

**LOURDES HEALTH  
NETWORK  
HEALTH CARE PLAN**

**Summary Plan Description  
Effective January 1, 2011**

**LOURDES HEALTH NETWORK  
HEALTH CARE PLAN  
TABLE OF CONTENTS**

INTRODUCTION	3
IMPORTANT HIGHLIGHTS	4
SCHEDULE OF MEDICAL BENEFITS - HEALTH AND WELLNESS PLAN	5
SCHEDULE OF MEDICAL BENEFITS - TRADITIONAL PLAN	8
CHILD WELLNESS HEALTH GUIDELINES	11
ADULT WELLNESS HEALTH GUIDELINES	12
IMPORTANT PLAN FACTS	13
PLAN PROVISIONS	15
HOW TO FILE A CLAIM	16
CLAIMS APPEAL PROCESS	17
CARE MANAGEMENT PROGRAM	19
LARGE CASE MANAGEMENT	19
ALTERNATIVE CARE	19
MEDCAT PROGRAM	21
ELIGIBILITY PROVISIONS	24
ENROLLMENT	25
TERMINATION OF BENEFITS	30
COVERAGE FOR ASSOCIATES AND DEPENDENTS OVER THE AGE OF 65	31
CONTINUATION OF COVERAGE	32
FAMILY AND MEDICAL LEAVE ACT/MILITARY LEAVE OF ABSENCE	36
COORDINATION OF BENEFITS PROVISION	37
SUBROGATION, REIMBURSEMENT & THIRD PARTY RECOVERY	40
COVERED MEDICAL EXPENSES	42
MEDICAL EXCLUSIONS AND LIMITATIONS	52
PRESCRIPTION DRUG EXPENSE BENEFIT	56
DEFINED TERMS	58
GENERAL PROVISIONS	66
RIGHTS AND PROTECTIONS	67
LEGISLATIVE COMPLIANCE	68
NOTICE OF PRIVACY PRACTICES	69
PERMITTED USES & DISCLOSURES OF PROTECTED HEALTH INFO (PHI)	70
YOUR RIGHTS	71
COMPLAINTS	71
HIPAA SECURITY REGULATIONS	72

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## INTRODUCTION

This Summary Plan Description describes the Medical and Prescription Drug benefits available to associates of Lourdes Health Network. The benefits described in this document become effective on January 1, 2011. This document summarizes the Plan rights and benefits for covered associates and their dependents. By carefully reading your summary plan description and understanding your relationship to your plan, you can be an informed participant. So know your plan, what it requires of you, how to become eligible for benefits, and what steps you can take to assure that you will receive your earned benefits.

When you become a Covered Person, you will have available to you a listing of the participating hospitals and physicians of the Preferred Provider Organization (PPO). At the time of service, it is your responsibility to confirm with the medical provider and/or facility that they continue to participate in the PPO. A telephone number is provided on the front of your Identification Card to contact the network to assist you with locating providers in your area. Additionally, The Loomis Company, website [www.loomisco.com](http://www.loomisco.com), contains links to many online provider directories under the *Provider List* option. Printed provider directories are also available to you free of charge; however, due to changes the printed directories become obsolete quickly.

If you live within the geographic service area of your PPO network and utilize the services of network providers, the Lourdes Health Network Health Care Plan will provide higher levels of benefits to you.

The participating Hospitals and physicians of the network have agreed to extend a discount to those associates and covered dependents that utilize their facilities. When your claims for Hospital services are processed, you will see the amount of the discount on the Explanation of Benefits (EOB). This, of course, helps reduce your liability for the cost of the services.

One of the advantages of the PPO network to you, as a consumer of medical care, deals with the determination of what charges are acceptable for benefit payment. As defined later in this booklet, *covered expenses* will be considered only up to the usual, customary and reasonable charge for the geographic area in which the service is rendered. This means that if a network physician bills an amount in excess of the usual, customary and reasonable amount, you cannot be billed for the excess charge. This provision of the Plan can be meaningful and offers additional financial benefits when PPO providers are used for medical care.

## IMPORTANT HIGHLIGHTS

- (1) Lourdes Health Network Health Care Plan believes this plan is a “grandfathered health plan” under the Patient Protection and Affordable Care Act (the Affordable Care Act). As permitted by the Affordable Care Act, a grandfathered health plan can preserve certain basic health coverage that was already in effect when that law was enacted. Being a grandfathered health plan means that your plan may not include certain consumer protections of the Affordable Care Act that apply to other plans, for example, the requirement for the provision of preventive health services without any cost sharing. However, grandfathered health plans must comply with certain other consumer protections in the Affordable Care Act, for example, the elimination of lifetime limits on essential benefits.

Questions regarding which protections apply and which protections do not apply to a grandfathered health plan and what might cause a plan to change from grandfathered health plan status can be directed to the plan administrator. You may also contact the Employee Benefits Security Administration, U.S. Department of Labor at 1-866-444-3272 or [www.dol.gov/ebsa/healthreform](http://www.dol.gov/ebsa/healthreform).

- (2) **YOU MUST NOTIFY THE HUMAN RESOURCES DEPARTMENT WHEN ONE OF THE FOLLOWING EVENTS OCCURS.**

- Birth of a child. (*Within 30 days*).
- Your covered child turns 26. (*Within 60 days*).
- Divorce. (*Within 60 days*).
- Marriage. (*Within 30 days*).
- Adoption of a child. (*Within 30 days*).

Failure to notify the Human Resources Department of these events could result in loss of eligibility and claims being denied.

- (3) **YOU MUST BE SURE NETWORK PROVIDERS HAVE CURRENT BILLING INSTRUCTIONS PROVIDED ON YOUR IDENTIFICATION CARD. FAILURE TO SUBMIT CLAIMS PROPERLY WILL RESULT IN DELAYED CLAIMS PROCESSING.**

- (4) **BILLS SHOULD BE SUBMITTED FOR PAYMENT IN A TIMELY BASIS.**

Claims filed more than 12 months after the date of service will not be eligible for payment.

*A Summary Plan Description (SPD) is intended to summarize the features of your Health Care Plan in clear, understandable and informal language. The terms under which the Plan administers benefits are contained in this booklet.*

**LOURDES HEALTH NETWORK  
HEALTH CARE PLAN  
SCHEDULE OF MEDICAL BENEFITS FOR  
THE HEALTH AND WELLNESS PLAN**

Maximum Lifetime Benefit for Medical Care

Unlimited

	<b>Lourdes, PPO Providers &amp; Non-PPO Providers</b>	<b>Comments</b>
<b>Calendar Year Deductible:</b> Per Covered Person Per Family	\$250 \$500	Deductibles for PPO and Non-PPO accumulate to one another.
<b>Note:</b> The deductible does not apply to the following services: <ul style="list-style-type: none"> <li>• Newborn Care</li> <li>• Prescription Drugs</li> <li>• Health Education Program</li> <li>• Second or Third Surgical Opinions</li> <li>• Well Care Visits</li> </ul>		
<b>Out-of-Pocket Maximum:</b> <i>(Excluding Deductible)</i> Per Covered Person Per Family	\$1,250 N/A	
The charges for the following do not accrue to the Out-of-Pocket Maximum and are never reimbursed at 100% by the Plan: <ul style="list-style-type: none"> <li>• Inpatient Rehabilitation Services</li> <li>• Health Education Program</li> <li>• Out-of-Network Provider Expenses</li> <li>• Prescription Medications</li> <li>• Co-pays</li> <li>• Expenses incurred for Non-Covered Services</li> </ul>		

<b>Benefits and Services</b>	<b>Lourdes Health Network (After Deductible)</b>	<b>PPO Providers (After Deductible)</b>	<b>Non-PPO Providers (After Deductible)</b>	<b>Comments</b>
<b>HOSPITAL BENEFIT</b>				
Inpatient Hospital Services	80%	50%	50%	
Diagnostic Laboratory	80%	80%	50%	
Diagnostic X-ray	80%	50%	50%	
Outpatient Hospital	80%	50%	50%	
Skilled Nursing Facility	80%	80%	50%	
Rehabilitation Services				
Inpatient	80%	50%	50%	
Outpatient	80%	50%	50%	
Urgent Care	80%	80%	50%	
Emergency Room <i>Medical Emergency &amp; accidental injuries</i>	\$75 Co-pay, then 80%	\$75 Co-pay, then 80%	\$75 Co-pay, then 80%	Co-payment will be waived if admitted.
Professional Fees	80%	80%	50%	
Non-Emergent Professional Fees	50%	50%	50%	

Benefits and Services	Lourdes Health Network (After Deductible)	PPO Providers (After Deductible)	Non-PPO Providers (After Deductible)	Comments
<b>MENTAL HEALTH &amp; SUBSTANCE ABUSE BENEFITS</b>				
Inpatient Mental Health Treatment	80%	50%	50%	
Outpatient Mental Health Treatment	80%	80%	50%	
Inpatient Substance Abuse Treatment	Not Available	80%	50%	
Outpatient Substance Abuse Treatment	80%	50%	50%	
<b>MISCELLANEOUS SERVICES AND SUPPLIES</b>				
Home Health Care	100%	100%	50%	Limited to 130 visits per calendar year.
Hospice Care	100%	100%	50%	Limited to 6 months in duration.
Private Duty Nursing	100%	100%	100%	Limited to \$5,000 per calendar year.
Ambulance Service	Not Available	80%	80%	
Durable Medical Equipment	80%	80%	50%	
Orthognathic Surgery	80%	80%	50%	Limited to \$1,000 per lifetime.
Sleep Disorders	80%	50%	Not Covered	
Dental Accident	100%	100%	100%	Limited to \$500 per accident.
<b>PRESCRIPTION DRUG BENEFITS</b> <i>(Available through a separate Pharmacy Benefit Manager)</i>				
	<b>Retail</b>	<b>Mail-Order</b>		
Generic	\$10	\$20		
Preferred Brand	\$30	\$60		
Non Preferred	\$60	\$120		
<b>PROFESSIONAL SERVICES BENEFIT</b>				
Physician's Visits				
• Office Visit	80%	80%	50%	
• Inpatient Hospital Visit or Consultation	80%	80%	50%	
• Allergy Treatment	80%	80%	50%	
• Second Surgical Opinion	80%	80%	50%	
Surgical Services	80%	80%	50%	
Outpatient Cardiac Rehabilitation	80%	80%	50%	
Transplant Services	80%	80%	50%	Refer to the <i>Covered Medical Expenses</i> section for limitation on this benefit.
Diagnostic Laboratory & X-ray Expenses	80%	80%	50%	

Benefits and Services	Lourdes Health Network (After Deductible)	PPO Providers (After Deductible)	Non-PPO Providers (After Deductible)	Comments
<b>REHABILITATION THERAPY</b>				
Chiropractic Care	80%	80%	Not Covered	Limited to \$500 per calendar year.
Acupuncture Treatment	80%	80%	Not Covered	
Naturopathic Treatment	80%	80%	Not Covered	
Temporomandibular Joint Disorders (TMJ) & Myofacial Pain Syndrome (MPS)	100%	100%	50%	Limited to \$1,000 per calendar year and a lifetime maximum of \$5,000.
Neurodevelopmental Therapy	80%	80%	50%	Coverage is limited up to the age of 7.
Chemotherapy	80%	80%	50%	
Radiation Therapy	80%	80%	50%	
Speech Therapy	80%	50%	50%	
Physical Therapy	80%	50%	50%	
Occupational Therapy	80%	50%	50%	
Vision Therapy	80%	50%	50%	
Massage Therapy	Not Available	80%	50%	
<b>PREVENTIVE CARE</b>				
Well Child Care	\$10 Co-pay, then 100%	\$25 Co-pay, then 100%	Not Covered	Exams limited to the age of 2, 4, 6, 9, 12 & 18 months.
Well Adult Care	\$10 Co-pay, then 100%	\$25 Co-pay, then 100%	Not Covered	Annual exam beginning at age 2. <i>Includes exam required for administrative purposes.</i>
Well Care includes 100% reimbursement for all related testing. Additional expenses will be subject to the Plan deductible and payable at 80%. <i>Refer to the Covered Medical Expenses Section for more details.</i>				
Mammogram	80%	50%	50%	
Health Education Program	80%	50%	50%	

\* Allowed amount - The Plan will consider the allowed amount designated by the Preferred Provider Organization.

\*\* UCR - The Plan will consider the Usual, Customary and Reasonable amount of the services based on the geographic location of the provider of service.

**LOURDES HEALTH NETWORK  
HEALTH CARE PLAN FOR  
THE TRADITIONAL PLAN**

**SCHEDULE OF MEDICAL BENEFITS**

Maximum Lifetime Benefit for Medical Care

Unlimited

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Speech Therapy	80%	50%	50%	
Physical Therapy	80%	50%	50%	
Occupational Therapy	80%	50%	50%	
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Well Adult Care	\$10 Co-pay, then 100%	\$25 Co-pay, then 100%	Not Covered	Annual exam beginning at age 2. <i>Includes exam required for administrative purposes.</i>
Well Care includes 100% reimbursement for all related testing. Additional expenses will be subject to the Plan deductible and payable at 80%. <i>Refer to the Covered Medical Expenses Section for details.</i>				
Mammogram	80%	50%	50%	
Health Education Programs	80%	50%	50%	

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## Child Wellness Health Guidelines

	0 to 12 months	12 to 24 months	Ages 3, 4, 5	Ages 6, 8	Ages 10 to 18
<b>Physician Guidance/ Health Assessment &amp; Screening</b>	At 2,4,6,9 & 12 months	Annually from ages 2 thru 18			
<b>Testing</b>	Vision and hearing (subjective)	Vision and hearing (subjective); TB tine test (at 12 months)	Dental at 3 years, TB tine, vision and hearing at 5 years	See Physician Guidance / Health Assessment for 6 years to 18 years	Teaching of self exam: males-testicular at 14 years; females-breast at 18 years
<b>Lab Tests</b>					
Blood test (HCT or HGB)	At 9 months	Between 15 months to 5 years	Between 15 months to 5 years	Between 6 years to 12 years; then at 18 years	Between 6 years to 12 years; then at 18 years
Cholesterol screening		Between 15 months to 5 years	Between 15 months to 5 years		At 18 years
Lead Screening	At 9 months				
Urinalysis	At 9 months	Between 15 months to 5 years	Between 15 months to 5 years		At 18 years
<b>Immunizations</b>					
<i>See Centers for Disease Control recommendations based on age. Any dose not administered at the recommended age should be administered at any subsequent visit, when indicated and feasible.</i>					
DTaP (Diphtheria, Tetanus, Acellular Pertussis)	At 2, 4, & 6 months	Between 12 to 18 months	Final dose between 4 – 6 years of age		
Tdap (Tetanus, Diphtheria toxoids, Acellular Pertussis Vaccine)					One Time
IPV (Inactivated Polio Vaccine)	At 2 & 4 months; then between 6 – 18 months		Booster between 4 – 6 years of age		
Hib (Haemophilus b)	At 2, 4, & 6 months <i>6 month dose not required if administered at 2 &amp; 4 months</i>	Booster at 12 months as necessary			
MMR (Measles, Mumps, Rubella)		At 12 to 15 months	At 5 years or before middle school/junior high		
Hepatitis A		Two doses administered at least 6 months apart.			
Hepatitis B	At birth; Then at 1- 2 months; final dose at 6 months	Between 9 – 18 months if necessary			
Flu Shot (Influenza)	Annually for ages 6 months to 5 years.				
Gardasil				As required for ages 9 thru 26	
Meningitis					One time
Pneumococcal	At 2, 4, 6 & 12 - 15 months				
RotaTeq (Rotavirus Vaccine)	3 doses at ages 2, 4, and 8 months. The first dose should be between ages 6--12 weeks. Subsequent doses should be at 4--10 week intervals, and all 3 doses should be administered by age 32 weeks.				
Varivax (Varicella Vaccine)		First dose between the age of 12 – 18 months	Second dose between the ages of 4 – 6.		
		<i>Minimum age is 12 months for the first dose. The second dose can be administered three months after the initial dose up to the age of 6</i>			
<b>Males: Testicular exam</b>					At 14, then every 2 yrs
<b>Females: Breast exam</b>					At 18, then every year
Pap smear	One per year (Not subject to age limitation)				
Pelvic exam	One per year (Not subject to age limitation)				

