (3) More than one (1) pair of therapeutic shoes and one (1) shoe insert per calendar year **Exclusions:** Diabetic services processed as Preventive Care when utilizing Out-of-Network Providers
Durable Medical Equipment (DME) Durable Medical Equipment (DME) (continued)	(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 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 Authorization may be required on certain DME devices. Upgrades to DME are the responsibility of the Participant. **Exclusions:** (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

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SERVICE OR SUPPLY	**CRITERIA AND COVERAGE PROVIDED**	**AUTHORIZATION REQUIREMENTS, LIMITATIONS, AND EXCLUSIONS**
Durable Medical Equipment (DME) (continued)	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; h) one (1) pair of therapeutic shoes, including fitting of shoes and inserts, per calendar year for diabetic foot disease or peripheral neuropathy; i) TENS unit; and j) Two (2) pairs of TEDS and Jobst Stockings per year. 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-	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) (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 Services and supplies processed as Preventive Care when utilizing Out-of-Network Provider

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SERVICE OR SUPPLY	**CRITERIA AND COVERAGE PROVIDED**	**AUTHORIZATION REQUIREMENTS, LIMITATIONS, AND EXCLUSIONS**
	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. 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.	For information on Coverage for glucose monitors, refer to the "Diabetic Services and Supplies" section of this article.
Emergency Services Emergency Services (continued)	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, if the patient is admitted as a Hospital Inpatient directly from the Emergency room, or the participant has met their calendar year Out-Of-Pocket Maximum. See Appendices A and B of Article 4 for non-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 Those health services and associated expenses for orthoptics, eye exercises, blepharoplasty, radial keratotomy, LASIK, and other refractive eye surgery
Family Planning and Fertility Services Family Planning and Fertility Services (continued)	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 k) travel costs l) donor eggs or semen and related costs including

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SERVICE OR SUPPLY	**CRITERIA AND COVERAGE PROVIDED**	**AUTHORIZATION REQUIREMENTS, LIMITATIONS, AND EXCLUSIONS**
		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 Services and supplies, including but not limited to Contraceptives (oral and others), processed as Preventive Care when utilizing Out-of-Network Provider.
Gender Reassignment Services Gender Reassignment Services (continued)	Coverage is provided for expenses in connection with medically necessary reassignment services.	Prior Authorization is required <u>Exclusions</u> The following procedures that may be performed as a component of gender reassignment: (1) abdominoplasty, (2) blepharoplasty, (3) brow lift, (4) calf implants, (5) cheek/ malar implants, (6) chin/nose implants, (7) collagen injections, (8) construction of a clitoral hood, (9) drugs for hair loss or growth, (10) forehead lift, (11) jaw reduction, (12) hair removal, (13) hair transplantation, (14) lip reduction, (15) liposuction, (16) mastopexy, (17) neck tightening, (18) nose implants, (19) pectoral implants, (20) removal of redundant skin, (21) rhinoplasty, (22) voice therapy/voice lessons.

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SERVICE OR SUPPLY	**CRITERIA AND COVERAGE PROVIDED**	**AUTHORIZATION REQUIREMENTS, LIMITATIONS, AND EXCLUSIONS**
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.
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.	**Exclusions:** Non-symptomatic gynecological services processed as Preventive Care service when utilizing Out-of-Network Providers.
Hearing Services Hearing Services (continued)	(1) Hearing aids and screenings will be Covered for Dependent children with Developmental Delays up to twenty-six (26) years of age as follows: a) once every twenty-four (24) months per ear; b) for In-Network Benefit services only and will be applied to the Participant's applicable Deductible and Coinsurance amounts; c) one hearing screening and/or audiogram to determine hearing loss per twelve (12) month period; and d) for the following types of hearing aids: 1) conventional	The purchase of hearing aids or cochlear implants 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

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SERVICE OR SUPPLY	**CRITERIA AND COVERAGE PROVIDED**	**AUTHORIZATION REQUIREMENTS, LIMITATIONS, AND EXCLUSIONS**
	2) programmable 3) digital 4) BAHAs. (2) Cochlear Implants When deemed medically necessary. For newborn hearing screening, refer to the "Newborn Care" section of this article.	tests, except as provided in this article. (5) Cochlear implants not meeting clinical guidelines
Home Health Care Services	Covered service when <u>all</u> 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. **<u>Exclusions:</u>** Home services to help meet personal, family, or domestic needs.
Hospice Care Hospice Care (continued)	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	**<u>Exclusions:</u>**

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	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 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. 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.	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.
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:	Prior Authorization may be required. **Exclusions:** (1) Dental, oral, or Nanometric implants (2) Cochlear implants when not deemed medically necessary (including services related to

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SERVICE OR SUPPLY	**CRITERIA AND COVERAGE PROVIDED**	**AUTHORIZATION REQUIREMENTS, LIMITATIONS, AND EXCLUSIONS**
	(1) penile implants except as listed under Exclusions; (2) implants for the purpose of contraception; and (3) implants for the delivery of medication. (4) Cochlear implants deemed medically necessary.	cochlear implants), except as provided in the "Hearing Services" 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.
Inpatient Hospital Care Inpatient Hospital Care (continued)	(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;	Prior Authorization required. **Limitations:** Payment for a private room is an allowance equal to the definition of Semi-Private Accommodations. **Exclusions:** (1) Diagnostic Admissions

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SERVICE OR SUPPLY	**CRITERIA AND COVERAGE PROVIDED**	**AUTHORIZATION REQUIREMENTS, LIMITATIONS, AND EXCLUSIONS**
Inpatient Hospital Care (continued)	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). (4) Special Surgery. Special surgeries are limited to Reconstructive Surgery 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;	(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

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SERVICE OR SUPPLY	**CRITERIA AND COVERAGE PROVIDED**	**AUTHORIZATION REQUIREMENTS, LIMITATIONS, AND EXCLUSIONS**
Inpatient Hospital Care (continued)	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. (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. (9) 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. (10) 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	

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	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. The Plan exclusions in Article 7.	
Invisible Providers Invisible Providers (continued)	Represents a category of non-par specialist providers who are typically Hospital based, which include, but are not limited to, the following specialties: a) Hospitalist (full-time in-hospital physician); b) Anesthesiologist; c) Intensivists (includes cardiology, pulmonology and others who staff ICU); d) Radiologist; e) Pathologist; f) Emergency Room Physicians, and g) Neonatologist. Participants may encounter Invisible Providers while obtaining services from Providers participating in the network. 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.	
Laboratory Services/ Outpatient Services and	Covered service. Refer to the "Outpatient Services and Diagnostic Procedures and Tests" and "Preventive Care" sections in Appendices	Prior Authorization may be required for some genetic testing. **<u>Exclusions:</u>**

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Diagnostic Procedures and Tests	A and B of Article 4 for non-Medicare Participants.	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 Long-term Care Services (continued)	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 (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	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.

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SERVICE OR SUPPLY	**CRITERIA AND COVERAGE PROVIDED**	**AUTHORIZATION REQUIREMENTS, LIMITATIONS, AND EXCLUSIONS**
	federal law, and meet the quality standards of the Plan for similar Providers.	
Mammograms Mammograms (continued)	In accordance with the current American Cancer Society guidelines, Coverage for any non-symptomatic woman is provided as follows: (1) a baseline mammogram for women thirty-five (35) years of age to thirty-nine (39) years of age, inclusive; (2) a mammogram every calendar year for women forty (40) years of age and over; (3) 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; (4) office visit related to mammogram; (5) Digital tomosynthesis breast imaging including three-dimensional (3D) digital tomosynthesis (i.e., 3D mammography). Also refer to the "Preventive Care" section of this article and to Appendices A and B of Article 4 for non-Medicare Participants. (1) Mammogram is Covered for any symptomatic woman as needed. (2) 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 non-Medicare Participants.	**<u>Exclusions:</u>** Non-symptomatic mammograms processed as Preventive Care when utilizing Out-of-Network Providers.

