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PLAN DOCUMENT

FOR

COUNTY OF HENRICO
HEALTH PLAN

ADMINISTERED BY



SOUTHERN HEALTH SERVICES, INC.
A COVENTRY HEALTH CARE PLAN

Effective Date: January 1, 2010

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Important Resources

Southern Health Customer Service	866-533-5149
Pharmacy Help Desk	800-378-7040
Behavioral Health and Substance Abuse Services	800-975-8919
Routine Vision Care Services	800-877-7195
Net Support Team	866-213-0802
Richmond Office	804-747-3700

SECTION 1 INTRODUCTION

1.1 ESTABLISHMENT OF PLAN

The County of Henrico (hereinafter referred to as the "County") hereby establishes the County of Henrico Health Plan (the "Plan"), effective January 1, 2008. The County has established the Plan for the exclusive benefit of the Employees, Dependents, and non-Medicare eligible Retirees of the County and of certain other related government entities (that are defined in Section 2.1. and Section 10) to provide health care benefits to such individuals.

1.2 PLAN DOCUMENT

This document shall constitute the written plan document for this Plan. It provides a description of the County of Henrico Health Plan. This document, its attachments and any amendments, the Plan ID card, enrollment change form, the Administrative Services Agreement and its amendments and its addenda constitute the entire agreement between the Participants and the Plan. No oral interpretations or statements of any person shall modify or otherwise affect the benefits, limitations, and exclusions of this Plan, convey or void any coverage, increase or reduce benefits under this Plan, or be used in the support or defense of a claim under this Plan.

The Plan described herein is designed to help covered individuals meet the cost of health care by providing benefits for hospital care, medical/surgical services, behavioral health services, prescription drug and vision services. The effective date of coverage for each Participant's current benefits is indicated on the Participant's Plan ID card.

This document describes the Plan rights and benefits for covered Employees and their Dependents and is divided into the following parts:

General Information about the Plan.

General Provisions including Eligibility, Enrollment, Effective Date, and Termination.

Explains eligibility for coverage under the Plan and when the coverage takes effect and terminates.

Participant Rights and Responsibilities. Outlines basic Participant rights and responsibilities with regard to receiving benefits under the Plan.

Schedule of Benefits. Provides an outline of the Plan reimbursement formulas as well as payment limits on certain services.

Medical Benefits. Explains when the benefit applies and the types of charges covered.

Utilization Management Services. Explains the methods used to curb unnecessary and excessive charges.

Prescription Drug Benefit. Explains when the benefit applies and the types of charges covered.

Vision Benefit. Explains the benefits available and the types of charges covered.

Defined Terms. Defines those Plan terms that have a specific meaning within the Plan Document.

Plan Exclusions. Shows what charges are **not** covered.

How to Submit a Claim and Claim Review Procedures. Explains the rules for filing claims and the claim appeal process.

Coordination of Benefits. Shows the Plan payment order when a person is covered under more than one plan.

Protected Health Information. Explains the roles of the Plan and the Plan Sponsor with regard to protecting the privacy of protected health information.

Continuation Coverage Rights Under COBRA. Explains when a person's coverage under the Plan ceases and the continuation options which are available.

Qualified Medical Child Support Orders. Explains the rights under the legislation and the Plan's and the Participants' responsibilities to ensure the order is correctly followed.

Other Federal Benefits Legislation. Provides an overview of the requirements under the Newborns' and Mothers' Health Protection Act of 1996 and the Women's Health and Cancer Rights Act of 1998.

SECTION 2 INFORMATION ABOUT THE PLAN

2.1 IDENTIFYING INFORMATION

Name of the Plan

The name of the Plan is the County of Henrico Health Plan.

Effective Date

The initial Effective Date of the Plan is January 1, 2008.

Plan Year

The Plan Year begins January 1st and ends on the following December 31st, and Plan records are maintained on that basis.

Name and Address of Plan Sponsor and Plan Administrator

County of Henrico, Virginia
4301 East Parham Road
Henrico, VA 23228

Employer

This Plan covers eligible employees of:

The County of Henrico, Virginia; EIN: 54-6001344

The County School Board of Henrico County, Virginia EIN: 54-6001344

Economic Development Authority of Henrico County, Virginia EIN: 54-1197472

Type of Plan

Health

Claims Administrator and Customer Service Contact:

The Plan has appointed a third-party administrator to process claims and administer the day-to-day operations of the Plan. The third-party administrator is:

Southern Health Services, Inc.
9881 Mayland Drive
Richmond, VA 23233
(866) 533-5149

Delegation of Duties to Claims Administrator

The County has delegated to the Claims Administrator the authority (1) to determine eligibility for Plan benefits and (2) to interpret coverage of benefits under the Plan in connection with the decision to pay claims and administration of appeal of claims denied, in whole or in part, as such reviews are required under applicable state and federal laws. The Claims Administrator shall interpret the language of the Plan in accordance with a uniform benefit coverage standard across localities, regions, and state lines regardless of the Plan Participant's geographic location. Any determination or interpretation made by the Claims Administrator pursuant to this discretionary authority shall be given full force and effect and be binding on the Employer and Participant, subject to applicable state and federal laws. The Claims Administrator serves as a fiduciary of the Plan for the limited purpose of providing claims administration services.

2.2 FUNDING MEDIUM/SOURCE OF CONTRIBUTIONS

The Plan is funded through Employer and Employee contributions.

SECTION 3 GENERAL PROVISIONS

3.1 ELIGIBILITY

Eligible Classes of Employees

A person is eligible for Employee coverage from date of hire or the first day of the month following date of employment if he or she is a regular full-time or part-time, active Employee of the Employer. An Employee is considered to be regular full-time or part-time if he or she normally works at least 20 hours per week and is on the regular payroll of the Employer.

Eligible Classes of Dependents

A Dependent is any one of the following persons:

- (1)** A covered Employee's Spouse and unmarried children from birth to the limiting age of 25 years. The Dependent children must be primarily dependent upon the covered Employee for support and maintenance.

The term "Spouse" shall mean the person recognized as the covered Employee's husband or wife under the laws of the Commonwealth of Virginia. The Plan Administrator may require documentation proving a legal marital relationship.

The term "children" shall include each unmarried child who is less than twenty-five (25) years old. Child includes: your natural children; legally adopted children; step children; children for whom you are the Legal Guardian; children for whom you have court-ordered legal custody and children for whom you are the proposed adoptive parent and who are residing with you and dependent upon you during the waiting period prior to the adoption becoming final.

The phrase "child placed with a covered Employee in anticipation of adoption" refers to a child whom the Employee intends to adopt, whether or not the adoption has become final, who has not attained the age of 18 as of the date of such placement for adoption. The term "placed" means the assumption and retention by such Employee of a legal obligation for total or partial support of the child in anticipation of adoption of the child. The child must be available for adoption and the legal process must have commenced.

Any child of a Participant who is an alternate recipient under a qualified medical child support order shall be considered as having a right to Dependent coverage under this Plan. A Participant of this Plan may obtain, without charge, a copy of the procedures governing qualified medical child support order (QMCSO) determinations from the Plan Administrator.

In all cases, to qualify as an eligible Dependent under the Plan, the child must be dependent upon the covered Employee for over one-half of his support during the Plan Year. A special rule applies in the case of a child of divorced parents, legally separated parents or parents who lived apart at all times of the year or during the last six months of the calendar year. The child will be considered dependent upon the Employee for over one-half of his support if the child is in the custody of the Employee and/or the other parent for more than one-half of the year and the child is dependent upon one and/or both parents for more than one-half of his support for the year. The Plan Administrator may require documentation proving dependency, including birth certificates, tax records or initiation of legal proceedings severing parental rights.

- (2)** A covered Dependent child who reaches the limiting age and is Totally Disabled, incapable of self-sustaining employment by reason of mental or physical handicap, primarily dependent

upon the covered Employee for support and maintenance and unmarried. The Claims Administrator may require, at reasonable intervals during the two years following the Dependent's reaching the limiting age, subsequent proof of the child's Total Disability and dependency.

After such two-year period, the Claims Administrator may require subsequent proof not more than once each year. The Claims Administrator reserves the right to have such Dependent examined by a Physician of the Claims Administrator's choice, at the Plan's expense, to determine the existence of such incapacity.

These persons are excluded as Dependents:

- other individuals living in the covered Employee's home, but who are not eligible as defined;
- the divorced former Spouse of the Employee;
- any person who is on active duty in any military service of any country.

If a person covered under this Plan changes status from Employee to Dependent or Dependent to Employee, and the person is covered continuously under this Plan before, during and after the change in status, credit will be given for Deductibles and all amounts applied to maximums.

If both mother and father are Employees, their children will be covered as Dependents of the mother or father, but not both. If two Employees (the mother and father of the child(ren)) are covered under the Plan and the Employee who is covering the Dependent child(ren) terminates coverage, the Dependent coverage may be continued by the other covered Employee.

Eligibility Requirements for Dependent Coverage

A family member of an Employee will become eligible for Dependent coverage on the first day that the Employee is eligible for Employee coverage and the family member satisfies the requirements for Dependent coverage. At any time, the Plan may require proof that a spouse or a child qualifies or continues to qualify as a Dependent as defined by this Plan.

Eligible Classes of Retirees

Retirees who leave service with an immediate (non-deferred) VRS monthly retirement benefit and who are not Medicare eligible may enroll in Retiree coverage under this Plan. Eligible Retirees must enroll for coverage within 31 days of termination of employment or within 31 days of the loss of Active Employee coverage.

Medicare eligible Retirees and Medicare eligible Dependents of Retirees are not eligible for coverage under this Plan. These individuals may be eligible for coverage on a separate County-sponsored health plan.

Medicare-eligible Dependents of active Employees will continue to be covered (or to be eligible for coverage) under this Plan until the Employee retires and becomes eligible for Retiree coverage. Upon retirement of the Employee, the dependent will be eligible under a separate County-sponsored Retiree health plan for Medicare eligible Participants.

Retirees who do not enroll for coverage during their initial eligibility period, will not be allowed to enroll at a later date. They will not be allowed to re-enter the Health Plan once they have terminated coverage.

3.2 ENROLLMENT

Enrollment Requirements for Employees

An Employee must enroll timely for coverage by using the method available at the time of enrollment: either 1) completing an enrollment form, or 2) enrolling electronically.

Enrollment Requirements for Newborn Children

A newborn child of a covered Employee who has Dependent coverage is not automatically enrolled in this Plan. Charges for covered nursery care and routine Physician care will be applied toward the Plan of the newborn child. The newborn child must be enrolled in this Plan on a timely basis, as defined in the section "Timely Enrollment" following this section, or there will be no payment from the Plan and the parents will be responsible for all costs.

Timely Enrollment

The enrollment will be "timely" if the completed form is received by the Plan Administrator no later than 31 days after the person becomes eligible for the coverage, either initially or under a Special Enrollment Period.

Enrollment Requirements for Retirees

A Retiree must enroll for coverage by submitting a completed enrollment form within 31 days of the date of termination of employment or within 31 days of the loss of Active Employee coverage. Enrolled Retirees may add or drop Dependents within 31 days after the Dependent(s) become eligible under a Special Enrollment period or cease to become eligible dependents.

3.3 HIPAA SPECIAL ENROLLMENT RIGHTS

HIPAA provides Special Enrollment provisions under some circumstances. If an Employee has declined enrollment for himself or his Dependents (including his spouse) because of other health insurance or group health plan coverage, there may be a right to enroll in this Plan if there is a loss of eligibility for that other coverage. However, a request for enrollment in this Plan must be made within 31 days after the other coverage ends.

In addition, in the case of a birth, marriage, adoption or placement for adoption, there may be a right to enroll in this Plan. However, a request for enrollment must be made within 31 days after the birth, marriage, adoption or placement for adoption.

The Special Enrollment rules are described in more detail below. To request Special Enrollment or obtain more detailed information regarding these portability provisions, contact the Human Resources Benefits Division (General Government) at (804) 501-7371 or the Health Benefits Office (Schools) at (804) 652-3625. Employees of Economic Development Authority should contact the Human Resources Benefits Division (General Government) at (804) 501-7371.

Special Enrollment Periods

The enrollment date for anyone who enrolls under a HIPAA Special Enrollment period is the first date of coverage.

- (1) Individuals losing other coverage creating a Special Enrollment right.** An Employee or Dependent who is eligible, but not enrolled in this Plan, may enroll within 31 days of loss of eligibility for other coverage under the following circumstances:

- (a) The Employee or Dependent was covered under a group health plan or had health insurance coverage at the time coverage under this Plan was previously offered to the individual. However, Special Enrollment will be available to Employees who decline coverage without having coverage under another plan and subsequently enroll in other coverage and lose that coverage.
- (b) The coverage of the Employee or Dependent who had lost the coverage was under COBRA and the COBRA coverage was exhausted, or was not under COBRA and either the coverage was terminated as a result of loss of eligibility for the coverage or because Employer contributions towards the coverage were terminated.
- (c) The Employee or Dependent requests enrollment in this Plan not later than 31 days after the date of exhaustion of COBRA coverage or the termination of non-COBRA coverage due to loss of eligibility or termination of Employer contributions, described above. Coverage will begin no later than the first day of the first calendar month following the date the completed enrollment form is received.
- (d) The Employee or Dependent reaches the Lifetime limit for all benefits under other coverage. The Special Enrollment period in this instance would be 31 days after the earliest date that a claim is denied due to reaching the lifetime limit.
- (e) For purposes of these rules, a loss of eligibility occurs if:
 - (i) The Employee or Dependent has a loss of eligibility on the earliest date a claim is denied that would meet or exceed a lifetime limit on all benefits.
 - (ii) The Employee or Dependent has a loss of eligibility due to the plan no longer offering any benefits to a class of similarly situated individuals (for example, part-time Employees).
 - (iii) The Employee or Dependent has a loss of eligibility as a result of divorce, cessation of dependent status (such as attaining the maximum age to be eligible as a dependent child under the plan), death, termination of employment, or reduction in the number of hours of employment or contributions towards the coverage were terminated.
 - (iv) The Employee or Dependent has a loss of eligibility when coverage is offered through an HMO (or other arrangement) that does not provide benefits to individuals who no longer reside, live or work in a Service Area (whether or not within the choice of the individual).

If the Employee or Dependent lost the other coverage as a result of the individual's failure to pay premiums or required contributions or for cause (such as making a fraudulent claim or an intentional misrepresentation of a material fact in connection with the plan), that individual does not have a Special Enrollment right.

(2) Dependent beneficiaries. If:

- (a) The Employee is a Participant under this Plan (or is eligible to be enrolled under this Plan but for a failure to enroll during a previous enrollment period), and
- (b) A person becomes a Dependent of the Employee through marriage, birth, adoption or placement for adoption,

Then the Dependent (and if not otherwise enrolled, the Employee) may be enrolled under this Plan. In the case of the birth or adoption of a child, the Spouse of the covered Employee may

be enrolled as a Dependent of the covered Employee if the Spouse is otherwise eligible for coverage. If the Employee is not enrolled at the time of the event, the Employee must enroll under this Special Enrollment Period in order for his eligible Dependents to be enrolled.

An Employee who is already enrolled in a benefit option may enroll in another benefit option under the Plan if their Dependent has a Special Enrollment right because the Dependent lost other health coverage.

The Dependent Special Enrollment period is a period of 31 days and begins on the date of the marriage, birth, adoption or placement for adoption. To be eligible for this Special Enrollment, the Employee must request enrollment for himself (if not already enrolled) and for the Dependent during this 31-day period.

The coverage of the Dependent and/or Employee enrolled in the Special Enrollment Period will be effective:

- (a) in the case of marriage, the first of the month following the date of the marriage or following receipt of the enrollment request, whichever is later. Enrollment requests must be received within 31 days of the marriage date;
- (b) in the case of loss of coverage, the first of the month following the date of the loss of prior coverage if the Employee completes and returns the enrollment/change form in a timely manner and pays any required premiums for such new coverage;
- (c) in the case of a Dependent's birth, as of the date of birth; or
- (d) in the case of a Dependent's adoption or placement for adoption, the date of the adoption or placement for adoption.

Other Special Enrollment Periods

Eligible employees and their dependents, who are not enrolled in the group health plan, may enroll for coverage if either of the following conditions are met:

- (1) The employee/dependents' Children's Health Insurance Program (CHIP) or Medicaid coverage is terminated due to loss of eligibility and the employee requests coverage under the group health plan within 60 days after his and/or his dependents' loss of coverage under Medicaid or the CHIP; or
- (2) The employee/dependent becomes eligible for premium assistance from the CHIP or Medicaid and requests coverage under the group health plan within 60 days after the date that the CHIP or Medicaid determines that the employee/dependent is eligible for such assistance.

The employee also has the right to terminate his and/or his dependents' enrollment in the group health plan and enroll in Medicaid or the CHIP.

3.4 UNIFORMED SERVICES EMPLOYMENT AND RE-EMPLOYMENT RIGHTS ACT (USERRA)

In accordance with Federal law, certain Employees who return to employment following active duty service as a member of the United States Reserves or National Guard will be reinstated to coverage under the Plan (for themselves and any Dependents who were covered prior to the military assignment). No new waiting period requirement will apply, except for any waiting period still remaining from prior to the active military assignment. However, this provision is intended to comply with the minimum requirements of the USERRA and, if it is in conflict or incomplete in any way, such law (38 U.S.C. Section 4301) will prevail.

3.5 ENROLLMENT OF DEPENDENT PURSUANT TO A QUALIFIED MEDICAL CHILD SUPPORT ORDER

If the Plan Administrator receives a Qualified Medical Child Support Order (QMCSO), as determined by the Plan Administrator, for an eligible Dependent, the Effective Date shall be the later of (a) the date of the QMCSO, or (b) thirty (30) days prior to the date the QMCSO was received by the Plan Administrator. If the Employee is not enrolled in the Plan, the Plan Administrator shall enroll the Employee as of the same Effective Date as the eligible Dependent and the Employee shall be responsible for any required Employee contributions.

3.6 EFFECTIVE DATE OF COVERAGE

Effective Date of Employee Coverage. An Employee will be covered under this Plan as of the 1) date of hire or 2) the first day of the calendar month following the date of hire and that the Employee satisfies all of the following:

- (1) The Eligibility Requirement (see Section 3.1).
- (2) The Active Employee Requirement.
- (3) The Enrollment Requirements of the Plan.

Active Employee Requirement. An Employee must be an Active Employee (as defined in Section 3.1 of this Plan) for this coverage to take effect.

Effective Date of Dependent Coverage. A Dependent's coverage will take effect on the day that the Eligibility Requirements are met; the Employee is covered under the Plan; and all Enrollment Requirements are met.

3.7 TERMINATION OF COVERAGE

When coverage under this Plan stops, Participants will receive a certificate that will show the period of Creditable Coverage under this Plan. Please contact the Human Resources Benefits Division (General Government) at (804) 501-7371 or Schools Health Benefits Office (Schools Employees) at (804) 652-3625 for information on how to receive a Certificate of Creditable coverage under this Plan. Health Plan Participants at the Economic Development Authority should contact Human Resources Benefits Division (General Government) at (804) 501-7371.

When Employee Coverage Terminates. Employee coverage will terminate on the earliest of the following dates:

- (1) The date the Plan is terminated.
- (2) The end of the month in which the covered Employee ceases to be in one of the Eligible Classes. This includes death or termination of Active Employment of the covered Employee. (See the section entitled Continuation Coverage Rights under COBRA.) It also includes an Employee on disability or leave of absence unless the Plan specifically provides for continuation during these periods.
- (3) The end of the month in which an employee terminates, as long as the employee contribution for that month has been paid. If the employee contribution for the month in which employment terminates has not been paid when due, then coverage will be terminated to the last day of the preceding month.
- (4) The earliest date the Employee has a claim that is denied in whole or in part because the Employee has met or exceeded a lifetime limit on all benefits.

- (5) If an Employee commits fraud or makes a material misrepresentation in applying for or obtaining coverage, or obtaining benefits under the Plan, then the Plan may either void coverage for the Employee and covered Dependents for the period of time coverage was in effect or may immediately terminate coverage.
- (6) If an Employee misuses the Plan identification card or allows persons other than the one specifically named on the ID card to attempt to obtain benefits, then coverage will be terminated for the Employee and covered Dependents upon thirty-one (31) days written notice from the Plan.

When an Employee's coverage terminates, he may be eligible for COBRA continuation coverage. For a complete explanation of when COBRA continuation coverage is available, what conditions apply and how to select it, see the section entitled Continuation Coverage Rights under COBRA.

Continuation During Periods of Employer-Certified Disability, Leave of Absence or Layoff. A person may remain eligible for a limited time if Active, full-time work ceases due to disability, leave of absence or layoff. This continuance will end as follows:

For disability leave only: the date the Employer ends the continuance.

For leave of absence or layoff only: the date the Employer ends the continuance.

While continued, coverage will be that which was in force on the last day worked as an Active Employee. However, if benefits reduce for others in the class, they will also reduce for the continued person.

Continuation During Family and Medical Leave. Regardless of the established leave policies mentioned above, this Plan shall at all times comply with the Family and Medical Leave Act of 1993 as promulgated in regulations issued by the Department of Labor.

During any leave taken under the Family and Medical Leave Act, the Employer will maintain coverage under this Plan on the same conditions as coverage would have been provided if the covered Employee had been continuously employed during the entire leave period.

If Plan coverage terminates during the FMLA leave, coverage will be reinstated for the Employee and his or her covered Dependents if the Employee returns to work in accordance with the terms of the FMLA leave. Coverage will be reinstated only if the person(s) had coverage under this Plan when the FMLA leave started, and will be reinstated to the same extent that it was in force when that coverage terminated.

Rehiring a Terminated Employee. A terminated Employee who is rehired will be treated as a new hire and be required to satisfy all Eligibility and Enrollment requirements.

Employees on Military Leave. Employees going into or returning from military service may elect to continue Plan coverage as mandated by the Uniformed Services Employment and Reemployment Rights Act under the following circumstances. These rights apply only to Employees and their Dependents covered under the Plan immediately before leaving for military service.

- (1) The maximum period of coverage of a person under such an election shall be the lesser of:
 - (a) The 24 month period beginning on the date on which the person's absence begins; or
 - (b) The day after the date on which the person was required to apply for or return to a position of employment and fails to do so.

- (2) A person who elects to continue health plan coverage must pay the employee contribution under the Plan.

When Dependent Coverage Terminates. A Dependent's coverage will terminate on the earliest of the following dates:

- (1) The date the Plan or Dependent coverage under the Plan is terminated.
- (2) The end of the month in which the Employee's coverage under the Plan terminates for any reason (or date of death). (See the section entitled Continuation Coverage Rights under COBRA.)
- (3) The end of the month in which a covered Spouse loses coverage due to loss of dependency status. (See the section entitled Continuation Coverage Rights under COBRA.)
- (4) The end of the month in which a Dependent child ceases to be a Dependent as defined by the Plan. (See the section entitled Continuation Coverage Rights under COBRA.)
- (5) The end of the month in which an employee terminates, as long as the employee contribution for that month has been paid. If the employee contribution for the month in which employment terminates has not been paid when due, then coverage will be terminated to the last day of the preceding month.
- (6) The earliest date the Dependent has a claim that is denied in whole or in part because it meets or exceeds a lifetime limit on all benefits.
- (7) If a Dependent commits fraud or makes a material misrepresentation in applying for or obtaining coverage, or obtaining benefits under the Plan, then the Plan may either void coverage for the Dependent for the period of time coverage was in effect or may immediately terminate coverage.
- (8) If a Dependent misuses the Plan identification card or allows persons other than the one specifically named on the ID card to attempt to obtain benefits, then coverage will be terminated for the Dependent upon thirty-one (31) days written notice from the Plan.

When a Dependent's coverage terminates, he may be eligible for COBRA continuation coverage. For a complete explanation of when COBRA continuation coverage is available, what conditions apply and how to select it, see the section entitled Continuation Coverage Rights under COBRA).

SECTION 4

PARTICIPANT RIGHTS AND RESPONSIBILITIES

4.1 PARTICIPANTS' RIGHTS

Participants of the Health Plan have the right to:

- Be provided with accurate information about the Plan's services, benefits, and about their rights and responsibilities as Plan Participants.
- Be provided with accurate information about Participating Providers.
- Participate with their Physician in decisions made regarding their health care.
- Discuss appropriate or Medically Necessary treatment options for medical conditions.
- To use advance directives in directing your health care, including living wills and power of attorney for health care documents.
- Access the Claims Administrator's Customer Services Department.
- Be treated with respect and recognition of their dignity and need for privacy and confidentiality.
- Voice complaints and submit appeals about the Health Plan, the Claims Administrator, or the care provided by Participating Providers and to have a clear, documented method for addressing any complaints and appeals.

4.2 PARTICIPANTS' RESPONSIBILITIES TO PROVIDERS

Participants of the Health Plan have the responsibility for cooperating with Providers of health care services by:

- Providing information needed by health care professionals.
- Informing the Provider's office and facility staff of their coverage with this Health Plan and notifying the Provider's staff if they disenroll.
- Following instructions and guidelines given by health care Providers.

4.3 PARTICIPANTS' RESPONSIBILITIES TO KNOW HOW AND WHEN TO SEEK CARE

Health Plan Participants have the responsibility of knowing their health benefits, as well as any procedures required for seeking care, such as:

- Knowing the benefit plan option in which you and your family members are currently enrolled.
- Knowing whether they are seeking care from a Participating or Non-Participating Provider. In most cases, benefits will vary according to the participation status of the Provider delivering Covered Services.
- Verifying the current participation status of any Provider for their specific benefit plan prior to receiving services.
- Always obtaining any required authorizations as described in Section 7 of this Plan document for Medical Benefits and Section 8 of this document for Prescription Drug Benefits. When seeking services from a Non-Participating Provider, Participants will need to ensure that the Claims Administrator, on behalf of the Plan, has approved the services before receiving services.
- Understanding the terms and limitations of Preauthorizations for Covered Services and whether Preauthorizations are approved at the In-Network benefit level (all plans) or Out-of-Network benefit level (POS and PPO plans).
- Obtaining Preauthorization from the Claims Administrator, on behalf of the Plan, prior to continuation of care if they or a covered family member are receiving health care from a Non-Participating Provider when they enroll.
- Accessing Behavioral Health and Substance Abuse services as described in this Plan document.
- The responsibility of promptly notifying Human Resources Benefits Division (General Government) or Health Benefits Office (Schools) and the Claims Administrator of any address

or telephone number changes. Health Plan Participants at the Economic Development Authority should notify Human Resources Benefits Division (General Government).