## Adult Wellness Health Guidelines

	Ages 19 to 20	Ages 21 to 39	Ages 40 to 49	Ages 50 to 65	Over Age 65
<b>Physical Exam</b>	One time	Every 5 years	Every year	Every year	Every year
<b>Blood Pressure</b>	Every 2 years	Every 2 years	Every year	Every year	Every year
<b>Lab Tests</b>					
Blood test (HCT or HGB)	As required in conjunction with physical exam frequency above.				
Cholesterol	One time	Every 5 years	Every 5 years	Every 5 years	Every 5 years
Stool for blood			Every 3 years	Every 3 years	Every 3 years
Urinalysis	As required in conjunction with physical exam frequency above.				
<b>Immunizations</b>	<i>See Centers for Disease Control recommendations based on age. Any dose not administered at the recommended age should be administered at any subsequent visit, when indicated and feasible.</i>				
Pneumococcal pneumonia	1 – 2 doses				Once
Tetanus, diphtheria, pertussis (Td/Tdap)	Every 10 years	Every 10 years	Every 10 years	Every 10 years	Every 10 years
Measles, mumps, rubella MMR (if not previously administered)	1 – 2 doses		1 dose		
Meningitis	One time				
Influenza	One dose annually				
Zostavax				Once over the age of 60	
Varivax ( <i>Varicella Vaccine</i> )	2 doses				
Hepatitis A	2 doses				
Hepatitis B	3 doses				
<b>Colonoscopy</b>	Age 50 and over one every 10 years regardless of the diagnosis. More frequently if medically necessary (Subject to Plan deductible and if applicable the office visit co-pay).				
<b>Rectal Exam</b>			Every year	Every year	Every year
<b>Sigmoidoscopy</b>				Every 3 to 5 years	Every 3 to 5 years
<b>Men only</b>					
Prostate exam including any required testing	Every 2 years	Every 2 years	Every year	Every year	Every year
Testicular exam	Every 2 years	Every 2 years	Every year	Every year	Every year
<b>Woman only</b>					
Human Papillomavirus (HPV)	3 doses <i>2<sup>nd</sup> and 3<sup>rd</sup> doses 2 and 6 months after the initial dose</i>				
Breast exam	One time	Every 3 years	Every year	Every year	Every year to 75
Mammogram			Every 1 to 2 years	Every year	Every year
Pap smear	One per year (Not subject to age limitation)				
Pelvic exam	One per year (Not subject to age limitation)				

## IMPORTANT PLAN FACTS

This Summary Plan Description has been compiled in accordance with Public Law 93-406 (known as the EMPLOYEE RETIREMENT SECURITY ACT OF 1974; “ERISA”.)

<b>PLAN NAME</b>	Lourdes Health Network Health Care Plan
<b>EMPLOYER (PLAN SPONSOR) AND PLAN ADMINISTRATOR</b>	Our Lady of the Lourdes 520 North Fourth Ave Pasco, WA 99301
<b>EMPLOYER I.D. NUMBER</b>	91-0349750
<b>GROUP NUMBER</b>	W910
<b>PLAN NUMBER</b>	501
<b>TYPE OF PLAN</b>	Self-Funded Medical and Prescription
<b>PLAN EFFECTIVE DATE</b>	January 1 <sup>st</sup>
<b>PLAN YEAR</b>	January 1 <sup>st</sup> to December 31 <sup>st</sup>
<b>PLAN COSTS</b>	Paid by Employer and Associates
<b>AGENT FOR LEGAL PROCESS</b>	Our Lady of the Lourdes 520 North Fourth Ave Pasco, WA 99301
<b>THIRD PARTY ADMINISTRATOR</b>	The Loomis Company PO Box 7011 Wyomissing, PA 19610-6011 (610) 374-4040 Customer Service Number (866) 218-6008
<b>PLAN WAITING PERIOD</b> <b>Associates and Dependents:</b>	First of the month following the date of hire.
<b>PLAN WAITING PERIOD FOR BENEFITS RELATED TO TRANSPLANT COVERAGE</b> <b>Associates and Dependents:</b>	A 6 month waiting period must be satisfied for transplant benefits to be eligible. Refer to the <i>Covered Medical Expenses</i> section for additional information.
<b>DEFINITION OF AN ELIGIBLE ASSOCIATE</b>	A non-exempt/hourly associate regularly scheduled to work full-time at least 48 hours per pay period.  An exempt/professional hourly associate regularly scheduled to work full-time at least 40 hours per pay period.  Sisters of St. Joseph of Carondelet who are regularly scheduled to work full-time at least 36 hours per pay period.
<b>PHARMACY BENEFIT MANAGER</b>	Refer to ID Card
<b>UTILIZATION REVIEW ADMINISTRATOR</b>	Refer to ID Card

**NON-PPO SERVICES WILL BE PAYABLE AT THE PPO RATE UNDER THE FOLLOWING CIRCUMSTANCES:**

- Individuals residing outside a PPO Service area (See the Human Resources Department to determine PPO service area).
- Services not available within the PPO system.
- Services rendered by a Non-PPO provider when referred by a PPO provider. You may be required to provide evidence that the Non-PPO referral is medically necessary and/or appropriate treatment is not available from a PPO provider. The claim may be processed at the Non-PPO rate until the documentation has been received by the Third Party Administrator.
- Services rendered by a Non-PPO provider at a PPO facility. This is limited to radiologists, anesthesiologists, pathologists, and emergency room physicians.
- Services rendered by a Non-PPO provider that takes the place or is called in to take the place of a PPO provider in the event the PPO provider is unavailable to provide the treatment.
- Medical emergency.

If an associate or dependent was covered by Lourdes Health Network Health Care Plan, which was in force immediately prior to this Plan, and if there was no lapse of coverage between this Plan and the prior Plan, the associate or dependents will be covered without interruption. If an associate or dependent was in the process of treatment by a provider of service that is not part of the Preferred Provider Organization (PPO) of this Plan, coverage will be provided under this Plan at the PPO level of benefits for the continued treatment of that condition only. In the event another diagnosis or treatment begins after the effective date of this Plan, providers will be paid at the level of benefits according to their relationship to the PPO. If the provider does not participate in the Plan's PPO Network, benefits will be considered at the Out-of-Network level. The Plan Administrator will review all facts and documentation in determining the payment level of a Non-Participating Provider.

Note – Reimbursements for these providers will be subject to the usual, reasonable and customary fee schedule. You may be billed for any amounts in excess of the usual, customary and reasonable charges for services rendered by a Non-PPO provider.

## PLAN PROVISIONS

Lourdes Health Network Health Care Plan (the "Plan") has been designed to provide all eligible associates and covered eligible dependents with a program of Health Care Protection. The benefit plan is based on the calendar year. Deductibles are calculated based on expenses incurred during the 12 months of each calendar year. Covered expenses incurred in, and applied toward the deductible in October, November, and December will be applied toward the deductible in the next calendar year.

**Coinsurance:** The percentage of the charge the Covered Person pays.

**Co-pay:** A fixed dollar amount the Covered Person pays for a service.

**Deductibles:** A deductible is the amount of covered expenses, which you ("Covered Persons") must pay before the Plan will pay. The individual deductible applies separately to each Covered Person. The family deductible applies collectively to all Covered Persons in the same family. When the family deductible is satisfied, no further deductible will be applied for any covered family member during the remainder of the calendar year.

**Out-of-Pocket Maximums:** An out-of-pocket maximum is the amount of covered expenses that must be paid during a calendar year before the payment percentage of the Plan increases to 100%. This applies separately to each Covered Person. When a Covered Person reaches the annual out-of-pocket maximum, the Plan will pay 100% of additional covered expenses for the individual during the remainder of the calendar year.

Certain expenses do not apply toward the out-of-pocket maximum. Please refer to the schedule of benefits for a list of those items.

**Lifetime Maximum:** The lifetime maximum benefit available under this Plan to any Covered Person for medical coverage. Under no circumstances does lifetime mean during the lifetime of the Covered Person.

## HOW TO FILE A CLAIM

For purposes of this Plan a filed claim for payment of benefits shall mean a completed paper or electronic claim form submitted to the Plan naming the specific claimant, the date of service, the specific medical condition or symptom, a specific treatment or service that was rendered or product provided by a qualified provider.

### **In-Network (PPO) Claims**

When you or a covered dependent utilize the services of PPO Hospitals, physicians and other providers, your involvement in the claims process will be minimal. After you identify yourself as covered through the Lourdes Health Network Health Care Plan, bills incurred for covered expenses under this Plan will be sent directly to the address identified on your health plan ID card.

When the Hospital or other provider submits their bills, the payment will be sent to the providers directly. You will receive a copy of the Explanation of Benefits showing the payments made and any deductibles or co-insurance involved in the benefits calculation.

**Please ensure the PPO Provider has the current billing instructions provided on your identification card. Failure to submit claims properly will result in delayed claims processing.**

### **Non-Network Claims**

When you or a covered dependent have incurred medical expenses for which you believe reimbursement is due under the terms of the Plan, you must file the necessary documentation. Refer to your Medical Benefits Identification Card for specific instructions as to where to submit claims. This may differ based upon the provider network that you utilize.

It is your responsibility to provide any information that is necessary for the Plan to make a prompt and fair evaluation of your claim. It is suggested that each time you file a claim the following information is provided:

- Identify yourself and your employer by using your Personal Identification Number and the Plan Number as shown on your Identification Card. If the claim is for a dependent, identify that individual in the same fashion as you did on your enrollment form.
- Have all charges presented on an original itemized bill listing dates of service, type of service and the charge for each service as rendered, including the provider's name, address, telephone number, and tax identification number.
- Either on the claim form or the bill have the attending physician identify the diagnosis for which treatment was rendered.

### **Claim Timely Filing**

If you or a covered dependent claim benefits, a proof of claim must be furnished to The Loomis Company within 12 months following the date of loss. If a written claim form is not furnished to the claims processor within 12 months, the claim may be denied or reduced. Benefits are based on the Plan's provisions at the time that the charges are incurred. Claims submitted after the 12-month period will not be considered for payment or may be reduced unless it is not reasonably possible to submit the claim in that time, such as the person is not legally capable of submitting the claim.

The Plan Administrator will determine if enough 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 Covered Person seek a second medical opinion.

If a claim is wholly or partially denied, the Covered Person will be notified in writing, of the determination. The denial notification will: (1) State the specific reason(s) for the denial; (2) Refer to the pertinent Plan provisions on which the denial is based; (3) Describe any additional

information needed to perfect the claim and explain why the additional information is necessary; and (4) Describe the Plan's appeal procedures including its time limits.

### **How To Appeal A Claim Denial**

You or your representative has 180 days after receipt of an adverse benefit determination to appeal to the Plan Administrator. To appeal an adverse benefit determination or to review administrative documents pertinent to the claim, send a written request to The Loomis Company. *If any appeal is not filed on time, the right to appeal the adverse benefit determination will be lost.* A full and fair review of the claim will be made with no deference given to the initial benefit determination. As part of the review, you or your representative are allowed to review all Plan Documents and other information that affect the claim and are allowed to submit issues, comments, documents, records or other information that had not previously been submitted.

During the period that the claim is being reconsidered, if there is reason to believe that your medical records contain information that should be disclosed by a physician or other health professional, you or your representative will be referred to the physician for the information before the Plan will provide the requested documents directly to you or your representative. Neither you nor your representative will be provided access to or copies of files of other Plan participants. For any appeal resulting in an adverse benefit determination, the identity of any medical or vocational expert consulted in connection with the appeal will be provided, without regard to whether the advice was relied upon in making the determination. However, the identity will not be provided unless requested by you or your representative.

All interpretations, determinations, and decisions of the reviewing entity with respect to any claim will be its sole decision based upon the Plan documents. All decisions of the Plan Administrator will be deemed final and binding. If appeal is denied, in whole or in part, however, you have a right to bring a civil action under Section 502(a) of ERISA.

### **Adverse Benefit Determination**

Any denial, reduction or termination of a benefit, or failure to provide or make payment (in whole or in part) for a benefit. An adverse benefit determination includes denials made on the basis of eligibility, utilization review, and restrictions involving services determined to be experimental or investigational, or not medically necessary or appropriate.

### **Compliance with Regulations**

It is intended that the claims procedures be administered in accordance with the claims procedure regulations of the Department of Labor as set forth in 29 CFR § 2560.503-1. You have a right to these procedures free of charge. Please call The Loomis Company if you wish to obtain a copy of these procedures.

### **Authorized Representative**

A person who is chosen by and identified to assist or authorized to represent the Covered Person, including a family member, provider, employer representative or attorney. An assignment of benefits by a Covered Person to a health care provider does not constitute designation of an authorized representative.

### **Other Important Claims Information**

If you or your representative fail to file a request for review in accordance with the claims procedures as described above, you or your representative will have no right to review and you or your representative will have no right to bring an action in any court. The denial of your claim will become final and binding except as otherwise provided by ERISA.

**Right to Receive and Release Needed Information**

Certain facts are needed to adjudicate claims in accordance with the provisions set forth in the Plan. The Plan Administrator has the right to decide which facts are required and may obtain the needed facts from or provide them to any other organization or persons. Each person claiming benefits under this Plan must provide any information required to pay the claim.

**Medical Privacy**

Medical information that is obtained and maintained in the course of processing claims will be secured and protected in accordance with state and federal laws regarding participant privacy rights.

## CARE MANAGEMENT PROGRAM

Lourdes Health Network desires to provide you and your family with a health care plan that financially protects you from significant health care expenses and assists you in locating quality care. While part of increasing health care costs results from new technology and important medical advances, another significant cause is the way health care services are used.

Some studies indicate that a significant percentage of the health care services rendered may be unnecessary. For example, Hospital stays can be longer than necessary. Some hospitalizations may be entirely avoidable, such as, when surgery could be performed on an outpatient basis with equal quality and safety. Also, surgery is sometimes performed when other treatment could be more effective. Unnecessary or avoidable health services increase costs for you and Lourdes Health Network Health Care Plan.

Lourdes Health Network Health Care Plan contracts with a professional Utilization Review Administrator to assist you in determining whether or not proposed services are appropriate for reimbursement under the Plan. The program is not intended to diagnose or treat medical conditions, guarantee benefits, or validate eligibility. The medical professionals who conduct the program focus their review on the appropriateness of Hospital stays, proposed surgical procedures and excessive, costly procedures.

### **Large Case Management**

When a catastrophic condition occurs, such as a spinal cord injury, a degenerative sickness, or a neurological paralytic disease, a person will require long-term, perhaps lifetime care. After the person's condition is stabilized in the Hospital, he or she might be able to be moved out of the Hospital and into another type of care setting - even to his or her home.

The Case Management program is designed to assist the patient and their family in coordinating all the aspects of care that may be required, and to find the most cost effective care while protecting the patient from undue expense. For example, sometimes specialized care or adaptations to the home are required, but are not covered under the Plan. *The Case Management program can help in these situations in which there could be a large cash outlay for non-covered expenses for catastrophic conditions, and appropriate high quality less expensive alternatives could be recommended that might not otherwise be covered.* If you believe you might benefit from case management please contact the Utilization Review Administrator listed on your ID card for further information.

The case manager will coordinate and implement the large case management program by providing guidance and information on available resources and suggesting appropriate treatment alternatives. The Plan Administrator, attending physician, patient and patient's family must all agree to the alternate treatment plan. Once agreement has been reached, the Plan Administrator will direct the Plan to reimburse for expenses as stated in the treatment plan, even if these normally would not be reimbursed by the Plan.