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SERVICE OR SUPPLY	**CRITERIA AND COVERAGE PROVIDED**	**AUTHORIZATION REQUIREMENTS, LIMITATIONS, AND EXCLUSIONS**
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 Maternity Services (continued)	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 Treatment Services Received in a Physician's Office" section of this article	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) intracytoplasmic sperm injection (ICSI) b) artificial insemination c) in vitro or in vivo fertilization d) gamete intrafallopian transfer (GIFT) procedures

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SERVICE OR SUPPLY	**CRITERIA AND COVERAGE PROVIDED**	**AUTHORIZATION REQUIREMENTS, LIMITATIONS, AND EXCLUSIONS**
	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.	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.	
Mental Health Conditions and Chemical Dependency Services Mental Health Conditions and	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	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

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**
Chemical Dependency Services (continued)	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.	(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 sexual therapy or counseling, sexual dysfunctions or inadequacies except conditions resulting from gender reassignment services, injury or organic disease (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 Newborn Care (continued)	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	**<u>Exclusions:</u>** (1) Newborn home delivery and mid-wives (2) Newborn care processed as Preventive Care when utilizing Out-of-Network Providers

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SERVICE OR SUPPLY	**CRITERIA AND COVERAGE PROVIDED**	**AUTHORIZATION REQUIREMENTS, LIMITATIONS, AND EXCLUSIONS**
	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, audio logical 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. (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.	
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; and hyperlipidemia.	**Exclusions:** (1) Food or food supplements. (2) Nutritional counseling 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**
Nutritional Counseling (continued)	Coverage includes self-management training used in the management and treatment of diabetes.	
Occupational Therapy	Refer to the "Therapy/Rehabilitation Services and Supplies" section of this article.	
Office Visits, Diagnostic and Treatment Services Received in Physician's Office Office Visits, Diagnostic and Treatment Services	(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; and 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	**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**
Received in Physician's Office (continued)	Deductible as described in Appendices A and B of Article 4 for non-Medicare Participants.	
Oral Surgery and Diseases of the Mouth Oral Surgery and Diseases of the Mouth (continued)	(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; and i) removal of teeth as a complication of radionecrosis. (2) A dental examination prescribed by a Physician prior to joint replacement, valve replacement or transplant surgery to verify an infection or bacteria is not present, which could jeopardize the success of the surgery. The Coverage will not	Prior Authorization may be required. **<u>Exclusions:</u>** (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**
	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.	
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 Services, Surgeries, and Supplies Outpatient Services, Surgeries, and	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);	Prior Authorization may be required. **<u>Exclusions:</u>** (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**
Supplies (continued) Outpatient Services, Surgeries, and	(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. (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. (b) 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. (i) Special surgeries are limited to Reconstructive Surgery, while a Participant in the Plan, to	

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**
Supplies (continued) Outpatient Services, Surgeries, and	correct: - a disfiguration of the face or hand(s); - Reconstructive Surgery of a diseased breast upon which surgery was performed; - 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 (ii) 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; (iii) elective Sterilizations (Refer to the "Birth Control" section of this article); or (iv) 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.) Out-of-Pocket Limit will not be applicable with regard to these services (3) Administration of anesthesia ordered by the attending Physician and rendered by a Physician or other professional Provider 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**
Supplies (continued)	(4) 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.	
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.	**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 Phenylketonuria (PKU) or any other Amino and Organic Acid	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 diseases for Dependents less than six (6) years of age are Covered. (2) Coverage is provided for all potentially treatable or manageable	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

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**
Inherited Disease Formula/Food (continued)	disorders, including cystic fibrosis, galactosemia, bitotinidase deficiency, congenital adrenal hyperplasia, maple syrup urine disease (MSUD) and other amino acid disorders, glucose-6-phosphate dehydrogenase deficiency (G-6-PD), MCAD and other fatty acid oxidation disorders, methylmalonic academia, propionic academia, isovaleric academia and glutaric academia Type 1. (3) Formula for the treatment of inherited diseases of amino acids and organic acids are Covered.	(3) Oral supplements and/or enteral feedings, either by mouth or by tube
Physical Therapy	Refer to the "Therapy/Rehabilitation Services and Supplies" section of this article.	
Podiatry Podiatry (continued)	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. **Exclusions:** (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) (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	**Limitations:**

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SERVICE OR SUPPLY	**CRITERIA AND COVERAGE PROVIDED**	**AUTHORIZATION REQUIREMENTS, LIMITATIONS, AND EXCLUSIONS**
Preventive Care (continued)	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. (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 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;	Breast pumps are limited to one (1) per pregnancy. **<u>Exclusions:</u>** Preventive Care service when utilizing Out-of-Network Providers and Out-of-Network pharmacies.

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SERVICE OR SUPPLY	**CRITERIA AND COVERAGE PROVIDED**	**AUTHORIZATION REQUIREMENTS, LIMITATIONS, AND EXCLUSIONS**
	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 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.	
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.

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	(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 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.	**Exclusions:** Non-symptomatic prostate screenings, processed under Preventive Care service, when utilizing Out-of-Network Providers.
Prosthetic Devices and Orthotic Appliances Prosthetic Devices and Orthotic Appliances (continued)	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	Prior Authorization required on certain appliances and devices If Participant requires refitting and a replacement due to structural change in anatomy, the replacement must receive Prior Authorization. **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

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)	cost. The Plan will not Cover replacement batteries or routine maintenance or maintenance agreements. (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 Services" 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.	b. adjustments, batteries, and other services related to hearing aids c. all Out-of-Network services More than one (1) pair of therapeutic shoes, including fitting of shoes and inserts, per calendar year for diabetic foot disease or peripheral neuropathy (4) 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 (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

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SERVICE OR SUPPLY	**CRITERIA AND COVERAGE PROVIDED**	**AUTHORIZATION REQUIREMENTS, LIMITATIONS, AND EXCLUSIONS**
		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 Services” 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 Reconstructive Surgery (continued)	Covered Service for repair of: (1) disfigurement resulting from an Injury 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.
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
Surgical Services	Surgical services and other related medical care ordered by and provided by or under the direction of a Physician in a	Prior Authorization may be required. **Exclusions:**

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**
	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"	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.
Temporo-mandibular 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/	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 expected to result in significant functional improvement of the Participant's condition.	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 director are subject to significant improvement of the condition through relatively short-term therapy. **Exclusions:**

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**
Rehabilitation Services and Supplies (continued) Therapy/	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. (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 modalities; b) bio-mechanical and neurophysiological principles; c) devices to relieve pain, restore maximum function, and prevent	(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, acupressure) (8) Fees or costs associated with services that are primarily exercise. Examples include, but are not limited to, membership

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**
Rehabilitation Services and Supplies (continued) Therapy/	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 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.	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**
Rehabilitation Services and Supplies (continued)	(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 two (2) ninety (90) days' supply of FDA approved tobacco cessation medications per lifetime.	**Limitations:** Coverage provided for over-the-counter products through CarelonRx's tobacco cessation program only. Exclusion: No out-of-network coverage
Transplants (Human Organ) Transplants	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. **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 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.