- Checking with Human Resources Benefits Division (General Government) or Health Benefits Office (Schools) regarding dependent eligibility and notifying Human Resources Benefits Division (General Government) or Health Benefits Office (Schools) and the Claims Administrator within thirty-one (31) days of any changes. Health Plan Participants at the Economic Development Authority should contact and notify Human Resources Benefits Division (General Government).
- Making sure all family members are aware of the correct procedures for obtaining the Health Plan coverage described in this Plan document and administered by the Claims Administrator.
- Failure to meet the responsibilities listed in this Plan Document may cause Health Plan Participants to be held financially responsible for services provided.

SECTION 5 SCHEDULES OF BENEFITS

All benefits described in the Schedules are subject to the exclusions and limitations described more fully herein including, but not limited to, the Claims Administrator's determination that: care and treatment is Medically Necessary; that charges are within the Maximum Allowable Charges; that services, supplies and care are not Experimental and/or Investigational. The meanings of these capitalized terms are in the Defined Terms section of this document.

The Schedules of Benefits for the following plans are included in this section.

- Care HMO Plan
- Value HMO Plan
- Care POS Plan
- Value PPO Plan
- Vision Plan
- Prescription Drug Plan

The Plan utilizes a Claims Administrator to administer many of the benefits described in this document. The Claims Administrator is:

Southern Health Services, Inc.
9881 Mayland Drive
Richmond, VA 23233
(866) 533-5149
www.southernhealth.com

Please see the Utilization Management section in this plan document for additional details. Certain services must be Preauthorized or reimbursement from the Plan may be denied.

The Claims Administrator has entered into an agreement with certain Hospitals, Physicians, and other health care Providers, which are called Participating Providers. Pursuant to their agreement with the Claims Administrator these Participating Providers have agreed to accept the Claims Administrator's Allowable Charge as payment in full for services rendered to persons covered under this Plan. If a Participant is enrolled in one of the HMO options offered under this Plan, he must receive services exclusively from an HMO Participating Provider except for Medical Emergencies or when Out-Of-Network services have been Preauthorized at the In-Network level of benefits.

If a Participant is enrolled in either the POS or PPO plan option under this Plan, he may choose to use Non-Participating (or Out-of-Network) Providers. For Non-Participating Providers, the Claims Administrator's Allowable Charge is equal to the Out-of-Network Rate. The Out-of-Network Rate is based on: a defined Virginia Medicare fee schedule, a fixed per diem rate, a St. Anthony's fee schedule, or a fixed percentage of billed charges. The type and place of service determine the applicable Out-of-Network schedule/rate. The Participant is responsible for paying the difference between the amount the Non-Participating Provider charges and the Claims Administrator's Out-of-Network schedule/rate. The amount that is over the allowable amount will not be applied towards the Participant's Deductible or Out-of-Pocket Maximum.

For example:

Non-Participating Provider's Billed Charges	\$50,000
Claims Administrator's Allowable Charge	\$20,000
Participant's Responsibility	\$30,000 plus any Copayment, Coinsurance, or Deductible

\$30,000 is not applied towards the Participants Deductible or Out-of-Pocket Maximum

Care HMO Plan Schedule of Benefits

OUTPATIENT SERVICES	In-Network MEMBER PAYS
Physician Home/Office Visit (includes allergy testing/treatment) Primary Care Visit including OB-GYN physician Specialist Visit	\$20 \$40
Allergy Serum & Allergy Injections Primary Care Visit Specialist Visit In-Network, if the office visit Copayment is greater than the amount of the serum & injection, then the Member will only be charged the amount of the serum & injection.	\$10 \$10
Lab Services	\$0
Mammogram	\$0
Diagnostic Services (other than specialty diagnostics)	\$0
Specialty Diagnostic Services Including, but not limited to, MRA, MRI, CAT Scan, PET Scan, and Sleep Studies	\$200 ¹
Outpatient Facility/Outpatient Surgery Per visit/study	\$200 ¹
Urgent Care Center When Medically Necessary, as determined by Southern Health	\$20

MATERNITY SERVICES	In-Network MEMBER PAYS
Prenatal Care & Postpartum Home or Office Visit (after the initial office visit for diagnosis of Pregnancy)	\$0
Maternity Ultrasounds	\$0
Inpatient Hospital Services Per day, up to total per admission Total per admission Inpatient PCP/OB-GYN services	\$200 ¹ \$1,000 ¹ \$50

EMERGENCY CARE	In-Network MEMBER PAYS
Emergency Room Services (Copayment waived if admitted) Total per admission	\$150
Ambulance Transportation Non-emergency transportation must be Preauthorized by Southern Health.	\$0

BEHAVIORAL HEALTH AND SUBSTANCE ABUSE SERVICES	In-Network MEMBER PAYS
Inpatient Per day, up to total per admission Total per admission	\$200 ¹ \$1,000 ¹
Outpatient Per Visit	\$40
Medication Management Visit	\$40

INPATIENT HOSPITAL SERVICES	In-Network MEMBER PAYS
Per day, up to total per admission Total per admission (excluding PCP/OB-GYN for maternity services)	\$200 ¹ \$1,000 ¹

OTHER BENEFITS	In-Network MEMBER PAYS
Nutritional Counseling Maximum 5 visits per Benefits Year. Maximum benefit payable per visit \$45 (or cost of visit, whichever is less)	\$0
Cardiac Rehabilitation Therapy Maximum 18 outpatient visits per condition	\$0 ¹
Durable Medical Equipment (DME) ² Medical Supplies ² Combined maximum of \$2,500 per benefit year for DME and Medical Supplies. Oxygen and diabetes supplies do not count toward this Benefit Maximum.	\$0 ¹
Early Intervention Services Maximum benefit of \$5,000 per Benefit Year. For qualified dependents from birth to age 3. See eligibility requirements in your Plan Document. Home or Outpatient Therapy and Assistive Technology Services Assistive Technology Devices	\$40 \$0
Home Health Care Services Maximum 90 visit per Benefit Year	\$0 ¹
Hospice Care	\$0 ¹
Infusion Therapy (including Chemotherapy), Radiation Therapy & Dialysis	\$0
Non-Implanted Prosthetic Devices ²	\$0 ¹
Occupational, Speech and Physical Therapy Inpatient Combined Maximum 30 days per Benefit Year Per day, up to total per admission Total per admission Outpatient – No Maximum Per visit	\$200 ¹ \$1,000 ¹ \$25
Spinal Manipulations Maximum of 20 outpatient visits per Benefit Year	\$40
Skilled Nursing Facility Maximum 100 inpatient days per Benefit Year	\$0 ¹
Therapeutic Injectable Medications When shipped directly to a Member from a third party vendor	\$0
Wisdom Tooth Extraction (bony impacted only) Initial Provider Office Visit Surgical Procedure Performed in Provider's office Surgical Procedure Performed in Outpatient Facility	\$40 \$40 \$200 ¹

DEDUCTIBLES AND MAXIMUMS	
Benefit Year Out-of-Pocket Maximum Individual Family	\$2,500 \$5,000
Lifetime Maximum Benefit Per Member	Unlimited
Benefit Year Deductible Individual Family	\$150 \$150

Southern Health's Benefit Payable is calculated after subtracting from the AC any applicable Deductible, Copayment, or Coinsurance owed by the Member.

BENEFITS AND BENEFIT YEAR: Benefits listed in this Schedule of Benefits are for Covered Services only. The Benefit Year is the contract year.

CONTRIBUTORY/NON-CONTRIBUTORY: This plan is contributory.

¹ Deductible applies

² Does NOT apply to out-of-pocket maximum

AC Allowable Charge

Value HMO Plan Schedule of Benefits

OUTPATIENT SERVICES	In-Network MEMBER PAYS
Physician Home/Office Visit (includes allergy testing/treatment) Primary Care Visit Specialist Visit	\$25 \$45
Allergy Serum & Allergy Injections Primary Care Visit Specialist Visit In-Network, if the office visit Copayment is greater than the amount of the serum & injection, then the Member will only be charged the amount of the serum & injection.	\$25 \$45
Lab Services	\$0
Mammogram	\$0
Diagnostic Services (other than specialty diagnostics)	\$0
Specialty Diagnostic Services Including, but not limited to, MRA, MRI, CAT Scan, PET Scan, and Sleep Studies	30% AC ¹
Outpatient Facility/Outpatient Surgery Per visit/study to facility and each physician or professional provider	30% AC ¹
Urgent Care Center When Medically Necessary, as determined by Southern Health	\$25

MATERNITY SERVICES	In-Network MEMBER PAYS
Prenatal Care & Postpartum Home or Office Visit (after the initial office visit for diagnosis of Pregnancy)	\$0
Maternity Ultrasounds	\$0
Inpatient Hospital Services Total per admission to facility and each physician or professional provider Inpatient PCP/OB-GYN services	30% AC ¹ \$50

EMERGENCY CARE	In-Network MEMBER PAYS
Emergency Room Services (Copayment waived if admitted) Total per admission	\$150
Ambulance Transportation Non-emergency transportation must be Preauthorized by Southern Health.	\$0

BEHAVIORAL HEALTH AND SUBSTANCE ABUSE SERVICES	In-Network MEMBER PAYS
Inpatient Total per admission to facility and each physician or professional provider	30% AC ¹
Outpatient Per visit	\$45
Medication Management Visit	\$45

INPATIENT HOSPITAL SERVICES	In-Network MEMBER PAYS
Total per admission to facility and each physician or professional provider (excluding PCP/OB-GYN for maternity services)	30% AC ¹

OTHER BENEFITS	In-Network MEMBER PAYS
Nutritional Counseling Maximum 5 visits per Benefit Year Maximum benefit payable per visit \$45 (or cost of visit, whichever is less)	\$0
Cardiac Rehabilitation Therapy Maximum 18 outpatient visits per condition.	30% AC ¹
Durable Medical Equipment (DME) ² Medical Supplies ² Combined maximum of \$2,500 per benefit year for DME and Medical Supplies. Oxygen and diabetes supplies do not count toward this Benefit Maximum.	\$0 ¹
Early Intervention Services Maximum benefit of \$5,000 per Benefit Year. For qualified dependents from birth to age 3. See eligibility requirements in your Plan Document. Home or Outpatient Therapy and Assistive Technology Services Assistive Technology Devices	\$45 \$0
Home Health Care Services Maximum 90 visit per Benefit Year	\$45 ¹
Hospice Care	30% AC ¹
Infusion Therapy (including Chemotherapy), Radiation Therapy & Dialysis	\$0
Non-Implanted Prosthetic Devices ²	50% AC ¹
Occupational, Speech and Physical Therapy Inpatient Combined Maximum 30 days per Benefit Year Total per admission to facility and each physician or professional provider Outpatient – No Maximum Per visit	30% AC ¹ \$45
Spinal Manipulations Maximum of 20 outpatient visits per Benefit Year.	\$45
Skilled Nursing Facility Maximum 100 inpatient days per Benefit Year	30% AC ¹
Therapeutic Injectable Medications When shipped directly to a Member from a third party vendor	\$0
Wisdom Tooth Extraction (bony impacted only) Initial Provider Office Visit Surgical Procedure Performed in Provider's office Surgical Procedure Performed in Outpatient Facility	\$45 \$45 30% AC ¹

DEDUCTIBLES AND MAXIMUMS	
Benefit Year Out-of-Pocket Maximum	
Individual	\$2,500
Family	\$5,000
Lifetime Maximum Benefit Per Member	Unlimited
Benefit Year Deductible	
Individual	\$150
Family	\$150

Southern Health's Benefit Payable is calculated after subtracting from the AC any applicable Deductible, Copayment, or Coinsurance owed by the Member.

BENEFITS AND BENEFIT YEAR: Benefits listed in this Schedule of Benefits are for Covered Services only. The Benefit Year is the contract year.

CONTRIBUTORY/NON-CONTRIBUTORY: This plan is contributory.

¹ Deductible applies

² Does NOT apply to out-of-pocket maximum

AC Allowable Charge

Care POS Plan Schedule of Benefits

OUTPATIENT SERVICES	In-Network MEMBER PAYS	Out-of-Network MEMBER PAYS
Physician Home/Office Visit (includes allergy testing/treatment) Primary Care Visit Specialist Visit	\$25 \$25	30% AC ¹ 30% AC ¹
Allergy Serum & Allergy Injections Primary Care Visit Specialist Visit In-Network, if the office visit Copayment is greater than the amount of the serum & injection, then the Member will only be charged the amount of the serum & injection.	\$10 \$10	30% AC ¹ 30% AC ¹
Lab Services	\$0	30% AC ¹
Mammogram	\$0	30% AC ¹
Diagnostic Services (other than specialty diagnostics)	\$0	30% AC ¹
Specialty Diagnostic Services Including, but not limited to, MRA, MRI, CAT Scan, PET Scan, and Sleep Studies	\$200 ¹	30% AC ¹
Outpatient Facility/Outpatient Surgery Per visit/study to facility and each physician or professional provider	\$200 ¹	30% AC ¹
Urgent Care Center When Medically Necessary, as determined by Southern Health	\$25	30% AC ¹

MATERNITY SERVICES	In-Network MEMBER PAYS	Out-of-Network MEMBER PAYS
Prenatal Care & Postpartum Home or Office Visit (after the initial office visit for diagnosis of Pregnancy)	\$0	30% AC ¹
Maternity Ultrasounds	\$0	30% AC ¹
Inpatient Hospital Services Total per admission to facility and each physician or professional provider Inpatient PCP/OB-GYN services	20% AC ¹ \$50	30% AC ¹ 30% AC ¹

EMERGENCY CARE	In-Network MEMBER PAYS	Out-of-Network MEMBER PAYS
Emergency Room Services (Copayment waived if admitted.) Total per admission	\$150	\$150
Ambulance Transportation (Non-emergency transportation must be Preauthorized by Southern Health.)	\$0	\$0

BEHAVIORAL HEALTH & SUBSTANCE ABUSE SERVICES	In-Network MEMBER PAYS	Out-of-Network MEMBER PAYS
Inpatient Total per admission to facility and each professional provider	20% AC ¹	30% AC ¹
Outpatient Per Visit	\$25	30% AC ¹
Medication Management Visit	\$25	30% AC ¹

INPATIENT HOSPITAL SERVICES	In-Network MEMBER PAYS	Out-of-Network MEMBER PAYS
Total per admission to facility and each physician or professional provider (excluding PCP/OB-GYN for maternity services)	20% AC ¹	30% AC ¹

OTHER BENEFITS	In-Network MEMBER PAYS	Out-of-Network MEMBER PAYS
Nutritional Counseling Maximum 5 visits per Benefit Year Maximum benefit payable per visit \$45 (or cost of visit, whichever is less)	\$0	\$0
Cardiac Rehabilitation Therapy Maximum 18 outpatient visits per condition.	\$0 ¹	30% AC ¹
Durable Medical Equipment (DME) ² Medical Supplies ² Combined maximum of \$2,500 per Benefit Year for DME and Medical Supplies. Oxygen and diabetes supplies do not count toward this Benefit Maximum.	\$0 ¹ \$0 ¹	30% AC ¹ 30% AC ¹
Early Intervention Services Maximum of \$5,000 per Benefit Year. For qualified dependents from birth to age 3. See eligibility requirements in your Plan Document. Home or Outpatient Therapy and Assistive Technology Services Assistive Technology Devices	\$25 \$0	30% AC ¹ 30% AC ¹
Home Health Care Services Maximum 90 visits per Benefit Year	\$0 ¹	30% AC ¹
Hospice Care	\$0 ¹	30% AC ¹
Infusion Therapy (including Chemotherapy), Radiation Therapy & Dialysis	\$0	30% AC ¹
Non-Implanted Prosthetic Devices ²	\$0 ¹	30% AC ¹
Occupational, Speech and Physical Therapy Inpatient – Combined Maximum 30 days per Benefit Year Total per admission to facility and each physician or professional provider Outpatient – No Maximum Per visit	20% AC ¹ \$25	30% AC ¹ 30% AC ¹
Spinal Manipulations Maximum of 20 outpatient visits per Benefit Year	\$25	30% AC ¹
Skilled Nursing Facility Maximum 100 inpatient days per Benefit Year	\$0 ¹	30% AC ¹
Therapeutic Injectable Medications When shipped directly to a Member from a third party vendor	\$0	30% AC ¹
Wisdom Tooth Extraction (bony impacted only) Initial provider's office visit Surgical Procedure performed in provider's office Surgical Procedure performed in outpatient facility	\$25 \$25 \$200 ¹	30% AC ¹ 30% AC ¹ 30% AC ¹

DEDUCTIBLES AND MAXIMUMS	In-Network	Out-of-Network
Benefit Year Out-of-Pocket Maximum Individual Family	\$2,500 \$5,000	
Lifetime Maximum Benefit Per Member Transplant Services	Unlimited Unlimited	Unlimited \$10,000
Benefit Year Deductible Individual Family	\$150 \$150	\$400 \$800

Southern Health's Benefit Payable is calculated after subtracting from the AC any applicable Deductible, Copayment, Coinsurance or Penalty owed by the Member. All Benefit Maximums are combined for In-Network and Out-of-Network unless otherwise specified.

BENEFITS AND BENEFIT YEAR: Benefits listed in this Schedule of Benefits are for Covered Services only. The Benefit Year is the contract year.

CONTRIBUTORY/NON-CONTRIBUTORY: This plan is contributory.

¹ Deductible applies

² Does NOT apply to out-of-pocket maximum

AC Allowable Charge



SHS Value PPO Plan Schedule of Benefits

OUTPATIENT SERVICES	In-Network MEMBER PAYS	Out-of-Network MEMBER PAYS
Preventive Care Services (as defined by Southern Health)	\$25	30% AC ¹
Physician Home/Office Visit (includes allergy testing/treatment)		
Primary Care Visit	20% AC ¹	30% AC ¹
Specialist Visit including OB-GYN physician	20% AC ¹	30% AC ¹
Allergy Serum & Allergy Injections		
Primary Care Visit	20% AC ¹	30% AC ¹
Specialist Visit	20% AC ¹	30% AC ¹
In-Network, if the office visit Copayment is greater than the amount of the serum & injection, then the Covered Individual will only be charged the amount of the serum & injection.		
Lab Services	20% AC ¹	30% AC ¹
Mammogram	\$0	30% AC ¹
Diagnostic Services (other than specialty diagnostics)	20% AC ¹	30% AC ¹
Specialty Diagnostic Services		30% AC ¹
Including, but not limited to, MRA, MRI, CAT Scan, PET Scan and Sleep Studies		
Outpatient Facility/Outpatient Surgery		
Per visit/study to facility and each physician or professional Provider		
20% AC ¹		30% AC ¹
Urgent Care Center		
When Medically Necessary, as determined by the Company		
20% AC ¹		20% AC ¹

MATERNITY SERVICES	In-Network MEMBER PAYS	Out-of-Network MEMBER PAYS
Prenatal Care & Postpartum Home or Office Visit (after the initial office visit for diagnosis of Pregnancy)	\$0	30% AC ¹
Maternity Ultrasounds	20% AC ¹	30% AC ¹
Inpatient Hospital Services		
Total per admission to facility and each physician or professional Provider		
20% AC ¹		30% AC ¹
Inpatient PCP/OB-GYN services	\$50	30% AC ¹

EMERGENCY CARE	In-Network MEMBER PAYS	Out-of-Network MEMBER PAYS
Emergency Room Services (Copayment waived if admitted)		
Total per admission		
20% AC ¹		20% AC ¹
Ambulance Transportation		
Non-emergency transportation must be Preauthorized by the Company.		
20% AC ¹		20% AC ¹

BEHAVIORAL HEALTH & SUBSTANCE ABUSE SERVICES	In-Network MEMBER PAYS	Out-of-Network MEMBER PAYS
Inpatient		
Total per admission to facility and each physician or professional Provider		
20% AC ¹		30% AC ¹
Outpatient		
Per Visit		
20% AC ¹		30% AC ¹
Medication Management Visit	20% AC ¹	30% AC ¹

INPATIENT HOSPITAL SERVICES	In-Network MEMBER PAYS	Out-of-Network MEMBER PAYS
Total per admission to facility and each physician or professional Provider (excluding PCP/OB-GYN for maternity services)		
20% AC ¹		30% AC ¹

OTHER BENEFITS	In-Network MEMBER PAYS	Out-of-Network MEMBER PAYS
Nutritional Counseling Maximum 5 visits per Benefit Year Maximum benefit payable per visit \$45 (or cost of visit, whichever is less)	\$0	\$0
Cardiac Rehabilitation Therapy Maximum 18 outpatient visits per condition	20% AC ¹	30% AC ¹
Durable Medical Equipment (DME) Medical Supplies Combined maximum of \$2,500 per Benefit Year for DME and Medical Supplies. Oxygen and diabetes supplies do not count toward this Benefit Maximum.	20% AC ¹ 20% AC ¹	30% AC ¹ 30% AC ¹
Early Intervention Services Maximum of \$5,000 per Benefit Year. For qualified dependents from birth to age 3. See eligibility requirements in your Certificate of Insurance. Home or Outpatient Therapy and Assistive Technology Services Assistive Technology Devices	20% AC ¹ 20% AC ¹	30% AC ¹ 30% AC ¹
Home Health Care Services Maximum 90 visits per Benefit Year	20% AC ¹	30% AC ¹
Hospice Care	20% AC ¹	30% AC ¹
Infusion Therapy (including Chemotherapy), Radiation Therapy & Dialysis	20% AC ¹	30% AC ¹
Non-Implanted Prosthetic Devices	50% AC ¹	50% AC ¹
Occupational, Speech and Physical Therapy Inpatient – Combined Maximum 30 days per Benefit Year Total per admission to facility and each physician or professional Provider Outpatient – No Maximum Per visit to facility and each physician or professional Provider	20% AC ¹ 20% AC ¹	30% AC ¹ 30% AC ¹
Spinal Manipulations Maximum of 20 outpatient visits per Benefit Year	20% AC ¹	30% AC ¹
Skilled Nursing Facility Maximum 100 inpatient days per Benefit Year	20% AC ¹	30% AC ¹
Therapeutic Injectable Medications When shipped directly to a Member from a third party vendor	20% AC ¹	30% AC ¹
Wisdom Tooth Extraction (bony impacted only) Initial provider's office visit Surgical Procedure performed in provider's office Surgical Procedure performed in Outpatient Facility to facility and each physician or professional Provider	20% AC ¹ 20% AC ¹ 20% AC ¹	30% AC ¹ 30% AC ¹ 30% AC ¹

DEDUCTIBLES AND MAXIMUMS	In-Network	Out-of-Network
Benefit Year Out-of-Pocket Maximum Copayments do not apply to the Benefit Year Out-of-Pocket Maximum Individual Family	\$2,500 \$5,000	\$3,000 \$6,000
Lifetime Maximum Benefit Per Member Transplant Services, including ABMT	Unlimited Unlimited	Unlimited \$10,000
Benefit Year Deductible Individual Family	\$400 \$800	\$1,000 \$2,000

Coventry Health and Life Insurance Company's benefit payable is calculated after subtracting from the AC any applicable Deductible, Copayment, Coinsurance or Penalty owed by the Covered Individual. All Benefit Maximums are combined for In-Network and Out-of-Network unless otherwise specified.

BENEFITS AND BENEFIT YEAR: Benefits listed in this Schedule of Benefits are for Covered Services only. The Benefit Year is the contract year.

CONTRIBUTORY/NON-CONTRIBUTORY: This plan is contributory.

¹ Deductible applies

AC Allowable Charge



CVTY Value PPO Plan Schedule of Benefits

OUTPATIENT SERVICES	In-Network MEMBER PAYS	Out-of-Network MEMBER PAYS
Preventive Care Services (as defined by Southern Health)	\$25	30% AC ¹
Physician Home/Office Visit (includes allergy testing/treatment)		
Primary Care Visit	20% AC ¹	30% AC ¹
Specialist Visit including OB-GYN physician	20% AC ¹	30% AC ¹
Allergy Serum & Allergy Injections		
Primary Care Visit	20% AC ¹	30% AC ¹
Specialist Visit	20% AC ¹	30% AC ¹
In-Network, if the office visit Copayment is greater than the amount of the serum & injection, then the Covered Individual will only be charged the amount of the serum & injection.		
Lab Services	20% AC ¹	30% AC ¹
Mammogram	\$0	30% AC ¹
Diagnostic Services (other than specialty diagnostics)	20% AC ¹	30% AC ¹
Specialty Diagnostic Services		30% AC ¹
Including, but not limited to, MRA, MRI, CAT Scan, PET Scan and Sleep Studies		
Outpatient Facility/Outpatient Surgery		
Per visit/study to facility and each physician or professional Provider	20% AC ¹	30% AC ¹
Urgent Care Center		
When Medically Necessary, as determined by the Company		

MATERNITY SERVICES	In-Network MEMBER PAYS	Out-of-Network MEMBER PAYS
Prenatal Care & Postpartum Home or Office Visit (after the initial office visit for diagnosis of Pregnancy)	\$0	30% AC ¹
Maternity Ultrasounds	20% AC ¹	30% AC ¹
Inpatient Hospital Services		
Total per admission to facility and each physician or professional Provider	20% AC ¹	30% AC ¹
Inpatient PCP/OB-GYN services	\$50	30% AC ¹

EMERGENCY CARE	In-Network MEMBER PAYS	Out-of-Network MEMBER PAYS
Emergency Room Services (Copayment waived if admitted)		
Total per admission	20% AC ¹	20% AC ¹
Ambulance Transportation		
Non-emergency transportation must be Preauthorized by the Company.		