**Please Note:** Case Management is a voluntary service. There is no reduction of benefits and no penalties if the patient and family choose not to participate.

### **Alternative Care**

In addition to the benefits specified in this booklet, the Plan may elect to offer benefits for services furnished by any Provider pursuant to an alternate treatment plan approved by the Plan and/or the Utilization Review Administrator for a Covered Person. Alternative care occurs when this alternate benefit will be beneficial to both the patient and the Plan.

The Plan shall provide such alternative benefits for as long as the services are medically necessary and cost effective as determined by the Plan and/or Utilization Review Administrator. Once an agreement

has been reached, the Plan will reimburse for Medically Necessary expenses as stated in the treatment plan, even if these expenses normally would not be paid by the Plan.

The fee, which may be generated due to realizing a savings as the result of utilizing a Cost Containment program or Alternate treatment plan, will be considered as a covered expense under the Plan.

If the Utilization Review Administrator makes a negotiation with a Non-Participating Provider and the discount provides a substantial savings to the Plan, benefits will be considered at the In-Network level of benefits.

If the Plan elects to provide alternative benefits for a Covered Person in one instance, it shall not be obligated to provide the same or similar benefits for other Covered Persons under the Plan in any other instance. Nor shall it be construed as a waiver of the Third Party Administrator's right to administer the Plan thereafter in strict assurance with its express terms.

## MedCAT Program

### MedCAT Care Support Services

The following services are available to assist employees with catastrophic medical conditions and/or procedures. These services are provided at no cost to employees and their dependents who are eligible and currently have medical benefits under the group health plan. The following services are available:

#### Care Support

Cancer Care Services – An expert Oncology Nurse Case Manager reviews your treatment plan, provides a personalized educational support packet, reviews claims for possible cost reduction and facilitates medical review by oncology physicians to help ensure your treatment plan is the standard of care for your specific cancer. Pre-notification of chemotherapy and radiation is required. Please see more details below in the section titled “*Oncology Pharmaceutical and Clinical Management Program*”.

Dialysis – An expert Dialysis Treatment Coordinator contacts you to offer cost savings techniques to help extend your group medical plan benefits. Cost savings techniques include purchasing Medicare B supplement during the dialysis waiting period prior to Medicare becoming your primary payer; self injecting epogen at home; and exploring home hemodialysis as an option. Pre-notification of dialysis is required. Please see more details below in the section titled “*Outpatient Dialysis Claims*”.

Premature Baby (initial inpatient stay) – An expert Neonatology Nurse Case Manager reviews your baby’s treatment plan while hospitalized, provides personalized support to parents, interacts with the neonatology nurses and doctors caring for your baby and facilitates medical review by neonatology physicians to ensure your baby’s treatment plan is the standard of care.

Transplant – An expert Transplant Nurse Case Manager provides education and support as you progress through evaluation to listing and eventual transplantation. Additionally, qualified transplant centers are identified and offered through a transplant provider network.

Hemophilia – An expert Hemophilia Nurse Case Manager visits you personally, assesses your self care techniques and provides educational support for adults as well as children and their parents. Factor is shipped direct to the home in the exact amounts needed on a regular basis.

Once you are identified as a potential MedCAT candidate, you will be contacted by a MedCAT representative to offer enrollment in the applicable program. We believe that MedCAT services can have a positive impact in supporting you during the treatment of your condition. Please contact your benefit representative should you have questions about this program.

#### Outpatient Dialysis Claims

Benefits provided under this Plan for treatment received in connection with Outpatient Dialysis are subject to the following provisions and supersedes language found in other areas of the Plan Document as they relate to in-network providers and usual and reasonable.

The Plan provides an alternative basis for payment of claims associated with dialysis-related services and products provided on an outpatient basis (“Outpatient Dialysis”). This alternative basis may be applied to claims by any healthcare provider, regardless of the healthcare provider’s participation in the Preferred Provider Organization (PPO).

All eligible employees and their dependents requiring Outpatient Dialysis are subject to cost containment review, negotiation and/or other related administrative services which the Plan Administrator may elect to apply in the exercise of the Plan Administrator’s discretion.

The Plan shall pay no more than the Usual and Reasonable Charge for covered services and/or

supplies incurred in connection with Outpatient Dialysis. The Plan Administrator has the discretionary authority to decide whether a charge is Usual and Reasonable. The Plan Administrator shall determine the benefits based on the Usual and Reasonable Charge including amounts payable by coinsurance or deductibles, if any. The Plan Administrator may pay or reimburse charges greater than the Usual and Reasonable Charge based upon factors concerning the nature and severity of the condition being treated, geographic and market considerations and provider availability, in the exercise of the Plan Administrator's discretion. All charges must be billed in accordance with generally accepted industry standards.

*Usual and Reasonable Charge* shall mean charge(s) based upon the average payment actually made for reasonably comparable services and/or supplies to all providers of the same services and/or supplies by all types of plans in the same market area during the preceding calendar year, adjusted for the National Consumer Price index medical care rate of inflation.

### **Oncology Pharmaceutical and Clinical Management Program**

This provision describes a special medical management program designed for certain aspects of care received by cancer patients.

The Plan has entered into an arrangement with Biologics, a company specializing in oncology management. The purpose of this oncology management program is to assist the covered person and the covered person's oncologist during the covered person's course of cancer treatment when administered either in an outpatient setting (e.g. in the physician's office or other covered outpatient setting) or inpatient setting. The program applies to the chemotherapy plan of treatment ("POT") and other oncology pharmaceuticals to be used in connection with the covered person's cancer treatment.

In order to initiate the oncology management process, the oncologist should contact your Plan Administrator to verify Plan benefits. The oncologist will be asked to contact Biologics to discuss the POT. The oncologist may also contact Biologics toll free directly at 800-983-1590. Once the oncologist has contacted Biologics, a certified oncology nurse or Oncology Nurse Specialist (ONS) will be assigned to the covered person's case. The ONS will contact the covered person periodically to provide support, education, and answer any questions the covered person might have. At the same time, the ONS will contact the oncologist to discuss the proposed POT and assist in coordinating subsequent information pertaining to the various cycles of the POT. In addition, clinical oncology pharmacists will be available to the covered person and the oncologist on a 24/7 basis by calling toll free 800-983-1590. The covered person is encouraged to call this number if (s)he has questions regarding the cancer drugs being used in his or her POT, related side effects and other quality of life issues.

If the covered person's oncologist determines that oral anti-cancer drugs and/or supportive medications should be taken in the home setting following the inpatient or outpatient chemotherapy, the oncologist may request that the drugs be sent to the covered person's home address. Under this arrangement, the drugs will be sent to the covered person's home in time to meet the medication schedule specified by the oncologist. A clinical oncology pharmacist will call the covered person to discuss the medications and answer any questions (s)he may have about the specific drugs to be taken in the home.

Unless the treating oncologist has entered into an agreement with Biologics to accept other reimbursement rates, the payment for all drugs used in the treatment of cancer shall be limited to the rate of Medicare Average Sales Price ("ASP") plus 10 %. Average Sales Price is updated quarterly by Medicare.

In order to receive benefit payments under the Plan, the oncologist's chemotherapy plan of treatment must be received by Biologics, and deemed not to be Experimental and/or Investigative as described below:

**Experimental and/or Investigative**

The Plan will not pay for or otherwise cover the cost of drugs considered Experimental and/or Investigative.

Notwithstanding the Plan's definition of Experimental and/or Investigative, in the context of drugs used in the treatment of cancer, the use of a drug will not be considered Experimental and/or Investigative where the use of the drug has been recognized as safe and effective for the treatment of the specific type of cancer in the Drugs and Biologics Compendium published by the National Comprehensive Cancer Network, Thomson Micromedex DrugDex or Clinical Pharmacology.

## ELIGIBILITY PROVISIONS

If you are an associate of Our Lady of the Lourdes and satisfy the applicable provision:

- A non-exempt/hourly associate regularly scheduled to work at least 48 hours per pay period;
- An exempt/professional hourly associate regularly scheduled to work at least 40 hours per pay period;
- Sisters of St. Joseph of Carondelet who are regularly scheduled to work at least 36 hours per pay period;

You are eligible for coverage under the terms of Lourdes Health Network Health Care Plan. The effective date of coverage is enrollment in the plan upon completion of any applicable waiting period.

You may obtain coverage for you and your eligible dependents by completing the enrollment form and contributing any required amounts as defined by Lourdes Health Network Health Care Plan. If a husband and wife are associates, they may be covered as associates, and any eligible dependents may be covered as dependents of one parent but not both.

An eligible dependent shall mean any one or more of the following:

- The lawful spouse of the associate under a legally existing marriage.
- Children of the employee, who are under the age of 26 including legally adopted children, children legally placed for adoption, step-children, and foster children, and children for whom the employee and/or the employee's spouse has been appointed guardian by a court of competent jurisdiction.

*Coverage for dependent children will be terminated if said dependent child is eligible to receive coverage through his/her employer. In addition, a spouse or biological child of a covered dependent child will not be eligible for coverage under this Plan.*

- Children of the employee, including legally adopted children, children legally placed for adoption, step-children and foster children as defined above who are primarily dependent upon the employee for support and maintenance and who are incapable of self-sustaining employment due to mental or physical disability, provided such disability started before the attainment of age 26. Also, such children must have been covered prior to the attainment of such age and covered continuously thereafter. The Plan Administrator may require proof of the dependents incapacity status. The Plan Administrator reserves the right to have such dependent examined by a physician of the Plan Administrator's choice, at the Plan's expense, to determine the existence of such incapacity.

In order to continue a dependent child's coverage beyond age 26, you must furnish written verification of their incapacity for self-support within 60 days of the child's 26th birthday.

- Alternate recipients under qualified medical child support orders (QMCSO) required to be covered according to the provisions of ERISA Section 609 (a) (2) (A). Any child of a Covered Person 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. Under a QMCSO, the fact that the child is eligible for, is entitled to, or is provided benefits under Title XIX of the Social Security Act, will not affect the child or children's receipt of benefits under the QMCSO.

A **qualified medical child support order** (QMCSO) is a medical child support order issued by a court, which has jurisdiction, under state law requiring a non-custodial parent to provide medical coverage for his or her children that specifies the individuals involved, the type of coverage to be provided and the Plan that provides the coverage. The QMCSO may not require the Plan to provide

any type or form of benefit, or any benefit option, not otherwise provided under the Plan, except to the extent necessary to meet the requirements of Section 1908 of the Social Security Act.

The phrase **child placed with a covered associate in anticipation of adoption** refers to a child whom the associate 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 associate of 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.

These persons are excluded as dependents: other individuals living in the covered associates’ home, but who are not eligible as defined; the divorced former spouse of the associate; any person who is on active duty in any military service of any country; or any person who is covered under the Plan as an associate.

If a person covered under the Plan changes status from associate to dependent or dependent to associate, 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.

## **Funding**

### Contribution Determinations

The Plan Sponsor will, from time to time, evaluate the costs of the Plan and determine the amount to be contributed by the employer and the amount to be contributed (if any) by each associate.

### Associate Obligations

The coverage afforded to an associate by this Plan may require associate contributions but will be at least partially funded by the employer. If an associate elects to enroll dependents under the Plan, the associate may be responsible for payment of all or a portion of the dependent contributions suitable to cover such enrollment. For associates, the employer will deduct such costs on a regular basis from the associate’s wages or salary.

## ENROLLMENT

*If for any reason eligible dependents are not enrolled within the 30 days following their initial eligibility date and coverage is subsequently desired, coverage may be requested during an Open Enrollment Period or if you qualify subject to the Special Enrollment provisions described herein.*

### **Initial Enrollment Period**

If you desire Plan benefits, you must enroll in the Plan by properly completing and returning an enrollment form to Lourdes Health Network within 30 days of your eligibility date. If you also desire dependent coverage, you must enroll your eligible dependents by this deadline. If you do not have any eligible dependents at the time of initial enrollment but later acquire eligible dependents, including newborns, you may enroll them under a special enrollment period.

Failure to enroll by the deadline noted above may result in your and/or your dependents' inability to secure coverage under this Plan except as specified in the special enrollment and late enrollment provisions below.

### **Special Enrollment Periods**

Those individuals who do not enroll in the Plan at the first opportunity and subsequently lose coverage may be able to enroll in the Plan in compliance with the Health Insurance Portability and Accountability Act of 1996. The enrollment date for anyone who enrolls under a special enrollment period is the first date of coverage. Thus, the time between the date a special enrollee first becomes eligible for enrollment under the Plan and the first day of coverage is not treated as a waiting period.

An individual must be allowed to enroll under the Plan if:

- The associate or dependent had been covered under another group health plan or had an individual health policy at the time coverage was initially offered;
- If required by the Plan Administrator, the associate stated at the time initial enrollment was offered that other coverage was the reason for declining enrollment in the Plan;
- The individual lost coverage as a result of a certain event, such as the loss of eligibility for coverage, loss of eligibility due to the Plan no longer offering any benefits to a class of similarly situated individuals (e.g. part-time associates), expiration of COBRA continuation coverage, termination of employment, reduction in the number of hours of employment, or employer contributions towards such coverage were terminated;
- A new model notice of special enrollment rights is provided. This notice must be provided on or before the time an associate is initially offered the opportunity to enroll in a group health plan;
- The employee must request special enrollment within 30 days of the date coverage is lost, except in the case of a qualifying event involving Medicaid or SCHIP (loss of eligibility or premium assistance eligibility). For these events, the individual must request special enrollment within 60 days of the event.
- The employee's or dependent's Medicaid or State Child Health Insurance Plan (SCHIP) coverage is terminated as a result of loss of eligibility;
- The employee or dependent becomes eligible for a premium assistance subsidy under Medicaid or SCHIP.

If the associate 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), that individual does not have a special enrollment right.

## **Dependent Special Enrollment Period**

Since the Plan provides dependent coverage, when a person becomes a dependent through marriage, birth or adoption, the Plan must provide a dependent special enrollment period of not less than 30 days. If an individual seeks to enroll a dependent during the first 30 days, coverage must become effective:

- In the case of marriage, no later than the first day of the first month beginning after the date the request was completed.
- In the case of a dependent's birth, the date of such birth.
- In the case of adoption or placement for adoption, the date of such adoption, or placement of adoption.
- The date the employee or the employee's spouse is required to provide health coverage to a child under a Qualified Medical Child Support Order (QMCSO), National Medical Child Support Notice (NMCSN) or administrative order.
- The date on which legal guardianship status begins.

## **Newborn Enrollment**

A newborn child will automatically be covered for the first 30 days immediately following birth. Such coverage will end 31 days after the birth of the child. If you agree to contribute any required amounts as defined by the Plan and complete an enrollment form within the initial 30-day period, coverage on the child may continue.

**If for any reason you do not enroll within 30 days after the termination of coverage or within 30 days after marriage, adoption or placement for adoption, or 30 days after a birth, you and your dependents will not be eligible for coverage until the next open enrollment period. The only exception is for special enrollments related to Medicaid or SCHIP (loss of eligibility or gain of premium assistance eligibility), which must be requested within 60 days of the date of the event.**

## **Late Enrollment**

If you or your dependents are not enrolled within 30 days of the date you become eligible, under the terms of this Plan you may only request Plan coverage during the open enrollment period unless you experience a special enrollment situation as outlined above.

## **Election Changes**

In general, you will not be able to revoke or change your election for a plan year. Federal law generally prohibits you from making any changes to your election that affect the dollar amount or taxability of your payroll contributions, except during open enrollment. However, such changes are permitted if they are needed because of a "change of status" and the election is consistent with the change in status. It is possible to experience a "change in status" event, but not have the change affect your eligibility to participate in this Plan or another plan. In this case you cannot make a change in your election.

