Calendar Year Maximum Benefit

The following Calendar Year maximums apply to each Participant.

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

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

Deductible Carryover Applies: Covered Charges incurred in, and applied toward the deductible in October, November and December will be applied to the deductible in the next Calendar Year as well as the Current Calendar Year.

Billing Error Incentive: If you find an error in your medical bill (where the provider has charged you for items or services you did not receive), the plan will compensate you 50% of the amount saved to a maximum of **$300**, after the corrected bill has been received by Rocky Mountain Administrators.

Deductibles, per Calendar Year

Per Covered Person $1,500

Per Family Unit (aggregate)..... $3,000

Maximum out-of-pocket payments, per Calendar Year (Deductible & Co-Insurance combined)

The Plan will pay the percentage of Covered Charges designated until the following amounts of out-of-pocket payments are reached, at which time the Plan will pay 100% of the remainder of Covered Charges for the rest of the Calendar Year unless stated otherwise.

Per Covered Person $3,500

Per Family Unit (aggregate)..... $7,000

The charges for the following do not apply to the 100% benefit limit and are never paid at 100%: Cost Containment Penalties; 50% Benefits; Non-Covered Charges; and Charges over Usual and Customary.

Summary of Benefits – Medical

The following benefits are per Participant per Calendar Year:

Supplementary Accident Charge

Maximum benefit per accident..... first $500 payable at 100%, deductible waived

Hospital Room and Board – Semi Private Room Rate

Reimbursement rate ..... 80% after deductible

Intensive Care Unit

Reimbursement rate ..... 80% after deductible

Ancillary Charges

Reimbursement rate ..... 80% after deductible

Outpatient Hospital Charges

Reimbursement rate ..... 80% after deductible

Emergency Room – Other than for Accidental Injury

Reimbursement rate ..... 80% after deductible

Surgical Center / Ambulatory Care Center

Reimbursement rate ..... 80% after deductible

Skilled Nursing Facility

Reimbursement rate ..... 80% after deductible

Calendar Year Maximum ..... 120 days

Home Health Care

Reimbursement rate ..... 80% after deductible

Urgent Care Facility

Reimbursement rate ..... 80% after deductible

Birthing Center

Reimbursement rate ..... 80% after deductible

Rehabilitation Center

Reimbursement rate ..... 80% after deductible

Hospice Care – 6- month benefit period

Reimbursement rate ..... 80% after deductible

Bereavement Counseling

Reimbursement rate ..... 80% after deductible

IV Therapy

Reimbursement rate ..... 80% after deductible

Dialysis

Reimbursement rate ..... 80% after deductible

Blood & Plasma (See Limitations)

Reimbursement rate ..... 80% after deductible

Pre-Admission Testing

Reimbursement rate ..... 80% deductible waived

Physician Services

Inpatient Reimbursement rate ..... 80% after deductible

Office Visit Reimbursement rate..... 80% after deductible

Emergency Room Visit Reimbursement rate ..... 80% after deductible

Allergy Testing / Serum and Injections Reimbursement rate ..... 80% after deductible

Eye Care

Reimbursement rate..... 80% after deductible

Glaucoma Testing (See Limitations)

Reimbursement rate ..... 80% after deductible

X-Ray Charges

Reimbursement rate ..... 80% after deductible

Laboratory Charges

Reimbursement rate ..... 80% after deductible

MRI Testing

Reimbursement rate ..... 80% after deductible

CAT Scan Testing

Reimbursement rate ..... 80% after deductible

PET Scan Testing

Reimbursement rate ..... 80% after deductible

Supplies

Reimbursement rate ..... 80% after deductible

Medical Supplies

Reimbursement rate ..... 80% after deductible

Surgical Services – Inpatient and Outpatient Surgeon

Reimbursement rate ..... 80% after deductible

Assistant Surgeon – M.D. – 20% of Surgeon's allowable fees

Reimbursement rate ..... 80% after deductible

Assistant Surgeon – **N.P., P.A., R.N.** – 12% of Surgeon's allowable fees

Reimbursement rate ..... 80% after deductible

Anesthesiologist

Reimbursement rate ..... 80% after deductible

Second & Third Surgical Opinion

Reimbursement rate ..... 100% deductible waived

Temporomandibular Joint Syndrome (TMJ) Surgery

Reimbursement rate ..... 80% after deductible

Orthognathic Surgery (Osteotomies)

Reimbursement rate ..... 80% after deductible

Morbid Obesity Surgery – Guidelines apply

Reimbursement rate ..... 80% after deductible

Lifetime Maximum..... $15,000.00

Mastectomy

Reimbursement rate..... 80% after deductible

Sterilization

Reimbursement rate..... 80% after deductible

Chemotherapy & Radiation

Reimbursement rate ..... 80% after deductible

Inpatient Private Duty Nursing

Reimbursement rate ..... 80% after deductible

Ambulance Service

Reimbursement rate ..... 80% after deductible

Occupational Therapy

Reimbursement rate ..... 80% after deductible

Speech Therapy

Reimbursement rate ..... 80% after deductible

Physical Therapy – Directed by M.D.