BEHAVIORAL HEALTH & SUBSTANCE ABUSE SERVICES	In-Network MEMBER PAYS	Out-of-Network MEMBER PAYS
Inpatient		
Total per admission to facility and each physician or professional Provider	20% AC ¹	30% AC ¹
Outpatient		
Per Visit	20% AC ¹	30% AC ¹
Medication Management Visit	20% AC ¹	30% AC ¹

INPATIENT HOSPITAL SERVICES	In-Network MEMBER PAYS	Out-of-Network MEMBER PAYS
Total per admission to facility and each physician or professional Provider (excluding PCP/OB-GYN for maternity services)	20% AC ¹	30% AC ¹

OTHER BENEFITS	In-Network MEMBER PAYS	Out-of-Network MEMBER PAYS
Nutritional Counseling Maximum 5 visits per Benefit Year Maximum benefit payable per visit \$45 (or cost of visit, whichever is less)	\$0	\$0
Cardiac Rehabilitation Therapy Maximum 18 outpatient visits per condition	20% AC ¹	30% AC ¹
Durable Medical Equipment (DME) Medical Supplies Combined maximum of \$2,500 per Benefit Year for DME and Medical Supplies. Oxygen and diabetes supplies do not count toward this Benefit Maximum.	20% AC ¹ 20% AC ¹	30% AC ¹ 30% AC ¹
Early Intervention Services Maximum of \$5,000 per Benefit Year. For qualified dependents from birth to age 3. See eligibility requirements in your Certificate of Insurance. Home or Outpatient Therapy and Assistive Technology Services Assistive Technology Devices	20% AC ¹ 20% AC ¹	30% AC ¹ 30% AC ¹
Home Health Care Services Maximum 90 visits per Benefit Year	20% AC ¹	30% AC ¹
Hospice Care	20% AC ¹	30% AC ¹
Infusion Therapy (including Chemotherapy), Radiation Therapy & Dialysis	20% AC ¹	30% AC ¹
Non-Implanted Prosthetic Devices	50% AC ¹	50% AC ¹
Occupational, Speech and Physical Therapy Inpatient – Combined Maximum 30 days per Benefit Year Total per admission to facility and each physician or professional Provider Outpatient – No Maximum Per visit to facility and each physician or professional Provider	20% AC ¹ 20% AC ¹	30% AC ¹ 30% AC ¹
Spinal Manipulations Maximum of 20 outpatient visits per Benefit Year	20% AC ¹	30% AC ¹
Skilled Nursing Facility Maximum 100 inpatient days per Benefit Year	20% AC ¹	30% AC ¹
Therapeutic Injectable Medications When shipped directly to a Member from a third party vendor	20% AC ¹	30% AC ¹
Wisdom Tooth Extraction (bony impacted only) Initial provider's office visit Surgical Procedure performed in provider's office Surgical Procedure performed in Outpatient Facility to facility and each physician or professional Provider	20% AC ¹ 20% AC ¹ 20% AC ¹	30% AC ¹ 30% AC ¹ 30% AC ¹

DEDUCTIBLES AND MAXIMUMS	In-Network	Out-of-Network
Benefit Year Out-of-Pocket Maximum Copayments do not apply to the Benefit Year Out-of-Pocket Maximum Individual Family	\$2,500 \$5,000	\$3,000 \$6,000
Lifetime Maximum Benefit Per Member Transplant Services, including ABMT	Unlimited Unlimited	Unlimited \$10,000
Benefit Year Deductible Individual Family	\$400 \$800	\$1,000 \$2,000

Coventry Health and Life Insurance Company's benefit payable is calculated after subtracting from the AC any applicable Deductible, Copayment, Coinsurance or Penalty owed by the Covered Individual. All Benefit Maximums are combined for In-Network and Out-of-Network unless otherwise specified.

BENEFITS AND BENEFIT YEAR: Benefits listed in this Schedule of Benefits are for Covered Services only. The Benefit Year is the contract year.

CONTRIBUTORY/NON-CONTRIBUTORY: This plan is contributory.

¹ Deductible applies

AC Allowable Charge

Vision Schedule of Benefits

VISION	Copayment/ Benefit Payable	Benefit Maximum
<i>Complete (Spectacle) Eye Exam</i>		1 exam during a 12 month period
Copayment per visit	\$15	
Benefit Payable	100%	
<i>Eye Exam for Nonspecialty Contact Lenses</i>		
Copayment	\$35	
Benefit Payable	100%	
<i>Eye Exam for Specialty Contact Lenses</i>		
Copayment	None	
Benefit Payable	\$40	

Also see Section 9 for additional benefit information.

Prescription Drug Schedule of Benefits

PRESCRIPTION DRUGS	PARTICIPANT PAYS
<p>Tier 1 (Formulary Generic Drugs) Copayment for 1 Prescribing Unit Copayment for 3 Prescribing Units (mail order drugs)</p>	<p>Participating Pharmacies must be used</p> <p>\$ 10 * \$ 10</p>
<p>Tier 2 (Formulary Brand Drugs) Copayment for 1 Prescribing Unit Copayment for 3 Prescribing Units (mail order drugs)</p>	<p>\$ 30 * \$ 60</p>
<p>Tier 3 (Non-Formulary Drugs) Copayment for 1 Prescribing Unit Copayment for 3 Prescribing Units (mail order drugs)</p>	<p>\$ 55 * \$165</p>

*For Retail Maintenance Drugs, the Participant pays 3 Copayments for 3 Prescribing Units.

Also see Section 8 for additional benefit information.

SECTION 6 MEDICAL BENEFITS

Medical Benefits apply when Covered Charges are incurred by a Participant for care of an Injury or Sickness and while the person is covered for these benefits under the Plan.

Deductible

- **Deductible Amount.** This is an amount of Covered Charges for which no benefits will be paid. Before benefits can be paid in a Calendar Year a Participant must meet the Deductible shown in the Schedule of Benefits.
- **Family Unit Limit.** When the maximum amount shown in the Schedule of Benefits has been incurred by members of a Family Unit toward their Calendar Year Deductibles, the Deductibles of all members of that Family Unit will be considered satisfied for that year.

Copayment

A Copayment is the amount of money that is paid each time a particular Covered Service is used. Typically, there may be Copayments on some services and other services will not have any Copayments. Copayments do not accrue toward the Out-of-Pocket Maximum.

Benefit Payment

Each Calendar Year, benefits will be paid for the Covered Charges of a Participant that are in excess of the Deductibles and any Copayments. Payment will be made at the rate shown under reimbursement rate in the Schedule of Benefits. No benefits will be paid in excess of the Maximum Benefit Amount or any listed limit of the Plan.

Out-Of-Pocket Maximum

Covered Charges are payable at the amounts shown in the Schedule of Benefits until the Out-of-Pocket Maximum shown in the Schedule of Benefits is reached for the Calendar Year. Once the Out-of-Pocket Maximum is reached for the Calendar Year, then Covered Charges incurred by a Participant or Family Unit will be payable at 100% of the Allowable Charge without any Copays or Coinsurance for the rest of the Calendar Year (except for the charges identified as not applying toward the Out-of-Pocket Maximum).

Care and Value HMO Plans. All amounts paid by the Participant or Family Unit for In-Network care for Covered Services contribute toward the Annual Out-of-Pocket Maximum except for amounts paid for the following: durable medical equipment, non-implanted prosthetic devices, prescription drugs, vision service expenses, charges incurred for noncovered expenses, notification penalties, charges in excess of day or dollar limits, and amounts in excess of the Allowable Charge.

Care POS Plan. All amounts paid by the Participant or Family Unit for both In-Network and Out-of-Network care for Covered Services contribute toward the Annual Out-of-Pocket Maximum except for amounts paid for the following: durable medical equipment, non-implanted prosthetic devices, prescription drugs, vision service expenses, charges incurred for noncovered expenses, notification penalties, charges in excess of day or dollar limits (including an \$80/day limit for Out-of-Network inpatient substance abuse rehabilitation services), and amounts in excess of the Allowable Charge. Even if You reach the Annual Out-of-Pocket Maximum, a Non-Participating Provider may require you to pay amounts in excess of the Allowable Charge. As stated above, amounts above the Allowable Charge which you pay to Non-Participating Providers do not count toward Your Out-of-Pocket Maximum.

Value PPO Plan. All coinsurance and deductibles paid both In-Network and Out-of-Network contribute to the Annual Out-of-Pocket Maximum except for amounts paid for the following: prescription drug benefits, charges in excess of the Allowable Charge, notification penalties, charges incurred for a noncovered service, and charges in excess of the benefit limitations. Copayments paid by the Participant or Family Unit also do not apply to the Annual Out-of-Pocket Maximum. Even if You reach the Annual Out-of-Pocket Maximum, a Non-Participating Provider may require you to pay amounts in excess of the Allowable Charge. As stated above, amounts above the Allowable Charge which you pay to Non-Participating Providers do not count toward Your Out-of-Pocket Maximum.

Maximum Benefit Amount

The Maximum Benefit Amount is shown in the Schedule of Benefits. It is the total amount of benefits that will be paid under the Plan for all Covered Charges incurred by a Participant.

Covered Services are covered at the In-Network level only when provided by a Participating Provider or when appropriate Preauthorization has been obtained as described in Section 7 for a Non-Participating Provider to perform the services. For Participants enrolled in the Point of Service (POS) or Preferred Provider Organization (PPO) plans, non-emergency services provided by Non-Participating Providers are Covered Services only at the Out-of-Network benefit level unless the appropriate Preauthorization has been obtained as described in Section 7 of this Plan Document. For Participants enrolled in the HMO plans, only Emergency services or services Preauthorized at the in-network level of benefits are covered by Non-Participating Providers. **Even when the Plan is the secondary payer, the appropriate Preauthorizations must be obtained in order for these services to be considered Covered Services at any level.**

Behavioral Health and Substance Abuse

The Claims Administrator contracts with an outside vendor to coordinate and Preauthorize the diagnosis and treatment of **all** Substance Abuse and psychiatric conditions covered under this benefit. The Preauthorization for Behavioral Health and Substance Abuse care (inpatient and outpatient) must be obtained through the contracted vendor and is required for both the In-Network and Out-of-Network (POS and PPO plans only) level of benefits. If Preauthorization from the Mental Health vendor is not received, claims may be denied.

Only Participants enrolled in either the POS or PPO plans are eligible to receive benefits from Non-Participating Providers. There is no coverage out-of-network for Participants enrolled in an HMO plan except in the case of a Medical Emergency.

When care is received from Participating Providers, In-Network benefits apply. When care is received from Non-Participating Providers, Out-of-Network benefits (POS and PPO plans only) apply. Participants should consult the Schedule of Benefits to determine the amount of their payment responsibility.

Coverage is dependent upon the establishment of Medical Necessity for the care. If the inpatient or outpatient service or a portion thereof is determined not to be Medically Necessary, the Provider will be notified that services are not Covered Services or that coverage will cease. In a situation where the Participant will be responsible for the charges, the Participant will be notified that coverage will cease.

What is Covered:

- **Inpatient care (Acute or Partial Hospitalization)** at a facility.
- **Behavioral (Mental) Disorders and Substance Abuse.** Any aggregate lifetime limit, annual limit, financial requirement, out-of-network exclusion or treatment limitation on Behavioral Disorders and Substance Abuse benefits imposed by the Plan shall comply with federal parity requirements, if applicable.

Covered Charges for care, supplies and treatment of Behavioral Disorders and Substance Abuse will be limited as follows:

Psychiatrists (M.D.), psychologists (Ph.D.), counselors (Ph.D.) or Masters of Social Work (M.S.W.) may bill the Plan directly. Other licensed mental health practitioners must be under the direction of and must bill the Plan through these professionals.

- **Outpatient Visits** to Providers as may be necessary and appropriate for short-term evaluative or crisis intervention services. Family counseling is covered if provided in conjunction with the treatment of a covered Dependent under the age of 25.
- **Psychological or Neuropsychological Testing.**

Emergency Benefits

A Medical Emergency is a sudden onset of a medical condition that manifests itself by symptoms of sufficient severity, including severe pain, that the absence of immediate medical attention could reasonably be expected by a Prudent Layperson to result in (i) serious jeopardy to the mental or physical health of the Participant; (ii) danger of serious impairment of the Participant's bodily functions; (iii) serious dysfunction of any of the Participant's bodily organs; or (iv) in the case of a pregnant woman, serious jeopardy to the health of the fetus. Screening and stabilization services provided in a Hospital Emergency room for a Medical Emergency may be received from either Participating or Non-Participating Providers and are not required to be Preauthorized.

A Prudent Layperson is someone without medical training who draws on his or her practical experience when making a decision regarding whether Emergency medical treatment is needed. A Prudent Layperson will be considered to have acted "reasonably" if other similarly situated Laypersons would have believed, on the basis of observation of the medical symptoms at hand, that Emergency medical treatment was necessary.

The Claims Administrator will review all information and documentation with respect to a Participant's claim in accordance with established medical criteria and guidelines. **If this review results in the determination that a Participant did not experience a Medical Emergency, he may be responsible for the entire bill.** Claims resulting from a Medical Emergency are eligible for payment at the In-Network level of benefits. If a Participant's claim is denied or paid at the Out-of-Network benefit level (POS and PPO plans only) when he believes a Medical Emergency existed, he should contact the Customer Service Department of the Claims Administrator.

Some examples of a Medical Emergency include, but are not limited to:

- Severe or unusual bleeding
- Severe burns
- Trouble breathing
- Seizures or convulsions
- Suspected poisoning
- Broken bone
- Any vaginal bleeding in Pregnancy
- Unconsciousness
- Chest pain

Procedures: If a Medical Emergency exists that could reasonably be expected by a Prudent Layperson to be life-threatening, a Participant should immediately call 911 or their local Emergency access telephone number for help or go directly to the nearest Hospital Emergency room. Whenever possible, the Participant's treating Physician should be consulted if the Participant believes he is experiencing a Medical Emergency. A Participant's treating Physician or a Physician on-call for the Participant's treating Physician can be reached twenty-four (24) hours a day. To be eligible for the In-Network level of benefits, follow-up care resulting from an Emergency must be provided by a Participating Provider or Preauthorized by the Claims Administrator.

The following services are covered at the in-network level of benefits when a Participant experiences a Medical Emergency:

- **Covered Services provided by Non-Participating Providers:** Only if seeking care from a Participating Provider could reasonably be expected by a Prudent Layperson to cause the Participant's condition to worsen if left unattended.
- **Covered Services Provided by Participating Providers.**
- **Emergency Inpatient Hospitalization:** If a Participant is admitted as an inpatient to a Non-Participating Hospital as the result of a Medical Emergency, the Claims Administrator must be notified at (866) 533-5149 within twenty-four (24) hours or by the end of the next working day if the twenty-four (24)-hour deadline falls on a weekend or legal holiday. If the Participant is incapacitated and unable to contact the Claims Administrator, the Participant must make arrangements for the Claims Administrator to be notified as soon as medically possible. After admission to the Hospital in an Emergency, in order to continue receiving services from a Non-Participating Provider at the In-Network level of benefits, the Participant must have these services authorized once the Participant is considered clinically stable.
- **Emergency Room visits to a Participating Hospital:** If a Participant is treated and released, he will be responsible for the amount of his payment associated with an Emergency room visit. If he is admitted to the Hospital through the Emergency room, the Plan will waive the Emergency room Copayment or Coinsurance. Participants should consult the Schedule of Benefits to determine the amount of their payment responsibility.
- **Emergency Room Visits to Non-Participating Hospitals:** Only when the delay in receiving care from a Participating Hospital could reasonably be expected by a Prudent Layperson to cause the Participant's condition to worsen if left unattended or if the Participant is incapacitated and unable to select a Participating facility.
- **Physician or Hospital Care While Out of the Country:** For acute illnesses and injuries outside of the country when the Participant could not return for treatment, the treatment was Medically Necessary, and the Participant was out of the country for reasons other than obtaining medical care.

Dependent children residing outside of the Service Area on a temporary or permanent basis are subject to all of the coverage provisions and limitations described above for services obtained for Medical Emergencies unless they have been approved for out-of-area coverage through the Plan's **Passport Program** prior to the date of the services. Refer to Section 7 of this Plan document for further details about the **Passport Program**.

Inpatient Hospital Care

Inpatient Hospital care requires Preauthorization from the Claims Administrator unless the admission is the result of a Medical Emergency. For information on what to do if admitted to the Hospital as the result of a Medical Emergency, refer to the **Emergency Benefits** in this Section. Failure to obtain Preauthorization for a non-emergency inpatient admission will result in a denial of coverage on the HMO Plans and in a Notification Penalty on the POS and PPO Plans.

Consistent with the Plan's Utilization Review Policy, all Hospital admissions and continued stays are reviewed during the inpatient stay. Coverage is dependent upon the establishment of Medical Necessity for the care in question. If the Hospital stay or portion thereof is determined not to be Medically Necessary, the Provider will be notified in writing that coverage will cease. In a situation where the Participant will be responsible for the charges, the Subscriber or a family Participant will be notified in writing that coverage will cease.

A Participant's payment responsibility for an inpatient admission is shown in the Schedule of Benefits. All Medically Necessary services for a Hospital admission as described above are covered after any applicable Penalty, Deductible, Copayment, and/or Coinsurance. When a Participant is admitted to a

Participating Hospital and is under the care of a Non-Participating Provider, only the Hospital charges will be eligible for the In-Network level of benefits.

Coverage for Inpatient Hospital Care Includes But is Not Limited to:

Medications: On an inpatient basis, that are prescribed to treat a covered indication if the drug has been approved by the FDA for at least one indication and the drug is recognized for treatment of the covered indication in one of the Standard Reference Compendia or in substantially accepted Peer-Reviewed Medical Literature. This includes cancer drugs on an inpatient basis that are FDA approved for use in the treatment of cancer and that have been recognized in any of the Standard Reference Compendia as safe and effective for treatment of the specific type of cancer diagnosed. Any drug approved by the FDA for use in the treatment of cancer pain shall not be denied for coverage on the basis that the dosage is in excess of the recommended dosage of the pain relieving agent if the prescription in excess of the recommended dosage has been prescribed in compliance with Virginia law for a patient with intractable cancer pain.

Nursery Care: The Plan will pay for initial nursery care for newborns following delivery. Services or treatment for health conditions which arise and prolong the initial nursery stay will be considered a separate admission and require Preauthorization. (Refer to Section 7 of this Plan Document for information about the Preauthorization process.) The inpatient Hospital Copayment listed in the Schedule of Benefits will apply. Newborns who have not been added to the plan within thirty-one (31) days of birth, as explained in Section 3.2, are not eligible for coverage of any portion of the Hospital and Physician charges during the inpatient stay following birth or any subsequent services.

Room and Board: A semi-private room and general nursing care when part of a covered inpatient stay. A private room is only covered if Medically Necessary or if a semi-private room is not available.

Specialized Care Units: Such as intensive care or cardiac care units.

Surgical and Anesthetist Services and Supplies, When Medically Necessary and Preauthorized: In addition, the Plan will cover a minimum Hospital stay of not less than twenty-three (23) hours for a laparoscopy-assisted vaginal hysterectomy and forty-eight (48) hours for a vaginal hysterectomy. This length of stay may be shortened if the treating Physician in consultation with the patient determines that a shorter stay would be appropriate; and We will cover inpatient Hospital care for at least forty-eight (48) hours following a radical or modified radical mastectomy and at least twenty-four (24) hours following a total mastectomy or a partial mastectomy with lymph node dissection for the treatment of breast cancer. However, inpatient Hospital care for these stated periods are not required when the attending Physician in consultation with the patient determines that a shorter Hospital stay is appropriate.

New Technology

The Plan evaluates new and existing technologies for inclusion as a Covered Service and continually assesses and reviews clinical literature. Prior to an acceptance as a Covered Service, the Plan confirms that the appropriate regulatory body has assessed any new or existing technology to be covered in cases where that assessment is required by law. New and existing technologies to be considered Covered Services must, based on clinical evidence reported by Peer Reviewed Medical Literature, demonstrate a marked improvement in health outcomes, health risks, and health benefits when compared with established procedures and products.

Preventive Care

The Plan has adopted preventive health recommendations for Participants to promote preventive health services. These guidelines are based on the recommendations of national medical associations and leading health organizations.

Preventive Care Services are covered at the In-Network level of benefits only when Covered Services are received from Participating Providers. For certain services, the Plan may require that care be received from specific Participating Providers in order to receive the In-Network level of benefits. Participating

Providers may not be considered participating for all services they are able to offer patients. Participating Providers are aware of these services. A Participant may also consult the Claims Administrator on questions about the scope of Covered Services when performed by a Participating Provider. Participating Providers are informed of designated places of service. When Medically Necessary, the following preventive, diagnostic and treatment services are covered:

Colorectal Cancer Screening: Specific screening with an annual fecal occult blood test, flexible sigmoidoscopy or colonoscopy, or in appropriate circumstances radiologic imaging in accordance with the most recently published recommendations established by the American College of Gastroenterology, in consultation with the American Cancer Society, for the ages, family histories, and frequencies referenced in such recommendations.

Hearing and Vision Screenings:

- For children up to age eighteen (18) when performed by a general practitioner, family practice Physician, pediatrician, or internist.
- Newborn infant hearing screenings and all necessary audiological examinations provided in a Hospital. The infant hearing screenings and all necessary audiological examinations must use FDA approved technology that is recommended by the Joint Committee on Infant Hearing in its most current position statement addressing early hearing detection and intervention programs. Follow-up audiological examinations as recommended by the infant's Physician or audiologist and performed by a licensed audiologist to confirm the existence or absence of hearing loss are also covered.

Immunizations: Routine and necessary immunizations and boosters including, but not limited to, diphtheria, pertussis, tetanus, polio, hepatitis B, measles, mumps, rubella, HiB, varicella and other such immunizations as may be prescribed by the Virginia Commissioner of Health.

Mammogram: Mammograms are covered.

Office Visits: For Preventive Care including well-baby care and periodic check-ups according to the Preventive Care Guidelines established by the Plan. Participating Providers have access to these guidelines.

Pap Smear: Annual testing performed by any FDA approved gynecologic cytology screening technologies.

PSA (Prostate Specific Antigen) Test: One test in a twelve (12) month period and digital rectal examinations, all in accordance with American Cancer Society guidelines for (i) persons age fifty (50) and over and (ii) persons age forty (40) and over who are at high risk for prostate cancer, according to the most recent published guidelines of the American Cancer Society.

Treatment of Illness or Injury

Diagnosis and Medically Necessary treatment of Illness or Injury includes:

Allergy Treatment: Allergy testing, diagnosis and Medically Necessary treatment.

Ambulance: Ambulance services are covered in the event of a true Medical Emergency. Limited non-emergency ambulance services are covered, when Medically Necessary and Preauthorized by the Claims Administrator.

Anesthesia for Dental Procedures:

- Hospital services and general anesthesia for dental procedures are covered when determined to be Medically Necessary for a Participant who is under the age of five (5), is severely disabled, or has a medical condition, and requires admission to a Hospital or outpatient surgery facility and general anesthesia for dental care treatment. Preauthorization of Hospitalization and anesthesia should not be construed as Preauthorization and payment of dental care incident to the Hospitalization and anesthesia benefits.

Blood:

- Blood and plasma processing fees;
- Costs associated with drawing, preparation, and storage of Participant's blood, blood plasma, or blood derivatives for use by the Participant;
- Charges incurred in connection with the treatment of routine bleeding episodes associated with hemophilia and other congenital bleeding disorders. Covered Charges include the purchase of blood products and blood infusion equipment required for home treatment of routine bleeding episodes associated with hemophilia and other congenital bleeding disorders when the home treatment program is under the supervision of the state-approved hemophilia treatment center.

Cardiac Rehabilitation: Cardiac rehabilitation is covered according to coverage guidelines used by the Plan. The Schedule of Benefits will show any Benefit Maximum.

Chemotherapy.**Clinical Trials:**

- Clinical Trials for Treatment Studies on Cancer, including ovarian cancer trials, are covered as described in this Section. Medically Necessary Covered Services that are incurred by the Participant as a result of the treatment being provided for purposes of a clinical trial are referred to as patient costs in this Section. Patient costs incurred during Phase II, Phase III, or Phase IV clinical trials for treatment studies on cancer approved by the National Cancer Institute (NCI), an NCI cooperative group or an NCI center, the FDA in the form of an investigational new drug application, the Federal Department of Veterans Affairs, or an institutional review board of an institution in Virginia that has a multiple project assurance contract approved by the Office of Protection from Research Risks of the NCI are covered. The facility and personnel where this treatment is provided must be capable of such provision of care by virtue of their experience, training, and expertise. Phase I clinical trials are not covered.
- Coverage under this Section shall only apply if: (i) there is no clearly superior, non-investigational treatment alternative, (ii) the available clinical or preclinical data provides a reasonable expectation that the treatment will be at least as effective as the non-investigational alternative, and (iii) the Participant, Participant's treating Physician or other treating Provider conclude that the Participant's participation in the clinical trial would be appropriate, pursuant to procedures established by the Plan and disclosed in this Plan Document. Non-health care services that a Participant may receive as a result of this treatment, costs related to managing the research associated with the clinical trial, and investigational drugs and devices are not covered. The Participant's payment responsibility for this coverage will relate to the place of service where services are received.

Consultations: Appointments with Specialists and/or appointments for second opinions for Covered Services.

Dental Injury: The Plan provides benefits for Medically Necessary dental services as result of accidental injury if treatment is sought within sixty (60) days of the accident for injuries occurring on or after the effective date of coverage. The Claims Administrator will review the Participant's claim for dental Injury in accordance with established medical and dental guidelines. If this review results in the determination that the services that were received were not Medically Necessary, then the Participant may be responsible for the entire bill. The Participant may call the Claims Administrator's Customer Service Department at (866) 533-5149 to request treatment.