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**
(Human Organ) (continued)		(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.
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	**<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

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 (continued)	submitted in order to be reimbursed. All original receipts must be forwarded to the member's *TRANSPLANT CASE MANAGER* at Anthem. 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.	Personal care services
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.
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. 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. **Exclusions:** Preventive Care service when utilizing Out-of-Network Providers

Appendix C Immunization Schedules

18 Years or Younger

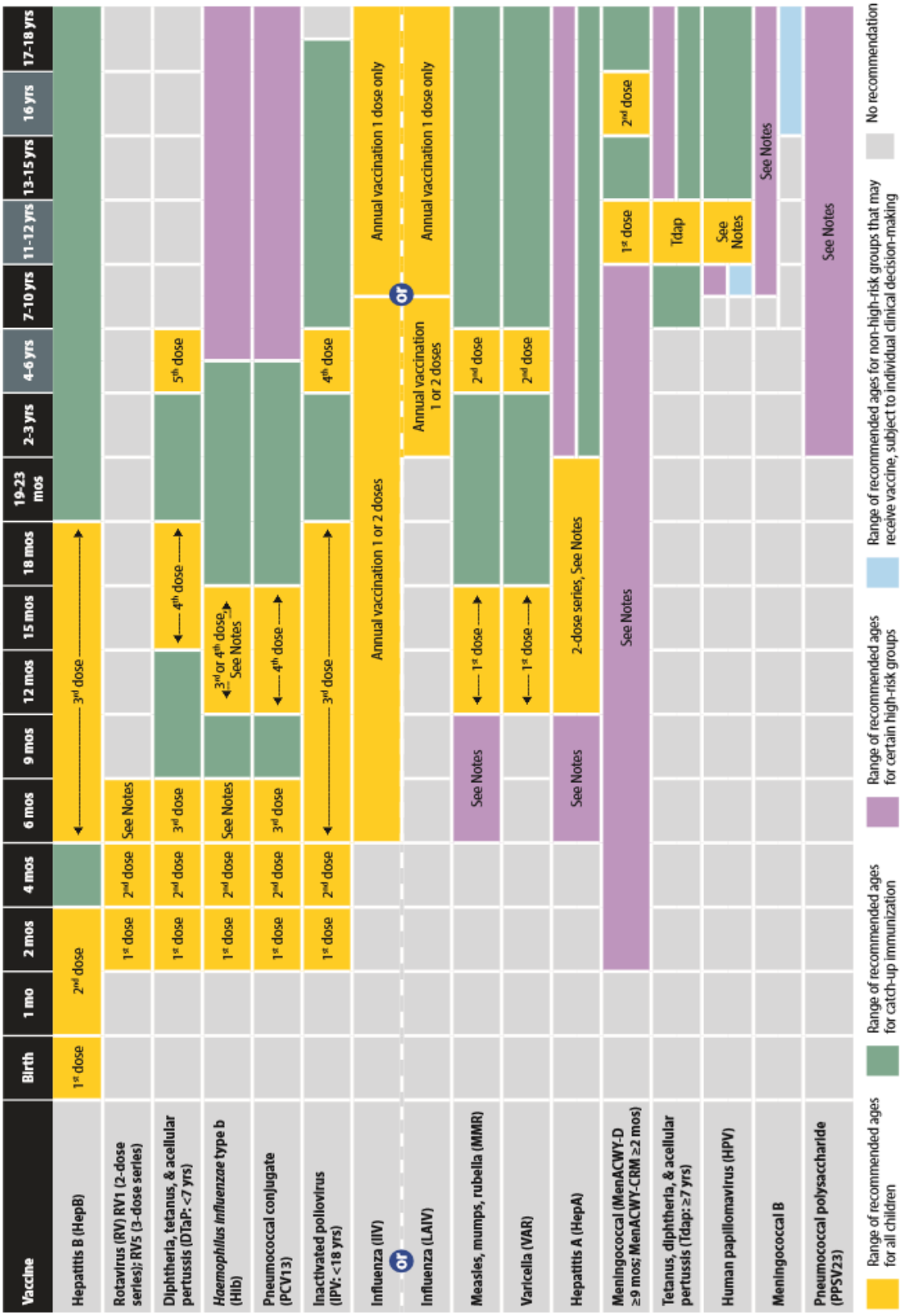

Table 2 Catch-up immunization schedule for persons aged 4 months–18 years who start late or who are more than 1 month behind, United States, 2019

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 Table 1 and the notes 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	Birth	**4 weeks**	**8 weeks *and* at least 16 weeks after first dose.** Minimum age for the final dose is 24 weeks.		
Rotavirus	6 weeks Maximum age for first dose is 14 weeks, 6 days	**4 weeks**	**4 weeks** Maximum age for final dose is 8 months, 0 days.		
Diphtheria, tetanus, and acellular pertussis	6 weeks	**4 weeks**	**4 weeks**	**6 months**	**6 months**
Haemophilus influenzae type b	6 weeks	**No further doses needed** if first dose was administered at age 15 months or older. **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 previous dose was administered at age 15 months or older. **4 weeks** 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, Hiberix) or unknown. **8 weeks *and* age 12 through 59 months (as final dose)** 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.	**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 conjugate	6 weeks	**No further doses needed** for healthy children if first dose was administered at age 24 months or older. **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 previous dose administered at age 24 months or older. **4 weeks** if current age is younger than 12 months and previous dose given at <7 months 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.	**8 weeks (as final dose)** This **dose** only necessary for children age 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	6 weeks	**4 weeks**	4 weeks if current age is < 4 years. 6 months (as final dose) if current age is 4 years or older.	**6 months** (minimum age 4 years for final dose).	
Measles, mumps, rubella	12 months	**4 weeks**			
Varicella	12 months	**3 months**			
Hepatitis A	12 months	**6 months**			
Meningococcal	2 months MenACWY-CRM 9 months MenACWY-D	**8 weeks**	See Notes	See Notes	
Children and adolescents age 7 through 18 years					
Meningococcal	Not Applicable (N/A)	**8 weeks**			
Tetanus, diphtheria; tetanus, diphtheria, and acellular pertussis	7 years	**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 or Tdap/Td was administered at or after the 1st birthday.	**6 months** if first dose of DTaP/DT was administered before the 1st birthday.	
Human papillomavirus	9 years	**Routine dosing intervals are recommended.**			
Hepatitis A	N/A	**6 months**			
Hepatitis B	N/A	**4 weeks**	**8 weeks *and*** at least 16 weeks after first dose.		
Inactivated poliovirus	N/A	**4 weeks**	**6 months** A fourth dose is not necessary if the third dose was administered at age 4 years or older and at least 6 months after the previous dose.	A fourth dose of IPV is indicated if all previous doses were administered at <4 years or if the third dose was administered <6 months after the second dose.	
Measles, mumps, rubella	N/A	**4 weeks**			
Varicella	N/A	**3 months** if younger than age 13 years. **4 weeks** if age 13 years or older.			