Reimbursement rate ..... 80% after deductible

Respiratory Therapy

Reimbursement rate ..... 80% after deductible

Sleep Apnea Testing

Reimbursement rate ..... 80% after deductible

Spinal Manipulations / Chiropractic Services – Not directed by M.D.

Reimbursement rate ..... 80% after deductible

Calendar Year Maximum $750.00

Durable Medical Equipment

Reimbursement rate ..... 80% after deductible

Diabetic Education and Training

Reimbursement rate ..... 80% after deductible

Prosthetics

Reimbursement rate ..... 80% after deductible

Orthotics

Reimbursement rate ..... 80% after deductible

Calendar Year Maximum $500.00

Birth Control Devices, Patches and Injections

Reimbursement rate ..... 80% after deductible

Note: Birth control pills are covered under the Prescription Drug Benefit.

Infertility Benefits

Reimbursement rate ..... 80% after deductible

Coverage includes: care, supplies and services for the **diagnosis of infertility only**.

Pregnancy Benefits – Employee, Lawfully Married Spouse and Dependent daughters are covered

Reimbursement rate ..... 80% after deductible

Genetic Testing (See Limitations)

Reimbursement rate ..... 80% after deductible

Newborn Care (during mother's eligible Hospital stay) Nursery / Physician

Reimbursement rate ..... 80% deductible waived

Self-Inflicted Injuries When Related to Mental Illness

Reimbursement rate ..... 80% after deductible

Type I and Type II Organ Transplant Coverage

Reimbursement rate ..... 80% after deductible

Donor Expenses (See Limitations)

Reimbursement rate ..... 80% after deductible

Mental Disorders Treatment

Inpatient / Partial Hospitalization reimbursement rate ..... 80% after deductible

Outpatient reimbursement rate ..... 80% after deductible

Substance Abuse Treatment

Inpatient / Partial Hospitalization reimbursement rate ..... 80% after deductible

Outpatient reimbursement rate ..... 80% after deductible

Routine Well Adult and Child Preventive Care

Wellness Benefit.

The following will be paid at 100% Deductible Waived

Preventive Care Services That Must Be Covered without Cost-Sharing:

- Screenings:

  Any screenings that have a recommendation rating a “A” or “B”, which include the following: Breast and colon cancer tests, Diabetes testing, Cholesterol and high blood pressure tests, Testing for pre-natal vitamin deficiency

- Well-baby Visits
- Routine Vaccinations:
  - ✓ All Childhood immunizations
  - ✓ Adult boosters
- Vision and Hearing Exams for Children
- Weight Loss Counseling for Children
- Women’s Health Screenings
- Smoking Cessation Counseling
- Obesity Screening and Counseling
- AIDS Virus Testing

Coordination / Facilitation Care Services

Reimbursement rate ..... 100% deductible waived

Discount Negotiation Services

Reimbursement rate ..... 100% deductible waived

Audit Review Services

Reimbursement rate ..... 100% deductible waived

PPO Fees

Reimbursement rate ..... 100% deductible waived

MEDICAL BENEFITS

Medical Benefits

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

Allergy Services. Charges related to the treatment of allergies.

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

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

Anesthesia. Anesthesia, anesthesia supplies, and administration of anesthesia by facility staff.

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

Blood and Plasma. Blood transfusions, plasma and blood derivatives and charges for whole blood not donated or replaced by a blood bank.

Chemotherapy. Charges for chemotherapy/radiation.

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

Contraceptives. The Plan will also cover contraception related services, including the initial visit to the prescribing Physician and any follow up visits or Outpatient services, to the same extent, and on the same terms, as it offers coverage for other Outpatient services for preventive care.

Dental. Emergency repair due to Injury to sound natural teeth, if the repair is made within 12 months from the date of the Injury (unless otherwise required by applicable law).

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

Dialysis Treatment - Outpatient. This Section describes the Plan's Dialysis Benefit Preservation Program (the "Dialysis Program"). The Dialysis Program shall be the exclusive means for determining the amount of Plan benefits to be provided to Plan members and for managing cases and claims involving dialysis services and supplies, regardless of the condition causing the need for dialysis.