**Consistency Rule** – Requires that the change in status result in the Associate, Spouse or Dependent gaining or losing eligibility for accident or health coverage under either the cafeteria plan or an accident or health plan of the Spouse's or Dependent's employer, and that the election change correspond with that gain or loss of coverage.

To revoke your election and make a new election, Human Resources must receive the appropriate forms within 30 days of the date of your change of status. If your change in status occurs with less than 30 days remaining in the plan year, the 30-day requirement will extend into the New Year (however, if you wait until the new year to make your adjustments, it can only affect the benefits you

have in the new year). **No change in your election will be permitted after this 30-day period.** You may change your elections once a year during the annual open enrollment period or within 30 days of the following events. These events are referred to as a “Change in Status”:

- **Legal Marital Status** – Events that change your legal marital status, including marriage, death of spouse, divorce, legal separation or annulment.
- **Number of Dependents** – Events that change your number of dependents including birth, adoption, placement for adoption or death of dependent. (Note: Gaining or losing a dependent that is not a tax dependent-such as a parent, domestic parent, or child will not be considered an allowable event for an election change.)
- **Employment Status/Work Schedule** – Events that change your employment status or the employment status of your spouse or dependents that effect your eligibility for benefits including termination or commencement of employment, a strike or lockout, a commencement of or return from an unpaid leave of absence or a change in worksite.
- **Dependent Satisfies or Ceases to Satisfy the Requirements for Dependents** – Events that cause your dependents to satisfy or cease to satisfy the requirements for coverage due to attainment of age or any other similar circumstances.
- **Residence or Worksite** – Events that change your place of residence, the place of residence of your spouse or dependent that effect eligibility for benefits under the Plan.

*You may also change your elections within 30 days of the following events:*

- **Cost Changes** – If there is an increase or decrease in the cost of a benefit plan, the Plan may automatically change the amount of your premium election to cover the change in cost. If the cost change is a significant increase, you may be allowed to either make a new election of the higher cost or revoke your election, but you must elect similar coverage if available. If the cost change is a significant decrease, you may be allowed to commence participation of the option with a decrease in cost.
- **Significant Curtailment of Coverage** – If your coverage is markedly reduced or eliminated all together you may revoke your election and make a new election for similar coverage under a new benefit package option or drop coverage if no similar benefit package option is available. The loss of a physician in the network would not constitute significant curtailment of coverage.
- **Addition (or Improvement) of a Plan Option Providing Similar Coverage** – If during a period of coverage an option is added to the Plan (or an existing option is significantly improved), you may be allowed to elect the new option (or improved benefit option) prospectively on a pre-tax basis and change your election with respect to the other benefit option providing similar coverage.
- **Change in Coverage of Spouse or Dependent Under Another Employer Plan** – You may make an election change that is on account of and corresponds with a change in coverage under another employer plan (including a plan of the same employer or a plan of the spouse’s for dependent’s employer) if one of two conditions are met (a) The other Plan must permit participants to make an election change; or (b) The period of coverage under the associate’s Plan is different from the period of coverage under the other employer plan.
- **Loss of Other Health Coverage** – You may make an election to add coverage under the Plan if you or your covered dependents lose coverage under any group health coverage sponsored by a governmental or educational institution.
- **FMLA Leave** – You may change an election under the Plan upon FMLA and non-FMLA leave.

- **Exception for COBRA Qualifying Events** – If you, your spouse or dependent gains or loses coverage due to a COBRA qualifying event, you may change your election to pay for the continuation of coverage on a pre-tax basis or to reduce your election for the corresponding loss of coverage.
- **Judgment, Decree or Order** – If there is a judgment, decree or order resulting from a divorce, legal separation, annulment or change in legal custody that requires a change in accident or health coverage for your dependent child, you may make an election change to add or drop coverage as ordered.
- **Entitlement to Medicare or Medicaid** – If you, your spouse or dependent becomes entitled to Medicare or Medicaid, you may make a prospective election change to cancel health coverage under this Plan. If you, your spouse or dependent loses coverage under Medicare or Medicaid, you may make a prospective election to begin or increase coverage under this Plan.
- **HIPAA Special Enrollment Rights** – If you gain the right to enroll in this Plan or to add coverage for a family member under the special enrollment rights of HIPAA, the Covered Person may revoke an election for coverage during a period of coverage and make a new election.

If you make a change in election, your new election amount will be effective the date of the qualifying event.

### **Open Enrollment Period**

Within each 12-month period during this program, an open enrollment period shall be authorized to allow eligible associates to change their participation elections, to obtain new participation for the associate and/or eligible dependents or to accept transfers of associates covered under a health maintenance organization. Please contact your Benefits Department for dates of open enrollment.

## TERMINATION OF BENEFITS

### **Associate's coverage will terminate on the earliest of the following dates:**

- The end of the month upon termination of the Plan, the end of the month the Plan ceases for the class of associates to which you belong, or the end of the month the employer terminates its participation in the Plan;
- The end of the month an associate ceases to meet the eligibility requirements.
- The date an associate is no longer actively employed.
- The end of the month upon failure to make any required contributions as regularly scheduled;
- The date of entry to the military service of any country or international organization on a full-time active duty basis other than scheduled drill or other training not exceeding one month in any calendar year; or
- The last day of an approved leave of absence under the Family and Medical Leave Act, if the associate does not return to work.

### **Dependent's coverage will terminate on the earliest of the following dates:**

- The date an associate's coverage is terminated;
- The last day of an approved leave of absence under the Family and Medical Leave Act, if the associate does not return to work;
- The end of the month in which the dependent ceases to meet the definition of a dependent as defined in the Plan; or
- The date the dependent commences participation in the plan as an associate.

Certificates of Coverage will be issued within the time periods specified in federal regulations following loss of coverage in compliance with the provisions of the Health Insurance Portability and Accountability Act of 1996.

**NOTE:** It is the associate's responsibility to notify the Human Resources Department in writing within the designated time frames as noted in the *Important Highlights* Section when an associate or a dependent has a qualifying event occur and that associate or dependent is no longer eligible for benefits. **Failure to notify the Human Resources Department will result in coverage being terminated as of the original date of the occurrence. Any claims paid after that date must be reimbursed to the employer.**

## **COVERAGE FOR ASSOCIATES AND DEPENDENTS OVER THE AGE OF 65**

If you remain an associate after reaching age 65, you and/or your spouse may elect or reject coverage under this Plan. If you elect to remain covered under Lourdes Health Network Health Care Plan, this Plan will be the primary payer of benefits and Medicare will be secondary payer. However, if you choose Medicare to be your primary plan, coverage under this Plan will end. If you do not specifically choose one of the options, this Plan will continue to be primary.

If you choose Lourdes Health Network Health Care Plan as your primary payer, this Plan will pay the same benefits as if you or your spouse were under age 65. If you have enrolled in Medicare, you may then also send any unpaid portion of your bills to Medicare. If you are under age 65 and your spouse is over age 65, he or she can make their own choice. Please contact the Human Resources Department for further details in making this important decision.

## CONTINUATION OF COVERAGE

The Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA) requires that continuation of employer-sponsored health care coverage be made available to formerly covered employees and dependents for a specified period of time. If you become ineligible for coverage as the result of a change in your employment status, your coverage ends on the date of termination. You may choose to continue coverage if you lose your group health coverage because of a reduction in hours scheduled or because of termination for reasons other than gross misconduct.

A covered spouse of an employee may elect to continue coverage under Lourdes Health Network Health Care Plan on a self-pay basis if group health coverage is lost for any of the following reasons:

- The death of the employee;
- Reduction in the employee's hours of employment or termination of the employee's employment for other than gross misconduct;
- Divorce or legal separation from the employee;
- The employee becomes entitled to Medicare; or
- The Employer files for re-organization under Chapter XI of the Bankruptcy Law (only relates to retiree plans).

In the case of a dependent child of an employee covered by Lourdes Health Network Health Care Plan, he or she may choose to continue coverage on a self-pay basis if group health coverage under the Plan is lost for any of the following reasons:

- The death of the employee;
- The termination of the employee's employment for other than gross misconduct or reduction in a parent's hours of employment;
- Parents divorce or legal separation;
- The employee becomes entitled to Medicare;
- The dependent ceases to be a "dependent child" as defined under Lourdes Health Network Health Care Plan; or
- The Employer files for re-organization under Chapter XI of the Bankruptcy Law (only relates to retiree plans).

The employee or the eligible family member has the responsibility to inform the Human Resources Department of a divorce, legal separation, or a child losing dependent status under the Plan within 60 days of the event. It is the responsibility of the Human Resources Department to notify the COBRA Administrator within 30 days of an employee's termination of employment, reduction in hours, \*Medicare entitlement, or \*death.

*\* If a second qualifying event is the death of the covered employee or the covered employee becoming entitled to Medicare benefits, a group health plan may require qualified beneficiaries to notify the Plan Administrator within 60 days of those events, as well. Ordinarily, the employer is responsible for notifying the Plan Administrator of an event that is the death of a covered employee or the covered employee becoming entitled to Medicare benefits. However, if the covered employee's employment has been terminated, the employer may not be in a position to be aware of those events. If the plan does not require qualified beneficiaries to notify the plan within 60 days of a second qualifying event that is the death of the covered employee or the covered employee becoming entitled to Medicare benefits, a qualified beneficiary should provide that notice by the later of the last day of the 18-month period or the date that is 60 days after the date of the second event.*

Children born to, or placed for adoption with a covered employee during a continuation coverage period also have the right to elect COBRA continuation coverage. Enrollment must be completed

and submitted in writing within 30 days of the event and any additional premiums (*if applicable*) paid prior to eligibility. Coverage will be retroactive to the date of the event

You will be notified of your rights to continue coverage on a self-pay basis. You have at least sixty days from the date of the notice of your COBRA continuation of coverage rights to elect COBRA continuation coverage. If you do not choose continuation coverage, your group health insurance coverage will end as of the date you became ineligible to continue as a covered member of Lourdes Health Network Health Care Plan.

If an employee becomes ineligible for employer paid health care coverage because of a reduction in hours scheduled or because of voluntary resignation, the employee's continuation of coverage on a self-pay basis may last for up to 18 months. The 18 months may be extended to 29 months if a qualified beneficiary is determined to be disabled under Title II or XVI of the Social Security Act at any time within the first 60 days of continuation coverage. To benefit from this extension, you must notify the Plan Administrator of the disability determination within 60 days after the determination, and prior to the expiration of the initial 18-month COBRA period. The affected individual also must notify the Plan Administrator within 30 days of any final determination that the individual is no longer disabled.

**18 to 36-Month Period (Second Qualifying Event):** A spouse and dependent children who experience a second qualifying event may be entitled to a total of 36 months of COBRA coverage. Second qualifying events may include the death of the covered employee, divorce or legal separation from the covered employee, the covered employee becoming entitled to Medicare benefits (under Part A, Part B or both), or a dependent child ceasing to be eligible for coverage as a dependent under the group health plan. The following conditions must be met in order for a second event to extend a period of coverage:

- (1) The initial qualifying event is the covered employee's termination of employment, or reduction of hours, which calls for an 18-month period of continuation coverage;
- (2) The second event that gives rise to a 36-month maximum coverage period occurs during the initial 18-month period of continuation coverage (or within the 29-month period of coverage if a disability extension applies);
- (3) The second event would have caused a qualified beneficiary to lose coverage under the plan in the absence of the initial qualifying event;
- (4) The individual was a qualified beneficiary in connection with the first qualifying event and is still a qualified beneficiary at the time of the second event; and
- (5) The individual meets any applicable COBRA notice requirement in connection with a second event, such as notifying the Plan Administrator of a divorce or a child ceasing to be a dependent under the plan within 60 days after the event.

If all conditions associated with a second qualifying event are met, the period of continuation coverage for the affected qualified beneficiary (or beneficiaries) is extended from 18 months (or 29 months) to 36 months.

**18 to 36-Month Period (Special Rule):** A special rule for dependents provides that if a covered employee becomes entitled to Medicare benefits (either Part A or Part B) before experiencing a qualifying event that is a termination of employment or a reduction of employment hours, the period of coverage for the employee's spouse and dependent children ends with the later of the 36-month period that begins on the date the covered employee became entitled to Medicare, or the 18- or 29-month period that begins on the date of the covered employee's termination of employment or reduction of employment hours. (Note that under this special rule, the employee's Medicare entitlement is not a qualifying event because it does not result in loss of coverage for the employee's

dependents; thus, the 36-month coverage period would be part regular plan coverage and part continuation coverage.)

Although an employee or eligible dependent may elect to continue coverage as outlined above, this period may be reduced because of any of the following events:

- The employer no longer provides group health coverage to any of its employees;
- The premium is not paid within the 45-day grace period following the election of COBRA continuation coverage;
- The premium for your continuation coverage is not paid; (the premium is due on the first of each month and will not be accepted after the thirtieth calendar day after the due date);
- You become an employee covered under another group health plan (the Covered Person may be able to maintain continuation of coverage if there is a pre-existing condition clause that would limit your coverage under the other group plan); However, if other group health coverage is obtained prior to the COBRA election, COBRA coverage may not be discontinued, even if the other coverage continues after the COBRA election.
- You or a covered dependent becomes entitled to Medicare after the COBRA election. However, if Medicare is obtained prior to COBRA election, COBRA coverage may not be discontinued, even if the other coverage continues after the COBRA election.

*Additional information can be found regarding COBRA provisions for public-sector employees at [www.cms.hhs.gov/](http://www.cms.hhs.gov/) (The Center for Medicare and Medicaid Services).*

- You were divorced from a covered employee and subsequently remarry, and are covered under your new spouse's group health plan.

If an employee or covered dependent elects to continue coverage on a self-pay basis, they may do so without proving insurability. However, if the election is not made within 60 days, health care coverage under the Plan will terminate retroactively to the day of the qualifying event. Further if the eligible employee or eligible dependent fails to make the initial COBRA continuation coverage premium payment within the 45-day grace period following the election of COBRA coverage they will be deemed ineligible for COBRA continuation coverage.

**NOTE:** Payment will not be considered made if a check is returned for non-sufficient funds.

The Plan Administrator reserves the right to terminate Plan coverage retroactively to the date the employee or covered dependent lost their eligibility under the terms of the employer-sponsored health care plan. This section of the Summary Plan Description is a summary of a very complicated law. In the event of any inconsistency between this Notice and federal law, federal law will take precedence.

### **Special Additional Continuation Coverage Election Period For "TAA-Eligible Individuals"**

In addition to the other COBRA rules described above, there are some special rules that apply if you are classified as a "TAA-eligible individual" by the U.S. Department of Labor. (This applies only if you qualify for assistance under the Trade Adjustment Assistance Reform Act of 2002 because you become unemployed as a result of increased imports or the shifting of production to other countries.) The *Plan Administrator* will require documentation evidencing eligibility of TAA benefits, including but not limited to, a government certificate of TAA eligibility, federal income tax filings, etc. The plan need not require every available document to establish evidence of TAA eligibility. You will be responsible for providing evidence of TAA eligibility when applying for coverage under the plan. The plan will not be required to assist you in gathering such evidence.

If you are classified by the Department of Labor as a TAA-eligible individual, and you do not elect continuation coverage when you first lose coverage, you may qualify for an election period that

begins on the first day of the month in which you become a TAA-eligible individual and lasts up to 60 days. However, in no event can this election period last later than 6 months after the date of your TAA-related loss of coverage. If you elect continuation coverage during this special election period, your continuation coverage would begin at the beginning of that election period, but, for purposes of the required coverage periods described in this notice, your coverage period will be measured from the date of your TAA-related loss of coverage. For example:

The Trade Adjustment Assistance Act also provides for a tax credit that may apply to some of your expenses for continuation coverage. You should consult with a financial advisor if you have questions about the tax credit.