Appendix C Immunization Schedules

19 or Older

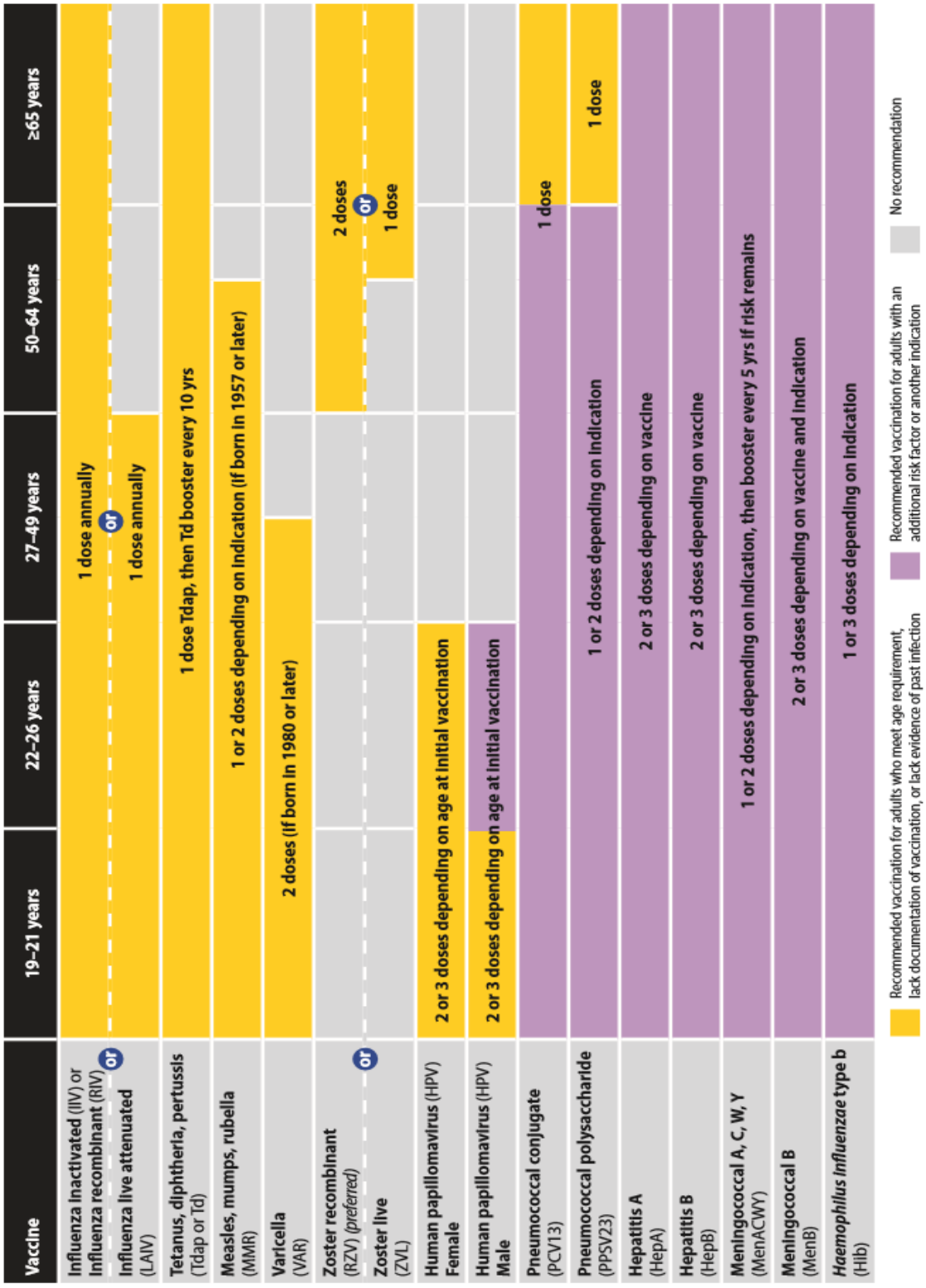

Table 2 Recommended Adult Immunization Schedule by Medical Condition and Other Indications
United States, 2019

Vaccine	Pregnancy	Immuno-compromised (excluding HIV infection)	HIV infection CD4 count <200	HIV infection CD4 count ≥200	Asplenia, complement deficiencies	End-stage renal disease, on hemodialysis	Heart or lung disease, alcoholism[1]	Chronic liver disease	Diabetes	Health care personnel[2]	Men who have sex with men
IIV or RIV or LAIV	1 dose annually	CONTRAINDICATED			PRECAUTION					1 dose annually	
Tdap or Td	1 dose Tdap each pregnancy	1 dose Tdap, then Td booster every 10 yrs									
MMR	CONTRAINDICATED	1 or 2 doses depending on indication									
VAR	CONTRAINDICATED	2 doses									
RZV (*preferred*) or ZVL	DELAY	CONTRAINDICATED			2 doses at age ≥50 yrs or 1 dose at age ≥60 yrs						
HPV Female	DELAY	3 doses through age 26 yrs			2 or 3 doses through age 26 yrs						
HPV Male		3 doses through age 26 yrs			2 or 3 doses through age 21 yrs						2 or 3 doses through age 26 yrs
PCV13		1 dose									
PPSV23		1, 2, or 3 doses depending on age and indication									
HepA		2 or 3 doses depending on vaccine									
HepB		2 or 3 doses depending on vaccine									
MenACWY		1 or 2 doses depending on indication, then booster every 5 yrs if risk remains									
MenB	PRECAUTION	2 or 3 doses depending on vaccine and indication									
Hib		3 doses HSCT[3] recipients only			1 dose						

Recommended vaccination for adults who meet age requirement, lack documentation of vaccination, or lack evidence of past infection

Recommended vaccination for adults with an additional risk factor or another indication

Precaution—vaccine might be indicated if benefit of protection outweighs risk of adverse reaction

Delay vaccination until after pregnancy if vaccine is indicated

Contraindicated—vaccine should not be administered because of risk for serious adverse reaction

No recommendation

1. Precaution for LAIV does not apply to alcoholism. 2. See notes for influenza; hepatitis B; measles, mumps, and rubella; and varicella vaccinations. 3. Hematopoietic stem cell transplant.

ARTICLE 6

PRESCRIPTION DRUG PROGRAM

A Prescription Drug program for the benefit of non-Medicare 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 Non-Medicare Participants

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

(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 is 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 CarelonRx 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 CarelonRx 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;

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; and

m) Some low to moderate dose statins.

(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-aide pumps, mini-med pumps, etc. (check with the medical Plan Claims Administrator);

d) implantable time-released medication unless otherwise 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 antivirals and COVID-19 antivirals;

q) prescription strength non-sedating antihistamines 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 an 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.

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/Rebalance Billings 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 jawbone) 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) Repair, 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 Services" 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

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

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 ~~sexual transformation~~, sexual therapy or counseling, sexual dysfunctions or inadequacies, except conditions resulting from gender reassignment services, 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 an 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) removal of excess fat or skin following weight loss;

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

(3) 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;

f) toenails (except for the partial or complete removal of nail roots or 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 Services” 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, sexual therapy or counseling, or sexual dysfunctions or inadequacies except conditions resulting from gender reassignment services, 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 has not received Prior Authorization 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

UTILIZATION MANAGEMENT SERVICES

8.1 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 8.2. 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. The 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, the Participant may call the Participant Services number on the back of their 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.

8.2 Services Requiring Prior Authorization

Precertification is the determination that selected inpatient and outpatient medical services, including surgeries, major diagnostic procedures and referrals meet criteria for medical necessity under the Participant's benefits contract. For the Participant to receive maximum benefits, Anthem must authorize these covered services prior to being rendered. Precertification helps avoid unnecessary charges or penalties by ensuring that the Participant's care is administered at a network facility and by a network provider.

- Precertification includes a review of both the service and the setting.
- Care will be covered according to the Participants benefits for the number of days pre-certified unless our concurrent review determines that additional days qualify for coverage.
- Certain services may require the Participant to use a provider designated by their health benefit plan.

- A copy of the approval will be provided to the Participant, the physician and the hospital or facility.
- For benefits to be paid, the Participant must be eligible for benefits, the service must be eligible for benefits and the service must be a covered benefit under the contract at the time the services are rendered.

Precertification Responsibility

Network physicians are required to obtain precertification for patients with HMO, POS, PPO, and EPO coverage. If a Participant visits an out-of-network physician, precertification is their responsibility. Regardless of whether a Participant visits a doctor in the network, or out-of-network, it is always a good idea to check with their physician if the services have been pre-certified.

The Precertification number is listed on the back of the Participant's Anthem ID card.

Services listed are effective and current January 1, 2025 unless specified. For benefits to be paid, the Participant must be eligible on the date of service and the service must be a covered benefit under the policy. This list is subject to change.

(1) Inpatient Admission:

a) Elective Admissions
b) Emergency Admissions (Anthem requires plan notification within 24 hours)
c) OB Related Medical Stay (OB complications, Excludes childbirth)
d) Newborn Stays beyond Mother
e) Inpatient Skilled Nursing Facility (SNF)
f) Long Term Acute Care Facility (LTAC)
g) Rehabilitation facility admissions

(2) Observation stays: (KY ACA Individual)

(3) Outpatient Services:

Medical Policies and Clinical Guidelines are available by visiting our Provider website. For all services listed below go to **www.anthem.com**, select Menu and then under the Support heading, select Providers. Choose state from the drop-down list and enter to the Provider Home page, select Anthem Medical Policies and Clinical UM Guidelines under self-service and support.