A. Reasons for the Dialysis Program. The Dialysis Program has been established for the following reasons:
    a. The concentration of dialysis providers in the market in which Plan members reside may allow such providers to exercise control over prices for dialysis-related products and services.
    b. The potential for discrimination by dialysis providers against the Plan because it is a non-governmental and non-commercial health plan, which discrimination may lead to increased prices for dialysis-related products and services charged to Plan members.

c. Evidence of (i) significant inflation of the prices charged to Plan members by dialysis providers, (ii) the use of revenues from claims paid on behalf of Plan members to subsidize reduced prices to other types of payers as incentives, and (iii) the specific targeting of the Plan and other non-governmental and non-commercial plans by the dialysis providers as profit centers,
d. The fiduciary obligation to preserve Plan assets against charges which (i) exceed reasonable value due to factors not beneficial to Plan members, such as market concentration and discrimination in charges, and (ii) are used by the dialysis providers for purposes contrary to the Plan members' interests, such as subsidies for other plans and discriminatory profit-taking.

B. Dialysis Program Components. The components of the Dialysis Program are as follows:

a. Application. The Dialysis Program shall apply to all claims filed by, or on behalf of, Plan members for reimbursement of products and services provided for purposes of outpatient dialysis, regardless of the condition causing the need for dialysis ("dialysis-related claims").

b. Claims Affected. The Dialysis Program shall apply to all dialysis-related claims received by the Plan on or after **August 1, 2012**, regardless when the expenses related to such claim were incurred or when the initial claim for such products or services was received by the Plan with respect to the Plan member.

c. Mandated Cost Review. All dialysis-related claims will be subject to cost review by the Plan Administrator to determine whether the charges indicate the effects of market concentration or discrimination in charges. In making this determination the Plan Administrator shall consider factors including:

i. Market concentration: The Plan Administrator shall consider whether the market for outpatient dialysis products and services is sufficiently concentrated to permit providers to exercise control over charges due to limited competition, based on reasonably available data and authorities. For purposes of this consideration multiple dialysis facilities under common ownership or control shall be counted as a single provider.
ii. Discrimination in charges: The Plan Administrator shall consider whether the claims reflect potential discrimination against the Plan, by comparison of the charges in such claims against reasonably available data about payments to outpatient dialysis providers by governmental and commercial plans for the same or materially comparable goods and services.

d. In the event that the Plan Administrator's charge review indicates a reasonable probability that market concentration and/or discrimination in charges have been a material factors resulting in an increase of the charges for outpatient dialysis products and/or services for the dialysis- related claims under review, the Plan Administrator may, in its sole discretion, determine that there is a reasonable probability that the charges exceed the reasonable value of the goods and/or services. Based upon such a determination, the Plan Administrator may subject the claims and all future claims for outpatient dialysis goods and services from the same provider with respect to the Plan member, to the following payment limitations, under the following conditions:
i. Where the Plan Administrator deems it appropriate in order to minimize disruption and administrative burdens for the Plan member, dialysis-related claims received prior to the cost review determination may, but are not required to be, paid at the face or otherwise applicable rate.

ii. Where the provider is or has been a participating provider under a Preferred Provider Organization (PPO) available to the Plan's members, upon the Plan Administrator's determination that payment limitations should be implemented, the rate payable to such provider shall be subject to the limitations of this Section.

iii. Maximum Benefit. The maximum Plan benefit payable to dialysis-related claims subject to the payment limitation shall be the Usual and Reasonable Charge for covered services and/or supplies, after deduction of all amounts payable by coinsurance or deductibles.

iv. Usual and Reasonable Charge. With respect to dialysis-related claims, the Plan Administrator shall determine the Usual and Reasonable Charge based upon the average payment actually made for reasonably comparable services and/or supplies to all providers of the same services and/or supplies by all types of plans in the applicable market during the preceding calendar year, based upon reasonably available data, adjusted for the national Consumer Price Index medical care rate of inflation. The Plan Administrator may increase or decrease the payment based upon factors concerning the nature and severity of the condition being treated.

v. Additional Information related to Value of Dialysis-Related Services and Supplies. The Plan member, or where the right to Plan benefits has been properly assigned to the provider, may provide information with respect to the reasonable value of the supplies and/or services, for which payment is claimed, on appeal of the denial of any claim or claims. In the event the Plan Administrator, in its sole discretion, determines that such information demonstrates that the payment for the claim or claims did not reflect the reasonable value, the Plan Administrator shall increase or decrease the payments (as applicable) to the amount of the reasonable value, as determined by the Plan Administrator based upon credible information from identified sources. The Plan Administrator may, but is not required to, review additional information from third-party sources in making this determination.

vi. All charges must be billed by a provider in accordance with generally accepted industry standards.

e. Provider Agreements. Where appropriate, and a willing appropriate provider acceptable to the Plan member is available, the Plan Administrator may enter into an agreement establishing the rates payable for outpatient dialysis goods and/or services with the provider, provided that such agreement must identify this Section of the Plan and clearly state that such agreement is intended to supersede this Section.

f. Discretion. The Plan Administrator shall have full authority and discretion to interpret, administer and apply this Section, to the greatest extent permitted by law.