#### *TAA Coverage and HIPAA Creditable Coverage*

If you are a TAA-eligible individual who elects COBRA after becoming TAA eligible, the period beginning on the date of the TAA-related loss of coverage and ending on the first day of the TAA-related election period will be disregarded for purposes of determining the 63-day break-in-coverage period pursuant to HIPAA rules regarding determination of prior creditable coverage for application to the plan's pre-existing condition provision.

#### *Applicable Premium Payments*

Payments of any portion of the applicable COBRA premium by the federal government on behalf of a TAA-eligible individual pursuant to TAA will be treated as a payment to the plan. Where the balance of any premium owed the plan by such individual is determined to be significantly less than the required applicable premium, as explained in IRS regulations 54.4980B-8, A-5 (b), the plan will notify such individual of the deficient payment and permit 30 days to make full payment. Otherwise the plan will return such deficient payment to the individual and coverage will terminate as of the original premium due date.

#### **If You Have Questions**

If you have questions about your COBRA coverage, you should contact The COBRA Administrator or you may 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 the EBSA's website at [www.dol.gov/ebsa](http://www.dol.gov/ebsa).

#### **Keep Your Plan Informed of Address Changes**

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

## **Family and Medical Leave Act**

The Family and Medical Leave Act (FMLA) provides leaves of absence up to 12 weeks for the birth or adoption of a child, care of an immediate family member with a serious health condition, or because of the associate's inability to perform the functions of his or her job due to the associate's own serious health condition. Health coverage benefits during your approved leave of absence under The Family and Medical Leave Act will continue as long as you pay any required contributions. If you do not return to work at the end of an approved leave, you will be required to reimburse the employer the difference between any required contributions and the total monthly premium.

Under the law, associates are eligible if they have worked for a covered employer for at least one year, and for 1,250 hours over the previous 12 months, and if there are at least 50 associates within 75 miles. Lourdes Health Network will consider the 12-month period to begin on the date the associate's FMLA leave first begins.

It is the associate's responsibility to request leave under the FMLA and to comply with all requests for information, such as medical certifications, made by your employer. When the need for leave is foreseeable, the associate must provide reasonable prior notice and make efforts to schedule leave so as not to disrupt company operations. If you have any questions concerning your rights under the Family and Medical Leave Act, or your employer's responsibilities under the Act, please contact the Human Resource Department.

*Service Member Family Leave:* An eligible employee who is the spouse, son, daughter, parent, or next of kin of a service member who is recovering from a serious illness or injury sustained in the line of duty on active duty is entitled to 26 weeks of leave in a single 12-month period to care for the service member. This leave is available during a "single 12-month period" during which an eligible employee is entitled to a combined total of 26 weeks of all types of FMLA Leave combined.

## **Military Leave of Absence**

In the event an associate, who is a member of the United States Armed Forces Reserves, is called to active duty he may elect to continue Plan coverage for up to 24 months, beginning on the date the associate's absence starts. The associate may be required to pay up to 102% of the full premium cost for continuation coverage, except a person on active duty for 30 days or less will not be required to pay more than the associate's share, if any, for the coverage. These rights apply only to associates and their dependents covered under the Plan before leaving for military service. If you have any questions regarding military leave of absence, continuation of coverage, the cost of continued coverage or the maximum period of such coverage, please contact the Human Resources Department.

If your participation in this Plan is terminated by reason of service in the uniformed services, your coverage will be reinstated upon re-employment without any exclusions or waiting periods that would not have applied if coverage had not been terminated. However, applicable exclusions may be imposed with respect to coverage of any illness or injury determined by the Secretary of Veterans Affairs to have been incurred or aggravated during service in the military.

## COORDINATION OF BENEFITS PROVISION

The purpose of this Plan is to provide you with reimbursement of your covered medical expenses based on the description of coverage as outlined in this Summary Plan Description. In the event that you or any of your covered dependents incur expenses for which benefits are payable under this Plan and at the same time benefits are payable under any other plan, the Plan will coordinate benefits.

In coordinating benefits, one of the two or more Plans involved will be the primary Plan, and the other Plans will be secondary to it. The primary Plan pays without regard to the other Plans. The secondary Plans will coordinate their payments so that the total paid from all plans shall not exceed 100% of the actual charges.

An allowable expense is defined as any necessary health care service or supply when the service or supply is covered at least in part under any of the Plans involved. An example would be the difference between the cost of a private Hospital room and the cost of a semiprivate Hospital room is not considered an allowable expense if both the plans did not allow the cost.

Benefits, however, will still be limited under our Plan such that we will pay no more than what the Plan would have been paid in the absence of this coordination provision. The applicable deductible and co-insurance limits will be applied to those expenses for which this Plan is liable either as the primary Plan or the secondary Plan.

Examples of other types of coverage with which benefits will be coordinated are:

- Insurance or any other arrangement of benefits for individuals of a group, including coverage for students sponsored by or provided through a school or other educational institution.
- Pre-payment coverage or any other coverage toward the costs of which any employer makes contributions or payroll deductions or any labor union makes contributions.
- Any governmental program or coverage required by statute including Medicare.
- Liability, homeowner's or automobile insurance, which is subject to any Motor Vehicle Financial Responsibility Law. This Plan shall have secondary liability for those medical expenses incurred as a result of a motor vehicle accident, on behalf of a Covered Person subject to any state automobile insurance law, regardless of the terms and conditions of any specific automobile policy. Furthermore, if a Covered Person has no Personal Injury Protection or medical benefits coverage, in a state where such coverage is mandated, coverage under this Plan shall be reduced by the minimum coverage requirement of the state with jurisdiction. In addition to the above, for those Covered Persons subject to no-fault automobile insurance law or the law of any other state which permits issuance of a state mandated motor vehicle policy with an optional high personal injury protection deductible, this Plan shall not recognize as a covered expense, the personal injury protection deductible selected by any Covered Person. Such deductible amount shall be the direct responsibility of the Covered Person.

The Plan will not consider as an allowable expense any charge that would have been covered by an HMO had a Covered Person for whom the HMO would be primary payer used the services of an HMO participating provider. The Plan will not consider any charge in excess of what an HMO provider has agreed to accept as payment in full.

*The rules establishing the order of benefit determination are as follows:*

### **No Coordination of Benefit Provision**

If the other plan contains no provision for coordination of benefits, then its benefits shall be paid before all other Plan(s).

### **Non-Dependent or Dependent**

The Plan covering the person other than as a dependent (for example, as an associate, member, subscriber, or retiree) is the primary plan, and the plan covering the person as a dependent is the secondary plan.

### **Associate or Retiree**

If an individual is covered under one plan as an associate and another plan as a retiree, the associate plan is primary. However, if an individual is covered both as a retiree under one plan and as a dependent under a spouse's associate plan, order of benefit determination is that the retiree plan pays first and the dependent plan pays second.

### **Continuation Coverage (COBRA)**

If an individual has continuation coverage under the federal COBRA law or state continuation laws and also is covered under another group health plan as an associate or retiree, then the continuation coverage pays second.

### **Effect of Medicare**

This program provides primary coverage when both Medicare and this program cover you or your dependents. This means that this program pays benefits first and Medicare pays benefits second.

If the associate or spouse is under age 65, disabled and eligible for Medicare, this program is primary unless the disability is due to end-stage renal disease (ESRD). If the disability is due to ESRD, then this program is primary for the first 30 months of ESRD care. At the start of the thirty-first month, Medicare becomes primary.

When this program is not primary, it will coordinate benefits with Medicare. This will be done if you are entitled to Medicare, whether or not you choose to enroll or claim benefits to which you are entitled.

*The specific rules establishing the order of benefit determination for a child covered under more than one plan are as follows:*

### **Birthday Rule**

If the parents are married or if a court order awards joint custody without specifying which parent has responsibility for providing health care coverage, the primary plan is the plan of the parent whose birthday is earlier in the year.

### **Court Order**

If a court order specifies that one parent is responsible for health coverage, the plan of that parent will be the primary plan.

### **Parents are Separated or Divorced**

In the absence of a specific court order the order of benefit determination is as follows:

- The plan of the custodial parent.
- The plan of the spouse of the custodial parent.
- The plan of the non-custodial parent.
- The plan of the spouse of the non-custodial parent.

When the above referenced rules fail to establish an order of benefit determination, the plan that has covered the person for the longer period of time is the primary payer.

### **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 Covered Person will give this Plan the information it asks for about other plans and their payment of 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 Covered Person. That repayment will count as a valid payment under the other benefit plan.

## SUBROGATION, REIMBURSEMENT & THIRD PARTY RECOVERY

The Covered Person may incur medical or dental charges due to injuries, which may be caused by the act or omission of a third party or a third party may be responsible for payment. In such circumstances, the Covered Person may have a claim against the liable third party, including but not limited to any Third Party's liability insurance and uninsured or underinsured motorist. The benefits advanced, or to be advanced by this medical plan will be paid only if the Covered Person fully cooperates with the terms and conditions of the Plan. When the Plan advances benefits for accidental injury or illness or other loss for the benefit of a Covered Person, the Plan shall be subrogated to all rights of recovery that the person, his heirs, guardians, executors, agents or other representatives may have as a result of the loss.

The Covered Person under the Plan who claims and receives an advance(s) of benefits on account of an injury caused by a third party must execute a reimbursement agreement at the time the first claim is submitted. The signed reimbursement agreement indicates that the Covered Person agrees to promptly reimburse the Plan for benefits advanced, out of any monies recovered against the person causing the injury or any other source as the result of judgment, award, settlement or otherwise.

Accepting advanced benefits under this Plan for incurred medical or dental expenses automatically assigns to the Plan any rights the Covered Person may have to recover payments from any third party or insurer. This subrogation right allows the Plan to pursue any claim, which the Covered Person has against any third party, or insurer, whether or not the Covered Person chooses to pursue that claim. The Plan may make a claim directly against the third party or insurer, but in any event, the Plan has a lien on any amount recovered by the Covered Person whether or not designated as payment for medical expenses. This lien shall remain in effect until the Plan is repaid in full.

The Covered Person agrees to recognize the Plan's right to subrogation and reimbursement from the first dollars recovered. The Plan specifically states that it has priority over **any and all** funds paid by any party to a Covered Person relative to the injury or sickness, including a priority over any claim for non-medical or dental charges, attorney fees, other costs or expenses, whether or not the Covered Person is made whole. If the Covered Person fails to reimburse the Plan for all benefits paid or to be paid, as a result of said injury or condition, out of any recovery or reimbursement received, the Covered Person will be liable for expenses (whether fees or costs) associated with the Plan's attempt to recover such money from the Covered Person. However, if the Plan chooses to be represented by your attorney, it will pay, on a contingent basis, a reasonable portion of the attorney's fees which are necessary and which benefit the Plan's rights of recovery in the case. This portion will usually not be more than 20% of the amount the Plan seeks to recover. The Plan may not pay for any legal costs incurred by you as the enrollee, or for costs incurred on your behalf. You will not be required to pay any portion of costs incurred by or on behalf of the Plan. The Plan may not pay for any additional care or treatment for the Covered Person, whether anticipated or unanticipated, until the Plan is reimbursed in accordance with the Plan terms.

If the injured person is a minor, any amount recovered by the minor, the minor's trustee, guardian, parent, or other representative, shall be subject to this provision regardless of state law and/or whether the minor's representative has access or control of any recovery funds. If the injury or condition giving rise to subrogation involves wrongful death of a Covered Person, this provision applies to the parent, guardian or the executor, agent or other personal representative of the estate.

When a right of recovery exists, the Covered Person will execute and deliver all required instruments and papers as well as doing whatever else is needed to secure the Plan's right of subrogation as a condition to having the Plan advance benefits. Failure or refusal to execute such

agreements or furnish information does not preclude the Plan from exercising its right to subrogation or obtaining full reimbursement. In addition, the Covered Person will do nothing to prejudice the right of the Plan to subrogate. Any settlement or recovery received shall first be deemed for reimbursement of medical expenses paid by the Plan.

The Plan shall have no obligation to share the costs of, or pay any part of, the Covered Person's attorney's fees and costs incurred in obtaining any recovery. The Plan Administrator retains sole and final discretion for interpreting the terms and conditions of this Plan Document. Please refer to the *Defined Terms* Section for definitions of Subrogation, Recovery and Reimbursement.

## COVERED MEDICAL EXPENSES

Your benefit plan is designed to reimburse you for covered medical expenses you incur for treatment necessary because of an illness or an accident. All expenses must be reasonable and customary in order to be considered for benefit payment.

**Usual, Customary and Reasonable (UCR)** means the usual charge made by the physician, Hospital or other medical professional providing the service or medical supplies. However, this is limited also in that the charge shall not be in excess of the normal charges for similar services or supplies within the local area in which your service is rendered. Generally, the local area is defined as a county or such additional area as is necessary to obtain a reasonable cross section of other medical professionals or institutions providing such services or supplies.

When possible, it is recommended that the Covered Person obtain from their medical professionals an indication of what services are to be rendered, and the cost of those services prior to the actual treatments being performed. This information should then be forwarded to the Plan for review. The Plan will provide the Covered Person with a written statement in advance of the treatment, identifying how much of the expense can be reimbursed through the benefit schedule.

**Acupuncture** – The insertion of needles into the human body to control the flow and balance of energy in the body and to cure and relieve any ailment or disease of the mind or body or any wound, bodily injury or deformity.

**Ambulance** – Professional ground ambulance service when used to transport the Covered Person from the place where they are injured or stricken by a Sickness to the nearest Hospital where treatment can be given.

The Plan will also cover air ambulance to transport the Covered Person to the nearest medical facility equipped to provide care.

Ambulance transportation is also covered when transportation is from one hospital or facility to another when deemed medically necessary.

**Breast Reconstruction** – In accordance with the Women's Health and Cancer Rights Act the following coverage is offered to a Covered Person who elects the following services in connection with a mastectomy:

- Reconstruction of the breast on which the mastectomy has been performed;
- Surgery and reconstruction of the other breast to produce symmetrical appearance; and
- Coverage for prostheses and physical complications of all stages of mastectomy, including lymphedemas, in a manner determined in consultation with the attending physician and the patient.

**Chiropractic Care** – Modalities (hot, cold therapy, etc.) manipulation and adjunctive therapy by a Covered Provider to anatomically correct vertebral disorders such as incomplete dislocation, off-centering, misalignment, misplacement, abnormal spacing, sprain or strain.

**Dental** – Accidental dental injuries are covered under the following limitations:

- Dental benefits must be exhausted before any benefits are payable under medical.
- Treatment must begin within 30 days of the date of injury.
- Treatment will only be covered for 12 months from the date of injury.
- The patient must be covered under this Plan when injury occurs.

**Please Note:** For services provided to a natural tooth, the tooth must be the enrollee's natural, living tooth that was free from decay and otherwise functionally sound at the time of the injury.

"Functionally sound" means that the affected teeth:

- Do not have extensive restoration, veneers, crowns or splints;
- Do not have periodontal disease or other condition that, in our judgment, would cause the tooth to be in a weakened state prior to the injury.

Dental hospital services are paid the same as any other condition with the following limitation:

- Adequate care can not be provided outside the hospital and underlying medical condition requires hospitalization.

**Diabetic Management** – The following diabetic education and self-management programs are covered:

- All Physician prescribed medically appropriate and necessary equipment and supplies used in the management and treatment of diabetes; and
- Diabetes outpatient self-management training and education, including medical nutrition therapy that is provided by a certified, registered, or licensed health care professional working in a program consistent with the national standards of diabetes self-management education as established by the American Diabetes Association. Coverage is provided for individuals with gestational, Type I or Type II diabetes.

**Diagnostic Services** – Charges for professional fees from a physician, as well as facility charges for diagnostic x-ray and laboratory services.

**Durable Medical Equipment** – Rental of durable basic (i.e. non-luxury) medical equipment (not to exceed the purchase price) or purchase of such equipment where only purchase is permitted or where purchase is more cost-effective due to a long-term need for the equipment. This will also include repair, maintenance, delivery services and disposable supplies of such equipment. Such equipment must be prescribed by a Physician and required for therapeutic use in treatment of an active Sickness or Accidental Injury.