Diabetes Treatment:

- Diabetes counseling is covered for in-person outpatient self-management training and education including medical nutritional therapy required for the treatment of insulin-dependent diabetes, insulin-using diabetes, gestational diabetes, and noninsulin using diabetes. This coverage is provided if: (i) prescribed by a Provider legally authorized to prescribe such services under law and (ii) provided by a Provider who is a certified, registered, or licensed health care professional.

- Diabetes supplies including insulin pumps and insulin pump supplies for the treatment of insulin dependent diabetes, insulin-using diabetes, gestational diabetes, and noninsulin-using diabetes are provided if prescribed by a Provider legally authorized to prescribe such items under law.

Dialysis: Peritoneal Dialysis and Hemodialysis.

Durable Medical Equipment (DME): DME is non-disposable equipment that can withstand repeated use and is primarily and customarily used to serve a medical purpose. This equipment is appropriate for use in the home and is generally not useful in the absence of the Illness or Injury for which it is used. DME is not primarily for the convenience of the caregiver. The Plan will cover rental or purchase of Medically Necessary DME, such as wheelchairs, crutches, walkers, hospital beds and apnea monitors. The decision to rent or purchase DME is based on which method is determined to be the most cost effective. Repair, replacement, and duplication are not covered if due to loss, neglect, abuse of equipment, or for the convenience or personal preference of the Participant. Refer to the **Schedule of Benefits for the Benefit Maximum.**

- Ostomy supplies are covered under this benefit and will accrue toward the DME Benefit Maximum.
- Coverage for mastectomy bras is limited to two (2) bras every six (6) months
- Orthotics are covered under this benefit and will accrue toward the DME Maximum.
- Covered orthotic devices must, (i) be a device added to the body to stabilize or immobilize a body part, prevent deformity or assist with function; and (ii) be semi-rigid and correct a diagnosed musculoskeletal misalignment of a weakened or diseased body part; or (iii) be rigid or semi-rigid and stop or limit motion of a weak or diseased body part. **Foot orthotics are not covered.**
- Oxygen and Respiratory equipment are covered under this benefit.
- Wigs for patients of chemotherapy or radiation therapy are covered under the DME benefit; however, the benefit for such wigs is limited to a maximum purchase price of \$250 per Benefit Year. This maximum for wigs contributes to any Benefit Maximum for Durable Medical Equipment.
- Equipment rental for Negative Pressure Wound Therapy is covered under this benefit and does not apply to the Benefit Maximum.

Early Intervention Services: Early intervention services are provided for Dependents from birth to age three (3) who are certified by the Department of Mental Health, Mental Retardation and Substance Abuse Services as eligible for such services under Part C of the Individuals with Disabilities Education Act (20 U.S.C. Section 1471 et seq.). Early intervention services are Medically Necessary speech and language therapy, occupational therapy, physical therapy, and assistive technology services and devices. In certain circumstances, services that are not ordinarily Covered Services are considered Covered Services when they are identified on the Individualized Family Service Plan. Any Copayment, Coinsurance, or Deductible required for these services may be paid through the use of federal Part C program funds, state general funds, or local government funds appropriated to implement Part C services for families who may refuse the use of their health care coverage to pay for early intervention services due to their payment responsibility. Refer to the Schedule of Benefits for the Benefit Maximum.

Eye: Diagnosis and Medically Necessary treatment of diseases and injuries of the eye to include the first pair of cataract lenses or glasses following cataract removal surgery or lenses for the treatment of Keratoconus.

Genetic Testing and Genetic Counseling: Genetic testing, screenings, counseling, and subsequent prophylactic procedures when Medically Necessary and not specifically excluded by the Plan.

Home Health Care Services: These services are covered when ordered by a Participant's Physician and the attendance of a skilled professional nurse is required to perform the care. Each visit by a registered nurse or a licensed practical nurse to provide nursing care or by a physical therapist,

occupational therapist, or speech therapist will be considered one (1) visit. Only visits by licensed professionals are covered. Homemaker services, home health aide services, Custodial Care (including outpatient Custodial Care), respite care, and private duty nursing are not covered. Refer to the Schedule of Benefit for the Benefit Maximum.

Home Visits: Visits to the Participant's home by a Physician to perform Covered Services.

Hospice Care: Hospice Care is covered for Participants who have been diagnosed with a terminal illness and have chosen to receive palliative care only. Hospice patients may be managed through the Complex Case Management Program to assist with palliative and supportive physical, psychological, and psychosocial care and other health services for Participants with a terminal illness. Inpatient hospice respite care is covered for up to five (5) days in a six (6) month period. Hospice care involves a program of home and inpatient care provided directly or under the direction of a licensed hospice. A terminal illness is a condition that has been diagnosed as terminal by a licensed Physician and the medical prognosis is a life expectancy of six (6) months or less.

Implanted Devices: Surgically implanted devices. This includes but is not limited to implanted or soft lenses when replacing an injured lens.

Infertility: Infertility is the inability to conceive after one year of intercourse without contraception. Diagnostic services to establish and identify the cause of infertility are covered.

Inhalation Therapy.

Injectables: Therapeutic drugs are covered when FDA approved, Medically Necessary and administered in an inpatient setting or as the reason for a visit to an outpatient facility or Physician's office. The Participant's cost sharing will be the appropriate Copayment based on the place of service. Additional copays may apply if the drugs are shipped directly to the Participant as indicated on the Prescription Drug Schedule of Benefits.

Laboratory Tests: In-Network benefits apply when obtained at the office of a Participating Physician or through a Participating laboratory listed in the Directory of Health Care Providers.

Lymphedema:

- Treatment of Lymphedema is covered including equipment, supplies, complex decongestive therapy, and outpatient self-management training and education if prescribed by a health care professional legally authorized to prescribe or provide such items under law.
- Equipment and supplies for the treatment of Lymphedema are subject to the DME benefit limitations and Copayment/Coinsurance amounts as listed in the Schedule of Benefits.
- Outpatient self-management training and education for the treatment of Lymphedema will be handled as part of the short-term rehabilitation therapy benefit and is subject to benefit limitations, and Copayment/Coinsurance amounts as described in the Schedule of Benefits.

Maternity: Obstetrical care, including prenatal, delivery, and postpartum care, in an inpatient setting and/or a home visit or visits in accordance with the medical criteria 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. A nurse midwife may provide obstetrical care. Obstetrical care does not include services for childbirth performed in a home setting.

Medical Supplies: Medical Supplies are small and often disposable items that are part of medical treatment for an illness or injury. The supply must be compatible with the diagnosis and generally must not be useful in the absence of the illness or injury. Covered medical supplies include, but are not limited to, the following items: catheters, irrigation trays, oxygen tubing, urinary bags, some surgical dressing, and disposable items prescribed by a Physician that are used as part of Covered DME. The medical supply benefit is limited to a maximum per Benefit Year as described in the Schedule of Benefits. This

maximum for medical supplies is combined with any Benefit Maximum for DME.

Neuro-psychological Testing when Medically Necessary and Preauthorized.

Non-implanted Prosthetic Devices: are covered, except for charges for repair, replacement, or duplication if due to loss, neglect, abuse of device, or if for the convenience or personal preference of the Participant. Refer to the Schedule of Benefits for the Benefit Maximum.

- Non-implanted Prosthetic breasts are covered and subject to the following limitations: (i) silicone prosthetics will be covered at one (1) prosthesis every two years, and (ii) fabric, foam, or fiber prosthetics will be covered at two (2) prostheses per Plan Year.

Oral Surgery:

- Nondental surgical and Hospitalization procedures incidental to fractures of the jaw, excision of tumors, and for congenital defects, such as cleft lip and cleft palate.
- Excision of partial or complete bony impacted third molars. Anesthesia services rendered in connection with the covered removal of impacted teeth are also covered if performed by a person licensed to do so.
- Examination, evaluation, and Medically Necessary treatment of temporomandibular joint (TMJ) pain dysfunction and myofascial pain dysfunction (MPD).
- Surgery that is required to treat a medical condition or Injury which prevents normal function of the joint or bone and is deemed Medically Necessary to attain functional capacity of the affected part is covered.

All other procedures involving the teeth or areas surrounding the teeth are not covered.

Radiation Therapy.

Reconstructive Surgery: Reconstructive surgery or procedures when performed to correct deformity caused by disease, trauma, or a previous therapeutic process that is considered a Covered Service. In the event a Participant is undergoing a multi-stage reconstruction or fulfilling a specific waiting period that is medically indicated, then the Provider must submit a treatment plan for approval.

Pursuant to the Women's Health and Cancer Rights Act, if a Participant elects reconstructive surgery in connection with a mastectomy, the Plan will provide benefits for:

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

Such services shall be performed in a manner determined in consultation with the attending Physician and the patient. Additionally, the Plan will provide benefits in connection with reconstructive breast surgery for:

- Nipple and areola reconstruction.
- Medical complications resulting from the rupture of the prostheses/implant, and appropriate treatment, including removal of the prostheses/implant, upon Preauthorization.

Short-term Rehabilitative Therapy: Short-term rehabilitative therapy is covered when Medically Necessary. In the event of an inpatient stay for rehabilitation, the amount of the Participant's payment responsibility associated with an inpatient Hospital stay will apply. Refer to the Schedule of Benefits for the Benefit Maximum.

Speech therapy is limited to services to correct a speech impairment which results from disease, surgery, Injury, congenital anatomical anomaly, or prior medical treatment. Conditions resulting from functional

nervous disorders are not covered.

Occupational therapy and physical therapy are limited to services that assist the Participant to achieve and maintain self-care and perform other activities of daily living.

Skilled Nursing Facility Confinement: Benefits are provided when Skilled Nursing Care is Medically Necessary. Custodial Care, respite care, rest cures, domiciliary, or convalescent care are not covered. Refer to the Schedule of Benefits for the Benefit Maximum.

Smoking Cessation: Counseling is covered during an office visit. Other services, such as a telephonic quit line, may be provided by the Plan through specified vendors.

Spinal Manipulation: is provided on an outpatient basis. Refer to the Schedule of Benefits for the Benefit Maximum.

Sterilization: Sterilization is covered; however, reversal of sterilization is not covered.

Surgical Procedures: Surgical procedures may be performed in an inpatient or outpatient setting.

Termination of Pregnancy: Termination of Pregnancy during the first trimester is covered, except in the case of multifetal Pregnancy reduction. Multifetal Pregnancy reduction is only covered if the life or physical health of the mother or fetuses would be endangered if the fetuses were carried to term. Termination of Pregnancy after the first trimester is a Covered Service only if the life or physical health of the mother or fetus would be endangered if the fetus were carried to term or if fetal abnormalities are detected. The first trimester is considered to be the first 13 weeks of Pregnancy.

Transplants: Services related to Medically Necessary organ, tissue and bone marrow transplants, when Preauthorized by the Claims Administrator and performed at a Coventry Transplant Network Participating Facility. This includes treatment of breast cancer by autologous bone marrow or stem cell transplants. Your physician must call the Claims Administrator to have all services, consults, evaluations and testing relating to a prospective transplantation preauthorized.

Donor screenings are covered and are subject to a lifetime Benefit Maximum of \$10,000 when performed at a Coventry Transplant Network Participating Facility.

If not covered by any other source, the cost of any care, including complications, arising from an organ donation by a non-covered individual when the recipient is a Participant will be covered for the duration of the contract of the Participant when approved by the Claims Administrator. The cost of any care, including complications, arising from an organ donation by a Participant when the recipient is not a Participant is excluded.

Travel expenses for Participants and living donors are covered according to the Plan's transplant travel benefit. Participants are covered when this Plan is paying primary and a Coventry Transplant Network Participating Facility is used.

All potential transplant cases are assigned a complex case manager to coordinate and Preauthorize all necessary care.

The Plan uses a transplant network. Facilities in this network are contracted to perform specific transplant services. The Plan reserves the right to require the Participant to obtain services from a contracted Provider who may be outside of the Service Area if the services are to be covered by the Claims Administrator at the In-Network benefit level. Organ, tissue, and bone marrow transplants performed by a Non-Participating Provider will be subject to the Out-of-Network benefit level and may be limited to a maximum benefit as described in the Schedule of Benefits. Any procedures involving organ and tissue donor expenses when the recipient is a Participant are also limited to any applicable maximum benefit when performed Out-of-Network. Participants enrolled in an HMO plan may access services Out-of-Network only if those services have been Preauthorized by the Claims Administrator.

X-rays: X-rays and diagnostic procedures.

Urgent Care Benefits: Urgent Care is Medically Necessary care for an unexpected Illness or Injury that does not qualify as a Medical Emergency but requires prompt medical attention. The Participant's treating Physician can help determine whether or not the Participant needs to receive care at an Urgent Care center.

The Claims Administrator will review the Participant's claim for Urgent Care in accordance with established medical criteria and guidelines. If this review results in the determination that the Participant did not require Urgent Care, the Participant may be responsible for the entire bill.

SECTION 7 UTILIZATION MANAGEMENT SERVICES

Preauthorization

Certain services require Preauthorization. The list of services required to be Preauthorized is subject to change from time to time. The services currently requiring Preauthorization are available at www.southernhealth.com, under “My Group Benefits” or by calling Customer Service at (866) 533-5149.

Behavioral Health/Substance Abuse Services also require Preauthorization from the Mental Health vendor. The phone number for Preauthorization of these services is (800) 975-8919.

Preauthorization and Customer Service phone numbers are listed on the Plan ID card.

When a Participant receives care from a Participating Provider, the Provider is responsible for following the Utilization Management policies and procedures. If a Participant receives care from a Non-Participating Provider, the Participant must comply with all of the policies and procedures of the Utilization Management Program.

For out-of-network services that require Preauthorization, the Participant or family member must call the number on the Plan ID card to receive certification of certain services in order for those services to be covered under this Plan. This call must be made at least three (3) days in advance of services being rendered. If there is an **Emergency** admission to a Medical Care Facility, the Participant or someone on the Participant’s behalf such as a family member, the Medical Care Facility or attending Physician, must contact the Claims Administrator **within 24 hours** or the first business day after the admission.

Participants enrolled in an HMO plan do not have coverage Out-Of-Network except for Medical Emergencies or when Out-Of-Network services have been Preauthorized at the In-Network level of benefits.

General Policies

Under all circumstances, the attending Physician bears the ultimate responsibility for the medical decisions regarding treatment of Participants.

Participants in the POS and PPO plans will incur an additional financial penalty as stated in the Schedule of Benefits when using a Non-Network Provider if the Participant fails to call the Claims Administrator at least three (3) days prior to an elective admission or outpatient surgery or procedure or, in the event of a Medical Emergency, within twenty-four (24) hours after the date of the Medical Emergency or as soon as reasonably possible. As stated above, Participants enrolled in an HMO plan do not have coverage Out-Of-Network except for Medical Emergencies or when Out-Of-Network services have been Preauthorized at the In-Network level of benefits.

Preauthorization is required when a Participant needs a medical or surgical procedure, diagnostic test, supply or medication that requires Preauthorization and is a Covered Service, regardless of whether services are provided In or Out-of-Network (POS and PPO plans only). The Physician ordering the services should notify the Claims Administrator to get Preauthorization. Payment for preauthorized services will be subject to the applicable limitations, exclusions, and conditions of Plan coverage. **The appropriate Preauthorization must be obtained even when the Plan is the secondary carrier; otherwise, the claim may be denied.** For a complete listing of the services that require Preauthorization, go to www.southernhealth.com under “My Group Benefits” or call Customer Service.

Preauthorization requirements are updated periodically. To verify Preauthorization requirements, contact the Claims Administrator at the number printed on the back of the Plan ID card. The Claims Administrator

reserves the right to require documentation of Medical Necessity and/or second opinions prior to its Preauthorization of Covered Services. Notwithstanding any review conducted by the Claims Administrator before the provision of a health care service, all benefits are subject to the terms and conditions of this Plan Document.

If a Participant receives services from a Non-Participating Provider and fails to follow these procedures, all claims may be denied and the participant may be responsible for all amounts charged by the Provider.

Payments for Preauthorized services will be subject to the applicable limitations, exclusions, and conditions of coverage.

Obtaining Preauthorization For Visits To Non-Participating Providers At The In-Network Benefit Level

If a Physician feels that there is a need for a Participant to be seen by a Physician or other medical Provider who does not participate in the network and that the services may be eligible for In-Network benefits, then the Physician must submit medical information to the Claims Administrator prior to the Participant receiving services. **Retroactive requests for consideration at the In-Network benefit level will not be considered.** Covered Services from a Non-Participating Provider are preauthorized by the Claims Administrator for In-Network benefits only when the Plan does not have a Participating Provider who can provide the service. The Physician must submit evidence that Participating Plan Providers are unable to perform the requested services. The Plan has the right to determine where the services can be provided for coverage when a Participating Provider cannot render the service.

Passport Program for Dependents Living Outside of the Service Area

A Dependent living outside of the Service Area may request to be enrolled in the Passport Program by calling Customer Service at (866) 533-5149. If the Dependent's enrollment submission is accepted, the Dependent is allowed to access the Plan's national network to obtain routine care at the In-Network level of benefits for the types of covered services listed below.

- Sick visits
- Allergy shots
- Routine physician care
- Lab services
- Pharmacy
- Other services which do not require Preauthorization
- Emergency services that meet the definition of emergency care

There are certain covered services that require Preauthorization prior to the Dependent receiving care. A list of those services is available at www.southernhealth.com. In order to obtain Preauthorization for these services, a Dependent must call the Claims Administrator's Preauthorization phone number (800) 235-2206 and select the option for Southern Health.

If at any time a Dependent is no longer living outside the Service Area or if he/she no longer qualifies as an eligible Dependent under the Plan, his/her coverage under the Passport Program will cease. The Dependent (or someone on his/her behalf) must notify the Claims Administrator if he/she no longer lives outside the Service Area or is no longer an eligible Dependent by calling the phone number listed on his/her Plan ID card. If the Claims Administrator is not notified, it has the right to recover payments on behalf of the Plan for any claims improperly paid.

Participant responsibilities when seeking services from Non-Participating Providers:

When the Participant is enrolled in a POS or PPO Plan:

- Administrative requirements usually fulfilled by Participating Providers are the Participant's responsibility when seeing a Non-Participating Provider. This includes, but is not limited to, filing of claims within the timely filing period and obtaining Preauthorization prior to receiving services.

When the Participant is enrolled in an HMO Plan:

- Preauthorization for visits to Non-Participating Providers will be granted for a specified condition and are assigned a specific number of visits. If the services received vary from the services that were Preauthorized, those services will not be covered by the Plan. Only those visits made after Preauthorization is given are covered. If the Participant is unsure whether or not the Physician's office has obtained a Preauthorization, or if the Participant wants to verify the number of visits or the expiration date, call the Claims Administrator's Customer Service for assistance.
- If the Participant is unable to schedule an appointment with the Non-Participating Provider on the date Preauthorized by the Claims Administrator, the Physician must contact the Claims Administrator to have the date of the Preauthorization changed to coordinate with the new appointment date.
- If a Non-Participating Provider is still treating the Participant and the number of visits expires, the Physician must call the Claims Administrator to have the number of visits increased or extended prior to receiving additional services.

A Participant has the right to appeal any Utilization Management Program payment decision according to the Complaint and Appeal Procedures.

Notification Penalty (Does Not Apply to HMO Plans)

If a Participant is admitted as an inpatient to a Non-Participating hospital, as the result of a Medical Emergency, he/she must notify the Claims Administrator of his/her admission within twenty-four (24) hours or by the end of the next working day if the twenty-four (24)-hour deadline falls on a weekend or legal holiday. An exception to the notification requirement will be made if the Participant is incapacitated and unable to contact the Claims Administrator. In this event, the Participant must make arrangements for the Claims Administrator to be notified as soon as medically possible. If a Participant fails to notify the Claims Administrator, as outlined in this paragraph, then a notification penalty of \$500 will apply to charges for services determined to be Medically Necessary based on retrospective review by the Claims Administrator. This penalty will be subtracted from any benefits paid by the Plan. The penalty amount does not apply toward any deductibles or to the annual out-of-pocket maximum. Claims for services determined not Medically Necessary may be denied.

Utilization Review

Utilization review is a program designed to help ensure that all Participants receive necessary and appropriate health care while avoiding unnecessary expenses.

The program consists of:

- (a) Preauthorization of the Medical Necessity of non-emergency services (included on the list of services requiring Preauthorization) and all Behavioral Health and Substance Abuse treatment;
- (b) Retrospective review of the Medical Necessity of the listed services provided on an Emergency basis;
- (c) Concurrent review, based on the admitting diagnosis, of the listed services requested by the attending Physician; and

- (d) Certification of services and planning for discharge from a Medical Care Facility or cessation of medical treatment.

The purpose of the utilization review program is to determine what charges may be eligible for payment by the Plan. This program is not designed to be the practice of medicine or to be a substitute for the medical judgment of the attending Physician or other health care Provider.

If a particular course of treatment or medical service is not certified, it means that either the Plan will not pay for the charges or the Plan will not consider that course of treatment as appropriate for the maximum reimbursement under the Plan. If the Participant is seeking care from a Non-Participating Provider, and there is a discrepancy between what was requested and what was certified, he/she is urged to find out why before incurring any charges.

In order to maximize Plan reimbursements, please read the following provisions carefully.

Pre-Service Requests for benefits (requests for benefits that require Preauthorization and are for services that have not yet been provided).

To make a pre-service request for benefits that will be provided by a Non-Participating Provider, the Participant or the Non-Participating Provider on the Participant's behalf should contact the Claims Administrator's Preauthorization Department and provide the following information:

- The name of the patient and relationship to the covered Employee,
- The name, Social Security number and address of the covered Employee,
- The name of the Employer,
- The name and telephone number of the attending Physician,
- The name of the Medical Care Facility, proposed date of admission, and proposed length of stay,
- The diagnosis and/or type of surgery, and
- The proposed rendering of medical services.

After the Claims Administrator receives the request, it will notify the Provider of any additional information needed by the Plan to make its determination. The Claims Administrator will make its decision and notify the Provider within 15 days after it receives the request for benefits.

A Participant or Provider may make an Urgent Care request for benefits by contacting the Claims Administrator. The Claims Administrator will make its decision and notify the Provider of that decision as quickly as possible, taking into account medical exigencies, but in no event later than 72 hours after it receives the request. In some cases, the Participant or the Provider may not have provided the Claims Administrator with sufficient information to make a decision. If this is the case, the Claims Administrator will notify the Provider of the additional information that it needs to make a determination. The Claims Administrator will give the Provider a reasonable amount of time, to provide the information.

Urgent Care Requests for Benefits are requests for benefits related to services that the Participant or health care Provider believes that the Participant's life, health or ability to regain maximum function is in immediate jeopardy, or for care that the treating Physician determines is urgent, or determines that a delay would subject the Participant to severe pain that could not be adequately managed without the treatment requested.

Concurrent Care Benefit Determinations

If a Participant is undergoing an approved course of treatment, and the Claims Administrator determines that coverage for the frequency or course of the treatment should be denied and the Participant will be held financially responsible, the Claims Administrator will inform the Participant of its decision before the end of the approved course of treatment, so that the Participant has sufficient time to appeal the decision to reduce or limit the treatment.

Notifications of Benefit Determinations

If the Claims Administrator denies a request for benefits, in whole or in part, it will provide the Participant with a written explanation of the decision, including the specific reason that the request was denied, the Plan provision on which the denial was based, a description of any additional information that may be submitted and why the information is necessary, and a description of the appeal procedures.

Admission/Continued Stay Review

In the event of an Emergency Hospitalization or outpatient surgery or procedure, the Claims Administrator must be contacted within 24 hours after the Medical Emergency or as soon as reasonably possible following the receipt of the services.

If the Participant is being treated by a Participating Provider, it is the responsibility of the attending Participating Provider to contact the Claims Administrator.

If the Participant is being treated by a Non-Participating Provider, it is the Participant's responsibility to contact the Claims Administrator. A friend or relative, the attending Physician, the Hospital, or anyone a Participant designates may contact the Claims Administrator.

If the Claims Administrator was contacted by the Participant or the Participating Provider and the Emergency admission was not Medically Necessary, coverage for the services may be denied.

In the event that a Participant stays in the Hospital longer than authorized by the Claims Administrator, no further benefits will be provided.

Case Management

Complex Case Management. This is a program designed for the early identification and effective management of selected Participants for whom intensive management can be expected to improve the quality of care and reduce overall medical expenses. The Complex Case Management Program offers special assistance to Participants with serious and complex, long-term medical needs and promotes quality of care to reduce the likelihood of extended, more costly health care. The Case Management Program identifies serious and complex medical conditions as ones that are persistent and substantially disabling or life-threatening and that require treatments and services across a variety of domains of care to ensure the best possible outcome for each unique Participant. Long-term medical needs are those that are more chronic than acute and can be expected to require extended use of health care resources.

Complex Case management is a collaborative process which assesses, plans, implements, coordinates, monitors, and evaluates options and services to meet and individual Participant's health care needs through communication and available resources to promote quality, cost-effective outcomes.

Note: Case Management is a voluntary service. There are no reductions of benefits or penalties if the patient and family choose not to participate. Each treatment plan is individually tailored to a specific patient and should not be seen as appropriate or recommended for any other patient, even one with the same diagnosis.

SECTION 8 PRESCRIPTION DRUG BENEFIT

Many independent retail pharmacies and most national retail chains are Network Pharmacies. To find out if a pharmacy is in the network, Participants may call Customer Service at (866) 533-5149.

Covered Drugs means Prescription Drugs that are:

- Formulary or Non-Formulary Drugs that are covered according to the Schedule of Benefits,
- Medically Necessary,
- Prescribed by an Authorized Prescriber,
- Dispensed by a Network Pharmacy (except as covered by Non-Network Pharmacies as described in this Section), and
- Approved by the Plan.

Subject to the Exclusions and Copayments described in this Section, benefits are available for outpatient Prescription Drugs when the prescription is written by a Provider licensed to prescribe Prescription Drugs and when the Participant uses a Participating Pharmacy.¹ The benefits include mail order and retail maintenance drug benefits. Drugs will be dispensed according to the Plan's Formulary. Participating Physicians have a copy of the Formulary. If a Participant plans to visit a Non-Participating Physician on a regular basis, the Physician should contact the Claims Administrator for information regarding the Plan's Formulary.