Plan Administration Language.

(This language will be placed in the Plan Document in the "General Administrative Provisions" portion of the Plan.)

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

The Plan Administrator has the discretionary authority to decide whether a charge is Usual and Reasonable. Benefits under this Plan shall be paid only if the Plan Administrator decides in its discretion that a Plan member is entitled to them.

Secondary Coverage.

(This language will be placed in the Plan Document in the "General Plan Provisions" portion of the Plan.)

Plan members who are eligible for secondary coverage by any other health plan are encouraged to obtain such coverage. Failure to obtain secondary coverage may result in the Plan member incurring costs, which are not covered by the Plan and which would otherwise be covered by the secondary coverage. The Plan will not pay for any costs which would have been payable by such secondary coverage, except to the extent that such costs are payable in any event by the Plan.

1. A provider that accepts the payment from the Plan will be deemed to consent and agree that (i) such payment shall be for the full amount due for the provision of services and supplies to a Plan member and (ii) it shall not "balance bill" a Plan member for any amount billed but not paid by the Plan.

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

1. Any purchases without its advance written approval.
2. Replacements or repairs.
3. The rental or purchase of items which do not fully meet the definition of "Durable Medical Equipment."

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

Gleevec. For treatment of any of the following conditions:

1. CML myeloid blast crisis.
2. CML accelerated phase.
3. CML in chronic phase after failure of interferon treatment.

Prior authorization is required. In order to obtain such authorization, information from the patients' Physician indicating the condition being treated must be submitted to the Plan.

Home Health Care. Charges by a Home Health Care Agency for any of the following:

1. Registered Nurses or Licensed Practical Nurses.
2. Certified home health aides under the direct supervision of a Registered Nurse.
3. Registered therapist performing physical, occupational or speech therapy.
4. Physician calls in the office, home, clinic or outpatient department.
5. Services, Drugs and medical supplies which are Medically Necessary for the treatment of the Participant that would have been provided in the Hospital, but not including Custodial Care.
6. Rental of Durable Medical Equipment or the purchase of this equipment if economically justified, whichever is less.

NOTE: *Transportation services are not covered under this benefit.*

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

1. Room and Board for confinement in a Hospice.
2. Ancillary charges furnished by the Hospice while the patient is confined therein, including rental of Durable Medical Equipment which is used solely for treating an Injury or Sickness.
3. Medical supplies, Drugs and medicines prescribed by the attending Physician, but only to the extent such items are necessary for pain control and management of the terminal condition.
4. Physician services and nursing care by a Registered Nurse, Licensed Practical Nurse or a Licensed Vocational Nurse (L.V.N.).
5. Home health aide services.
6. Home care furnished by a Hospital or Home Health Care Agency, under the direction of a Hospice, including Custodial Care if it is provided during a regular visit by a Registered Nurse, a Licensed Practical Nurse or a home health aide.
7. Medical social services by licensed or trained social workers, Psychologists or counselors.
8. Nutrition services provided by a licensed dietitian.
9. Respite care.

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

Hospital. Charges made by a Hospital for:

1. Inpatient Treatment
    a. Daily semi private Room and Board charges.
    b. Intensive Care Unit (ICU) and Cardiac Care Unit (CCU) Room and Board charges.
    c. General nursing services.
    d. Medically Necessary services and supplies furnished by the Hospital, other than Room and Board.
2. Outpatient Treatment
    a. Emergency room.
    b. Treatment for chronic conditions.
    c. Physical therapy treatments.
    d. Hemodialysis.
    e. X ray, laboratory and linear therapy.

Impregnation and Infertility Treatment. Following charges related to Impregnation and Infertility Treatment. Coverage includes: care, supplies and services for the diagnosis of infertility only.

Mastectomy. The Federal Women's Health and Cancer Rights Act, signed into law on October 21, 1998, contains coverage requirements for breast cancer patients who elect reconstruction in connection with a Mastectomy. The Federal law requires group health plans that provide Mastectomy coverage to also cover breast reconstruction Surgery and prostheses following Mastectomy.