Durable medical equipment includes such items as braces, crutches, wheelchairs, hospital beds, traction apparatus, head halters, cervical collars, oxygen and dialysis equipment, etc. which:

- Can withstand repeated use.
- Are primarily and customarily used to serve a medical purpose.
- Generally are not useful to a person in the absence of Sickness or Accidental Injury.
- Are appropriate for use in the home.

**Health Education Programs** – Benefits will be provided for the following health education programs: Childbirth classes; Smoking cessation, and Diabetic instruction billed by a Preferred or Participating hospital; Dietary instruction given as part of diabetic instruction or, services of a registered dietician billed by a hospital as part of a covered inpatient or outpatient stay.

**Home Health Care** – These are the charges made by a licensed home health care agency for the following services and supplies furnished to a Covered Person in his/her home. A Physician must certify the services as medically necessary.

- Part-time or intermittent nursing care by a registered graduate nurse (RN) or by a licensed practical nurse (LPN).
- Part-time or intermittent home health aide services which consist primarily of caring for the patient.
- Therapy as deemed Medically Necessary including phototherapy by a registered nurse for treatment of jaundice or a newborn child.
- Medical supplies, drugs and medicines prescribed by a physician, and laboratory services provided by or on behalf of a hospital, but only to the extent that such charges would have been covered if the covered person had remained in the hospital.

Each visit by a registered graduate nurse (R.N.) licensed practical nurse (L.P.N.) or therapist, will count as one home health care visit. Four hours of home health aide services shall be considered as one home health care visit.

**Home Intravenous Therapy** – Includes professional services, supplies, drugs and solutions furnished and billed by one of the following providers:

- A home health agency or hospice that is Medicare-certified as such or licensed or certified as such by the state in which it operates.
- An intravenous therapy provider that is state-licensed or state certified as both a home health agency and a pharmacy.

**Hospice Care Benefits** – The Plan will cover as an eligible expense those charges incurred by a terminally ill patient and rendered by a Hospice care provider either in the patient's home or a Hospice facility. These services must be developed by a Hospice care program in consultation and in agreement with the patient's physician. The prognosis of the patient's life expectancy must be 6 months or less.

Hospice care shall consist of the following services and supplies:

- Room & Board, including special diets (not to exceed the semi-private room rate);
- Respite care to a maximum of 120 in each three month period;
- Services of a Physician, RN, LPN, home health aide and nutritionist;
- Medical supplies, nutritional supplements, drugs and medicines prescribed by a physician, and laboratory services, durable medical equipment, oxygen and any other eligible expenses normally covered under this Plan; and
- Family counseling directly related to the patient's terminal condition, which must be furnished within six months after the patient's death.

#### Limitations

This benefit is limited by all the limitations as listed in this section, as well as all limitations of the Plan as a whole. No hospice care benefits will be provided for:

- Medical care rendered by a private physician not affiliated with the Hospice Care Agency.
- Volunteers who do not regularly charge for services.
- Pastoral services.
- Homemaker services.
- Food or home delivered meals.

**Hospital Services** – Inpatient and outpatient hospital expenses will be eligible for coverage if they are determined to be medically necessary and appropriate for the proper treatment of the covered person's condition. Inpatient hospital stays will be payable according to the average semi-private room rate. Also covered under hospital services are:

*Ambulatory Surgical Center* – Services and supplies provided by an ambulatory surgical center in connection with a covered outpatient surgery.

*Birthing Center* – Services and supplies provided by a birthing center in connection with a covered pregnancy.

*Blood* – Charges for whole blood or blood plasma, administration of blood, blood processing and materials and supplies of technicians. *Please note that the cost for blood or plasma replaced by or for the patient is not reimbursed under the Plan.*

*Diagnostic X-ray and Laboratory* – Facility fees for diagnostic x-ray and laboratory examinations.

*Emergency Medical Care* – The initial treatment of a sudden onset of a medical condition or accidental injury with symptoms of sufficient severity to require immediate medical attention.

*Intensive Care Unit* – Hospital charges for intensive care accommodation.

*Medical Care or Supplies* – Special hospital charges for inpatient medical care or supplies received during any period room and board charges are made. This does not include personal supplies or convenience items.

*Pre-Admission Testing* – Outpatient tests and studies required for your scheduled admission to a hospital. Pre-admission testing must be done within 14 days before a pre-scheduled hospital confinement.

*Private Room Allowance* – If a Covered Person is confined to a hospital's private room, the Plan will pay the private room rate only if:

- The private room confinement is recommended by a physician and is medically essential for the necessary care and treatment of an injury or sickness; or
- A semi-private room is not available and the use of a private room is therefore necessary.

Otherwise, the Plan will pay the semi-private room rate.

**Infertility Diagnosis** – Charges for all tests billed by provider and counseling to determine the diagnosis of infertility.

*All other expenses for the promotion of conception including, but not limited to artificial insemination, in vitro fertilization, and GIFT are excluded by the Plan.*

**Maternity** – Pregnancy expenses are covered to the same extent as any other Sickness. Coverage will NOT include expenses incurred by a surrogate mother, who is not a Covered Person, nor a dependent child. However, complications of pregnancy are covered on the same basis as any other illness for the associate, spouse and eligible dependent child.

Benefits include:

- Prenatal care, including diagnostic and screening procedures, and genetic counseling for prenatal diagnosis of congenital disorders of the fetus.
- Delivery, including cesarean section.
- Postpartum care consistent with accepted medical practice which is ordered by the attending provider, in consultation with the mother. Postpartum care includes services of the attending provider, a home health agency and/or registered nurse.

In addition to "General Limitations and Exclusions," this Plan will not pay for:

- Sex typing or paternal typing, except as may be required for prenatal diagnosis of congenital disorders.

**Please note:** Attending provider as used in this benefit means a physician (M.D. or D.O.), a physician's assistant, a certified nurse midwife (C.N.M.), a licensed midwife, or an advanced registered nurse practitioner (A.R.N.P.).

**Maternity Home Health Care Visit** – If you are discharged from inpatient care prior to 48 hours following a normal vaginal delivery or 96 hours following a cesarean delivery, you are entitled to one maternity home health care visit within 48 hours of discharge. Services include but are not limited to post partum care, parent education, assistance and training in breast and bottle feeding, infant screening and clinical tests and the performance of any necessary maternal and neonatal physical assessments.

**Medical Services and Supplies** – Disposable medical supplies such as casts, splints, crutches, surgical dressings, colostomy bags and related supplies, and catheters.

**Mental Health** – For Plan purposes, a mental health condition will include schizophrenic disorders, paranoid disorders, affective disorders (depression, mania, and manic depressive illness), anxiety disorders, somatoform disorders, personality disorders, and disorders of infancy, childhood and adolescence, except for those conditions that are expressly excluded in the list of *Medical Limitations and Exclusions* Section. Mental health benefits are payable as described in the *Schedule of Benefits*. Psychiatrists (M.D.), Psychologists (Ph.D.), a Master of Social Work (MSW), a Master of Arts (MA), a Certified Mental Health Counselor (CMHC), and a Licensed Community Mental Health Agency may bill the Plan directly. Other licensed mental health practitioners must be under the direction of and must bill the Plan through these professionals. *Residential treatment or services of a facility licensed or registered as a residential treatment facility are not covered under the mental health benefit.*

**Midwife** – Services of a registered nurse midwife when provided in conjunction with a Covered Pregnancy.

**Newborn Care** – Hospital nursery services and a Physician's exam provided during the three weeks from birth to a covered well newborn child, including a PKU test (dietary formula when medically necessary for treatment of PKU) and circumcision.

**Nursing Services (Private Duty)** – Services of a registered graduate nurse (R.N.) or licensed practical nurse (L.P.N.) for private duty nursing services when medically necessary and prescribed in writing by the attending Physician or surgeon specifically as to duration and type.

**Organ Transplants** – Eligible Expenses incurred by a Covered Person who is the recipient of a human organ or tissue transplant includes:

- **Donor Costs.** Benefits for procurement of the donor organ or bone marrow are covered up to a \$75,000 donor maximum. The Plan will cover the evaluation of the donor organ or bone marrow, its removal and transport of both the surgical/harvesting team and donor organ or bone marrow. Also covered are bone marrow testing and typing of the brothers, sisters, parents and children of the enrollee who needs the transplant. Testing and typing of any other potential donor is not covered.
- **Travel Expenses.** A maximum of \$7,500 per transplant is allowed for reasonable and necessary transportation and living expenses of the member and one companion, not to exceed three months.

**Please Note:** Transplant-related services that are covered under the other benefits of this Plan are not subject to any preexisting condition waiting periods.

In addition to "General Limitations and Exclusions," the Plan will not provide this benefit for:

- Services and supplies that can be paid for by any government, foundation or charitable grant. This includes services performed on potential or actual living donors and recipients and on cadavers.
- Donor costs for a transplant that is not covered under this Plan, or for a recipient who is not an enrollee. However, complications and unforeseen effects from an enrollee's organ or bone marrow donation will be covered under this program as any other illness.
- Donor costs for which benefits are available under other group or individual coverage.
- Services and supplies that are experimental or investigative.
- Non-human or mechanical organs, unless deemed non-experimental and non-investigational.
- Transport, except as named under "Donor Costs" and "Travel Expenses" above.
- Organ or bone marrow search or selection costs (including registry charges), except as named under "Donor Costs" above.
- Personal care items.
- Antirejection drugs. These drugs are only covered under your Prescription Drug benefit.

- Corneal transplants, skin grafts and the transplant of blood or blood derivatives (except for hematopoietic stem cells) as these services are covered under a different benefit provision of the Plan.

### **Orthognathic Surgery**

Institutional, professional, and other related services will be covered to the same extent as any other condition for orthognathic surgery.

Orthodontic treatment is not covered under this benefit.

**Orthotics** – This benefit provides for one pair, per enrollee, per calendar year, of casted orthotics (including foot impression castings) medically necessary for prevention of complications associated with diabetes or for the treatment of any illness or injury eligible under this program.

The Plan will not provide this benefit for:

- Orthotics prescribed primarily for use during participation in sports, recreational and similar activities,
- Corrective shoes, and arch supports (except as required for prevention of complications associated with diabetes).

**Orthopedic Appliances** – This benefit provides for medically necessary orthopedic appliances such as therapeutic shoes for prevention of complications associated with diabetes; and braces and splints as may be reasonably required for normal daily activities for treatment of any illness or injury eligible under this program. Therapeutic shoes are limited to one pair, per enrollee, per calendar year. All appliances must be prescribed and furnished by a preferred provider.

The Plan will not provide this benefit for:

- Orthotics prescribed primarily for use during participation in sports, recreational and similar activities,
- Corrective shoes, and arch supports (except as required for prevention of complications associated with diabetes).

**Partial Hospitalization** – If a Covered Person incurs expenses for Partial Hospitalization as a result of Mental/Nervous/Alcohol/Substance Abuse, the Plan will pay for each day of confinement as follows:

- Partial hospitalization must be a medically necessary alternative to inpatient hospitalization and is designed for patients who do not require 24-hour care, but who would benefit from more intensive treatment than ordinarily offered on an outpatient basis.

**Physician Services** – Medical and surgical treatment by a physician (M.D. or D.O.) including office, home or Hospital visits, clinic care and consultations.

*Allergy Testing and Treatment* – Including coverage for allergy injections.

*Hospital Visits* – Physician consultation services during your Hospital confinement and expenses for inpatient visits by a physician.

*Office Visits* – Covered services for office visits.

**Preventive Care** – The Plan will provide preventive health care services as described in the *Schedule of Medical Benefits*. Preventative care includes:

*Wellness Examination* – Preventative Care examinations, including a complete medical history and necessary diagnostic services needed because of your sex, age and medical background. Refer to the child wellness health guidelines and adult wellness health guidelines for additional information.

*Mammography Screening*

If a woman of any age has a history of breast cancer or her mother or sister has a history of breast cancer, the Plan will cover mammograms as recommended by their physician. In no event will more than one screening per benefit plan year be covered.

**Prosthetics** – Charges for services and supplies including manmade limbs or eyes for the replacing of natural limbs or eyes (initial replacement of natural limbs only). Covered services include: purchase, fitting and adjustments to prosthetics and supplies; orthopedic braces; eyeglasses or contact lenses to replace function of the human lens; corneal or sclera lenses; and replacement of a prosthetic for a dependent child due to the normal growth process.

**Rehabilitation Therapy** – Benefits are provided for inpatient care in a hospital or in another rehabilitation facility, whether it is a separate admission or part of a continuous inpatient stay that began with acute care. Inpatient care is only covered when services cannot be done in a less intensive setting. Services must be medically necessary to restore and improve a bodily or cognitive function that was previously normal but was lost as a result of an injury, illness, or surgery.

- *Inpatient Care* Inpatient rehabilitation therapy services must be furnished in a specialized rehabilitative unit of a hospital and billed by the hospital or be furnished and billed by another approved rehabilitation facility. When rehabilitation follows acute care in a continuous inpatient stay, this benefit starts on the day that the care becomes primarily rehabilitative. This benefit only covers care you receive within 24 months from the onset of the injury or illness or from the date of the surgery that made rehabilitation necessary. The care must also be part of a written plan of multidisciplinary treatment prescribed and periodically reviewed by a physiatrist (a physician specializing in rehabilitative medicine).
- *Additional Inpatient Rehabilitation* Subject to the other provisions of the Rehabilitation Benefit, additional benefits are available for cerebral vascular accident and brain or spinal cord injuries caused by an external force and will be covered as follows: Inpatient and outpatient benefits furnished at PPO and Non-Contracting facilities are provided at 80% of allowable charges. All other Preferred and Non-PPO providers are covered at 50% of allowable charges.

Benefits for inpatient rehabilitation services will be provided when care cannot be rendered on an outpatient basis or in a lesser care facility such as a skilled nursing facility. Direct admission for rehabilitation must occur in a Medicare-certified rehabilitation unit.

**Please note:** The extension must be medically necessary, and there is expected functional improvement.

- *Outpatient* Benefits for outpatient care are subject to the following provisions:
  - You must not be confined in a hospital or other medical facility;
  - The therapy must be part of a formal written treatment plan prescribed by a physician;
  - Services must be furnished and billed by a hospital, another approved rehabilitation facility, a physician (M.D. or D.O.), or a physical, occupational, or speech therapist.

**Second Surgical Opinion** – A second surgical opinion consultation following a surgeon's recommendation for surgery. The Physician rendering the second opinion regarding the medical necessity of a proposed surgery must be qualified to render such a service, either through experience, specialist training or education, or similar criteria, and must not be affiliated in any way with the Physician who will be performing the actual surgery.

A third opinion consultation will also be covered if the second opinion obtained does not concur with the first Physician's recommendation. This third Physician must be qualified to render such a service and must not be affiliated in any way with the Physician who will be performing the actual surgery.

**Skilled Nursing Facility** – Benefits are provided for Semi-private room and board and ancillary supplies that are provided by a Skilled Nursing Facility, but only when confinement:

- Is not for custodial care;
- Is preceded by confinement of at least three (3) days of hospitalization;
- Covered Person's condition requires skilled nursing care for continued treatment; and
- Covered Person is admitted to the skilled nursing facility within seven (7) days following discharge from an accredited Hospital wherein services were rendered for the same or related conditions causing the confinement in the skilled nursing facility.

**Sleep Disorders** – Care and treatment for sleep disorders.

**Substance Abuse** – For Plan purposes substance abuse is physical and/or emotional dependence on drugs, narcotics, alcohol or other addictive substances to a debilitating degree. It does NOT include tobacco dependence or dependence on ordinary drinks containing caffeine. All treatment is subject to the benefit payment levels shown in the *Schedule of Medical Benefits*. Psychiatrists (M.D.), Psychologists (Ph.D.) or counselors (Ph.D.) may bill the Plan directly. Other licensed mental health practitioners must be under the direction of and must bill the Plan through these professionals.