a) Surgery:
    i. Ablative Techniques as a Treatment for Barrett's Esophagus
    ii. Acromioplasty and Rotator Cuff Repair
    iii. Artificial Intervertebral Discs
    iv. Arthroscopy – Knee
    v. Balloon Sinuplasty
    vi. Bariatric Surgery
    vii. Bone-Anchored Hearing Aids
    viii. Canaloplasty
    ix. Cardiac Resynchronization Therapy (CRT) with or without an Implantable Cardioverter Defibrillator (CRT/ICD) for the Treatment of Heart Failure

x. Carotid, Vertebral and Intracranial Artery Angioplasty with or without Stent Placement
xi. Cervical Spine Fusion
xii. Computer-Assisted Musculoskeletal Surgical Navigational Orthopedic Procedures
xiii. Cryoablation for Plantar Fasciitis and Plantar Fibroma
xiv. Cryosurgical Ablation of Solid Tumors Outside the Liver
xv. Deep Brain Stimulation
xvi. Electrothermal Shrinkage of Joint Capsules, Ligaments, and Tendons
xvii. Endoscopic sinus surgery
xviii. Extracorporeal Shock Wave Therapy for Orthopedic Conditions
xix. Gastric Bypass Surgery
xx. Gastric Electrical Stimulation
xxi. Gender Reassignment Surgery
xxii. Implantable Cardioverter-Defibrillator (ICD)
xxiii. Hip Arthroscopy
xxiv. Hip Replacement
xxv. Hip Resurfacing
xxvi. Hysterectomy
xxvii. Implantable Infusion Pumps
xxviii. Implantable Middle Ear Hearing Aids
xxix. Implanted Devices for Spinal Stenosis
xxx. Implanted spinal cord stimulators
xxxi. Intraocular Anterior Segment Aqueous Drainage Devices
xxxii. Intraocular Anterior Segment Aqueous Drainage Devices (without extraocular reservoir)
xxxiii. Knee Replacement
xxxiv. Locally Ablative Techniques for Treating Primary and Metastatic Liver Malignancies
xxxv. Lumbar spinal fusion, decompression, exploration or excision of disc(s) surgeries
xxxvi. Lung Volume Reduction Surgery
xxxvii. Lysis of Epidural Adhesions
xxxviii. Mandibular/Maxillary (Orthognathic) Surgery
xxxix. Mastectomy for Gynecomastia
xl. MAZE Procedure
xli. Nasal surgery for the treatment of obstructive sleep apnea (includes: excision of polyp(s), turbinate(s), ablation of turbinate(s), septoplasty, repair of vestibular stenosis)
xlii. Occipital nerve stimulation
xliii. Ovarian and Internal Iliac Vein Embolization as a Treatment of Pelvic Congestion Syndrome
xliv. Panniculectomy and Abdominoplasty
xlv. Partial Left Ventriculectomy
xlvi. Penile Prosthesis Implantation (only requires precertification if procedure is a benefit in the Participant certificate)
xlvii. Percutaneous Neurolysis for Chronic Back Pain
xlviii. Percutaneous Spinal Procedures (Vertebroplasty, Kyphoplasty and Sacroplasty)
xlix. Photocoagulation of Macular Drusen
l. Plastic/Reconstructive surgeries: (only specific procedures listed)

1. Blepharoplasty
2. Breast procedures including reconstructive surgery and implants.
3. Chin Implant, Mentoplasty, Osteoplasty Mandible
4. Cosmetic and Reconstructive Services of the Head and Neck
5. Cosmetic and Reconstructive Services of the Trunk and Groin
6. Cosmetic and Reconstructive Services Skin Related
7. Hairplasty
8. Insertion/Injection of Prosthetic Material Collagen Implants
9. Panniculectomy and Abdominoplasty
10. Panniculectomy, Lipectomy, Diastasis Recti Repair
11. Rhinoplasty

li. Presbyopia and Astigmatism
lii. Radiofrequency Ablation to Treat Tumors Outside the Liver
liii. Recombinant Human Bone Morphogenetic Protein
liv. Reduction Mammaplasty
lv. Sacral Nerve Stimulation as a Treatment of Neurogenic Bladder Secondary to Spinal Cord Injury
lvi. Scoliosis and Spinal Deformity Surgery effective 5/2/16
lvii. Septoplasty
lviii. Shoulder Arthroplasty and Hemiarthroplasty
lix. Extraosseous Subtalar Joint Implantation and Subtalar Arthroereisis
lx. Suprachoroidal Injection of a Pharmacologic Agent
lxi. Surgical and Minimally Invasive Treatments for Benign Prostatic Hyperplasia (BPH) and Other Genitourinary Conditions
lxii. Surgical treatment for migraine headaches
lxiii. Temporomandibular Disorders
lxiv. Tonsillectomy – for patients under the age of 18 years
lxv. Total Ankle Replacement
lxvi. Transcatheter Closure of Cardiac Defects
lxvii. Transcatheter Uterine Artery Embolization
lxviii. Treatment of Hyperhidrosis
lxix. Treatment of Osteochondral Defects of the Knee and Ankle
lxx. Treatment of Varicose Veins (Lower Extremities)
lxxi. UPPP surgery (uvulopalatopharyngoplasty, uvulopharyngoplasty)
lxxii. Vagus Nerve Stimulation

b) Medicine:

i. Ambulance Services-Air and Water
ii. Ambulatory and Inpatient Video Electroencephalography
iii. AmniSure® ROM (Rupture of Membranes) Test Cryopreservation of Oocytes or Ovarian Tissue
iv. Diagnosis of Sleep Disorders
v. Genetic Testing for Inherited Peripheral Neuropathies
vi. Genetic testing for PTEN Hamartoma Tumor Syndrome
vii. Hyperbaric oxygen Therapy (System/Topical)
viii. Manipulation Under Anesthesia of the Spine and Joints other than the Knee
ix. MRI Guided High Intensity Focused Ultrasound Ablation of Uterine Fibroids
x. Non-Emergent Ground Ambulance
xi. Private Duty Nursing services in the home setting
xii. Myocardial sympathetic innervations imaging with or without SPECT

xiii. Real-Time Remote Heart Monitors
xiv. Therapeutic Apheresis Thyroid Fine Needle Aspirate Molecular Markers
xv. Treatment for Obstructive Sleep Apnea in Adults
xvi. Wearable Cardioverter Defibrillators

c) Rehabilitation:
   i. Physical Therapy*
   ii. Occupational Therapy*

*Products in scope: Locally Fully Insured Large Group, Small Group, and individual products for both public and private exchange business including: HMO, PPO, Traditional, and ASO (as a buy up option)

d) DME/Prosthetics: recommendation is to verify benefits for all DME, and medical necessity on the list below.
   i. Automated Insulin Delivery Devices (effective 5/1/17)
   ii. Wheelchairs; motorized or powered, ultra-lightweight wheelchairs, power seating systems and accessories
   iii. Hospital Beds, Rocking Beds
   iv. Prosthetics: Electronic, Myoelectric, Microprocessor Controlled or externally powered and select other prosthetics
   v. External continuous insulin infusion pump
   vi. Oscillatory devices for airway Clearance including High Frequency Chest Compression and Intrapulmonary Percussive Ventilation
   vii. Cochlear implants and auditory brainstem implants
   viii. Electrical Bone Growth Stimulation
   ix. Functional Electrical Stimulation (FES); Threshold Electrical Stimulation (TES)
   x. Transtympanic Micropressure for the Treatment of Ménière's Disease
   xi. Ultrasound Bone Growth Stimulation
   xii. Standing Frames
   xiii. Augmentative and Alternative Communication (AAC) Devices/Speech Generating Devices (SGD Cooling Devices and Combined Cooling/Heating Devices

e) Services Medically Managed by AIM Specialty Health®
   i. Radiology Benefit Management including Imaging Level of Care
   ii. Genetic Testing
   iii. Cardiology - Cardiovascular Services
   iv. Outpatient Sleep Testing and Therapy Services
   v. Specialty Pharmacy Drugs
   vi. Radiation Oncology
   vii. Cancer Care Quality Program
   viii. Musculoskeletal Clinical Appropriateness Guidelines: Spine Surgery, Joint Surgery, and Interventional Pain Management
   ix. Upper Gastrointestinal Endoscopy in Adults. The AIM Surgical GI program (using CG-MED-59) for upper endoscopy procedures will be effective 11/1/18. Prior authorization will be managed by AIM for Local Fully Insured Participants.