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

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

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

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

Medical Supplies. Dressings, casts, splints, trusses, braces and other Medically Necessary medical supplies, with the exception of dental braces or corrective shoes, but including syringes for diabetic and allergy Diagnosis, and lancets and chemstrips for diabetics.

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

1. Inpatient Benefits. These benefits are also available when receiving treatment during the day only or during the night only at a day/night Psychiatric Hospital or at a Substance Abuse Treatment Center and/or Rehabilitation Hospital.
    a. Semi-private Hospital Room and Board.
    b. Miscellaneous facility charges on days a Room and Board charge is covered.
    c. Individual psychotherapy.
    d. Group psychotherapy.
    e. Psychological testing.
    f. Family counseling.
    g. Convulsive therapy treatment.
2. Outpatient Benefits.
    a. Individual psychotherapy.
    b. Group psychotherapy.
    c. Psychological testing.
    d. Family counseling.
    e. Convulsive therapy treatment.
    f. Prescription Drugs or medicines for the treatment of mental Illness or chemical dependency.

Newborn Care. Hospital and Physician nursery care for newborns who are natural Children of the Employee or lawfully married spouse and properly enrolled in the Plan, as set forth below. Benefits will be provided under the Child's coverage, and the Child's own Deductible and coinsurance provisions will apply:

1. Hospital routine care for a newborn during the Child's initial Hospital confinement at birth.
2. The following Physician services for well-baby care during the newborn's initial Hospital confinement at birth:
    a. The initial newborn examination and a second examination performed prior to discharge from the Hospital.
    b. Circumcision.

NOTE: *The Plan will cover Hospital and Physician nursery care for an ill newborn as any other medical condition, provided the newborn is properly enrolled in the Plan. These benefits are provided under the baby's coverage.*

Nursing Services. Services of a Registered Nurse or Licensed Practical Nurse.

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

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

Osseous Surgery. Charges for osseous surgery.

Pathology Services. Charges for pathology services.

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

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

Pregnancy Expenses. Expenses attributable to a Pregnancy. Pregnancy expenses of Employee, Lawfully Married Spouse, and Dependent Daughter(s) are covered.

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

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

Preventive Care. Charges for Preventive Care services.

Private Duty Nursing. Private duty nursing (outpatient only).

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

Radiation Therapy. Charges for radiation therapy and treatment.

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

Second Surgical Opinions. Charges for second surgical opinions.

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

Smoking Addiction. Nicotine withdrawal programs and facilities.

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

Sterilization (male and female). Charges related to sterilization procedures.

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

A. Charges for **multiple surgical procedures** will be a Covered Charge subject to the following provisions:
    a. If bilateral or multiple surgical procedures are performed by one (1) surgeon, benefits will be determined based on the Usual and Customary Charge that is allowed for the primary procedures; 50% of the Usual and Customary Charge will be allowed for each additional procedure performed through the same incision. Any procedure that would not be an integral part of the primary procedure or is unrelated to the diagnosis will be considered "incidental" and no benefits will be provided for such procedures. If bi-lateral or multiple procedures through separate incisions are performed, no more than 75% of Usual and Customary will be allowed. If the procedure being performed is exempt from “multiple procedure guidelines” according to the CPT guidelines, procedures will be payable at the normal rate based on Usual and Customary Charges.
    b. If multiple unrelated surgical procedures are performed by two (2) or more surgeons on separate operative fields, benefits will be based on the Usual and Customary Charge for each surgeon's primary procedure. If two (2) or more surgeons perform a procedure that is normally performed by one (1) surgeon, benefits for all surgeons will not exceed 125% of the Usual and Customary percentage allowed for that procedure. Each surgeon will receive 50% of the 125% allowed; and
    c. For Tubal Ligation performed at the same time as a cesarean section, the procedure will be allowed at 50% of the Usual and Customary fee allowance, payable as allowed in the Schedule of Benefits.
    d. For tubal ligation performed at the same time as a vaginal delivery, the procedure will be allowed at 100% of the Usual and Customary fee allowance, payable as allowed in the Schedule of Benefits.
    e. If an M.D. Assistant surgeon is required; the assistant surgeon's covered charge will not exceed 20% of the surgeon's Usual and Customary allowance.
    f. If a P.A., R.N. or N.P. Assistant surgeon is required; the assistant surgeon's covered charge will not exceed 12% of the surgeon's Usual and Customary allowance.

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

Temporomandibular Joint Disorder. Charges for the surgery of Temporomandibular Joint Disorder are covered under this Plan.

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

1. Bone marrow.
2. Heart.
3. Lung.
4. Heart and lung.
5. Liver.
6. Pancreas.
7. Kidney.
8. Cornea.

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

Recipient Benefits

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

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

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

When both the person donating the organ and the person receiving the organ are Participants, each will receive benefits under the Plan.