A Copayment applies to each Covered prescription or refill. The Prescription Drug benefit includes one Copayment for Tier 1 (formulary generic drugs), one Copayment for Tier 2 (formulary brand drugs), and one Copayment for Tier 3 (non-formulary drugs). The Copayment amounts for covered prescriptions are shown on the Schedule of Benefits in Section 5. Copayments for covered prescriptions do not apply to the Benefit Year annual maximum out-of-pocket that is described in Sections 6 and 10. The Plan does not coordinate benefits with other pharmacy benefit payers for services and supplies offered under the Prescription Drug Benefit.

If the medical plan in which the Participant is enrolled has a Deductible, which is stated in the Schedule of Benefits in Section 5, that Deductible does not apply to the Prescription Drug Benefit.

If a Physician prescribes a medication in a dose that requires two separate strengths and a pharmacy must dispense two separate prescriptions to accommodate the prescribed dose, the Participant will be required to pay the required Copayment for each pharmacy prescription dispensed.

Prescribing Units

Except as otherwise indicated, the quantity of a prescription dispensed by a retail pharmacy for each prescription or refill is limited to the lesser of the following and will be considered a Prescribing Unit:

- The amount prescribed in the Prescription Order or Prescription Refill;
- A 31 days' supply as defined by the Plan;
- The amount necessary to provide 31 days' supply according to the maximum dosage approved by the Food and Drug Administration for the indication for which the drug was prescribed; or
- Depending on the form and packaging of the product, the following:
 - 480cc. of oral liquids,
 - a sufficient amount to provide the prescribed dosage for 4 weeks (for drug prescribed based on the number of doses per week),
 - one inhaler or one commercially prepackaged set of doses (for inhaled drugs),
 - one commercially prepared or packaged tube of topical medications including salves, creams, ointments, suppositories or patches,
 - the number of vials of one type or strength of insulin needed to provide the prescribed dosage for 31 days, or one commercially pre-packaged set of doses (such as tablets or capsules).

- Any covered medication that has a duration of action extending beyond one (1) month shall require the number of Copayments that is equal to the anticipated duration of the medication. For example: Depo-Provera is effective for three (3) months and therefore will be considered as three (3) Prescribing Units. It is covered under this Plan and will require three (3) Copayments.

Retail Pharmacy Benefit

A Copayment applies to each initial and refill prescription (1 Prescribing Unit). When the stated quantity is not available, the Plan will cover the nearest available refill. A Prescription Refill will not be honored unless 75% of the initial prescription or most recent refill has been used. This retail benefit also includes coverage for the following Self-Administered Injectable Drugs: injectable diabetes agents (such as Insulin and Glucagon), Bee-Sting kits, Imitrex, and injectable contraceptives. Some of these injectable drugs may require Prior Authorization.

In order to receive this benefit, Participants must present their Plan Identification Card at the time the prescription is filled. Prescriptions filled at a Participating Pharmacy must be submitted by the pharmacy through the online claims adjudication process. The pharmacy will then charge the Participant the applicable Copayment up to the cost of the drug. The Plan will not reimburse Participants who fail to follow this procedure except in the case of a medical emergency.

Quantity or Dosage Limits

Coverage for certain drugs, as defined by the Plan, is subject to specific quantity or dosage limits. If a drug is not covered at the dosage or quantity prescribed by the Physician and the Physician deems that the non-covered dosage or quantity is Medically Necessary, then the Physician may request payment for the non-covered dosage or quantity by contacting the Claims Administrator. If the Claims Administrator's Pharmacy Director, after reasonable investigation and consultation with the prescribing Physician, approves an exception, the prescription will be covered at the applicable Copayment. Such an exception will be acted on within two (2) working days of the Claims Administrator's receipt of the request.

Mail Order Drug Benefit

The Copayment listed on the Schedule of Benefits in Section 5 will apply to each initial and refill prescription for up to a 90-day supply of maintenance drugs. A Prescription Refill will not be honored unless 75% of the initial prescription has been utilized. Only maintenance drugs, as defined by the Plan, are available through mail order. Controlled substances are not available through the mail order program.

Retail Maintenance Drug Benefit

In addition to the Mail Order Benefit, the Participant also has the option to obtain up to a 90-day supply for maintenance drugs from a Participating Pharmacy. The Participant will pay one Copayment for the first Prescribing Unit, a second Copayment for the second Prescribing Unit, and a third Copayment for the third Prescribing Unit. Only the maintenance drugs defined by the Plan will be available at the Retail Maintenance Drug Benefit. Controlled substances are not available at the Retail maintenance Drug Benefit.

Self-Administered Injectable Drug Benefit

A Self-Administered Injectable Drug is a Prescription Drug, other than those listed in the Retail Benefit section that is given by injection under the skin or into the muscle and is commonly and customarily administered by the patient or caregiver in the home setting. These types of Self-Administered Injectable Drugs require Prior Authorization. These Self-Administered Injectable Drugs are NOT available through Participating Retail Pharmacies or the mail Order Program. These drugs must be obtained through the Specialty Pharmacy specifically identified by the Plan and are limited to a maximum of up to a 31-day supply prescription filled.

Examples of Self-Administered Injectable Drugs include, but are not limited to, the following: multiple sclerosis agents, colony stimulating factors given more than once monthly, chronic medications for

hepatitis C, certain rheumatoid arthritis medications, growth hormones, certain injectable HIV drugs, certain osteoporosis agents, and certain anticoagulant products.

Please note that Self-Administered Injectable Drugs administered by a Provider or in a Provider's office are not covered under the Prescription Drug Benefit.

Generic Drug Substitution

If a brand name Prescription Drug is dispensed, and an equivalent generic Prescription Drug is available, the Participant shall pay an Ancillary Charge directly to the pharmacy in addition to the brand name Copayment. The Ancillary Charge is the difference between the price of the brand name drug and the generic drug. Participant payments shall not exceed the price of the Prescription Drug. The Ancillary Charge will be waived if the Prescribing Physician indicates the Prescription is "dispense as written" (DAW) or "brand name medically necessary."

Prior Authorization

Certain drugs require Prior Authorization by the Claims Administrator prior to coverage under Your Prescription Drug benefit. The Participant's Participating Physician and the Claims Administrator's Customer Service Department have a current list of these medications. If the Participant needs to take a drug that requires Prior Authorization, the Participant should request that the Physician contact the Claims Administrator with the medical indication for prescribing the medication. Prior Authorization is determined using criteria based on FDA approved uses.

The Plan reserves the right to include only one manufacturer's product on the Formulary when a drug with the same active ingredient is made by two or more different manufacturers. The product on the Formulary will be Covered at the applicable Copayment. The product or products of the same drug not listed on the Formulary requires Prior Authorization by the Claims Administrator prior to coverage under the Prescription Drug benefit. The Plan also reserves the right to include only one dosage or form of a drug on the Formulary when a drug with the same active ingredient is available in different dosages or forms (such as dissolvable tablets or capsules from the same or different manufacturers. The product, in the dosage or form, that is listed on the Formulary will be Covered at the applicable Copayment. The product or products, in different forms or dosages, not listed on the Formulary require(s) Prior Authorization by the Claims Administrator prior to coverage under the Prescription Drug benefit. The Participant should request that the Physician contact the Claims Administrator with the medical indications for prescribing a specific dosage or form of a medication.

In addition, high dollar claims will be reviewed by the Claims Administrator for efficacy and cost effectiveness in conjunction with FDA standards of care.

Loss of Benefits

In certain situations, the Plan may, upon written notification to the Participant, give notice that the Participant's Prescription Drug benefit is in jeopardy. These situations include, but are not limited to, a Participant using medications in a manner that contradicts his/her prescription or standard prescribing practices, or obtaining prescriptions for the same medication from multiple Physicians. Continued abuse of this nature may result in restrictions in the Participant's Prescription Drug benefits including termination upon thirty-one (31) days written notice to the Participant.

What is Covered

- Medically Necessary drugs:
 - obtained from a Participating Pharmacy ¹ (including mail order);
 - for which a prescription is required by federal or state law; and
 - which are not specifically excluded in this Section.

- Smoking Cessation Drug Benefit: FDA approved smoking cessation drugs are covered by the Prescription Drug Benefit. Certain over-the-counter (OTC) generic versions of nicotine replacement

therapies such as gums, patches and lozenges, are covered with a prescription. Quality limits may apply.

- Self-Administered Injectable Drugs.
- Diabetic supplies, including insulin, syringes, blood glucose strips, lancets, and glucose monitors.
- Compounded prescriptions when all of the following apply:
 - no suitable commercially-available alternative is available;
 - the main active ingredient is a covered Prescription Drug;
 - the purpose is solely to prepare a dose form that is Medically Necessary and is documented by the prescribing doctor; and
 - when the claim for the prescription is submitted electronically.

These compound drugs will be covered at the Tier 3 Copayment unless the main active ingredient is a Tier 1 or Tier 2 drug. In those cases, the cost of the compound drug will be the Copayment of the active ingredient.

What is not Covered (Exclusions)

- Drugs that are not Medically Necessary;
- Drugs obtained from Non-Participating pharmacies in a non-emergency situation when such pharmacies have not previously notified the Claims Administrator, by facsimile or otherwise, of their agreement to accept as payment in full reimbursement for their services at rates available to pharmacies that are Participating Providers, including any Copayment consistently imposed by the Plan.
- Any Prescription Drug to be administered, in whole or in part, while a Participant is in a Hospital, medical office or other health care facility;
- Any Prescription Drug that is being used or abused in a manner that is determined to be furthering an addiction to a habit-forming substance;
- Legend drugs for which there is a Non-Prescription Drug alternative (such as over-the-counter) and over-the counter (OTC) products not requiring a prescription to be dispensed (like aspirin, antacids, herbal products, oxygen, medicated soaps, food supplements, food replacements, and bandages) with the exception of OTC programs sponsored by the Plan, such as Prilosec and Claritin;
- Contraceptive implant systems and intrauterine devices (IUDs); Coverage for contraceptive implant systems and IUDs is described under Section 6.
- Dietary supplements, appetite suppressants, drugs used to treat obesity or assist in weight reduction or weight gain, and malabsorption agents;
- Medications prescribed for cosmetic purposes, including but not limited to, retinoid for aging skin and monoxide lotion.
- Drugs and products used to treat infertility;
- Injectable medications, except Self-Administered Injectable Drugs as described in this Section;
- Refill of prescriptions resulting from damage by the Participant;
- Medications for treatment of diseases of teeth and gums, except fluoride tablets or drops;
- Tubing for insulin pumps; ostomy supplies, including bags, adhesives, and tubing. These are covered as stated in Section 6.
- Allergy supplies, including syringes.
- Experimental and Investigational Drugs; products not approved by the FDA; drugs with no FDA-approved indications, medications prescribed at dosages in excess of FDA approval; drugs prescribed for purposes other than the FDA approved use, unless a drug is recognized for treatment of the covered indication in one of the Standard Reference Compendia or in substantially accepted Peer-Reviewed Medical Literature. Cancer drugs that are FDA approved for a certain cancer type may be used for treatment of other types of cancer, provided the drug has been recognized as safe and effective for treatment of that specific type of cancer in any of the Standard Reference Compendia. Any drug approved by the FDA for use in the treatment of cancer pain shall not be denied for coverage on the basis that the dosage is in excess of the recommended dosage of the pain relieving agent, if the prescription in excess of the recommended dosage has been prescribed in compliance with Virginia law for a patient with intractable cancer pain.
- Vitamins and minerals (both OTC and legend), except legend prenatal vitamins for pregnant and nursing females, liquid or chewable legend pediatric vitamins for children under age 13, and potassium supplements to prevent/treat low potassium.

- Medical supplies other than those specifically provided herein, medical equipment, and support garments.
- Immunizing agents, biological sera, and Hemophilia blood factors with the exception of programs sponsored by the Plan.
- Medications used to enhance athletic performance, including but not limited to, anabolic steroids.

Note

¹Participating Pharmacies may include Non-Participating pharmacies that have previously notified the Claims Administrator, by facsimile or otherwise, of their agreement to accept as payment in full reimbursement for their services at rates available to pharmacies that are Participating Providers, including any Copayment consistently imposed by the Plan. When a Participant obtains Prescription Drugs from a Non-Participating pharmacy, except as covered for an Emergency benefit, all conditions of coverage described in this section must be met.

SECTION 9 VISION BENEFIT

This section describes coverage for services for routine vision care. Coverage for diseases and Injuries of the eye are described in Section 6 of this Plan Document.

A summary of the benefits and the Participant's payment responsibility are shown on the Schedule of Benefits. In-Network benefits are only offered when a Participant receives services from a Participating vision Provider. Participating vision Providers can be found online at www.southernhealth.com or by calling Customer Service. Benefits do not apply to services received from ophthalmologists or other Specialists not considered vision Providers.

What is covered?

Complete refractive eye examinations, to include exams for the wearing of glasses, daily wear or extended wear hard or soft lenses and specialty lens exams. This benefit is subject to a maximum as stated in the Schedule of Benefits included in this Plan Document. Your payment responsibility is also shown in the Schedule of Benefits.

Medically Necessary Eye Care Not Covered By The Routine Vision Benefit.

In the event that a Participant requires Medically Necessary eye care other than services for eyeglasses or contact lenses, or the vision examiner suggests a medical eye evaluation, the Participant may be covered for services from a Participating ophthalmologist listed in the Directory of Health Care Providers.

SECTION 10 DEFINED TERMS

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

Active Employee

An Employee who is on the regular payroll of the Employer and who has begun to perform the duties of his or her job with the Employer on a regular full-time or regular part-time basis. The term "Active Employee" does not include independent contractors or temporary Employees.

Allowable Charge

The Allowable Charge is the amount that a Participating Provider has agreed to accept as payment in full for Covered Services. For Non-Participating Providers (in the POS and PPO plans) the Allowable Charge is equal to the Out-of-Network Rate.

Ancillary Charge

The charge the Participant is required to pay to a Network or Non-Network Pharmacy for Prescription Drugs when the Participant or the Participant's Physician requests that a Brand Name drug be dispensed when a Generic substitution is available. The Ancillary Charge, if any, is the difference between the Plan's contracted price for the Brand Name drug and the contracted price for the Generic Drug. The Participant must pay the Ancillary Charge directly to the Network or Non-Network Pharmacy at the time the Prescription Order or Refill is filled. The Ancillary Charge is in addition to the Pharmacy Copayment charge.

Authorized Prescriber

Any licensed dentist, licensed Physician, licensed podiatrist, certified nurse midwife to the extent permitted by applicable law, certified nurse practitioner to the extent permitted by applicable law, or other individual authorized by law to prescribe drugs or devices.

Balance Billing

Amounts above the Allowable Charge that are in addition to any applicable copayments or coinsurance that may be billed to Participants by Non-Participating Providers under the POS and PPO plans for covered services.

Benefit Maximum

The total amount payable for a service. Limits may be in terms of visits, days, or dollars. Specific Benefit Maximum amounts are listed in the Schedule of Benefits.

Benefit Year

The period during which the total amount of yearly benefits under the Plan is calculated. The Benefit Year is the Plan Year as stated in Section 2.1.

Certificate of Creditable Coverage

Under HIPAA, group health plans and health insurance issuers are required to furnish a certificate of coverage to an individual to provide documentation of the individual's prior creditable coverage. This certificate is commonly referred to as a Certificate of Creditable Coverage, and must be provided automatically to Participants when they lose coverage under the Plan or otherwise become entitled to elect COBRA continuation coverage as well as when COBRA continuation coverage ceases.

Creditable coverage includes most health coverage, such as coverage under a group health plan (including COBRA continuation coverage), HMO membership, an individual health insurance policy, Medicaid, Medicare or public health plans.

Creditable Coverage does not include coverage consisting solely of dental or vision benefits.

Creditable Coverage does not include coverage that was in place before a significant break of coverage of 63 days or more.

Claims Administrator

Southern Health Services, Inc.

COBRA

The Consolidated Omnibus Budget Reconciliation Act of 1985, as amended.

Coinsurance

A specified percentage of the Allowable Charge that the Participant must pay as a condition of the receipt of certain services as provided in this Plan Document. Specific Coinsurance amounts are listed in the Schedule of Benefits.

Copayment

The flat dollar amount as specified in the Schedule of Medical Benefits that will be charged to the Participant by the Network or Non-Participating Provider.

Cosmetic Services and Surgery

Services and/or plastic reconstructive surgery: (i) from which no significant improvements in physiologic function could be reasonably expected; or (ii) that does not meaningfully promote the proper function of the body or prevent or treat illness or disease; or (iii) is done primarily to improve the appearance or diminish an undesired appearance of any portion of the body. This does not apply to mastectomy-related services as described in Section 19 of this Plan Document.

Covered Charge(s)

Medically Necessary services or supplies that are covered under this Plan.

Covered Services

The services or supplies provided to a Participant for which the Plan will make payment, as described in Section 6 of this Plan Document.

Custodial Care

Custodial Care is maintenance care or on-going medical care that is not designed to improve the patient's condition when the patient's medical condition has stabilized, regardless of the place of service or the Provider by whom the services are prescribed, recommended or performed. Custodial Care may include, but is not limited to, the following services: activities of daily living such as, help walking, getting into or out of bed, bathing, dressing, feeding, and using or applying medications; routine palliative and prophylactic skin care; administration and supervision of catheters, colostomies, tracheotomies, intravenous feeding or ventilator care.

Customer Service Department

The Claims Administrator's Customer Service Department, which includes services for Participants. Those services include, but are not limited to, answering questions about benefits, providing information on how to use the health plan, helping in identifying Participating Providers, assisting with resolution of claims issues. The phone number for the Customer Service Department is located on Plan identification card.

Deductible

A fixed dollar amount that a Participant is responsible for paying for Covered Services in a Benefit Year before the Plan will pay for any remaining Covered Services during the Benefit Year. Amounts above the Allowable Charge do not accumulate towards the Deductible.

Dependent

Any individual of an Employee's or a Retiree's family who meets the eligibility requirements outlined in this Plan Document.

Directory of Health Care Providers

A listing of Participating Providers. The information in the Directory of Health Care Providers is subject to change. Upon request, an updated Directory of Health Care Providers will be sent to Participants. Participants may also access this Directory online through "My Group Benefits" at www.southernhealth.com.

Durable Medical Equipment

Equipment which (a) can withstand repeated use, (b) is primarily and customarily used to serve a medical purpose, (c) generally is not useful to a person in the absence of an Illness or Injury and (d) is appropriate for use in the home. Examples of durable medical equipment include hospital beds, wheelchairs, and oxygen equipment.

Employee

A person who is an Active, regular Employee of the Employer.

Employer

Includes the County of Henrico, Virginia, the County School Board of Henrico County, Virginia and the Economic Development Authority of Henrico County, Virginia.

Experimental/Investigational

- Except as covered in Section 6 under "Clinical Trials", medical, surgical or other health care procedures, services or supplies are considered Experimental or Investigational if any of the following applies:
 - Is in the testing stage or in early field trials on animals or humans.
 - Is under clinical investigation by health professionals or is undergoing clinical trials by any governmental agency, including but not limited to, the Department of Health and Human Services or the Food and Drug Administration. Drugs for the treatment of a specific type of cancer that are not FDA approved will be covered when they are approved for one type of cancer and the drug has been recognized as safe and effective for treatment of the specific type of cancer for which the drug has been prescribed in any of the Standard Reference Compendia. Similarly, drugs for the treatment of a specific indication that are not FDA approved will be covered so long as the drug has been approved by the United States Food and Drug Administration for at least one

indication and the drug is recognized for treatment of the covered indication in one of the Standard Reference Compendia or in substantially accepted Peer-Reviewed medical literature.

- Is a health product or service that is subject to Investigational Review Board (IRB) review or approval.
- Is a health product or service that is the subject of a clinical trial not meeting the criteria for coverage defined in the "Clinical Trials" section under Covered Benefits.
- Does not have required final federal regulatory approval for commercial distribution for the specific indications and methods of use assessed or has not been approved by the Centers for Medicare and Medicaid Services for coverage by Medicare.
- Is a health product or service for which effectiveness is unproven based on clinical evidence reported by Peer-Review Medical Literature and by generally recognized academic experts.

Formulary

A list of Prescription Drugs approved for coverage under this Plan that includes preferred generic drugs and preferred brand name drugs available at the Tier 1 and Tier 2 copayments, respectively. The Formulary is subject to periodic review and modification by the Plan, and it is available for review on the Claims Administrator's website or by contacting the Claims Administrator's Customer Services Department.

Formulary Drugs

Prescription Drugs listed on the Formulary.

Hospital

An institution that is engaged primarily in providing medical care and treatment of sick and injured persons on an inpatient basis at the patient's expense and that fully meets the following criteria: it is accredited as a Hospital by the Joint Commission on Accreditation of Healthcare Organizations or the American Osteopathic Association Healthcare Facilities Accreditation Program; it is approved by Medicare as a Hospital; it maintains diagnostic and therapeutic facilities on the premises for surgical and medical diagnosis and treatment of sick and injured persons by or under the supervision of a staff of Physicians; it continuously provides on the premises 24-hour-a-day nursing services by or under the supervision of registered nurses (R.N.s); and it is operated continuously with organized facilities for operative surgery on the premises.

The definition of "Hospital" shall be expanded to include the following:

- A facility operating legally as a psychiatric Hospital or residential treatment facility for Behavioral (Mental) Health and licensed as such by the state in which the facility operates.
- A facility operating primarily for the treatment of Substance Abuse if it meets these tests: maintains permanent and full-time facilities for bed care and full-time confinement of at least 15 resident patients; has a Physician in regular attendance; continuously provides 24-hour a day nursing service by a registered nurse (R.N.); has a full-time psychiatrist or psychologist on the staff; and is primarily engaged in providing diagnostic and therapeutic services and facilities for treatment of Substance Abuse.

Illness

A bodily disorder, disease, physical sickness or Mental Disorder. Illness includes Pregnancy, childbirth, miscarriage or complications of Pregnancy.

Injury

Accidental physical Injury to the body caused by unexpected external means.

In-Network

Pertaining to the payment level for services received from a Participating Provider.

Legal Guardian

A person recognized by a court of law as having the duty of taking care of the person and managing the property and rights of a minor child.

Lifetime Maximum

The total amount of benefits payable by the Plan for each Participant. This maximum is for the length of the coverage under this Plan. Lifetime Maximum amounts are listed in the Schedule of Benefits.

Medical Emergency/Emergency

A Medical Emergency is a sudden onset of a medical condition that manifests itself by symptoms of sufficient severity, including severe pain, that the absence of immediate medical attention could reasonably be expected by a Prudent Layperson to result in (i) serious jeopardy to the mental or physical health of the Participant, (ii) danger of serious impairment of the Participant's bodily functions, (iii) serious dysfunction of any of the Participant's bodily organs, or (iv) in the case of a pregnant woman, serious jeopardy to the health of the fetus.

Medically Necessary/Medical Necessity

Those services, supplies, equipment, and facilities charges that are not expressly excluded under this Plan Document and have been determined by the Claims Administrator to be: (i) medically appropriate so that expected health benefits (such as, but not limited to, increased life expectancy, improved functional capacity, prevention of complications, relief of pain) materially exceed the expected health risks; (ii) necessary to meet the health needs of the Participant, improve physiological function, and required for a reason other than improving appearance; (iii) rendered in the most cost-efficient manner and setting appropriate for the delivery of the health service; (iv) consistent in type, frequency, and duration of treatment with scientifically-based guidelines of national medical research, professional medical specialty organizations, or governmental agencies that are generally accepted as national authorities on the services, supplies, equipment, or facilities for which coverage is requested; (v) consistent with the diagnosis of the condition at issue; (vi) required for reasons other than the comfort or convenience of the Participant or his or her physician; and (vii) not Experimental or Investigational as defined in this Plan Document.

Medication Management Visit

A visit no more than twenty (20) minutes in length with a Provider with prescriptive authority. The sole purpose of this visit is to monitor and adjust drugs prescribed for a psychiatric condition. If such a visit is more than twenty (20) minutes, it shall be treated as a psychiatric services visit.

Medicare

The Health Insurance For The Aged and Disabled program under Title XVIII of the Social Security Act, as amended.

Non-Formulary Drugs

Non-preferred Prescription Drugs that are not listed on the Formulary. Most Non-Formulary Drugs are covered at a higher (Tier 3) copayment.

Non-Participating Provider

A health care Provider or facility that has not directly or indirectly contracted with the Plan or its Claims Administrator to participate in its network.

Out-of-Network

Pertaining to the payment level for services received from a Non-Participating Provider.

Out-of-Network Rate

The amount the Plan pays for Covered Services furnished by Non-Participating Providers, unless such services are Preauthorized at the In-Network level of benefits. The Out-of-Network Rate is based on: a defined Virginia Medicare fee schedule, a fixed per diem rate, a Virginia St. Anthony's fee schedule, or a fixed percentage of billed charges. The type and place of service determines the applicable schedule/rate. The Claims Administrator's Allowable Charge policy provides further details on the determination/calculation of Out-of-Network Rates. Participants may contact Customer Service to request a copy of the current Allowable Charge policy or to inquire about specific services and the applicable Out-of-Network Rates. Participants enrolled in an HMO plan do not have coverage Out-Of-Network except for medical emergencies or when services have been Preauthorized at the In-Network level of benefits.

Out-of-Pocket Maximum

The limit on the amount a covered Employee and covered Dependents must pay out of their pocket for specified Covered Charges in a Calendar Year. Please refer to Section 5 and Section 6.

Outpatient Care and/or Services

Treatment including services, supplies and medicines provided and used at a Hospital under the direction of a Physician to a person not admitted as a registered bed patient; or services rendered in a Physician's office, laboratory or X-ray facility, an Ambulatory Surgical Center, or the patient's home.