Note: The health plan uses guidelines developed by AIM Specialty Health (AIM), a separate company, to perform utilization management services of some procedures for certain health plan Participants. The UM guidelines applicable to those programs below are available at: http://www.aimspecialtyhealth.com/marketing/guidelines/185/index.html

f) Transplant Precertification:
   i. Depending on the Participant's coverage, transplant services may be covered at a reduced benefit, or may not be covered at all, if:
   ii. Participant fails to obtain precertification or
   iii. Participant uses a provider other than the one designated by Anthem. Additional penalties may apply.

g) Human Organ and Bone Marrow/Stem Cell Transplants:
   All Inpatient admits for the following:
   i. Heart transplant
   ii. Liver transplant
   iii. Lung or double lung transplant
   iv. Simultaneous Pancreas / Kidney
   v. Pancreas transplant
   vi. Kidney transplant
   vii. Small bowel transplant
   viii. Multi-visceral transplant
   ix. Stem cell/Bone Marrow transplant (with or without myeloablative therapy)

   All Outpatient services for the following:
   i. Stem Cell/Bone Marrow transplant (with or without myeloablative therapy)
   ii. Donor Leukocyte Infusion

h) Referrals:
   Out of Network Referrals (may be pre-authorized, based on network availability and or medical necessity.)

i) Specialty pharmacy medications:
   See: www.Anthem.com > Provider Home Page >>Precertification> Specialty Pharmacy Precertification Drugs and Codes for list of specialty pharmacy medications.

j) Mental health/Substance Abuse (MHSA):
   Professionals are available 24 hours a day 7 days a week.

   Specially trained professionals will handle referrals and coordinate care for mental health and substance abuse for all facility-based care:

   i. Inpatient admissions,
   ii. Intensive outpatient therapy,
   iii. Partial Hospitalization,
   iv. Residential Care, and
   v. Electric Convulsive Therapy (ECT).
   vi. Transcranial Magnetic Stimulation

vii. Intensive In-home Behavioral Health Services (effective 7/1/16)

(4) No Precertification for Emergencies:

Precertification is not required for emergency admissions. However, to ensure that Participants receive the maximum coverage possible, Anthem must be notified about the admission within 24 hours or as soon as reasonably possible. Failure to notify Anthem may result in denial of claims for services that we determine are not medically necessary under the benefits contract. Services listed above are effective and current as of January 1, 2025. For benefits to be paid, the Participant must be eligible on the date of service and the service must be a covered benefit under the policy. This list is subject to change.

Services not requiring pre-certification for coverage, but recommended for pre-determination of medical necessity due to the existence of post service claim edits and/or the potential cost of services to the Participant if denied by Anthem for lack of medical necessity:

Procedures, equipment, and/or specialty infusion drugs which have medically necessary criteria determined by Corporate Medical Policy or Clinical Guidelines.

Note: for a complete listing of Medical Policies and Clinical Guidelines go to www.anthem.com, select Menu and then under the Support heading, select Providers. Choose your state from the drop-down list and enter to the Provider Home page, select Anthem Medical Policies and Clinical UM Guidelines under self-service and support

Participants may also call the Customer Service number on the back of the Participant ID card to see if the specific requested code is subject to medical policy or clinical guideline criteria.

8.3 Pre-Admission Certification and Concurrent Review Requirements

Types of Reviews:

(1) Pre-service Review - A review of service, treatment or admission for a benefit coverage determination which is done before the service or treatment begins or admission date.

(2) Precertification - A required Pre-service Review for a benefit coverage determination for a service or treatment. Certain services require Precertification in order for the Participant to get benefits. The benefit coverage review will include a review to decide whether the service meets the definition of Medical Necessity or is Experimental/ Investigational as those terms are defined in the Booklet.

For admissions following Emergency Care, the Participant, the Participant's authorized representative or Physician must tell us within 48 hours of the admission or as soon as possible within a reasonable period of time. For childbirth admissions, Precertification is not needed unless there is a problem and/or the mother and baby are not sent home at the same time. Precertification is not required for the first 48 hours for a vaginal delivery or 96 hours for a cesarean section. Admissions longer than 48/96 hours require precertification.

(3) Continued Stay/ Concurrent Review – A Utilization Review of a service, treatment or admission for a benefit coverage determination which must be done during an ongoing stay in a facility or course of treatment.

Both Pre-Service and Continued Stay / Concurrent Reviews may be considered urgent when, in the view of the treating Provider or any Physician with knowledge of the Participant's medical condition, without such care or treatment, Participant's life or health or Participant's ability to regain maximum function could be seriously threatened or Participant could be subjected to severe pain that cannot be adequately managed without such care or treatment. Urgent reviews are conducted under a shorter timeframe than standard reviews.

(4) Post-service Review **–** A review of a service, treatment or admission for a benefit coverage that is conducted after the service has been provided. Post-service reviews are performed when a service, treatment or admission did not need a Precertification, or when a needed Precertification was not obtained. Post-service reviews are done for a service, treatment or admission in which we have a related clinical coverage guideline and are typically initiated by us.

8.4 Admission Review

Note: If a newborn child is required to stay as an Inpatient past the mother's discharge date, the services for the newborn child will then be considered a separate admission from the Maternity and an ordinary routine nursery admission and will be subject to a separate Inpatient Coinsurance/Copayment.

Coverage for the Inpatient postpartum stay for Participant and Participant's newborn child in a Hospital will be, at a minimum, 48 hours for a vaginal delivery and 96 hours for a cesarean section. Coverage will be for the length of stay recommended by the American Academy of Pediatrics and the American College of Obstetricians and Gynecologists in their Guidelines for Prenatal Care.

Coverage for a length of stay shorter than the minimum period mentioned above may be permitted if Participant's attending Physician determines further Inpatient postpartum care is not necessary for Participant or Participant's newborn child, provided the following are met and the mother concurs:

In the opinion of Participant's attending Physician, the newborn child meets the criteria for medical stability in the Guidelines for Perinatal Care prepared by the American Academy of Pediatrics and the American College of Obstetricians and Gynecologists that determined the appropriate length of stay based upon evaluation of:

(1) The antepartum, intrapartum, and postpartum course of the mother and infant;

(2) The gestational stage, birth weight, and clinical condition of the infant;

(3) The demonstrated ability of the mother to care for the infant after discharge; and

(4) The availability of post-discharge follow-up to verify the condition of the infant after the discharge.

8.5 Case Management

Health Plan Individual Case Management

Our health plan individual case management programs (Case Management) help coordinate services for Participants with health care needs due to serious, complex, and/or chronic health conditions. Our programs coordinate benefits and educate Participants who agree to take part in the Case Management program to help meet their health-related needs.

Our Case Management programs are confidential and voluntary and are made available at no extra cost to the Participant. These programs are provided by, or on behalf of and at the request of, the Participant's health plan case management staff. These Case Management programs are separate from any Covered Services you are receiving.

If the Participant meets program criteria and agree to take part, we will help the Participant meet their identified health care needs. This is reached through contact and teamwork with the Participant and/or the Participant's chosen authorized representative, treating Doctor(s), and other Providers.

In addition, we may assist in coordinating care with existing community-based programs and services to meet the Participant's needs. This may include giving the Participant information about external agencies and community-based programs and services.

In certain cases of severe or chronic illness or injury, the Plan may provide benefits for alternate care than is not listed as a Covered Service. The Plan may also extend Covered Services beyond the Benefit Maximums of the Plan. We will make any recommendation to the Plan for alternate or extended benefit in writing. A decision to provide extended benefits or approve alternate care in one case does not obligate us to provide the same benefits again to any Participant. The Plan reserves the right, at any time, to alter or stop providing extended benefits or approving alternate care. In such case, we will notify the Participant or the Participant's authorized representative in writing.

8.6 Disease Management

The Claims Administrator offers disease management programs designed to assist Participants 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 Participant chooses not to participate.

ARTICLE 9

COORDINATION OF BENEFITS

9.1 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.

9.2 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 9.3, “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.

(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.

9.3 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.