**Surgical Expenses** – Professional service charges made by a physician for medical services including surgery.

- *Anesthesia* – Anesthetics and services of a Physician or registered nurse anesthetist for the administration of anesthesia.
- *Assistant Surgeon* – The services of an assistant surgeon not to exceed 20% of the reasonable and customary charge of the primary surgeon.
- *Multiple Surgical Procedures* – When two or more surgical procedures are performed during the same session through the *same* incision, natural body orifice or operative field. The amount eligible for consideration is the reasonable and customary charge for the largest amount billed for one procedure, plus 50% of the reasonable and customary charge for the next largest procedure, and 25% of the sum of reasonable and customary charges for all other procedures performed.
- *Co-Surgeons* – The services of co-surgeons are eligible for consideration at 125% of the eligible charge divided evenly between the two surgeons. If more than one procedure is performed by the co-surgeons, multiple surgical reductions would apply as applicable.
- *Multiple Surgical Procedures* – When two or more surgical procedures are performed during the same session through *different* incisions, natural body orifices or operative fields. The amount eligible for consideration is the reasonable and customary charge for the largest amount billed for one procedure, plus 50% of the sum of the reasonable and customary charges billed for all other procedures performed.
- *Primary Surgeon* – Professional service charges made by a physician for medical services incurred related to the surgery.
- *Surgical Dressings* – Expenses related to surgical dressings, splints, casts and other devices used in the reduction of fractures and dislocations.

**Temporomandibular Joint Disorder (TMJ) and Myofacial Pain Syndrome (MPS)** – 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. Care and treatment shall include, but are not limited to:

- Reasonable and appropriate for the treatment of a disorder of the temporomandibular joint or

myofacial pain, under all the factual circumstances of the case;

- Effective for the control or elimination of one or more of the following, caused by a disorder of the temporomandibular joint: pain, infection, disease, difficulty in speaking, or difficulty in chewing or swallowing food;
- Recognized as effective, according to the professional standards of good medical practice;
- Not investigational or primarily for cosmetic services.

**Therapeutic Nuclear Medicine** – Services and supplies furnished in connection with radium, radioisotope and X-ray therapy.

**Therapy** – The Plan covers the following services you receive from a professional provider:

- *Cardiac Therapy* – Benefits for cardiac rehabilitative outpatient therapy are provided when furnished by a provider whose program has been approved by the Plan.

This benefit is limited to medically necessary acute cardiac rehabilitative therapy only, when initiated within 3 months subsequent to one of the following cardiac events:

- Myocardial infarction (MI)
  - Coronary revascularization (CABG)
  - Coronary angioplasty (PTCA)
  - Other, as recommended and approved by us
- *Chemotherapy* – The Plan covers the treatment of malignant disease by chemical or biological antineoplastic agents.
  - *Dialysis* – Charges for dialysis therapy when used for the treatment of a sickness or injury, and rendered in accordance with a Physician's written treatment plan. This includes, but not limited to dialysis equipment rental, supplies, upkeep and the training of the insured individual (or the one who attends him) to run the equipment.
  - *Infusion Therapy* – Coverage is available for infusion therapy, which is treatment by placing therapeutic agents into the vein, including intravenous feeding. This also includes enteral nutrition, which is the delivery of nutrients by tube into the gastrointestinal tract.
  - *Massage Therapy* – Coverage is available for massage therapy.
  - *Neurodevelopmental Therapy* – Benefits are provided for treatment of neurodevelopmental disabilities of an enrollee under age **seven**. The therapy must be medically necessary to restore and improve function, or to maintain function where, in our judgment, significant physical deterioration would occur without the therapy.

**Inpatient and Outpatient Care:** Services must be furnished and billed by a hospital or by another rehabilitation facility approved by us.

- You must not be confined in a hospital or other medical facility;
  - The therapy must be part of a formal written treatment plan prescribed by a physician; and
  - Services must be furnished and billed by a hospital, by another rehabilitation facility approved by us, by a physician, or by a physical, occupational, or speech therapist.
- *Occupational Therapy* – Coverage is available for occupational therapy, which is treatment to restore a physically disabled person's ability to perform activities such as walking, eating, drinking, dressing, toileting, transferring from wheelchair to bed, and bathing.
  - *Physical Therapy* – Coverage is available for physical therapy, which is treatment by physical means to relieve pain, restore function, and prevent disability following disease, injury, or loss of limb.

- *Radiation Therapy* – Radiation Therapy is covered including the rental or cost of radioactive materials. It covers the treatment of disease by x-ray, radium, cobalt, or high energy particle sources.
- *Respiratory Therapy* – Coverage for respiratory therapy that is the introduction of dry or moist gases into the lungs to treat illness or injury.
- *Speech Therapy* – Speech therapy is covered for the correction of a speech impairment that results from disease, surgery, injury, congenital anatomical anomaly, or prior medical treatment.
- *Vision Therapy* – Therapy for the eyes and brain directed toward correcting visual problems.

## MEDICAL EXCLUSIONS AND LIMITATIONS

No payment will be made under any provision of this Plan for expenses incurred by a Covered Person for:

**Abortion** – Unless the life of the mother would be endangered if the fetus were carried to term.

**Administration Fees** – Expenses for missed appointments, completion of claim forms or provided medical information to determine coverage, and/or charges for telephone consultations.

**Auto Accidents** – For expenses in connection with an injury arising out of or relating to an accident involving the maintenance or use of a motor vehicle. This exclusion shall apply to those expenses up to the minimum amount required by law in the state of residence for any injury arising out of an accident of the type for which benefits are or would be payable under automobile insurance, regardless of whether or not automobile insurance is in force and regardless of any benefit limits under such insurance. However, this exclusion does not apply to a *covered person* who is a non-driver when involved in an uninsured motor vehicle accident.

For purpose of this exclusion, a non-driver is defined as a *covered person* who does not have the obligation to obtain automobile insurance because he/she does not have a driver's license or because he/she is not responsible for a motor vehicle.

**Biofeedback** – Care, services as related to Biofeedback.

**Blood** – Blood and blood plasma to the extent a refund or credit is made as a result of operation of a group blood bank, replaced by or for the patient, or otherwise.

**Comfort Items** – Personal care or comfort items during hospitalization, such as, but not limited to, barber/beautician services, radio, television, and telephone services, guest meals, guest cots, rental of humidifiers, massage equipment, air conditioners, air-purification units, electric heating units, orthopedic mattresses, nonprescription drugs and medicines, elastic bandages or stockings, and first-aid supplies and non-hospital adjustable beds. Expenses for personal hygiene and convenience items considered personal comfort items are excluded from Plan coverage.

**Complications of Non-Covered Treatments** – Care, services or treatment required as a result of complications from a treatment not covered under the Plan, except as specified in the Plan.

**Cosmetic Surgery** – Cosmetic or reconstructive procedures and any related service or supplies, which alter appearance but do not restore or improve impaired physical function, *except as specifically provided, or when performed for the:*

- Repair, within one year of the accident, of defects resulting from an accident;
- Replacement of diseased tissue surgically removed; or
- Treatment of congenital abnormalities that causes functional impairment.

**Counseling** – Expenses for religious, marital or relationship counseling.

**Court Ordered** – Care and treatment when court ordered, related to deferred prosecution, deferred or suspended sentencing or to driving rights unless deemed medically necessary.

**Custodial Care** – Services or supplies provided mainly as a rest cure, maintenance or Custodial Care.

**Educational or Vocational Testing** – Services for educational or recreational therapy; vocational testing or training; learning disabilities; behavior modification therapy; any form of non-medical self-care or self-help training, including any related diagnostic testing; music therapy; health club memberships; aquatic or pool therapies. *Unless otherwise stated as covered.*

**Excess Charges** – The part of an expense for care and treatment of an Injury or Sickness that is in excess of the Usual and Reasonable Charge.

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

**Experimental or Investigational** – Drugs, medicines, treatments, procedures and therapies. A drug or medicine will be considered experimental unless, at the time it is provided, it is commercially available and approved for general use by the United States Food and Drug Administration as effective for treatment or diagnosis of the condition for which the charge is made. The approval must not be on a limited or an experimental basis. A treatment, procedure or therapy will be considered experimental unless at the time it is provided or performed, it is considered effective for the treatment or diagnosis of the condition for which the charge is made. The treatment, procedure or therapy must not be considered effective on a limited or an experimental basis.

**Eye Care** – Radial keratotomy, or other refractive surgery techniques; exercise for the eyes. Eye refraction, eye glasses, contact lenses, the fitting of eyeglasses. *The first pair of eyeglasses or contact lenses after cataract surgery is covered.*

**Foot Care** – Expenses for routine foot care, such as corns, calluses, flat foot conditions, supportive devices for the foot-unless deemed as medically necessary, treatment of subluxations of the foot (except capsular or bone surgery), toe nails (except surgery for ingrown nails), fallen arches, weak feet, chronic foot strain, and symptomatic complaints of the feet. *Unless otherwise stated to be covered.*

**Foreign Travel** – Care, treatment or supplies out of the U.S. if travel is for the sole purpose of obtaining medical services.

Charges incurred outside the United States or Canada are excluded, unless the Covered Person is a resident of the United States or Canada and the charges are incurred while traveling on business or for pleasure.

**Government Coverage** – Care, treatment or supplies furnished by a program or agency funded by any government for which the Covered Person is not liable for payment. This does not apply to covered expenses rendered by a United States Veteran's Administration Hospital when services are provided for a non-service related illness or injury, Medicaid or when otherwise prohibited by law.

**Hair Loss** – Care and treatment for hair loss including wigs, hair transplants or any drug that promises hair growth, whether or not prescribed by a Physician. **Expenses will be covered for one wig (limited to \$300) when hair loss is a result of chemotherapy or radiation treatment.**

**Hearing Aids and Exams** – Charges for services or supplies in connection with hearing aids, routine hearing exams, including the fitting of hearing aids.

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

**Hypnosis** – Services, supplies or treatment for hypnotherapy.

**Illegal Acts** – Charges for treatment received as a result of engaging in an illegal act or occupation; by committing or attempting to commit any crime, criminal act, assault or other felonious behavior; or by participating in a riot or public disturbance.

**Illegal Drugs or Medications** – Services, supplies, care or treatment to a Covered Person for Injury or Sickness resulting from that Covered Person's voluntary taking of or being under the influence of any controlled substance, drug, hallucinogen or narcotic not administered on the advice of a Physician. Expenses will be covered for Injured Covered Persons other than the person using

controlled substances and expenses will be covered for Substance Abuse treatment as specified in this Plan.

**Milieu therapy** – Treatment designed to provide a change in environment or a controlled environment.

**No Charge** – Charges for which the Covered Person and/or the Plan are not legally required to pay, including charges, which would not have been made if no coverage existed.

**No Fault Auto Accidents** – Expenses incurred for the treatment of injuries resulting from a motor vehicle accident to the extent such expenses are eligible for payment under the personal injury protection or compulsory medical payments provisions of a motor vehicle insurance contract or under similar provisions of a motor vehicle insurance contract required by any federal or state no-fault motor vehicle insurance law. This exclusion applies whether or not a proper and timely claim for payment is made under the motor insurance contract.

**No Obligation to Pay** – Expenses for services, which are furnished under conditions, which the Covered Person has no legal obligation to pay. This exclusion will not apply to eligible expenses that may be covered by state Medicaid coverage where federal law requires the Employer's plan to be primary.

**No Physician Recommendation** – Care, treatment, services or supplies not recommended, prescribed, performed or approved by a legally qualified Physician; or treatment, services or supplies when the Covered Person is not under the regular care of a Physician. Regular care means ongoing medical supervision or treatment that is appropriate care for the injury or sickness. This also applies to services recommended or received that are outside the scope of the provider's license, registration, or certification or that are furnished by a provider that is not licensed, registered, or certified by the jurisdiction in which the services or supplies were received.

**Not Medically Necessary** – All charges that are determined not to be medically necessary are excluded by the Plan. Ambulance service where no medical necessity or medical emergency exists will not be payable under the Plan.

**Obesity** – Treatment for expenses incurred specific to obesity due to overeating, weight reduction, dietary or weight control, including morbid obesity.

**Occupational and/or Work Related** – Expenses for or in connection with any injury or illness which arises out of or in the course of any occupation for wage or profit (including self-employment); or for which the Covered Person would be entitled to compensation under any Worker's Compensation Law or occupational disease law or similar legislation. This applies even if the Covered Person's rights have been waived or qualified.

**Orthodontics** – Including casts, models, X-rays, photographs, examinations, appliances, braces and retainers.

**Relative Giving Services** – Charges for treatment or services of physicians, nurses, chiropractors, physiotherapists, or other practitioners, who live in your home and/or if the provider of service is the associate, associate's spouse, child, brother, sister or parent, whether the relationship is by blood or exists in law.

**Replacement Braces** – Replacement of braces of the leg, arm, back, neck or artificial arms or legs.

**Routine Care** – Charges for the examinations, subsequent diagnostic testing, or corresponding forms including, but not limited to the following: premarital exams; physicals for college, camp, sports or travel; examinations for insurance, licensing or employment. Immunizations and inoculations are also excluded, except where specifically covered by the Plan.

**Self-Inflicted** – For any intentionally self-inflicted injury or illness. In compliance with the Health Insurance Portability and Accountability Act, if an injury (including self-inflicted injury) results from a medical condition or act of domestic violence, the Plan will not deny benefits for the injury. A medical condition includes both physical and mental illnesses.

**Services Before or After Coverage** – Charges for services and/or supplies provided before the effective date of coverage under the Plan, or provided after termination of coverage under the Plan.

**Sex Changes** – Care, services or treatment for non-congenital transsexualism, gender dysphoria or sexual reassignment or change. This exclusion includes medications, implants, hormone therapy, surgery, medical or psychiatric treatment.

**Sexual Dysfunction** – Expenses for services, supplies or drugs related to sexual dysfunction.

**Smoking Cessation** – Care and treatment for smoking cessation programs including, but not limited to, smoking deterrent patches and smoking deterrent gums unless covered by the *Health Education Programs* benefit listed in the *Covered Medical Expenses* section.

**Surgical Sterilization Reversal** – Care and treatment for the reversal of surgical sterilization.

**Travel or Accommodations** – Charges for travel or accommodations, whether or not recommended by a Physician, except for ambulance charges as defined as a covered expense.

**War** – Treatment of injury or illness that is occasioned by insurrection or war or any act of war, whether declared or undeclared.

## PRESCRIPTION DRUG EXPENSE BENEFIT

The prescription drug benefit provides coverage for prescription drugs when dispensed by a licensed pharmacist or physician. For purposes of this program, a prescription drug is any medical substance that, under federal law, must be labeled as follows: "Caution: Federal Law prohibits dispensing without a prescription." This includes insulin and allergy serums.

To find out if your local retail pharmacy is a member of the MedImpact pharmacy network, call 1-800-788-2949 or visit [www.medimpact.com/members](http://www.medimpact.com/members)

Your prescription drug program (retail and mail-order) has a three-tier co-payment design. With this benefit plan design, your prescription drugs fall into one of three categories or "tiers". Each tier has a different co-payment amount. Here's how it works:

		Retail Co-payment	Mail Order Co-payment
Generic	<i>Tier 1</i>	\$10	\$20
Preferred Brand	<i>Tier 2</i>	\$30	\$60
Non-Preferred Brand	<i>Tier 3</i>	\$60	\$120

In some cases, you or your physician may select a brand-name drug when a generic is available and allowed. In such cases, you may be responsible for paying the difference in price between the cost of the generic and brand-name drug, plus the applicable co-payment.