Partial Day Program (Partial Hospitalization)

This term means either of the following:

- A day or evening treatment program. It includes the major diagnostic, medical, psychiatric, and psychosocial rehabilitation treatment modalities designed for psychiatric or Substance Abuse patients. Patients require coordinated, intensive, comprehensive, and multi-disciplinary treatment. Programs last six (6) or more continuous hours per day. Such program must either be licensed by the state in which it operates or must be one offered by a contracting Mental Health or Substance Abuse Provider.
- An intensive outpatient program for the treatment of alcohol or drug dependence. This program provides care for three (3) or more continuous hours per day. Such program must either be licensed by the state in which it operates, or it must be one offered by a contracting Mental Health or Substance Abuse Provider.

Participant

Any Employee, Retiree or Dependent who is covered under this Plan.

Participating Provider/Provider Network

A Physician, Hospital, Skilled Nursing Facility, pharmacy, or other duly licensed institution, health professional, or organization of duly licensed health care institutions and/or health professionals that has directly or indirectly contracted with the Plan or its Claims Administrator to participate in its network. The

Participant should consult the Directory of Health Care Providers for a listing of these Participating Providers/Provider Networks; however, be aware that the information in the Directory is subject to change. Participants may search for health care Providers online at the Claims Administrator's website (www.Southernhealth.com) or they may call Customer Service for assistance.

Note: Specific providers may be contracted for specific services. For example, see transplant network in Section 6 and Vision Benefit in Section 9.

Peer-Reviewed Medical Literature

A scientific study published only after having been critically reviewed for scientific accuracy, validity, and reliability by unbiased independent experts in a journal that has been determined by the International Committee of Medical Journal Editors to have met the Uniform Requirements for Manuscripts submitted to biomedical journals. Peer-Reviewed medical literature does not include publications or supplements to publications that are sponsored to a significant extent by a pharmaceutical manufacturing company or health carrier.

Physician

A Doctor of Medicine (M.D.), Doctor of Osteopathy (D.O.), Doctor of Podiatry (D.P.M.), Doctor of Chiropractic (D.C.), Audiologist, Certified Nurse Anesthetist, Licensed Professional Counselor, Licensed Professional Physical Therapist, Master of Social Work (M.S.W.), Midwife, Occupational Therapist, Physiotherapist, Psychiatrist, Psychologist (Ph.D.), Speech Language Pathologist and any other practitioner of the healing arts who is licensed and regulated by a state or federal agency and is acting within the scope of his or her license.

Preauthorization/Preauthorized

Approval by the Claims Administrator that is required for payment for certain services to be performed. Preauthorization does not guarantee payment if the Participant is not covered at the time the service is provided. Preauthorization does not guarantee payment at the In-Network benefit level for services rendered by Non-Participating Providers.

Pregnancy

Childbirth and conditions associated with Pregnancy, including complications.

Prescription Drug

A drug approved by the FDA for a specific outpatient use and that is dispensed only pursuant to a Prescription Order or Refill (a Legend Medication) under applicable law. Prescription Drugs include contraceptive drugs and devices and some over-the-counter medications or disposable medical supplies specified by the Plan (for example, insulin and certain diabetic supplies).

Prescription Order or Refill

The authorization for a Prescription Drug issued by an Authorized Prescriber.

Preventive Care Guidelines

Preventive Care Guidelines are established by the Plan and updated at least annually. They are made available to Participating Providers and Participants upon request and are also available on the Claims Administrator's website.

Preventive Care Services

Preventive Care Services are Covered Services provided to prevent or arrest the further manifestation of Illness or Injury. These services include, but may not be limited to: periodic health evaluations, including

tests and diagnostic procedures in connection with routine examinations, such as adult physical examinations and well-woman examinations; well-child examinations; preventive adult and child immunizations; and mammography. Services do not include any service or benefit intended to treat an existing illness, injury or condition.

Provider

A doctor, Hospital, Skilled Nursing Facility, home health agency, or other duly licensed institution or health professional including:

- Chiropractor
- Optometrist
- Optician
- Professional Counselor
- Psychologist
- Clinical Social Worker
- Podiatrist
- Registered Physical Therapist
- Clinical Nurse Specialist in Psychiatric Mental Health
- Audiologist
- Speech Pathologist
- Certified Nurse Midwife
- Licensed Marriage or Family Therapist
- Licensed Acupuncturist
- Licensed Pharmacist
- Dentist

Prudent Layperson

A person who is without medical training and who draws on his or her practical experience when making a decision regarding whether Emergency medical treatment is needed. A Prudent Layperson will be considered to have acted “reasonably” if other similarly situated laypersons would have believed, on the basis of observation of the medical symptoms at hand, that Emergency medical treatment was necessary.

Retiree

Shall mean a former Employee of the Employer who meets the definition of retired Employees to whom the Employer offers coverage under this Plan Document.

Schedule of Benefits

A schedule of covered benefits, fully discussed in this Plan Document, which delineates the Participant’s Copayments, Coinsurance, Deductibles, Out-of-pocket Maximums, and other benefit limitations.

Self-Administered Injectable Drugs

Injectable Prescription Drugs that are commonly and customarily administered by the Participant. Examples of Self-Administered Injectable Drugs include but are not limited to the following: multiple sclerosis agents, growth hormones, colony stimulating factors given more than once monthly, chronic medications for hepatitis C, certain rheumatoid arthritis medications, certain injectable HIV drugs, certain osteoporosis agents, and heparin products. Self-Administered Injectable Drugs are obtained from a Specialty Pharmacy. The following are not considered Self-Administered Injectable Drugs because they are not obtained from a Specialty Pharmacy: insulin, glucagon, bee sting kits, Imitrex and injectable contraceptives.

Service Area

Areas in Virginia and West Virginia where Participating Providers are located.

Short-Term Rehabilitative Therapy

Physical, speech and occupational therapy provided on an inpatient or an outpatient basis if significant improvement can be expected.

Skilled Nursing Facility

An institution or a distinct part of an institution that primarily provides inpatient skilled nursing care and related services or rehabilitation services to injured, disabled or sick persons.

Specialist

A physician who provides medical services to Participants within the range of a medical specialty.

Specialty Pharmacy

A pharmacy that has a contract with the Plan or its Claims Administrator, and is designated as a Specialty Pharmacy by the Plan or its Claims Administrator for Participants to obtain Self-Administered Injectable Drugs.

Spinal Manipulation/Chiropractic Care

Skeletal adjustments, manipulation or other treatment in connection with the detection and correction by manual or mechanical means of structural imbalance or subluxation in the human body. Such treatment is done by a Physician to remove nerve interference resulting from, or related to, distortion, misalignment or subluxation of, or in, the vertebral column.

Standard Reference Compendia

The American Hospital Formulary Service Drug Information or the United States Pharmacopoeia Dispensing Information.

Substance Abuse

Regular excessive compulsive drinking of alcohol and/or physical habitual dependence on drugs. This does not include dependence on tobacco and ordinary caffeine-containing drinks.

Temporomandibular Joint (TMJ) Syndrome

The treatment of jaw joint disorders including conditions of structures linking the jaw bone and skull and the complex of muscles, nerves and other tissues related to the temporomandibular joint.

Total Disability (Totally Disabled)

In the case of a Dependent child, incapable of self-sustaining employment by reason of mental or physical handicap, primarily dependent upon the covered Employee for support and maintenance and unmarried.

Urgent Care

Urgent Care is Medically Necessary care for an unexpected Illness or Injury that a Participant needs sooner than a routine doctor's visit.

SECTION 11 PLAN EXCLUSIONS

The Plan does not cover any service or supply that is not Medically Necessary or any service or supply that is not a Covered Service or that is a direct result of receiving a non-covered service. For Participants enrolled in one of the HMO plans, services obtained from or ordered by Non-Participating Providers in a non-emergency setting without Preauthorization from the Claims Administrator as described in Section 7 of this Plan Document are not covered. This applies even when the plan is paying secondary. In addition the following services are specifically excluded:

Administrative Examinations/Immunizations: examinations or immunizations for employment, travel, school, camp, sports, licensing, insurance, adoption, marriage or those ordered by a third party.

Administrative Services: charges made to Participants by Providers for failure to appropriately cancel a scheduled appointment, telephone calls, completion of forms, transfer of records, copying of medical records or generation of correspondence.

Alternative Medicine: services or supplies related to alternative or complementary medicine. Services in this category may include, but are not limited to: hypnotherapy; acupuncture; sleep therapy; behavior training; recreational therapy (dance, arts, crafts, aquatic, gambling and nature therapy); hair analysis; holistic medicine; homeopathy; aroma therapy; massage therapy; herbal, vitamin, or dietary products or therapies.

Behavioral Health and Substance Abuse:

- Long term Mental Health care
- Residential Treatment
- Psychiatric evaluation or therapy when related to judicial or administrative proceedings or orders, when Employer requested, or when required for school
- Educational testing or psychological testing, unless part of a treatment program for Covered Services
- Marriage or relationship counseling; vocational or employment counseling
- Treatment of mental retardation and learning disabilities is not covered under Behavioral Health and Substance Abuse benefits.
- Any other services listed in this Plan Document as noncovered services that could be considered Behavioral Health services.

Bionic Devices (microprocessor controlled prosthetics) including, but not limited to, C-Leg.

Blood drawing, preparation and storage of umbilical cord blood.

Braces and supports needed for athletic participation or for employment.

Charges in excess of any benefit limitations

Cosmetic treatment and surgery performed mainly to improve a Participant's appearance or for psychological benefits

Custodial Care, including inpatient or outpatient Custodial Care, nursing home care, respite care, rest cures, domiciliary or convalescent care and all related services

Dental services or related expenses incurred as a result of the provision of dental services (performed in a Hospital or Outpatient Care facility) including:

- Dental or oral appliances or devices, including but not limited to, bite guards for teeth grinding, dental implants, dentures, and oral appliances for snoring regardless of Medical Necessity.
- Treatment of diseases of the teeth or gums except as allowable as a defined in Section 6.
- Oral surgery which (1) is part of an orthodontic treatment program, (2) is required for correction of an occlusal defect, or (3) is not specifically covered in this Plan Document or any amendments thereto. Shortening of the mandible or maxillae for cosmetic or orthodontic purpose, correction of malocclusion, and surgical orthodontics or orthognathices also are not covered except as stated in Section 6.
- Soft tissue impactions (wisdom tooth extraction).

Donor: procedures involving Participant's organ and tissue donors, unless the recipient is a Participant or as stated in Section 6. Charges for tests and procedures related to donor searches.

Educational classes, programs, and support groups including, but not limited to, prenatal courses, marital counseling, self-help training and other non-medical self care and those dealing with lifestyle changes.

Experimental/Investigational: Except as covered in Section 6 under "Clinical Trials", medical, surgical or other health care procedures, services or supplies are considered Experimental or Investigational if any of the following applies:

- Is in the testing stage or in early field trials on animals or humans.
- Is under clinical investigation by health professionals or are undergoing clinical trials by any governmental agency, including but not limited to, the Department of Health and Human Services or the Food and Drug Administration. Drugs for the treatment of a specific type of cancer that are not FDA approved will be covered when they are approved for one type of cancer and the drug has been recognized as safe and effective for treatment of the specific type of cancer for which the drug has been prescribed in any of the Standard Reference Compendia. Similarly drugs for the treatment of a specific indication that are not FDA approved will be covered so long as the drug has been approved by the United States Food and Drug Administration for at least one indication and the drug is recognized for treatment of the covered indication in one of the Standard Reference Compendia or in substantially accepted Peer-Reviewed medical literature.
- Is a health product or service that is subject to Investigational Review Board (IRB) review or approval.
- Is a health product or service that is the subject of a clinical trial not meeting the criteria for coverage defined in the "Clinical Trials" section under Covered Benefits.
- Does not have required final federal regulatory approval for commercial distribution for the specific indications and methods of use assessed or has not been approved by the Centers for Medicare and Medicaid Services for coverage by Medicare.
- Is a health product or service that is not considered to have demonstrated value based on clinical evidence reported by Peer-Review Medical Literature and by generally recognized academic experts.

Eye:

- Routine eye exams, refractions for eyeglasses or contact lenses, and all services associated with eyeglasses or contact lenses, except as covered under Section 9.
- Services for, or related to, eye surgery for the purpose of correcting refractive errors such as radial keratotomy, lasik, and other refractive and laser eye surgeries or vision correction procedures except as covered under Section 9
- Eye exercises
- Visual augmentation devices
- Vision therapy

Foot:

- Services for weak, strained, flat, unstable, or unbalanced foot or for a metatarsalgia or bunion. This does not apply to a surgical procedure.
- Routine foot care including trimming of hyperkeratotic lesions, calluses, and nails, except for foot care for diabetics.
- Foot orthotics, arch supports, corrective shoes, shoe inserts, heel elevations and fittings for such devices.

Genetic Testing/Counseling: parental screening and related genetic counseling for genetic predisposition either before or after conception, except for genetic testing for cystic fibrosis; pre-implantation genetic testing.

Growth Hormone, Growth Hormone for idiopathic short stature or for individuals over age eighteen (18) is not covered.

Hearing Aids.

Infertility: surgical or medical treatment of infertility is not covered. This includes services, office visits, lab and diagnostic tests, and procedures to promote conception once a diagnosis of infertility has been established. In the absence of a confirmed diagnosis of infertility, coverage for these services ends when drugs are prescribed or surgeries are performed to correct the condition. Treatment to promote conception by artificial means including, but not limited to, in vitro fertilization, gamete intrafallopian transfer (GIFT), zygote intrafallopian transfer (ZIFT), artificial insemination and embryo transfers; human chorionotropin, urofollitropin, menotropins or derivatives; cost of donor sperm, services for sperm collection or sperm preservation are not covered. Infertility services not specifically described as covered are not covered.

Medical Equipment, appliances, devices and supplies. The Plan does not include benefits for medical equipment, appliances, devices and supplies that have both a therapeutic and non-therapeutic use. These include: elastic or leather braces or supports; splints; canes; traction apparatus; cranial helmets; cervical collars; corsets; batteries and battery chargers; exercise equipment; equipment or services for use in altering air quality or temperature including, but not limited to, air conditioners, filters, humidifiers, dehumidifiers, bedliners, and mattress covers; other special supplies, appliances, and equipment such as office chairs, sun or heat lamps, whirlpool baths, and heating pads; rental or purchase of TENS units; personal hygiene, comfort, and convenience items including but not limited to grab/tub bars, tub benches, breast pumps, telephone, television, guest meals and accommodations, take home medications, and supplies; home improvement items, including but not limited to, escalators, elevators, ramps, stair glides or Emergency alert equipment; and expenses incurred at a health spa, gym or similar facility. An office visit for the purpose of fitting for a noncovered device or supply is not covered.

Newborn: Hospital and Physician charges for newborns for the birth and inpatient stays or any subsequent services when the newborn is not enrolled in the plan within 31 days of birth.

Nutritional formula or supplements, tube feeding and medical foods even if provided as the sole source of nutrition.

Out-of-Network: charges in excess of the Allowable Charge are not covered and will not accrue to the Out-of-Pocket Maximum.

Pregnancy: Implantation services for any reason.

Private duty nursing.

Private room unless Medically Necessary or if a semi-private room is not available.

Rehabilitation: long-term rehabilitation therapy; pulmonary rehabilitation.

Research: services for medical research, unless the services are specifically listed as covered elsewhere in this Plan Document.

Robotics: Charges related to robotics assistance during surgery are not covered.

Services or Supplies. The Plan does not include benefits for services or supplies if they are:

- The result of injuries sustained during the commission of an illegal act.
- Services rendered as a result of a Temporary Detention Order (TDO).
- Services or supplies related to care for conditions which state or local law require be treated in a public facility; care for military service connected disabilities for which the Participant is legally entitled to services when facilities are reasonably available to the Participant.
- Services received following the effective date of the termination of the Participant's coverage under the Plan.
- Services rendered outside the scope of a Participating or Non-Participating Provider's license, rendered by a Provider with the same legal residence as the Participant, or rendered by a person who is a Participant of the Participant's family including a spouse, brother, sister, parent, step-parent, child or step-child.

Sexual Dysfunction, Sexual Aids or Sex Transformation: treatment for **sexual dysfunction, sexual aids, or sex transformation** or the reversal thereof. This includes medical and Behavioral Health services.

Sterilization: the reversal of sterilization.

Stockings: elastic hose, graduated compression (TED) hose, Jobst stockings.

Testicular Implants.

Therapy. The following types of rehabilitative therapy are not covered, although this list is not meant to be exclusive:

- **Physical or Occupational Therapy** for the purpose of behavior modification or for improving performance in school or sports
- **Occupational Therapy** for the purpose of treating sensory hypersensitivity
- **Sensory Integration Therapy**

Travel and Transportation other than Medically Necessary transportation that has been Preauthorized by the Claims Administrator.

Weight reduction: dietary supplements or programs for weight reduction. Medical or psychiatric services, office visits, and associated charges for procedures primarily performed for the treatment of obesity or weight reduction, including but not limited to, gastric bypasses, "mini" gastric bypasses, stomach stapling, gastric balloons, jejunal bypasses, gastric banding, gastroplasty, Biliopancreatic Diversion Duodenal Switch (BPD-DS), and bariatric Specialist services.

Work related injuries or illnesses, including those injuries that arise out of or in any way result from an illness or injury that is work-related.

SECTION 12 HOW TO SUBMIT A CLAIM

Benefits under this Plan shall be paid only if the Claims Administrator decides in its discretion that a Participant is entitled to them.

Claims for services rendered by Non-Participating Providers that qualify as Benefits should be sent to:

Southern Health Services, Inc., Claims Department, P.O. Box 7704, London, KY 40742

If a charge is made to a Participant for any service that is reimbursable under this Plan, written proof of such charge shall include an itemized statement and diagnosis and must be submitted to Health Plan within 365 days after the delivery of the service. Such services must have been provided in accordance with the Plan's utilization management and Preauthorization policies and procedures. Failure to furnish such documentation within the specified period shall invalidate or reduce any such claim unless for good reason, as determined by the Plan, it was not possible to submit the claim within the specified period, provided such proof is produced in a timely basis.

The Plan may make payment to the person or institution providing the services, or at the Plan's discretion may make payment directly to the Participant. However, if the Covered Employee furnishes evidence satisfactory to the Plan that payment has been made to such person or institution for the service covered, reimbursement will be made to the Covered Employee after deducting any payment made by the Plan before receipt of such evidence. The Plan will reimburse up to the Out-of-Network Rate for services rendered.

The Plan at its own expense shall have the right to require that a Participant whose sickness or Injury is the basis of a claim under this Plan Document, be examined by a Participating Physician or other health care Provider of the Plan's choosing when and as often as the Plan may reasonably require.

No legal action for reimbursement of a claim for payment for services may be initiated prior to the exhaustion of the Plan's appeals procedures. No legal action for reimbursement of a claim for payment for services may be initiated more than three (3) years after the expiration of the date of service of the claim at issue.

When Claims Should Be Filed

Claims should be filed with the Claims Administrator within 365 days of the date charges for the service were incurred. Benefits are based on the Plan's provisions at the time the charges were incurred. Claims filed later than that date may be declined unless:

- (a) it is not reasonably possible to submit the claim in that time; and
- (b) the person is not legally capable of submitting the claim in that time.

The Claims Administrator will determine if sufficient information has been submitted to enable proper consideration of the claim. If not, more information may be requested from the claimant. The Plan reserves the right to have a Participant seek a second medical opinion.

A request for Plan benefits will be considered a claim for Plan benefits, and it will be subject to a full and fair review. If a claim is wholly or partially denied, the Claims Administrator will furnish the Plan Participant with a written notice of this denial. This written notice will be provided within 90 days after receipt of the claim. The written notice will contain the following information:

- (a) the specific reason or reasons for the denial;
- (b) specific reference to those Plan provisions on which the denial is based;

- (c)** a description of any additional information or material necessary to correct the claim and an explanation of why such material or information is necessary; and
- (d)** appropriate information as to the steps to be taken if a Plan Participant wishes to submit the claim for appeal.

SECTION 13 CLAIMS REVIEW PROCEDURES

13.1 Claims

A Claim is defined as any bill, claim, or proof of loss made by or on behalf of a Participant or a Provider to the Plan's Claims Administrator.

There are different kinds of Claims (Urgent Care, Pre-Service, and Post-Service) and each one has a specific timetable for approval, payment, request for further information, or denial of the Claim. "Days" mean calendar days. If you have any questions regarding the Claims review procedure, please contact the Claims Administrator.

The types of Claims are:

Urgent Care Claim

A Claim involving Urgent Care is any Claim for medical care or treatment where using the timetable for a non-urgent care determination could seriously jeopardize the life or health of the claimant; or the ability of the claimant to regain maximum function; or in the opinion of the attending or consulting Physician, would subject the claimant to severe pain that could not be adequately managed without the care or treatment that is the subject of the Claim.

A Physician with knowledge of the claimant's medical condition may determine if a Claim is one involving Urgent Care. If there is no such Physician, an individual acting on behalf of the Plan applying the judgment of a Prudent Layperson who possesses an average knowledge of health and medicine may make the determination.

In the case of a Claim involving Urgent Care, the following timetable applies:

Notification to claimant of benefit determination 72 hours

Insufficient information on the Claim or failure to follow the Plan's procedure for filing a Claim:

Notification to claimant, orally or in writing 24 hours

Response by claimant, orally or in writing 48 hours

Benefit determination, orally or in writing 48 hours

Notifications for ongoing courses of treatment:

Reduction or termination before the end of treatment..... 72 hours

Determination as to extending course of treatment 24 hours

If there is an adverse benefit determination on a Claim involving Urgent Care, a request for an expedited appeal may be submitted orally or in writing by the claimant. All necessary information, including the Plan's benefit determination on review, may be transmitted between the Claims Administrator and the claimant by telephone, facsimile, or other similarly expeditious method.

Pre-Service Claim

A Pre-Service Claim means any Claim for a benefit under this Plan where the Plan conditions receipt of the benefit, in whole or in part, on approval in advance of obtaining medical care. These are, for example, Claims subject to Preauthorization. Please see the Utilization Management Services (Section 7) of this Plan document for further information about Preauthorization of services.

In the case of a Pre-Service Claim, the following timetable applies:

Notification to claimant of benefit determination 15 days
Extension due to matters beyond the control of the Plan..... 15 days

Insufficient information on the Claim:

Notification of 15 days
Response by claimant 45 days

Notification, orally or in writing, of failure to follow procedures for filing a Claim: 5 days

Notification for ongoing courses of treatment:

Reduction or termination before the end of the treatment..... 15 days
Request to extend course of treatment 15 days
Review of adverse benefit determination 30 days
Reduction or termination before the end of the treatment..... 15 days
Request to extend course of treatment 15 days

Post-Service Claim

A Post-Service Claim means any Claim for a benefit under this Plan that is a request for payment for covered medical services already received by the claimant.

In the case of a Post-Service Claim, the following timetable applies:

Notification to claimant of benefit determination 30 days
Extension due to matters beyond the control of the Plan..... 15 days
Extension due to insufficient information on the Claim..... 15 days
Response by claimant following notice of insufficient information 45 days
Review of adverse benefit determination 60 days

13.2 Notice to Claimant of Adverse Benefit Determinations

Except with Urgent Care Claims, when the notification may be oral followed by written or electronic notification within three days of the oral notification, the Claims Administrator shall provide written or electronic notification of any adverse benefit determination. The notice will state, in a manner calculated to be understood by the claimant:

- (1) The specific reason or reasons for the adverse determination.
- (2) Reference to the specific Plan provisions on which the determination was based.
- (3) A description of any additional material or information necessary for the claimant to perfect the Claim and an explanation of why such material or information is necessary.
- (4) A description of the Plan's review procedures and the time limits applicable to such procedures.
- (5) A statement that the claimant is entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the Claim.
- (6) If the adverse benefit determination was based on an internal rule, guideline, protocol, or other similar criterion, the specific rule, guideline, protocol, or criterion will be provided free of charge. If this is not practical, a statement will be included that such a rule, guideline,

protocol, or criterion was relied upon in making the adverse benefit determination and a copy will be provided free of charge to the claimant upon request.

- (7) If the adverse benefit determination is based on the Medical Necessity or Experimental or Investigational treatment or similar exclusion or limit, an explanation of the scientific or clinical judgment for the determination, applying the terms of the Plan to the claimant's medical circumstances, will be provided. If this is not practical, a statement will be included that such explanation will be provided free of charge, upon request.

13.3 Complaint and Appeal Procedures

The Plan maintains both complaint and appeal procedures, administered by the Claims Administrator to resolve Participant inquiries, complaints, and appeals. All claims of any nature against the Plan, the Claims Administrator, their employees, agents, board members, or officers, whether filed by a Participant or the Authorized Representative, must first proceed through the complaint and appeal procedures. It is expressly understood that no action or proceeding may be pursued in court until the administrative remedies as provided in the complaint and appeal procedures are exhausted.

Providers may also file complaints and appeals on their own behalf. They have a separate appeals process, which is outlined in their Provider Manual provided by the Claims Administrator.

No Participant who exercises the right to file a complaint or appeal shall be subject to termination or otherwise penalized due to the filing of a complaint or appeal.

13.4 Informal Inquiry Process

Most Complaints begin as an informal inquiry. Participants should direct informal inquiries to the Plan by calling the Claims Administrator's Customer Services Department Monday through Friday from 8:00 a.m. to 5:00 p.m. at the telephone number listed below:

Toll-free: (866) 533-5149

A Customer Service Associate will review, research and resolve the inquiry. The Participant will be informed of the resolution within thirty (30) days. At the time of resolution, if the decision is adverse to the Participant, the Participant will be advised of his/her right to file a Complaint. Participants also have the right to bypass the informal inquiry procedures and immediately file a Complaint.

13.5 Filing a Complaint

If a Participant wishes to file a Complaint regarding a person, service, the quality of care, or the contractual benefits, he can express his concerns in writing at the following address:

Southern Health Services, Inc.
Attention: Customer Service Department
P.O. Box 7704
London, Kentucky 40742
(866) 533-5149
Fax: (302) 283-6785

Complaints must be received within ninety (90) calendar days of the date written notification of the issue that is the basis of the complaint or of the incident that gave rise to the complaint was received. All complaints will be initially addressed at staff level. Complaint records will be maintained for no less than five (5) years.