Donor Benefits

The Plan covers donation-related services for actual or potential donors, whether or not they are Participants, as long as the transplant recipient is a Participant. The Plan will cover these costs, provided such costs are not covered in whole or in part by any other source other than the donor's family or estate. This includes, but is not limited to, other insurance, including self-funded medical plans, grants, foundations, and government programs. If a Participant is donating the organ to a person who is not a Participant under this Plan, benefits are not available under this Plan. Benefits provided to the donor will be charged against the Participant's coverage.

Exclusions

Some health care services are not covered by the Plan. In addition to the General Exclusions set forth in the General Limitations and Exclusion section, these include, but are not limited to, any charge for care, supplies, or services, which are:

Abortion. Services, supplies, care or treatment in connection with an abortion unless the life of the mother is endangered by the continued Pregnancy or the Pregnancy is the result of rape or incest.

Acupuncture. Relating directly or indirectly to acupuncture.

Adoption. Expenses not covered include, but are not limited to court costs, expenses related to the natural mother and expenses for the child prior to placement for adoption.

Biofeedback. For biofeedback.

Consultations. For consultations.

Education or Training Program. Performed by a Physician or other Provider enrolled in an education or training program when such services are related to the education or training program, except as specifically provided herein.

Educational or Vocational Testing. Services for educational or vocational testing or training or care for learning disorders or behavioral problems whether or not associated with a manifest mental disorder or other disturbance will not be covered.

Exercise Programs. Exercise programs for treatment of any condition, except for Physician-supervised cardiac rehabilitation, occupational or physical therapy covered by this Plan.

Eye Care. Radial keratotomy or other eye surgery to correct refractive disorders. Also, routine eye examinations, including refractions, lenses for the eyes and exams for their fitting. This exclusion does not apply to aphakic patients and soft lenses or sclera shells intended for use as corneal bandages.

Foot Disorders. Surgical treatment of foot disorders, including associated services, performed by a licensed podiatrist (including routine foot care).

Genetic Counseling: Charges for genetic counseling or tests to determine the sex or characteristics of an unborn child are not covered, except if one of the following conditions applies, the testing only would be covered, if:

a. mother is age 35 or older at delivery;
b. close relative with a neural tube defect;
c. fetal sex for x-linked disease;
d. family history of metabolic disorders and disorders for which Restriction Fragment Length Polymorphism (RFLP) diagnostic testing is available;
e. previous trisomic infant;
f. parental translocations;
g. hemoglobinopathics;
h. significant abnormality suspected in ultrasound examination;
i. elevated or low maternal serum Alpha-Fetoprotein determination

Hair Pieces. For wigs, artificial hair pieces, human or artificial hair transplants, or any Drug, prescription or otherwise, used to eliminate baldness.

Hearing Devices. For hearing aids or examinations for the prescription, fitting, and/or repair of hearing aids.

Hospital employees. Professional services billed by a Physician or nurse who is an employee of a Hospital or Skilled Nursing Facility and paid by the Hospital or facility for the service.

Hypnosis. Related to the use of hypnosis.

Impotence. Care, treatment, services, supplies or medication in connection with treatment for impotence.

Infertility. Care, supplies, services and treatment for infertility, except for diagnostic services rendered for infertility evaluation.

Marital, pre-marital or family counseling. Treatment or services for marriage or pre-marital counseling and similar types of services which are defined as any act of providing psychotherapy to avoid or relieve family or marital discord, divorce, preparation for marriage, encounter groups, parental counseling, treatment for situational disturbances such as financial or environmental problems or other types of everyday stresses or strains.

Massage Therapy. Massage Therapy will not be considered eligible unless when a part of an overall patient treatment.

Non-compliance. All charges in connection with treatments or medications where the patient either is in non-compliance with or is discharged from a Hospital or Skilled Nursing Facility against medical advice.

Non-emergency Hospital admissions. Care and treatment billed by a Hospital for non-Medical Emergency admissions on a Friday or a Saturday. This does not apply if surgery is performed within 24 hours of admission.

Nutritional Supplements. For nutritional supplements.

Obesity. Related to the care and treatment of obesity, weight loss or dietary control, unless related to morbid obesity.

Orthopedic Shoes. For orthopedic shoes, unless they are an integral part of a leg brace and the cost is included in the orthotist's charge.

Personal Convenience Items. Personal comfort items or other equipment, such as, but not limited to, air conditioners, air-purification units, humidifiers, electric heating units, orthopedic mattresses, blood pressure instruments, scales, elastic bandages or stockings, nonprescription drugs and medicines, first-aid supplies and non-hospital adjustable beds.