9.4 Effect on the Benefits of the Plan

This section applies when, in accordance with Article 9.3, "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 9.4(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.

9.5 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.

9.6 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.

9.7 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 10

COBRA CONTINUATION COVERAGE RIGHTS

10.1 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 description. 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.

10.2 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.

10.3 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.

10.4 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.

10.5 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.

10.6 Applicable Premium

For purposes of this article, the term "applicable Premium" means the cost of the Coverage as determined pursuant to the law.

10.7 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.

10.8 Maximum Coverage Period

In the case of a qualifying event specified in Article 10.3, 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 10.3, 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 (60^{th}) 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.

10.9 Terminating Events

The eighteen (18), twenty-nine (29) and thirty-six (36) month periods specified in Article 10.8 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 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).

10.10 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.

10.11 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.

10.12 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 10.3 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 10.3 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 10.12 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 11

GRIEVANCE AND APPEALS PROCEDURES

11.1 Introduction

We want your experience with us to be as positive as possible. There may be times, however, when you have a complaint, problem, or question about your Plan or a service you have received. In those cases, please contact Member Services by calling the number on the back of your ID card. We will try to resolve your complaint informally by talking to your Provider or reviewing your claim. If you are not satisfied with the resolution of your complaint, you have the right to file an appeal, which is defined as follows:

For purposes of these Appeal provisions, "claim for benefits" means a request for benefits under the plan. The term includes both pre-service and post-service claims.

- A pre-service claim is a claim for benefits under the plan for which you have not received the benefit or for which you may need to obtain approval in advance.
- A post-service claim is any other claim for benefits under the plan for which you have received the service.

If your claim is denied or if your coverage is rescinded:

- you will be provided with a written notice of the denial or rescission; and
- you are entitled to a full and fair review of the denial or rescission.

The procedure we will follow will satisfy follows the minimum requirements for a full and fair review under applicable federal regulations.

11.2 Notice of Adverse Benefit Determination

If your claim is denied, our notice of the adverse benefit determination (denial) will include:

(1) information sufficient to identify the claim involved

(2) the specific reason(s) for the denial;

(3) a reference to the specific plan provision(s) on which our determination is based;

(4) a description of any additional material or information needed to perfect your claim;

(5) an explanation of why the additional material or information is needed;

(6) a description of the plan's review procedures and the time limits that apply to them, including a statement of your right to bring a civil action under ERISA within one year of the appeal decision if you submit an appeal and the claim denial is upheld; information about any internal rule, guideline, protocol, or other similar criterion relied upon in making the claim determination and about your right to request a copy of it free of charge, along with a discussion of the claims denial decision;

(7) information about the scientific or clinical judgment for any determination based on Medical Necessity or Experimental treatment, or about your right to request this explanation free of charge, along with a discussion of the claim's denial decision;

(8) the availability of, and contact information for, any applicable office of health insurance consumer assistance or ombudsman who may assist you; and

(9) information regarding your potential right to an External Appeal pursuant to federal law.

For claims involving urgent/concurrent care:

(1) our notice will also include a description of the applicable urgent/concurrent review process; and

(2) we may notify you or your authorized representative within 24 hours orally and then furnish a written notification.

11.3 Appeals

You have the right to appeal an adverse benefit determination (claim denial or rescission of coverage). You or your authorized representative must file your appeal within 180 calendar days after you are notified of the denial or rescission. You will have the opportunity to submit written comments, documents, records, and other information supporting your claim. Our review of your claim will take into account, all information you submit, regardless of whether it was submitted or considered in the initial benefit determination.

We shall offer a single mandatory level of appeal and an additional voluntary second level of appeal which may be a panel review, independent review, or other process consistent with the entity reviewing the appeal. The time frame allowed for us to complete its review is dependent upon the type of review involved (e.g., pre-service, concurrent, post-service, urgent, etc.).

For pre-service claims involving urgent/concurrent care, you may obtain an expedited appeal. You or your authorized representative may request it orally or in writing. All necessary information, including our decision, can be sent between us and you by telephone, facsimile or other similar method. To file an appeal for a claim involving urgent/concurrent care, you or your authorized representative must contact us at the number shown on your identification card and provide at least the following information:

- the identity of the claimant;
- The date (s) of the medical service;
- the specific medical condition or symptom;
- the provider's name
- the service or supply for which approval of benefits was sought; and
- any reasons why the appeal should be processed on a more expedited basis.

All other requests for appeals should be submitted in writing by the Member or the Member's authorized representative, except where the acceptance of oral Appeals is

otherwise required by the nature of the Appeal (e.g., urgent care). You or your authorized representative must submit a request for review to:

Anthem Blue Cross and Blue Shield, ATTN: Appeals,
P.O. Box 105568;
Atlanta, GA 30348-5568.

Upon request, we will provide, without charge, reasonable access to, and copies of, all documents, records, and other information relevant to your claim. "Relevant" means that the document, record, or other information:

- was relied on in making the benefit determination; or
- was submitted, considered, or produced in the course of making the benefit determination; or
- demonstrates compliance with processes and safeguards to ensure that claim determinations are made in accordance with the terms of the plan, applied consistently for similarly situated claimants; or
- is a statement of the plan's policy or guidance about the treatment or benefit relative to your diagnosis.

We will also provide you, free of charge, with any new or additional evidence considered, relied upon, or generated in connection with your claim. In addition, before you receive an adverse benefit determination on review based on a new or additional rationale, we will provide you, free of charge, with the rationale.

For Out of State Appeals you must file Provider appeals with the Host Plan. This means Providers must file appeals with the same plan to which the claim was filed.

How Your Appeal will be Decided

When we consider your appeal, we will not rely upon the initial benefit determination or, for voluntary second-level appeals, to the earlier appeal determination. The review will be conducted by an appropriate reviewer who did not make the initial determination and who does not work for the person who made the initial determination. A voluntary second-level review will be conducted by an appropriate reviewer who did not make the initial determination or the first-level appeal determination and who does not work for the person who made the initial determination or first-level appeal determination.

If the denial was based in whole or in part on a medical judgment, including whether the treatment is Experimental, Investigational, or not Medically Necessary, the reviewer will consult with a health care professional who has the appropriate training and experience in the medical field involved in making the judgment. This health care professional will not be one who was consulted in making an earlier determination or who works for one who was consulted in making an earlier determination.

Notification of the Outcome of the Appeal

If you appeal a claim involving urgent/concurrent care, we will notify you of the outcome of the appeal as soon as possible, but not later than 72 hours after receipt of your request for appeal.

If you appeal any other pre-service claim, we will notify you of the outcome of the appeal within 30 days after receipt of your request for appeal

If you appeal a post-service claim, we will notify you of the outcome of the appeal within 60 days after receipt of your request for appeal.

Appeal Denial

If your appeal is denied that denial will be considered an adverse benefit determination. The notification from us will include all the information set forth in the above section entitled "Notice of Adverse Benefit Determination."

If, after our determination that you are appealing, we consider, rely on, or generate any new or additional evidence in connection with your claim, we will provide you with that new or additional evidence, free of charge. We will not base our appeal(s) decision(s) on a new or additional rationale without first providing you (free of charge) with, and a reasonable opportunity to respond to, any such new or additional rationale. If we fail to follow the appeal procedures outlined under this section, the appeals process may be deemed exhausted. However, the appeals process will not be deemed exhausted due to minor violations that do not cause, and are not likely to cause, prejudice or harm so long as the error was for good cause or due to matters beyond our control.

Voluntary Second Level Appeals

If you are dissatisfied with the Plan's mandatory first level appeal decision, a voluntary second level appeal may be available. If you would like to initiate a second level appeal, please write to the address listed above. Voluntary appeals must be submitted within 60 calendar days of the denial of the first level appeal. You are not required to complete a voluntary second level appeal prior to submitting a request for an independent External Review.

11.4 External Review Process

If the outcome of the mandatory first level appeal is averse to you, and it was based on medical judgment, or if it pertained to a rescission of coverage, you may be eligible for an independent External Review pursuant to federal law.