13.6 Communication and Resolution

A complaint that involves a Physician or other contracted Provider will require information from that Provider in the resolution of the complaint. Complaints involving an institutional or ancillary Provider will be forwarded to the Provider for review through the Provider's internal appeal process. The Claims Administrator will monitor the Provider's resolution process and will require the Provider to communicate its decision.

General complaints about Providers (for example, matters involving interactions with office staff or referral matters or provider access complaints) are forwarded to the Claims Administrator's Quality Improvement Staff. Complaints related to administrative issues or coverage decisions where Medical Necessity is not an issue are handled by Customer Service. If the complaint is not valid according to the applicable contract, a staff representative will contact the Participant or the Participant's Authorized Representative to explain the Plan's position. If the concern is valid according to the applicable contract, a staff representative will respond with a description of the corrective action that will be taken and initiate the appropriate steps to implement the action.

Complaint determinations will be made within thirty (30) calendar days of receipt of the complaint.

13.7 Appeals

Appeals should be sent to the Claims Administrator's Appeals Coordinator at the following address:

Southern Health Services, Inc.
Attention: Appeal Coordinator
9881 Mayland Drive
Richmond, VA 23233
(866) 533-5149
Fax Number: (804) 747-8836

The appeal must include the following:

- Participant's name and mailing address
- Provider's name
- Date of the service if the service has already been provided, or if the service has not yet been provided, a description of the service for which Preauthorization was requested and denied
- An explanation of why the Plan should consider reversing the original decision
- A copy of any information that will support the Participant's request
- In cases where the Participant's Authorized Representative is appealing on the Participant's behalf, a completed Authorized Representative form supplied by the Claims Administrator.

Administrative Adverse Benefit Determination Appeals - Level I

Level I administrative Appeals must be received within one hundred eighty (180) calendar days of the date the Participant receives written notification of the denial. A letter notifying the Participant that the appeal has been received will be sent within five (5) working days of its receipt.

A First Level Appeal Committee consisting of one or more of the Claims Administrator's managers or their representatives will review appeals of Adverse Administrative Decisions. None of these individuals will have been involved in the initial decision. If the appeal is a Pre-service Appeal, the Appellant will be notified of the First Level Appeal Committee's decision within fifteen (15) calendar days of the date the Claims Administrator received the appeal request. If the appeal is a Post-service Appeal, the Appellant will be notified of the First Level Appeal Committee's decision within thirty (30) calendar days of the date the Claims Administrator received the appeal request.

Adverse Administrative Decisions Appeals - Level II

For both Pre-service Appeals and Post-service Appeals of Adverse Administrative Decisions, if the Appellant is not satisfied with the Level I appeal decision, he or she may request in writing a Level II appeal within thirty-one (31) calendar days of the date the Participant received the notice of the Level I appeal decision.

The Second Level Appeal Committee is comprised of one or more members of the Claims Administrator's director level or above management staff. For Pre-service Appeals, Level II appeal hearings will be held and decision letters sent within fifteen (15) calendar days of the date the Claims Administrator received the second level appeal request. For Post-service Appeals, Level II appeal hearing will be held and decision letters sent within thirty (30) calendar days of the date the Claims Administrator received the second level appeal request. In both cases, decision letters will be sent no later than five (5) working days after the decision was made. The Appellant has the option to meet in person with the Second Level Appeal Committee or via phone or to have the case reviewed based on the available written documentation. This level constitutes the final attempt at resolution within the Claims Administrator's Participant Administrative Complaint and Appeal Procedures.

Adverse Decisions: Decisions Involving Utilization Review/ Medical Judgment Decisions

In cases where an Adverse Decision is rendered, the medical aspect of the decision will be reviewed to determine Medical Necessity or Experimental/Investigational. To assist in making a Medical Necessity or Experimental/Investigational determination, the Claims Administrator, on behalf of the Plan, has developed standards and criteria that are objective, clinically valid, and compatible with established standards of health care. If the Participant would like to review the complete utilization review procedures, please contact the Claims Administrator's Customer Service Department. The Participant's compliance with any portion of the utilization review process is not a guarantee of benefits or payment.

Reconsideration of an Adverse Decision

If a Participant is dissatisfied with an Adverse Decision, he or she may request in writing an optional Reconsideration of the Adverse Decision or may choose to move directly to an appeal of an Adverse Decision. Should the Participant choose a Reconsideration of an Adverse Decision, the Participant still has a right to appeal as described below.

Requests for Reconsideration must be received within ninety (90) calendar days of the date of the written notification of the denial. The request for Reconsideration should be sent to the same address as listed for appeals.

If the Participant or the Participant's Authorized Representative chooses to request a Reconsideration of a Medical Necessity determination, a decision is made by either the Claims Administrator's Medical Director, a Physician Advisor, a peer of the treating Provider who is licensed in that Provider's same or similar specialty, or a panel of other appropriate health care Providers with at least one Physician Advisor or peer of the treating health care Provider on the panel. Notice of the decision will be provided to both the Participant or the Participant's Authorized Representative and the Participant's Provider in writing within two (2) working days of the decision, but no longer than ten (10) working days following the Claims Administrator's receipt of the request. This notification will include the criteria used in making the decision, the clinical reason for the Adverse Decision, alternate length of treatment of any alternate treatment recommended, and the ability to appeal this decision.

Appeals of an Adverse Decision

If the Participant is not satisfied with the Claims Administrator's Adverse Decision or with the outcome of the Reconsideration, the Participant or the Participant's Authorized Representative may request an appeal within one hundred eighty (180) calendar days of the date the Participant received the initial notice of the Adverse Decision.

The appeal will be reviewed by a panel that includes a Physician Advisor or peer of the treating Provider who is licensed in that Provider's same or similar specialty and (i) did not take part in any

of the previous reviews; (ii) is not employed by nor a director of the Claims Administrator; and (iii) is either licensed in Virginia as a peer of the treating Provider or under comparable law in a state within the United States as a peer of the treating Provider.

For Pre-service Appeals, the Appellant and the treating Provider will be notified of the results of this review within thirty (30) calendar days of the date the Claims Administrator received the request for the appeal.

For Post-service Appeals, the Appellant and the treating Provider will be notified of results of this review within sixty (60) calendar days of the date the Claims Administrator received the request for the appeal. Any final Adverse Decision will state the criteria used in and the clinical reason for the decision. The Participant has the right to request the criteria which will be provided at no cost to the Participant.

Expedited Appeals

When appropriate, the Participant or the Participant's Authorized Representative may request an Expedited Appeal. The Claims Administrator will immediately notify the Appellant of the decision to deny a request for Expedited Appeal of an Adverse Decision by telephone or facsimile.

If the Claims Administrator, on behalf of the Plan, determines that it will consider the Expedited Appeal, the decision will be made within one (1) working day after receipt of all information needed to make the decision, and no later than three (3) working days of the time of the request regardless of whether or not all required information has been received. However, a case relating to prescriptions for the alleviation of cancer pain shall be determined in twenty-four (24) hours or less from the time of the request.

13.8 Definitions Relating to the Complaint and Appeal Procedures

For the purposes of this Section the following definitions apply:

Administrative Adverse Benefit Determination: Any Adverse Benefit Determination that is not an Adverse Decision.

Adverse Benefit Determination: A denial of a request for benefits or a failure to provide or make payment (in whole or in part) for a benefit. An Adverse Benefit Determination also includes any reduction or termination of a benefit. An Adverse Benefit Determination based in whole or in part on medical judgment, including the failure to cover services because they are determined to be Experimental/Investigational or not Medically Necessary, is also considered an Adverse Decision.

Adverse Decision: An Adverse Decision is a type of Adverse Benefit Determination involving a utilization review determination by the Claims Administrator that the health care service rendered or proposed to be rendered was or is not Medically Necessary and/or is Experimental/Investigational, when such determination may result in noncoverage of the health care service.

Appeal: An Appeal is a request by the Participant or the Participant's Authorized Representative for consideration of an Adverse Benefit Determination of a health service or request or benefit that the Member believes he or she is entitled to receive. The Appeal must be received by the Plan within one hundred and eighty (180) calendar days after the Participant's receipt of the Adverse Benefit Determination for it to be considered an Appeal. The Appeals procedures give Participants the opportunity to ask the Claims Administrator to review any matter related to:

- Issues about the scope of coverage for health care services
- Medical Necessity of services requested
- Denial of coverage or
- Other Adverse Benefit Determinations, as defined in this Section.

Appellant: The Participant or the following persons may be considered an Appellant: (1) the individual authorized by the Participant in writing to act on the Participant's behalf for the appeals

process (2) the Participant's spouse, parent, committee, Legal Guardian, or other individual authorized by law to act on the Participant's behalf if the Participant is not a minor but incompetent or incapacitated.

Authorized Representative: An Authorized Representative is an individual authorized in writing by the Participant or state law to act on the Participant's behalf in obtaining claim payment or during the Appeal process. A Participating Provider may always act on the Participant's behalf. A Non-Participating Provider may also act on the Participant's behalf with the Participant's express written consent.

Complaint: A Complaint is an inquiry to the Claims Administrator about Covered Services, Participant rights or other issues or the communication of dissatisfaction about the quality of service or benefit or other issue which is not an Adverse Benefit Determination. Complaints do not involve utilization review decisions. The Complaint procedures give Participants the opportunity to ask the Claims Administrator to review any matter related to:

- The quality of health care service received
- General inquiries about Covered Services or benefit plan structure
- Participant rights

Expedited Appeal: An Expedited Appeal is an appeal for which a requested service requires Preauthorization, an Adverse Benefit Determination has been rendered, the requested service has not been provided, and the application of non-Expedited Appeal time frames could seriously jeopardize: (a) the life or health of the Participant, or in the case of a pregnant Participant, the Participant's unborn child; or (b) the Participant's ability to regain maximum function. In determining whether an appeal should be expedited, the Claims Administrator, on behalf of the Plan must apply the judgment of a Prudent Layperson who possesses an average knowledge of health and medicine. An Expedited Appeal is also an appeal involving (a) care that the treating Physician deems urgent in nature; (b) the treating Physician determines that a delay in the care would subject the Participant to severe pain that could not adequately be managed without the care or treatment that is being requested; or (c) the Participant is a cancer patient and the delay would subject the Participant to pain. Such appeal may be made by telephone, facsimile or other available similarly expeditious method. These appeals may also be called Urgent Care appeals.

Physician Advisor: A Physician Advisor is a Physician licensed to practice medicine in Virginia or under a comparable licensing law of a state of the United States and who provides advice regarding the medical necessity of a service to the Claims Administrator or to the Plan as part of the Plan's utilization review activities.

Post-service Appeal: A Post-service Appeal is an appeal for which an Adverse Benefit Determination has been rendered for a service that has already been provided.

Pre-service Appeal: A Pre-service Appeal is an appeal for which a requested service requires Preauthorization, an Adverse Benefit Determination has been rendered, and the service has not been provided.

Reconsideration: A review of an Adverse Decision by either the Claims Administrator's Medical Director, a Physician Advisor, a peer of the treating Provider who is licensed in the Provider's same or similar specialty, or a panel of other appropriate health care Providers with at least one Physician Advisor or peer of the treating health care Provider on the panel. The Participant or the Participants Authorized Representative may request the Reconsideration. Reconsiderations are not a required step in the Participant appeal process. It is the Participant's option whether to request Reconsideration or to go directly to the Appeal process.

SECTION 14 COORDINATION OF BENEFITS

Coordination of the benefit plans. Coordination of benefits sets out rules for the order of payment of Covered Charges when two or more plans are paying. When a Participant is covered by this Plan and another plan, or the Participant's Spouse is covered by this Plan and by another plan or the couple's Covered children are covered under two or more plans, the plans will coordinate benefits when a claim is received.

The plan that pays first according to the rules will pay as if there were no other plan involved. The secondary and subsequent plans will pay the balance due up to 100% of the total Allowable Charges.

Benefit plan. This provision will coordinate the medical benefits of a benefit plan. The term "benefit plan" means this Plan or any one of the following plans:

- (1) Group or group-type plans, including franchise or blanket benefit plans.
- (2) Blue Cross and Blue Shield group plans.
- (3) Group practice and other group prepayment plans.
- (4) Federal government plans or programs. This includes Medicare.
- (5) Other plans required or provided by law. This does not include Medicaid or any benefit plan like it that, by its terms, does not allow coordination.
- (6) No Fault Auto Insurance, by whatever name it is called, when not prohibited by law.

Allowable Charge. For a charge to be allowable it must be a Maximum Allowable Charge and at least part of it must be covered under this Plan.

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

In the case of service type plans where services are provided as benefits, the reasonable cash value of each service will be the Allowable Charge.

Automobile limitations. When medical payments are available under vehicle insurance, the Plan shall pay excess benefits only, without reimbursement for vehicle plan Deductibles. This Plan shall always be considered the secondary carrier regardless of the individual's election under PIP (personal injury protection) coverage with the auto carrier.

Which Plan pays First? Order of Benefit Determination Rules

When a Participant is covered by 2 plans, and	Then	Plan Primary	Plan Secondary
If one plan does not contain a COB provision	The plan without COB provision is The plan with COB provision is	0	0
The Participant is the subscriber under one plan and Dependent under the other	The plan covering the Participant as the subscriber is The plan covering the Participant as a Dependent is	0	0
The Participant is the subscriber under a Retiree plan and Dependent under an active plan	The plan covering the Participant as the subscriber is The plan covering the Participant as a Dependent is	0	0
The Participant is a subscriber in two active group plans	The plan that has been in effect longer is The plan that has been in effect the shorter amount of time is	0	0
The Participant is a subscriber under both an Active Employee plan and a Retiree plan	The plan which the subscriber is an Active Employee is The Retiree plan is	0	0
The Participant is an Active Employee on one plan and enrolled as a COBRA subscriber	The plan which the subscriber is an Active Employee is The COBRA plan is	0	0
The Participant is covered as a Dependent child under both plans	The plan of the parent whose birthday occurs earlier in the calendar year (known as the birthday rule) is The plan of the parent whose birthday is later in the calendar year is NOTE: If the parents have the same birthday (MM/DD), the plan that has been in effect longer is primary	0	0
The Participant is covered as a Dependent child under both a group plan and Medicaid	The Group Plan is Medicaid is	0	0
The Participant is covered as a Dependent child and coverage is specified in a court decree	The plan of the parent primarily responsible for health coverage under the court decree is The plan of the other parent is	0	0
The Participant is covered as a Dependent child and coverage is not specified in a court decree	The custodial parent or spouse of custodial parent's plan is The non-custodial parent's plan is	0	0
The Participant is covered as a Dependent child and the parents share joint custody	The plan of the parent whose birthday occurs earlier in the calendar year is The plan of the parent whose birthday is later in the calendar year is NOTE: If the parents have the same birthday (MM/DD), the plan that has been in effect longer is primary	0	0

Coordination of Benefits with Medicare for Participants under 65 with a Disability

When a Participant is covered by Medicare and a group plan, and	Then	Plan Primary	Medicare Primary
Is a Participant who is qualified for Medicare coverage due solely to End Stage Renal Disease (ESRD)	For the first 30-months after Medicare becomes effective	ö	
	Upon completion of the 30-months after Medicare becomes effective		ö
Is a disabled Subscriber who is an Active Employee	If the Employer employs 100 Employees or more	ö	
	If the Employer employs fewer than 100 Employees		ö
Is the disabled spouse or Dependent child of an active full-time Subscriber	If the Employer employs 100 Employees or more	ö	
	If the Employer employs fewer than 100 Employees		ö
Is a person who becomes qualified for Medicare Coverage due to ESRD after already being enrolled in Medicare due to disability	If Medicare had been secondary to the group plan before ESRD entitlement, then for the first 30 months following ESRD entitlement	ö	
	If Medicare had been primary to the group plan before ESRD entitlement		ö
Disabled and Subscriber not actively employed by the Employer group			ö

Claims determination period. Benefits will be coordinated on a Calendar Year basis. This is called the claims determination period.

Right to receive or release necessary information. To make this provision work, this Plan may give or obtain needed information from another insurer or any other organization or person. This information may be given or obtained without the consent of or notice to any other person. A Participant will give this Plan the information it asks for about other plans and their payment of Maximum Allowable Charges.

Facility of payment. This Plan may repay other plans for benefits paid that the Plan Administrator determines it should have paid. That repayment will count as a valid payment under this Plan.

Right of recovery. This Plan may pay benefits that should be paid by another benefit plan. In this case this Plan may recover the amount paid from the other benefit plan or the Participant. That repayment will count as a valid payment under the other benefit plan.

Further, this Plan may pay benefits that are later found to be greater than the Allowable Charge. In this case, this Plan may recover the amount of the overpayment from the source to which it was paid.

Exception to Medicaid. The Plan shall not take into consideration the fact that an individual is eligible for or is provided medical assistance through Medicaid when enrolling an individual in the Plan or making a determination about the payments for benefits received by a Participant under the Plan.

SECTION 15

PROVISION OF PROTECTED HEALTH INFORMATION TO PLAN SPONSOR

15.1 COMPLIANCE WITH HIPAA PRIVACY STANDARDS

Certain members of the Employer's workforce perform services in connection with administration of the Plan. In order to perform these services, it is necessary for these Employees from time to time to have access to Protected Health Information (as defined below).

Under the Standards for Privacy of Individually Identifiable Health Information (45 CFR Part 164, the "Privacy Standards"), these Employees are permitted to have such access subject to the following:

- (1) **General.** The Plan shall not disclose Protected Health Information to any member of the Employer's workforce unless each of the conditions set out in this HIPAA Privacy section is met. "Protected Health Information" shall have the same definition as set out in the Privacy Standards but generally shall mean individually identifiable health information about the past, present or future physical or Mental Health or condition of an individual, including information about treatment or payment for treatment.
- (2) **Permitted Uses and Disclosures.** Protected Health Information disclosed to members of the Employer's workforce shall be used or disclosed by them only for purposes of Plan administrative functions. The Plan's administrative functions shall include all Plan payment and health care operations. The terms "payment" and "health care operations" shall have the same definitions as set out in the Privacy Standards, but the term "payment" generally shall mean activities taken with respect to payment of premiums or contributions, or to determine or fulfill Plan responsibilities with respect to coverage, provision of benefits, or reimbursement for health care. "Health care operations" generally shall mean activities on behalf of the Plan that are related to quality assessment; evaluation, training or accreditation of health care Providers; underwriting, premium rating and other functions related to obtaining or renewing an insurance contract, including stop-loss insurance; medical review; legal services or auditing functions; or business planning, management and general administrative activities.
- (3) **Authorized Employees.** The Plan shall disclose Protected Health Information only to members of the Employer's workforce who are designated and are authorized to receive such Protected Health Information, and only to the extent and in the minimum amount necessary for these persons to perform duties with respect to the Plan. For purposes of this HIPAA Privacy section, "members of the Employer's workforce" shall refer to all Employees and other persons under the control of the Employer.
 - (a) **Updates Required.** The Plan Sponsor shall amend the Plan promptly with respect to any changes in the members of the Employer's workforce who are authorized to receive Protected Health Information.
 - (b) **Use and Disclosure Restricted.** An authorized member of the Employer's workforce who receives Protected Health Information shall use or disclose the Protected Health Information only to the extent necessary to perform his or her duties with respect to the Plan.
 - (c) **Resolution of Issues of Noncompliance.** In the event that any member of the Employer's workforce uses or discloses Protected Health Information other than as permitted by the Privacy Standards, the incident shall be reported to the privacy official. The privacy official shall take appropriate action, including:

- (i) Investigation of the incident to determine whether the breach occurred inadvertently, through negligence, or deliberately; whether there is a pattern of breaches; and the degree of harm caused by the breach;
 - (ii) Applying appropriate sanctions against the persons causing the breach, which, depending upon the nature of the breach, may include, oral or written reprimand, additional training, or termination of employment;
 - (iii) Mitigating any harm caused by the breach, to the extent practicable; and
 - (iv) Documentation of the incident and all actions taken to resolve the issue and mitigate any damages.
- (4) Certification of Employer.** The Employer must provide certification to the Plan that it agrees to:
- (a) Not use or further disclose the Protected Health Information other than as permitted or required by the Plan documents or as required by law;
 - (b) Ensure that any agent or subcontractor, to whom it provides Protected Health Information received from the Plan, agrees to the same restrictions and conditions that apply to the Employer with respect to such information;
 - (c) Not use or disclose Protected Health Information for employment-related actions and decisions or in connection with any other benefit or Employee benefit plan of the Employer;
 - (d) Report to the Plan any use or disclosure of the Protected Health Information of which it becomes aware that is inconsistent with the uses or disclosures hereunder or required by law;
 - (e) Make available Protected Health Information to individual Plan Participants in accordance with Section 164.524 of the Privacy Standards;
 - (f) Make available Protected Health Information for amendment by individual Plan Participants and incorporate any amendments to Protected Health Information in accordance with Section 164.526 of the Privacy Standards;
 - (g) Make available the Protected Health Information required to provide any accounting of disclosures to individual Plan Participants in accordance with Section 164.528 of the Privacy Standards;
 - (h) Make its internal practices, books and records relating to the use and disclosure of Protected Health Information received from the Plan available to the Department of Health and Human Services for purposes of determining compliance by the Plan with the Privacy Standards;
 - (i) If feasible, return or destroy all Protected Health Information received from the Plan that the Employer still maintains in any form, and retain no copies of such information when no longer needed for the purpose of which disclosure was made, except that, if such return or destruction is not feasible, limit further uses and disclosures to those purposes that make the return or destruction of the information unfeasible; and
 - (j) Ensure the adequate separation between the Plan and member of the Employer's workforce, as required by Section 164.504(f)(2)(iii) of the Privacy Standards.

The following members of the Employer's workforce are designated as authorized to receive Protected Health Information from the Plan in order to perform their duties with respect to the Plan.

- Benefits Manager, Henrico County General Government and Health Benefits Staff
- Accounting Section Manager, Henrico County Public Schools and Health Benefits Staff
- Director of Human Resources, Henrico County
- Assistant Directors of Human Resources, Henrico County
- Members of the Henrico County Employee Health Benefits Committee
- Payroll Staff, Henrico County and Public Schools
- Privacy Official, Henrico County
- Sr. Management Specialist/General Services, Henrico County

15.2 COMPLIANCE WITH HIPAA ELECTRONIC SECURITY STANDARDS

Under the Security Standards for the Protection of Electronic Protected Health Information (45 CFR Part 164.300 et. seq., the "Security Standards"), the Employer agrees to the following:

- (1)** The Employer agrees to implement reasonable and appropriate administrative, physical and technical safeguards to protect the confidentiality, integrity and availability of Electronic Protected Health Information that the Employer creates, maintains or transmits on behalf of the Plan. "Electronic Protected Health Information" shall have the same definition as set out in the Security Standards, but generally shall mean Protected Health Information that is transmitted by or maintained in electronic media.
- (2)** The Employer shall ensure that any agent or subcontractor to whom it provides Electronic Protected Health Information shall agree, in writing, to implement reasonable and appropriate security measures to protect the Electronic Protected Health Information.
- (3)** The Employer shall ensure that reasonable and appropriate security measures are implemented to comply with the conditions and requirements set forth in Compliance With HIPAA Privacy Standards provisions (3) Authorized Employees and (4) Certification of Employer described above.

SECTION 16

CONTINUATION COVERAGE RIGHTS UNDER COBRA

Under federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA), certain Employees and their families covered under of Henrico, Virginia Health Plan (the Plan) will be entitled to elect a temporary extension of health coverage (called "COBRA continuation coverage") where coverage under the Plan would otherwise end. This notice is intended to inform Participants, in summary fashion, of their rights and obligations under the continuation coverage provisions of COBRA, as amended and reflected in final and proposed regulations published by the Department of the Treasury. This notice is intended to reflect the law and does not grant or take away any rights under the law.

The Plan Administrator is County of Henrico, Virginia. The Plan Administrator is responsible for administering COBRA continuation coverage. Complete instructions on COBRA, as well as election forms and other information, will be provided by the Plan Administrator or its designee to Participants who become Qualified Beneficiaries under COBRA.

What is COBRA continuation coverage?

COBRA continuation coverage is the temporary extension of group health plan coverage that must be offered to certain Participants and their eligible family members (called "Qualified Beneficiaries") at group rates. The right to COBRA continuation coverage is triggered by the occurrence of a life event that results in the loss of coverage under the terms of the Plan (the "Qualifying Event"). The coverage must be identical to the Plan coverage that the Qualified Beneficiary had immediately before the Qualifying Event, or if the coverage has been changed, the coverage must be identical to the coverage provided to similarly situated Active Employees who have not experienced a Qualifying Event (in other words, similarly situated non-COBRA beneficiaries).

Who can become a Qualified Beneficiary?

In general, a Qualified Beneficiary can be:

- (1)** Any individual who, on the day before a Qualifying Event, is covered under a Plan by virtue of being on that day either a covered Employee, the Spouse of a covered Employee, or a Dependent child of a covered Employee. If, however, an individual who otherwise qualifies as a Qualified Beneficiary is denied or not offered coverage under the Plan under circumstances in which the denial or failure to offer constitutes a violation of applicable law, then the individual will be considered to have had the Plan coverage and will be considered a Qualified Beneficiary if that individual experiences a Qualifying Event.

- (2)** Any child who is born to or placed for adoption with a covered Employee during a period of COBRA continuation coverage, and any individual who is covered by the Plan as an alternate recipient under a qualified medical support order. If, however, an individual who otherwise qualifies as a Qualified Beneficiary is denied or not offered coverage under the Plan under circumstances in which the denial or failure to offer constitutes a violation of applicable law, then the individual will be considered to have had the Plan coverage and will be considered a Qualified Beneficiary if that individual experiences a Qualifying Event.

The term "covered Employee" includes eligible employees (whether part-time or full-time) as well as any individual who is provided coverage under the Plan due to his or her performance of services for the Employer sponsoring the Plan. However, this provision does not establish eligibility of these individuals. Eligibility for Plan coverage shall be determined in accordance with Plan eligibility provisions.