Radial Keratotomy. For radial keratotomy or other plastic surgeries on the cornea in lieu of eyeglasses.

Routine Physical Examinations. For routine or periodic physical examinations, related x-ray and laboratory expenses, and nutritional supplements, except as provided in the Summary of Benefits.

Sales tax. Charges for mailing or sales tax.

Sex Change Operation. Related to a sex change operation or treatment of sexual dysfunction not related to organic Disease.

Sleep disorders. Care and treatment for sleep disorders unless deemed Medically Necessary.

Sterilization Reversal. For sterilization procedure reversal.

Temporomandibular Joint Syndrome: Charges for treatment of Temporomandibular Joint Syndrome (TMJ) will not be a covered benefit under this plan. TMJ surgery is covered pursuant to the Schedule of Benefits.

Travel. For travel, whether or not recommended by a Physician, except as specifically provided herein.

Vitamins. For vitamins.

Workers' Compensation. Expenses for which Payment is required under applicable Workers' Compensation Statutes are not eligible for Payment under this medical Plan. This Plan is not in lieu of and does not affect any requirement for coverage by Workers' Compensation Insurance. However, work-related claims for Plan Participants for which Workers' Compensation is not required can be considered for benefits under this Plan.

Cost Containment

The cost containment company is:
CRITIQUE (888) 272-4002

A. Services that Require Pre-Certification

The following services will require Pre-Certification (or reimbursement from the Plan may be reduced):

1. Inpatient hospitalization.
2. Transplant candidacy evaluation and transplant (organ and/or tissue).
3. Home Health Services.
4. Rehab program (such as cardiac, chemical dependency, pain management, pulmonary).
5. Inpatient Mental/Nervous facility based programs.
6. Inpatient Substance Abuse facility based programs.
7. Skilled nursing facility stays.
8. Inpatient Hospice Care
9. Chemotherapy and Radiation
10. Clinical Trials
11. Outpatient surgery performed in an outpatient hospital setting or a surgical center.

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

Pre-certification does not verify eligibility for benefits nor guarantee benefit payments under the Plan. It is the Participant's responsibility to verify that the above services have been pre-certified as outlined below.

B. Pre-Certification Procedures and Contact Information

The Inpatient Utilization Management Service (CRITIQUE) is simple and easy for Participants to use. Whenever a Participant is advised that Inpatient Hospital care is needed, it is the Participant's responsibility to call the pre-certification department (CRITIQUE) at its toll free number, which is (888) 272-4002. The review process will continue, as outlined below, until the Participant is discharged from the Hospital. Pre-certification is not required for Inpatient admission to skilled nursing facilities, convalescent or rehabilitation facilities unless otherwise stated in this document.

Urgent Care or Emergency Admissions:

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

If a Participant must be admitted on an Emergency basis, the Participant should follow the Physician's instructions carefully and contact the pre-certification department (CRITIQUE) as follows:

1. For Emergency admissions after business hours on Friday, on a weekend or over a holiday weekend, a call to the pre-certification department (CRITIQUE) must be made within 72 hours after the admission date, but no later than the first business day following the Emergency admission, by or on behalf of the covered patient.
2. For Emergency admissions on a weekday, a call to the pre-certification department (CRITIQUE) must be made within 24 hours after the admission date.

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

Non-Emergency Admissions:

For Inpatient Hospital stays that are scheduled in advance, a call to the pre-certification department (CRITIQUE)should be completed within five days before actual services are rendered. Once the pre-certification call is received, it will be routed to an appropriate review specialist who will create an on-line patient file. The review specialist will contact the Participant's attending Physician to obtain information and to discuss the specifics of the admission request. If appropriate, alternative care will be explored with the Physician.

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

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

The pre-certification department (CRITIQUE) hours of operations are 8:00 AM to 5:00 PM. On weekends and evenings, the Participant can call (888) 272-4002, and leave a message.

C. Pre-Certification Penalty

The program requires the support and cooperation of each Participant. If a Participant follows the instructions and procedures, he or she will receive the normal Plan benefits for the services. However, if a Participant fails to notify pre-certification department (CRITIQUE) of any Inpatient Hospital stay as required in the provision entitled "Pre-Certification Procedures and Contact Information," allowed charges will be reduced by $250 for Room and Board, Hospital miscellaneous services, and any other charges related to that confinement which are billed by the Hospital. The Participant will be responsible for payment of the part of the charge that is not paid by the Plan.

D. Alternate Course of Treatment

Certain types of conditions, such as spinal cord Injuries, cancer, AIDS or premature births, may require long term, or perhaps lifetime, care. The claims selected will be evaluated as to present course of treatment and alternate care possibilities.