You must submit your request for External Review to us within four (4) months of the notice of your final internal adverse determination.

A request for an External Review must be in writing unless we determine that it is not reasonable to require a written statement. You do not have to re-send the information that you submitted for internal appeal. However, you are encouraged to submit any additional information that you think is important for review.

For pre-service claims involving urgent/concurrent care, you may proceed with an Expedited External Review without filing an internal appeal or while simultaneously pursuing an expedited appeal through our internal appeal process. You or your authorized representative may request it orally or in writing. All necessary information, including our decision, can be sent between us and you by telephone, facsimile or other similar method. To proceed with an Expedited External Review, you or your authorized representative must contact us at the number shown on your identification card and provide at least the following information:

- the identity of the claimant;
- The date (s) of the medical service;
- the specific medical condition or symptom;
- the provider's name
- the service or supply for which approval of benefits was sought; and
- any reasons why the appeal should be processed on a more expedited basis.

All other requests for External Review should be submitted in writing unless we determine that it is not reasonable to require a written statement. Such requests should be submitted by you or your authorized representative to:

Anthem Blue Cross and Blue Shield
ATTN: Appeals
P.O. Box 105568
Atlanta, GA 30348-5568.

This is not an additional step that you must take in order to fulfill your appeal procedure obligations described above. Your decision to seek External Review will not affect your rights to any other benefits under this health care plan. There is no charge for you to initiate an independent External Review. The External Review decision is final and binding on all parties except for any relief available through applicable state laws or ERISA.

Requirement to file an Appeal before filing a lawsuit

No lawsuit or legal action of any kind related to a benefit decision may be filed by you in a court of law or in any other forum unless it is commenced within one year of the Plan's final decision on the claim or other request for benefits. If the Plan decides an appeal is untimely, the Plan's latest decision on the merits of the underlying claim or benefit request is the final decision date. You must exhaust the Plan's internal Appeals Procedure but not including any voluntary level of appeal, before filing a lawsuit or taking other legal action of any kind against the Plan. If your health benefit plan is sponsored by your Employer and subject to the Employee Retirement Income Security Act of 1974 (ERISA) and your appeal as described above results in an adverse benefit determination, you have a right to bring a civil action under Section 502(a) of ERISA within one year of the appeal decision.

We reserve the right to modify the policies, procedures and timeframes in this section upon further clarification from Department of Health and Human Services and Department of Labor.

11.5 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.

11.6 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, regarding the investigation of a Claim, may result in denial of that Claim and subsequent Claims.

11.7 Appeal to the Board

If the claimant has exhausted all levels of the Claims 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 12

FUNDING POLICY

12.1 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 management.

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.

12.2 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 or Health Savings Account 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 the 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.

12.3 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.

12.4 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.

12.5 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 13

SUBROGATION

13.1 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.

13.2 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 14

RESPONSIBILITIES FOR PLAN ADMINISTRATION

14.1 Plan Administration

The operation of the Plan will be managed by 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 manage 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 management 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;

(5) to select Claims Administrators, counsel, accountants, consultants and actuaries as may be required to assist in managing the Plan. Agent/Broker of Record letters will not be provided for any account;

(6) recommend the total premiums necessary to adequately fund the Plan;

(7) when necessary, provide direction to MoDOT staff regarding contributions by the state and by participants and keeping the funds invested to the greatest extent possible;

(8) when necessary, provide direction to MoDOT staff regarding development and maintenance of a system of accounting for all funds;

(9) establish such reserves as are financially prudent or necessary to pay claims against the fund;

(10) offer a policy of life insurance for eligible members of the MoDOT and Patrol Employees Retirement System;

(11) if deemed beneficial to Plan funding, obtain underwriting for excess coverage (stop loss) to assure that all claims can be paid and that the plan is fully insured;

(12) provide notice to the Commission of determination of coverage to be provided by the Plan. The Board may from time to time change the coverage, but the coverage may not be reduced without sixty days' notice to Plan participants, and if any increase in coverage requires an increase in contributions, sixty days' notice must also be provided;

(13) in establishing total premiums, the Board will endeavor to establish premium levels so

that each rate group is sufficiently funded according to the cost of the Plan for that group, but to retain the group aspects of the Plan. The premium shall be based upon actuarial principles and shall be sufficient to pay all claims against the Plan and establish the necessary reserve to pay accrued but unpaid claims at any time. The rate of contribution shall also include any amount necessary to pay for administering the Plan, the necessary actuarial services, and for the payment of the premium for excess coverage (stop loss).

(14) establish a procedure for applying any state contributions made for to salaried employees, retired members, dependent coverage, disability recipients, survivors of employees/retirees, and spouses of members, and establish a special medical insurance rate category for surviving spouses and dependents of employees who lost their lives as a result a work-related injury or illness. State contributions will not be used to defray the cost of coverage for those on leave without pay;

(15) monitor the cost to the Plan to assure that an adequate reserve for benefits is maintained, and timely detect in advance the necessity to adjust the required total premiums. The Board is not to recommend total premiums that will accumulate reserves in excess of those reasonably necessary to assure the payment of claims and should recommend reducing the total premiums when sound reserving levels permit;

(16) maintain a reserve amount which will be sufficiently liquid so that a transfer of funds from the reserve account to the claims account can be made as necessary to permit the prompt payment of claims;

(17) when necessary, consult with MoDOT staff to select a depository for the funds and require security, such security to be the same as that required for the deposit of state funds;

(18) the Board shall have such additional duties and responsibilities as are necessary to fully carry out the insurance program for participating members; and

(19) the Board shall, through the Chairman of the Board, provide reports that represent the financial condition and plan trends to the Commission no less than semi-annually and at such other times as the Commission may request.

14.2 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 15

AMENDMENT OR TERMINATION OF PLAN

15.1 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.

15.2 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 16

MISCELLANEOUS

16.1 Plan Interpretation

The summary Plan description sets forth the provisions of the Plan. The Plan shall be read in its entirety and not severed except as provided below.

16.2 Conversion Privilege

There are no conversion privileges under the Plan.

16.3 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.

16.4 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.

16.5 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.

16.6 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.

16.7 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.

16.8 Non-Gender Clause

Whenever used in the Plan, the masculine gender will include the feminine and the plural form will include the singular.

ARTICLE 17

BASIC (STATE PAID) LIFE INSURANCE PLAN

17.1 General Information

(1) The life insurance coverage outlined in this Plan is subject to every term, condition, exclusion, limitation, and provision of the current MetLife Insurance group policy. In case of a conflict or inconsistency in the language of this Article and the language of the current MetLife Insurance group policy, the language of the current MetLife Insurance group policy shall govern.

(2) A copy of the current MetLife Insurance group policy is available for review at: http://www.modot.org/newsandinfo/documents/OptLifePolicy.pdf.

17.2 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.)

17.3 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.

17.4 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 17.4. 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.

17.5 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.

17.6 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.

17.7 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.

17.8 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 insurability.

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 18

OPTIONAL GROUP 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 MetLife Insurance group policy. In case of a conflict or inconsistency in the language of this Article and the language of the current MetLife Insurance group policy, the language of the current MetLife Insurance group policy shall govern.

(2) A copy of the current MetLife Insurance group policy is available for review at: http://www.modot.org/newsandinfo/documents/OptLifePolicy.pdf

18.2 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, he may reinstate his 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 insurability 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 18.4, “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 – a lawful spouse who is not legally separated from the employee 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.

18.3 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 18.3, “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 18.4(7) and 18.4(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 18.4(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 18.8, “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.

18.4 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) increments 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 18.4(3), 18.4(4), 18.4(5) and 18.4(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 did not carry the Basic (State Paid) Life Insurance at the time of their retirement **are ineligible** 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 18.4(4) and 18.4(5), and Spouse Coverage listed in Article 18.4(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 dollar ($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.

18.5 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 18.4(3), 18.4(4), 18.4(5) and 18.4(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.

18.6 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.

18.7 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.

18.8 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 18.3.

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.

18.9 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.

18.10 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.