Each Qualified Beneficiary (including a child who is born to or placed for adoption with a covered Employee during a period of COBRA continuation coverage) must be offered the opportunity to make an independent election to receive COBRA continuation coverage.

What is a Qualifying Event?

A Qualifying Event is any of the following if the Plan provided that the Participant would lose coverage (i.e., cease to be covered under the same terms and conditions as in effect immediately before the Qualifying Event) in the absence of COBRA continuation coverage:

- (1) The death of a covered Employee.
- (2) The termination (other than by reason of the Employee's gross misconduct), or reduction of hours, of a covered Employee's employment.
- (3) The divorce of a covered Employee from the Employee's Spouse. If the Employee reduces or eliminates the Employee's Spouse's Plan coverage in anticipation of a divorce, and a divorce later occurs, then the divorce may be considered a Qualifying Event even though the Spouse's coverage was reduced or eliminated before the divorce.
- (4) A covered Employee's enrollment in any part of the Medicare program.
- (5) A Dependent child's ceasing to satisfy the Plan's requirements for a Dependent child (for example, attainment of the maximum age for dependency under the Plan).

If the Qualifying Event causes the covered Employee, or the covered Spouse or a Dependent child of the covered Employee, to cease to be covered under the Plan under the same terms and conditions as in effect immediately before the Qualifying Event, the persons losing such coverage become Qualified Beneficiaries under COBRA if all the other conditions of COBRA are also met. For example, any increase in contribution that must be paid by a covered Employee, or the Spouse, or a Dependent child of the covered Employee, for coverage under the Plan that results from the occurrence of one of the events listed above is a loss of coverage.

The taking of leave under the Family and Medical Leave Act of 1993 ("FMLA") does not constitute a Qualifying Event. A Qualifying Event will occur, however, if an Employee does not return to employment at the end of the FMLA leave and all other COBRA continuation coverage conditions are present. If a Qualifying Event occurs, it occurs on the last day of FMLA leave and the applicable maximum coverage period is measured from this date (unless coverage is lost at a later date and the Plan provides for the extension of the required periods, in which case the maximum coverage date is measured from the date when the coverage is lost). Note that the covered Employee and family members will be entitled to COBRA continuation coverage even if they failed to pay the Employee portion of premiums for coverage under the Plan during the FMLA leave.

What factors should be considered when determining to elect COBRA continuation coverage?

You should take into account that a failure to continue your group health coverage will affect your rights under federal law. First, you can lose the right to avoid having pre-existing condition exclusions applied by other group health plans if there is more than a 63-day gap in health coverage and election of COBRA continuation coverage may help you avoid such a gap. Second, if you do not elect COBRA continuation coverage and pay the appropriate premiums for the maximum time available to you, you will lose the right to convert to an individual health insurance policy, which does not impose such pre-existing condition exclusions. Finally, you should take into account that you have special enrollment rights under federal law (HIPAA). You have the right to request special enrollment in another group health plan for which you are otherwise eligible (such as a plan sponsored by your Spouse's employer) within 30 days after Plan coverage ends due to a Qualifying Event listed above. You will also have the same special right at the end of COBRA continuation coverage if you get COBRA continuation coverage for the maximum time available to you.

What is the procedure for obtaining COBRA continuation coverage?

The Plan has conditioned the availability of COBRA continuation coverage upon the timely election of such coverage. An election is timely if it is made during the election period.

What is the election period and how long must it last?

The election period is the time period within which the Qualified Beneficiary must elect COBRA continuation coverage under the Plan. The election period must begin not later than the date the Qualified Beneficiary would lose coverage on account of the Qualifying Event and ends 60 days after the later of the date the Qualified Beneficiary would lose coverage on account of the Qualifying Event or the date notice is provided to the Qualified Beneficiary of her or his right to elect COBRA continuation coverage. If coverage is not elected within the 60 day period, all rights to elect COBRA continuation coverage are forfeited.

Is a covered Employee or Qualified Beneficiary responsible for informing the Plan Administrator of the occurrence of a Qualifying Event?

The Plan will offer COBRA continuation coverage to Qualified Beneficiaries only after the Plan Administrator or its designee has been timely notified that a Qualifying Event has occurred. The Employer (if the Employer is not the Plan Administrator) will notify the Plan Administrator of the Qualifying Event within 30 days following the date coverage ends when the Qualifying Event is:

- (1) the end of employment or reduction of hours of employment,
- (2) death of the Employee,
- (3) enrollment of the Employee in any part of Medicare.

IMPORTANT:

For the other Qualifying Events (divorce of the Employee and spouse or a Dependent child's losing eligibility for coverage as a Dependent child), the qualified beneficiary or someone on his behalf must notify the Plan Administrator or its designee in writing within 60 days after the Qualifying Event occurs, using the procedures specified below. If these procedures are not followed or if the notice is not provided in writing to the Plan Administrator or its designee during the 60-day notice period, any spouse or Dependent child who loses coverage will not be offered the option to elect continuation coverage. This notice must be sent to the Plan Sponsor.

NOTICE PROCEDURES:

Any notice must be ***in writing***. Oral notice, including notice by telephone, is not acceptable. The notice must be mailed, faxed or hand-delivered to the department listed below, at the following address:

General Government and Economic Development Authority:

Henrico County Human Resources Department
Benefits Division
P.O. Box 27032
Henrico, VA 23273
Fax: (804) 501-4426

Henrico County Public Schools:

Health Benefits Office
P.O. Box 23120
Henrico, VA 23223
Attention: Health Benefits
Fax: (804) 652-3988

If mailed, the notice must be postmarked no later than the last day of the required notice period. Any notice that is provided must state:

- the **name of the plan or plans** under which coverage has been lost or is being lost;
- the **name and address of the Employee** covered under the plan,
- the **name(s) and address(es) of the Qualified Beneficiary(ies)**, and
- the **Qualifying Event** and the **date** it happened.

If the Qualifying Event is a **divorce**, the notice must include a **copy of the divorce decree**.

Be aware that there are other notice requirements in other contexts, for example, in order to qualify for a disability extension.

Once the Plan Administrator or its designee receives ***timely notice*** that a Qualifying Event has occurred, COBRA continuation coverage will be offered to each of the qualified beneficiaries. Each Qualified Beneficiary will have an independent right to elect COBRA continuation coverage. Covered Employees may elect COBRA continuation coverage for their spouses, and parents may elect COBRA continuation coverage on behalf of their children. For each Qualified Beneficiary who elects COBRA continuation coverage, COBRA continuation coverage will begin on the date that plan coverage would otherwise have been lost. If the Employee or his spouse or Dependent children do not elect continuation coverage within the 60-day election period described above, the right to elect continuation coverage will be lost.

Is a waiver before the end of the election period effective to end a Qualified Beneficiary's election rights?

If, during the election period, a Qualified Beneficiary waives COBRA continuation coverage, the waiver can be revoked at any time before the end of the election period. Revocation of the waiver is an election of COBRA continuation coverage. However, if a waiver is later revoked, coverage need not be provided retroactively (that is, from the date of the loss of coverage until the waiver is revoked). Waivers and revocations of waivers are considered made on the date they are sent to the Plan Administrator or its designee, as applicable.

Is COBRA coverage available if a Qualified Beneficiary has other group health plan coverage or Medicare?

Qualified beneficiaries who are entitled to elect COBRA continuation coverage may do so even if they are covered under another group health plan or are entitled to Medicare benefits on or before the date on which COBRA is elected. However, a Qualified Beneficiary's COBRA coverage will terminate automatically if, after electing COBRA, he or she becomes entitled to Medicare or becomes covered under other group health plan coverage (but only after any applicable preexisting condition exclusions of that other plan have been exhausted or satisfied).

When may a Qualified Beneficiary's COBRA continuation coverage be terminated? During the election period, a Qualified Beneficiary may waive COBRA continuation coverage. Except for an

interruption of coverage in connection with a waiver, COBRA continuation coverage that has been elected for a Qualified Beneficiary must extend for at least the period beginning on the date of the Qualifying Event and ending not before the earliest of the following dates:]

- (1) The last day of the applicable maximum coverage period.
- (2) The first day for which Timely Payment is not made to the Plan with respect to the Qualified Beneficiary.
- (3) The date upon which the Employer ceases to provide any group health plan (including a successor plan) to any Employee.
- (4) The date, after the date of the election, that the Qualified Beneficiary first becomes covered under any other Plan that does not contain any exclusion or limitation with respect to any pre-existing condition, other than such an exclusion or limitation that does not apply to, or is satisfied by, the Qualified Beneficiary.
- (5) The day the Qualified Beneficiary is first enrolled in the Medicare program (either Part A or Part B). The Qualified Beneficiary must immediately notify the Plan Administrator of any such enrollment in Medicare. The notice must be provided as described in the Notice Procedures above.
- (6) In the case of a Qualified Beneficiary entitled to a disability extension, the later of:
 - (a) (i) 29 months after the date of the Qualifying Event, or (ii) the first day of the month that is more than 30 days after the date of a final determination under Title II or XVI of the Social Security Act that the disabled Qualified Beneficiary whose disability resulted in the Qualified Beneficiary's entitlement to the disability extension is no longer disabled, whichever is earlier; or
 - (b) the end of the maximum coverage period that applies to the Qualified Beneficiary without regard to the disability extension.

The Plan can terminate for cause the coverage of a Qualified Beneficiary on the same basis that the Plan terminates for cause the coverage of similarly situated non-COBRA beneficiaries, for example, for the submission of a fraudulent claim.

In the case of an individual who is not a Qualified Beneficiary and who is receiving coverage under the Plan solely because of the individual's relationship to a Qualified Beneficiary, if the Plan's obligation to make COBRA continuation coverage available to the Qualified Beneficiary ceases, the Plan is not obligated to make coverage available to the individual who is not a Qualified Beneficiary.

What are the maximum coverage periods for COBRA continuation coverage?

The maximum coverage periods are based on the type of the Qualifying Event and the status of the Qualified Beneficiary, as shown below:

- (1) In the case of a Qualifying Event that is a termination of employment or reduction of hours of employment, the maximum coverage period ends 18 months after the Qualifying Event if there is not a disability extension and 29 months after the Qualifying Event if there is a disability extension.

- (2) In the case of a covered Employee's enrollment in the Medicare program before experiencing a Qualifying Event that is a termination of employment or reduction of hours of employment, the maximum coverage period for Qualified Beneficiaries other than the covered Employee ends on the later of:
 - (a) 36 months after the date the covered Employee becomes enrolled in the Medicare program; or
 - (b) 18 months (or 29 months, if there is a disability extension) after the date of the covered Employee's termination of employment or reduction of hours of employment.
- (3) In the case of a Qualified Beneficiary who is a child born to or placed for adoption with a covered Employee during a period of COBRA continuation coverage, the maximum coverage period is the maximum coverage period applicable to the Qualifying Event giving rise to the period of COBRA continuation coverage during which the child was born or placed for adoption.
- (4) In the case of any other Qualifying Event than that described above, the maximum coverage period ends 36 months after the Qualifying Event.

Under what circumstances can the maximum coverage period be expanded?

If a Qualifying Event that gives rise to an 18-month or 29-month maximum coverage period is followed, within that 18- or 29-month period, by a second Qualifying Event that gives rise to a 36-months maximum coverage period, the original period is expanded to 36 months, but only for individuals who are Qualified Beneficiaries at the time of and with respect to both Qualifying Events. In no circumstance can the COBRA maximum coverage period be expanded to more than 36 months after the date of the first Qualifying Event. The Plan Administrator must be notified of the second Qualifying Event within 60 days of the second Qualifying Event. This notice must be sent to the Plan Sponsor in accordance with the procedures above.

How does a Qualified Beneficiary become entitled to a disability extension?

A disability extension will be granted if an individual (whether or not the covered Employee) who is a Qualified Beneficiary in connection with the Qualifying Event that is a termination or reduction of hours of a covered Employee's employment, is determined under Title II or XVI of the Social Security Act to have been disabled at any time during the first 60 days of COBRA continuation coverage. To qualify for the disability extension, the Qualified Beneficiary must also provide the Plan Administrator with notice of the disability determination on a date that is both within 60 days after the date of the determination and before the end of the original 18-month maximum coverage. This notice should be sent to the Plan Sponsor in accordance with the procedures above.

Does the Plan require payment for COBRA continuation coverage?

For any period of COBRA continuation coverage under the Plan, qualified beneficiaries who elect COBRA continuation coverage must pay for COBRA continuation coverage. Qualified beneficiaries will pay up to 102% of the applicable premium and up to 150% of the applicable premium for any expanded period of COBRA continuation coverage covering a disabled Qualified Beneficiary due to a disability extension. The Plan will terminate a Qualified Beneficiary's COBRA continuation coverage as of the first day of any period for which timely payment is not made.

Must the Plan allow payment for COBRA continuation coverage to be made in monthly installments?

Yes. The Plan is also permitted to allow for payment at other intervals.

What is Timely Payment for payment for COBRA continuation coverage?

Timely Payment means a payment made no later than 30 days after the first day of the coverage period. Payment that is made to the Plan by a later date is also considered Timely Payment if either under the terms of the Plan, covered Employees or Qualified Beneficiaries are allowed until that later date to pay for their coverage for the period or under the terms of an arrangement between the Employer and the Claims Administrator, the Employer is allowed until that later date to pay for coverage of similarly situated non-COBRA beneficiaries for the period.

Notwithstanding the above paragraph, the Plan does not require payment for any period of COBRA continuation coverage for a Qualified Beneficiary earlier than 45 days after the date on which the election of COBRA continuation coverage is made for that Qualified Beneficiary. Payment is considered made on the date on which it is postmarked to the Plan.

If Timely Payment is made to the Plan in an amount that is not significantly less than the amount the Plan requires to be paid for a period of coverage, then the amount paid will be deemed to satisfy the Plan's requirement for the amount to be paid, unless the Plan notifies the Qualified Beneficiary of the amount of the deficiency and grants a reasonable period of time for payment of the deficiency to be made. A "reasonable period of time" is 30 days after the notice is provided. A shortfall in a Timely Payment is not significant if it is no greater than the lesser of \$50 or 10% of the required amount.

Must a qualified beneficiary be given the right to enroll in a conversion health plan at the end of the maximum coverage period for COBRA continuation coverage?

If a Qualified Beneficiary's COBRA continuation coverage under a group health plan ends as a result of the expiration of the applicable maximum coverage period, the Plan will, during the 180-day period that ends on that expiration date, provide the Qualified Beneficiary with the option of enrolling under a conversion health plan if such an option is otherwise generally available to similarly situated non-COBRA beneficiaries under the Plan. If such a conversion option is not otherwise generally available, it need not be made available to Qualified Beneficiaries.

IF YOU HAVE QUESTIONS

If you have questions about your COBRA continuation coverage, you should contact the Plan Sponsor. For more information about your rights under COBRA, the Health Insurance Portability and Accountability Act (HIPAA), and other laws affecting group health plans, contact the nearest Regional or District Office of the U.S. Department of Labor's Employee Benefits Security Administration (EBSA). Addresses and phone numbers of Regional and District EBSA Offices are available through EBSA's website at www.dol.gov/ebsa.

KEEP YOUR PLAN ADMINISTRATOR INFORMED OF ADDRESS CHANGES

In order to protect your family's rights, you should keep the Plan Administrator informed of any changes in the addresses of family members. You should also keep a copy, for your records, of any notices you send to the Plan Administrator.

SECTION 17

QUALIFIED MEDICAL CHILD SUPPORT ORDER PROCEDURES

17.1 IN GENERAL

In the case of any medical child support order (“Order”) that is received with respect to the Plan, its status shall be determined in accordance with the provisions set forth in this Section.

17.2 NOTIFICATION OF RECEIPT

Promptly upon receipt of an Order, the Plan Administrator will notify in writing each person named therein, at the address specified in the Order (if applicable), of the receipt by the Plan of the Order and forward to them notification of the procedures set forth in this Section. If the Plan Administrator is able to determine whether an Order is qualified promptly upon receipt of such Order, the Plan Administrator may send one notice which informs each person named herein both of the receipt of the Order and of the Plan Administrator’s determination, as provided in Section 17.5 and 17.6.

17.3 REVIEW OF ORDER

The Plan Administrator will ascertain, with the assistance of legal counsel, as appropriate, whether:

- (1)** The Order is a judgement, decree, or order (including approval of a property settlement agreement) issued either by a court of competent jurisdiction, or through an administrative process established under state law that has the force and effect of law under applicable state law, which:
 - (a)** provides for child support with respect to a child of a Participant under a group health plan or provides for health benefit coverage to such a child under this Plan, made pursuant to a state domestic relations law (including a community property law), or
 - (b)** enforces a state medical child support law enacted under the Social Security Act with respect to a group health plan;
- (2)** The Order specifies the name and the last known full mailing address (if any) of the Participant and each alternate recipient covered by the Order, or if not, that the information is available from the records of the Plan or Employer;
- (3)** The Order clearly identifies the Plan or plan(s) to which it applies;
- (4)** The Order clearly specifies a reasonable description of the type of coverage to be provided by the Plan to each alternate recipient, or the manner in which such type of coverage is to be determined;
- (5)** The Order does not require the Plan to provide any type or form of benefit, or any option, not otherwise provided under the Plan, except to the extent necessary to meet the requirement of a law relating to medical child support under the Social Security Act; and
- (6)** The Order clearly specifies the period to which it applies including the effective date of coverage.

Provided, however, any appropriately completed National Child Support Notice, issued pursuant to the Child Support Performance and Incentive Act of 1998, shall be deemed to satisfy the requirements to be a “qualified medical support order.”

17.4 SUSPENSION OF CLAIMS

Claims for a proposed alternate recipient shall be suspended until the Plan Administrator has determined whether the order in question is qualified.

17.5 NOTIFICATION OF STATUS

When the Plan Administrator determines whether the Order satisfies the requirements to be a “qualified medical child support order”, the Plan Administrator shall notify in writing all persons named in the Order and any representatives designated in writing by such persons (“Interested Parties”) of the determination as soon as practicable following such determination

- (1)** If no Interested Party disputes this determination within thirty (30) days of receipt of such notice, or if all Interested Parties agree in writing not to dispute the Plan Administrator’s determination, the Plan Administrator shall proceed with implementing the Order as a “qualified medical child support order.”
- (2)** If any Interested Party disputes this determination within thirty (30) days of receipt of such notice, then the suspension of claims provided in Section 17.4 shall continue and the Interested Party disputing the determination may request a review of the determination in accordance with the claims procedures set forth in the Plan.

17.6 NOTIFICATION OF NON-QUALIFIED STATUS

If the Plan Administrator determines that the Order is not a “qualified medical child support order”, the Plan Administrator shall notify in writing all Interested Parties of its determination, and such notice will state the reasons for such determination. Following such determination, any Interested Parties may re-submit a revised Order to the Plan Administrator.

SECTION 18 NEWBORNS' AND MOTHERS' HEALTH PROTECTION ACT OF 1996

Group health plans generally may not, under Federal law, 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 child earlier than 48 hours (or 96 hours as applicable). In any case, plans may not, under Federal law, require that a Provider obtain authorization from the plan for prescribing a length of stay not in excess of 48 hours (or 96 hours).

SECTION 19

WOMEN'S HEALTH AND CANCER RIGHTS ACT OF 1998

If a female Participant has had or is going to have a mastectomy, she may be entitled to certain benefits under the Women's Health and Cancer Rights Act of 1998 (WHCRA). For individuals receiving mastectomy-related services, coverage will be provided in a manner determined in consultation with the attending Physician and the patient for:

- All stages of reconstruction of the breast on which the mastectomy was performed;
- Surgery and reconstruction of the other breast to produce a symmetrical appearance;
- Prostheses; and
- Treatment of physical complications of the mastectomy, including lymphedema.

These benefits will be provided subject to the same Deductibles and Coinsurance applicable to other medical and surgical benefits provided under the Plan.

SECTION 20 MISCELLANEOUS

20.1 AMENDMENT AND TERMINATION OF PLAN

The County fully intends to maintain this Plan indefinitely. However, it reserves the right to terminate, suspend, discontinue or amend the Plan at any time and for any reason provided no such action shall adversely affect any claims that have actually been incurred by a Participant that would otherwise be eligible for payment under the Plan as in effect when the expense was incurred.

If the Plan is terminated, amended, or benefits are eliminated, the rights of Participants are limited to Covered Charges incurred before termination, amendment or elimination.

Changes in the Plan may occur in any or all parts of the Plan including benefit coverage, Deductibles, maximums, Copayments, exclusions, limitations, definitions, eligibility and the like.

The Plan will pay benefits only for the expenses incurred while this coverage is in force. No benefits are payable for expenses incurred before coverage began or after coverage terminated. An expense for a service or supply is incurred on the date the service or supply is furnished.

20.2 PRIVACY OF HEALTH INFORMATION

The provisions set forth in Section 15 concerning the use of protected health information by any Employees of the Employer named in Section 2 of this document, acting in the capacity as Plan Sponsor, and/or agents or subcontractors, shall apply with respect to any group health care benefits subject to the Health Insurance Portability and Accountability Act of 1996 (P.L. 104-191) and its implementing regulations.

20.3 INFORMATION TO BE FURNISHED

Participants shall provide the Employer and Plan Administrator with such information and evidence, and shall sign such documents as may reasonably be requested from time to time for the purpose of administration of the Plan.

Failure to follow the eligibility or enrollment requirements of this Plan may result in delay of coverage or no coverage at all.

20.4 PLAN'S RIGHT TO REDUCE OR DENY BENEFITS

Reimbursement from the Plan may be reduced or denied because of certain provisions in the Plan, such as coordination of benefits, exclusions, timeliness of COBRA elections, utilization review or other cost management requirements, lack of Medical Necessity, lack of timely filing of claims or lack of coverage.

20.5 NO GUARANTY OF TAX TREATMENT

The Plan Administrator does not make any representation, commitment, or guaranty that the value of any coverage and any amounts paid to or for the benefit of a Participant under this Plan will be excludable from the Participant's gross income for federal or state income tax purposes, or that any specific federal or state tax treatment will apply or be available to any Participant.

20.6 INCAPACITY

If a Participant is, in the judgement of the Plan Administrator, legally, physically, or mentally incapable of personally receiving any payment due under the Plan, the Plan Administrator may direct payments due to such other person or institution who, in the opinion of the Plan Administrator, are then maintaining or having custody of such Participant until claim is made by a duly appointed guardian or other legal representative of such Participant. Such payment shall constitute a full discharge of liability of the Plan to the extent of such payment.

20.7 ALIENATION OF INTERESTS

Benefits under this Plan may not be assigned or alienated.

20.8 UNCLAIMED PAYMENTS

Checks that are issued by the Plan for benefit payments and that are not cashed within 90 days may be voided. A new check will be issued upon request of the party entitled to payment.

20.9 RECOVERY OF BENEFITS

If a Participant receives a benefit payment under the Plan in excess of the benefit payment that should have been made, the Plan or its agent shall have the right to recover such excess from the Participant. The Plan may, however, at its option, deduct the amount of such excess for any subsequent benefits payable to or for such Participant.

20.10 SCOPE OF LEGAL RIGHTS

Except as provided herein, neither the establishment nor maintenance of the Plan nor any amendment thereof, nor the payment of any benefits, will be construed as giving any Participant or other person any legal or equitable right against the Employer or Plan Administrator. Furthermore, the adoption and maintenance of the Plan shall not be deemed to constitute or modify a contract, if any, between the Employer and any Employee or Participant or to be consideration, inducement for, or condition of the performance of services by any person. Nothing contained herein or in any document incorporated herein shall be deemed to give any Employee or Participant the right to continue in the service of the Employer, to interfere with the right of the Employer to discharge any Employee or Participant at any time, or to give the Employer the right to require an Employee or Participant to remain in its service or to interfere with his right to terminate his service at any time.

No action at law or in equity shall be brought to recover under any section of this Plan until the appeal rights provided have been exercised and the Plan benefits requested in such appeals have been denied in whole or in part.

20.11 GENDER AND NUMBER

Wherever any words are used herein in the masculine, feminine, or neuter gender, they shall be construed as though they were also used in another gender in all cases where they would so apply, and whenever any words are used herein in the singular or plural form, they shall be construed as though they were also used in the other form in all cases where they would so apply.

20.12 COMPLIANCE WITH FEDERAL MANDATES

The Plan will comply, to the extent applicable, with the requirements of all applicable laws (as amended), including but not limited to the Uniform Services Employment and Reemployment Rights Act of 1974 (USERRA); Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA); Health Insurance Accountability and Portability Act of 1996 (HIPAA); Newborns' and

Mothers' Health Protection Act of 1996 (NMHP); Women's Health and Cancer Rights Act of 1998 (WHCRA); Mental Health Parity Act (MHPA); and Family and Medical Leave Act of 1993 (FMLA). With respect to any self-insured group health benefits that are provided under this Plan, the County may elect to not comply with the health care portability provisions of HIPAA, with NMHP, and/or WHCRA, provided the County complies with the applicable opt-out requirements as allowed under those laws.

20.13 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.

20.14 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 shall affect the Plan or the construction of any provision thereof.

20.15 CLERICAL ERROR

Any clerical error by the Plan Administrator or an agent of the Plan Administrator in keeping pertinent records or a delay in making any changes will not invalidate coverage otherwise validly in force or continue coverage validly terminated. An equitable adjustment of contributions will be made when the error or delay is discovered.

If, due to a clerical error, an overpayment occurs in a Plan reimbursement amount, the Plan retains a contractual right to the overpayment. The person or institution receiving the overpayment will be required to return the incorrect amount of money. In the case of a Participant, if it is requested, the amount of overpayment will be deducted from future benefits payable.

20.16 GOVERNING LAW

The Plan is governed by the Internal Revenue Code of 1986, the Public Health Service Act, and the regulations issued thereunder (as they might be amended from time to time). To the extent not preempted by Federal law, the provisions of the Plan shall be construed, administered, and enforced according to the laws of the Commonwealth of Virginia without regard to its conflict of law rules.