If the Plan Administrator should determine that an alternate, less expensive, course of treatment is appropriate, and if the attending Physician agrees to the alternate course of treatment, all Medically Necessary expenses stated in the treatment plan will be eligible for payment under the Plan, subject to the applicable lifetime benefit set forth in this Plan, even if these expenses normally would not be eligible for payment under the Plan. A more expensive course of treatment, selected by the Participant and/or their attending Physician may not be deemed to be Medically Necessary and/or Usual and Customary, as those terms are defined by the Plan. The Plan may provide coverage in such circumstances by providing benefits equivalent to those available had the Medically Necessary / Usual and Customary course of treatment been pursued.

E. Pre-Admission Testing

If a Participant is to be admitted to a Hospital for non-Emergency Surgery or treatment, one set of laboratory tests and x-ray examinations performed on an outpatient basis within seven days prior to such Hospital admission will be paid, with no Deductible, at 100% of the Usual and Customary fees, provided that the following conditions are met:

1. The tests are related to the performance of the scheduled Surgery or treatment.
2. The tests have been ordered by a Physician after a condition requiring Surgery or treatment has been diagnosed and Hospital admission has been requested by the Physician and confirmed by the Hospital.
3. The Participant is subsequently admitted to the Hospital, or confinement is cancelled or postponed because a Hospital bed is unavailable or if, after the tests are reviewed, the Physician determines that the confinement is unnecessary.
4. The tests are performed in the Hospital where the confinement will take place and accepted in lieu of duplicate tests rendered during confinement.

F. Second Surgical Opinion

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

In addition, the Plan recommends that a second opinion be obtained prior to the following Surgeries:

1. Adenoidectomy.
2. Bunionectomy.
3. Cataract removal.
4. Coronary Bypass.
5. Cholecystectomy (removal of gallbladder).
6. Dilation and curettage.
7. Hammer Toe repair.
8. Hemorrhoidectomy.
9. Herniography.
10. Hysterectomy.
11. Laminectomy (removal of spinal disc).
12. Mastectomy.
13. Meniscectomy (removal of knee cartilage, including arthroscopic approach).
14. Nasal surgery (repair of deviated nasal septum, bone or cartilage).
15. Prostatectomy (removal of all or part of prostate).
16. Release for entrapment of medial nerve (Carpal Tunnel Syndrome).
17. Tonsillectomy.
18. Varicose veins (tying off and stripping).

When a second opinion is requested, the Plan will pay 100% of Usual and Customary fees Incurred for that opinion along with laboratory, x-ray and other Medically Necessary services ordered by the second Physician without application of the Deductible. Second opinions for Cosmetic Surgery, normal obstetrical delivery and Surgeries that require only local anesthesia are not covered. If the second opinion does not concur with the first, the Plan will pay for a third opinion as outlined above. The second or third opinion must be given within 90 days of the first.

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

G. Pre-Surgical Approval

The Plan recommends that a pre-determination of benefits be obtained prior to the following Surgical Procedures, since they are usually Cosmetic Surgery or not Medically Necessary. These procedures include, but are not limited to:

1. Abdominoplasty.
2. Blepharoplasty.
3. Breast reduction or enlargement.
4. Dermabrasion.
5. Facial or nasal reconstruction.
6. Gastric bypass.
7. Lipectomy.
8. Penile implant.
9. Scar revision.
10. Sex alteration.
11. Any Experimental or research procedures which are not generally accepted medical practice.

Because of the broad range of Surgical Procedures available and under development, if a Participant is scheduled to undergo any questionable procedure, he or she should contact the Third Party Administrator for further information.

CRITIQUE, Inc. fees for following a member in Large Case Management and Disease Management are considered as a covered claims expense.

Chronic Disease Management Program Charges and Fees

The Plan is hereby amended to include services for Disease Management, paid 100%, no subject to deductible, co-insurance or co-pays, as provided by CRITIQUE, Inc., and all accompanying programs that the service entails to include, but not limited to:

a. Fees for monitoring of patients that have been identified, as having a “chronic” disease for which there is an established “Plan of Care”.

b. The purchase or rental of base tele monitoring equipment and the requisite peripheral equipment necessary to monitor vital indicators for the patient’s chronic condition, payable under the plan as durable medical equipment.

c. The monthly data collection and storage fees which are incurred in the monitoring of the patient.

HEALTH MANAGEMENT SERVICES: Utilization Review Services, Coordination / Facilitation Care Services, Discount Negotiation Services and Audit Review Services are payable at 100% deductible waived under this Plan.