### **Prescription Drug Co-payments (Limited to a 30 day supply):**

Each covered prescription or refill purchased at a participating pharmacy is subject to a co-payment. The enrollee pays a specified amount for each prescription or refill, and the Plan pays the remaining balance, unless stated otherwise. For each prescription you fill at a participating pharmacy you will be required to pay a \$10 co-payment for generic, \$30 co-payment for preferred name brand and a \$60 co-payment for non-preferred name brand drugs.

When you utilize this Plan's mail order system you will pay either a \$20 co-payment for generic, \$60 co-payment for preferred name brand drugs or a \$120 co-payment for non-preferred name brand drugs.

**Note:** To determine whether a drug is Tier 1, Tier 2 or Tier 3:

- Ask your physician if the drug he or she is prescribing is a generic or brand-name drug.
- Visit [www.medimpact.com/members](http://www.medimpact.com/members).
- Call MedImpact customer service at 1-800-788-2949.

### **Purchasing Prescription Drugs through Mail Order (Limited to a 90 day supply):**

Your prescription drug program offers members using maintenance medications (i.e., medications that you take on a long-term basis for conditions such as high blood pressure or diabetes) the option to get prescriptions filled through the mail-order pharmacy. You get the same high-quality prescriptions using the mail-order pharmacy as you do going to your registered pharmacist.

To use the mail-order pharmacy, just following these two steps:

1. Request that your physician provide you with a 90-day prescription with refills.
2. Complete the mail-order form, available from Human Resources or by calling MedImpact at 1-800-788-2949.

### **Covered Drugs Include:**

- Federal Legend Drugs
- State Restricted Drugs
- Compounded medications of which at least one ingredient is a legend drug
- Insulin

- Insulin needles and syringes
- Dexedrine (d-Amphetamine Sulfate) maximum patient age of 18
- OTC Diabetic Test Strips, Tapes, Reagents
- Lancets and Alcohol swabs/prep pads
- Ostomy supplies
- Retin A to age 25 maximum patient age 34

**In addition to "General Limitations and Exclusions," the program will not provide this benefit for:**

- Therapeutic devices or appliances, regardless of their intended use, including:
  - Hypodermic needles;
  - Syringes and other supplies, except as used for control of diabetes;
  - Support garments;
  - Any other nonmedical substances.
    - Services other than prescription drugs, including their administration.
    - Nicorette or other over-the-counter smoking cessation drugs and supplies.
    - Fertility drugs.
    - Drugs for the treatment of impotency.
    - Food supplements.
    - Non FDA approved legend drugs other than insulin.
- Oral Contraceptives (unless medically necessary), contraceptive jellies, creams, foams, implants or devices
- Injectable contraceptives.
- Anorexiant (drugs or products for the treatment of obesity or weight control)
- Diet/Nutritional supplements
- Allergy serum purchased at a pharmacy
- Drugs used for cosmetic purposes.
- Any prescription or refill that is in excess of the quantity specified by a physician or that is dispensed after one year from the physician's order.
- Drugs intended for use in a physician's office or setting other than home.
- Prescription drugs used while you are an inpatient in a medical facility.
- Take-home drugs dispensed and billed by a medical facility.
- Any claim or demand for injury or damage arising in connection with the manufacturing, compounding, dispensing, or use of any prescription drug.
- Any drug prescribed or dispensed in a manner contrary to normal medical or pharmaceutical practice.
- Investigational or experimental drugs including compounded medications for non-FDA use.
- Prescriptions which an eligible person is entitled to receive without charge under any worker compensation law or any municipal, state, or federal program.
- Any drug that does not require a physician's prescription.
- Any intravenous therapy drugs or solutions.
- Vitamins, including prenatal. Prescription prenatal vitamins are covered.

## DEFINED TERMS

**Accidental Injury** – An unforeseen and unintended injury.

**Ambulatory Surgical Center** – A licensed facility that is used mainly for performing Outpatient surgery, has a staff of physicians, has continuous physician and nursing care by registered nurses (R.N.s) and does not provide for overnight stays.

**Amendment (Amend)** – A formal document signed by the representatives of Lourdes Health Network Health Care Plan. The amendment adds, deletes, or changes the provisions of the Plan and applies to all Covered Persons, including those persons covered before the amendment becomes effective, unless otherwise specified.

**Assignment of Benefits** – Authorization by the associate for the Plan to pay benefits directly to the provider of the service.

**Associate** – A person directly employed in the regular business of, and compensated for services by Our Lady of the Lourdes on a regularly scheduled, full-time basis, and regularly scheduled to work for the Employer in an Associate/Employer relationship.

**Biofeedback** – Provides training to help an individual gain some element of voluntary control over autonomic body functions.

**Birthing Center** – Any freestanding health facility, place, professional office or institution which is not a Hospital or in a Hospital, where births occur in a home-like atmosphere. This facility must be licensed and operated in accordance with the laws pertaining to Birthing Centers in the jurisdiction where the facility is located.

The Birthing Center must provide facilities for obstetrical delivery and short-term recovery after delivery (no more than 24 hours); provide care under the full-time supervision of a physician and either a registered nurse (R.N.) or a licensed nurse-midwife; and have a written agreement with a Hospital in the same locality for immediate acceptance of patients who develop complications or require pre- or post-delivery confinement.

**Business Associate** – A person who, on behalf of a covered entity or of an organized health care arrangement in which the covered entity participates, but other than in the capacity of a member of the workforce of such covered entity or arrangement:

- Performs, or assists in the performance of a function or activity involving the use or disclosure of individually identifiable health information, including claims processing or administration, data analysis, processing or administration, utilization review, quality assurance, billing, benefit management, practice management and repricing; or
- Provides, legal, actuarial, accounting, consulting, data aggregation, management, administrative, accreditation, or financial services to or for such covered entity, or to or for an organized health care arrangement in which the covered entity participates, where the provision of the service involves the disclosure of individually identifiable health information from such covered entity or arrangement, or from another business associate of such covered entity or arrangement, to the person.

**Chiropractic Care/Spinal Manipulation** – 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.

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

**Company** – The Company is Our Lady of the Lourdes, and any affiliates who have adopted the Plan.

**Cosmetic Surgery** – Medically unnecessary surgical procedures, usually, but not limited to, plastic surgery directed toward preserving beauty or correcting scars, burns or disfigurements.

**Covered Entity** – In terms of the HIPAA Privacy Regulations a Covered Entity includes a health plan; a health care provider who transmits any health information in electronic form in connection with a covered transaction; or a health care clearinghouse that handles electronic claims from a provider.

**Covered Expenses** – Those expenses charged by a covered provider and medically necessary for the treatment of illness or injury.

**Covered Person** – An associate or dependent covered under this Plan.

**Custodial Care** – Care (including room and board needed to provide that care) that is given principally for personal hygiene or for assistance in daily activities and can, according to generally accepted medical standards, be performed by persons who have no medical training. Examples of Custodial Care are help in walking and getting out of bed; assistance in bathing, dressing, feeding; or supervision over medication, which could normally be self-administered.

**Dentist** – A legally qualified dentist or a legally qualified physician authorized by their license to perform, at the time and place involved, the particular dental procedure rendered by them.

**Durable Medical Equipment** – Equipment that (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.

**Emergency Medical Condition** – A medical condition manifesting itself by acute symptoms of sufficient severity including, but not limited to, severe pain, or by acute symptoms developing from a chronic medical condition that would lead a prudent layperson, possessing an average knowledge of health and medicine, to reasonably expect the absence of immediate medical attention to result in any of the following:

- Placing the health of an individual, or with respect to a pregnant woman, the health of the woman or her unborn child, in serious jeopardy.
- Serious impairment to bodily functions.
- Serious dysfunction of any bodily organ or part.

**Emergency Services** – Health care items and services furnished or required to screen for or treat an emergency medical condition until the condition is stabilized, including pre-Hospital care and ancillary services routinely available to the emergency department of a Hospital.

**Employer** – Our Lady of the Lourdes.

**End Stage Renal Disease** – A condition that may qualify the Covered Person for Medicare benefits. Should a Covered Person become eligible for Medicare benefits because of ESRD, this plan will provide primary coverage or coordinate against Medicare benefits, in accordance with the rules promulgated by Medicare regarding the liability of Medicare to provide benefits for care related to ESRD, including but not limited to dialysis or transplant, when group coverage is available.

**Enrollment Date** – First day of coverage, or first day of waiting period if there is a waiting period.

**ERISA** – The Employee Retirement Income Security Act of 1974, as amended.

**Experimental/Investigational** – Any treatment, procedure, facility, equipment, drugs, drug usage or supplies that are not recognized by the national board of the appropriate medical specialty as a

generally accepted course of treatment for the medical condition being treated or which is performed for research or educational purposes or which has not been approved by a federal or state agency having jurisdiction and authority to approve such treatment, procedure, facility, equipment, drug or supplies.

The Plan Administrator must make an independent evaluation of the experimental/non-experimental standings of specific technologies. The Plan Administrator shall be guided by a reasonable interpretation of Plan provisions. The decisions shall be made in good faith and rendered following a detailed factual background investigation of the claim and the proposed treatment. The Plan Administrator will be guided by the following principles:

- If the drug or device cannot be lawfully marketed without approval of the U.S. Food and Drug Administration and approval for marketing has not been given at the time the drug or device is furnished;
- If the drug, device, medical treatment or procedure, or the patient informed consent document utilized with the drug, device, treatment or procedure, was reviewed and approved by the treating facility's Institutional Review Board or other body serving a similar function, or if federal law requires such review or approval;
- If Reliable Evidence shows that the drug, device, medical treatment or procedure is the subject of on-going phase I or phase II clinical trials, is the research, experimental, study or investigational arm of on-going phase III clinical trials, or is otherwise under study to determine its maximum tolerated dose, its toxicity, its safety, its efficacy or its efficacy as compared with a standard means of treatment or diagnosis; or
- If Reliable Evidence shows that the prevailing opinion among experts regarding the drug, device, medical treatment or procedure is that further studies or clinical trials are necessary to determine its maximum tolerated dose, its toxicity, its safety, its efficacy or its efficacy as compared with a standard means of treatment or diagnosis.

Reliable Evidence shall mean only published reports and articles in the authoritative medical and scientific literature; the written protocol or protocols used by the treating facility or the protocol(s) of another facility studying substantially the same drug, device, medical treatment or procedure; or the written informed consent used by the treating facility or by another facility studying substantially the same drug, device, medical treatment or procedure.

**Extended Care Facility, Skilled Nursing Facility** – Any or all of these facilities shall mean an institution which is licensed pursuant to state and local laws and is operated primarily for the purpose of providing skilled nursing care, rehabilitation and treatment for individuals convalescing from an injury or illness. These services shall be under the supervision of a physician and/or registered graduate nurse while providing 24 hours per day of nursing services.

**Fiduciary** – The person or organization that has the authority to control and manage the operation and administration of the Plan. The fiduciary has discretionary authority to determine eligibility for benefits or to construe the terms of the Plan. The named fiduciary for this Plan is the Plan Administrator for Lourdes Health Network Health Care Plan.

**Generic Drug** – A prescription drug that has the equivalency of the brand name drug with the same use and metabolic disintegration. This Plan will consider as a Generic Drug any Food and Drug Administration-approved generic pharmaceutical dispensed according to the professional standards of a licensed pharmacist and clearly designated by the pharmacist as being generic.

**Group Health Plan** – Any individual or group plan, private or governmental, that provides or pays for medical care, to the extent specified in the HIPAA Privacy Regulations, 65 Fed. Reg. No. 250 (82463).

**HIPAA** – The Health Insurance Portability and Accountability Act of 1996.

**Home Health Care Agency** – An organization that meets all of these tests: its main function is to provide home health care services and supplies; it is federally certified as a home health care agency; and it is licensed by the state in which it is located, if licensing is required.

**Hospice Agency** – An agency where its main function is to provide hospice care services and supplies and it is licensed by the state in which it is located, if licensing is required.

**Hospital** – An institution which is engaged primarily in providing medical care and treatment of sick and injured persons on an Inpatient basis at the patient's expense and which fully meets these tests: it is accredited as a Hospital by the Joint Commission on Accreditation of Healthcare Organizations; 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 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** – Sickness or disease, including pregnancy, mental/nervous disorders, alcoholism and substance abuse, requiring treatment by a physician.

**Injury** – Accidental physical injury caused by unexpected external means requiring treatment by a physician.

**Intensive Care Unit** – A separate, clearly designated service area, which is maintained within a Hospital solely for the care and treatment of patients who are critically ill and or injured. This also includes what is referred to as a "coronary care unit" or an "acute care unit". It has: facilities for special nursing care not available in regular rooms and wards of the Hospital; special life saving equipment which is immediately available at all times; at least two beds for the accommodation of the critically ill; and at least one registered nurse (R.N.) in continuous and constant attendance 24 hours a day.

**Late Enrollee** – A Covered Person who enrolls under the Plan other than during the earliest date on which coverage can become effective under the terms of the plan; or during a special enrollment period.

**Lifetime** – Refers to benefit maximums and limitations while covered under this Plan.

**Medical Care Facility** – A Hospital, a facility that treats one or more specific ailments or any type of Skilled Nursing Facility.

**Medical Emergency** – Accidental injury or sudden onset of a medical condition for which failure to get immediate medical care could be life threatening, cause serious harm to bodily functions, or seriously damage a body organ or part with acute symptoms requiring immediate medical care,

including, but not limited to, conditions as heart attacks, cardiovascular accidents, poisonings, loss of consciousness or respiration, convulsions or other such acute medical conditions.

**Medically Necessary (Medical Necessity)** – Care and treatment recommended or approved by a physician, which is consistent with the patient's condition and accepted standards of medical practice, medically proven to be effective treatment of the condition, not performed solely for the convenience of the patient or provider, not conducted for investigative, educational, experimental or research purposes, and is the most appropriate level of service that can be safely provided to the patient. The fact that a physician may prescribe, order, recommend, or approve a service does not, of itself, make it medically necessary or make the charge a covered expense, even though it is not specifically listed as an exclusion under this Plan.

**Medicare** – The program established by Title 1 of Public Law 89.97 (79 Stat. 291) as amended, entitled Health Insurance for the Aged Act, and which includes: Part A - Hospital Insurance Benefits for the Aged; Part B - Supplementary Medical Insurance Benefits for the Aged.

**Medicare Entitlement** – Receiving coverage from Medicare. Normally this is accomplished when an individual who is age 65 signs up for Social Security benefits, which automatically enrolls the individual in the Medicare Program. Medicare coverage also is possible for individuals with kidney (end-stage renal) disease, or for individuals younger than age 65 who Social Security deems disabled, effective on the first day of the 25<sup>th</sup> month after the date the individual's Social Security disability began. Social Security disability benefits do not begin until the sixth full month of disability.

**Mental Disorder** – Any disease or condition that is classified as a Mental Disorder in the current edition of International Classification of Diseases, published by the U.S. Department of Health and Human Services or is listed in the current edition of Diagnostic and Statistical Manual of Mental Disorders, published by the American Psychiatric Association.

**No-Fault Auto Insurance** – The basic reparations provision of a law providing for payments without determining fault in connection with automobile accidents.

**Outpatient Care** – 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 Hospitalization** – A medically necessary alternative to Inpatient Hospitalization with continuous treatment for at least four hours, but not more than 12 hours, in any consecutive 24 hour period in a Hospital or Treatment Center.

**Pharmacy** – A licensed establishment where covered prescription drugs are filled and dispensed by a pharmacist licensed under the laws of the state where he or she practices.

**Physician** – Physician shall mean a legally qualified and licensed Doctor of Medicine (M.D.), Doctor of Osteopathy (D.O.), Doctor of Chiropractic (D.C.), Doctor of Dentistry (D.M.D. or D.D.S.), Doctor of Podiatry (D.P.M.), Doctor of Ophthalmology or Optometry (O.D. or M.D.).

A **Provider** shall include an Audiologist, Certified Nurse Anesthetist, Advanced Registered Nurse Practitioner (A.R.N.P.), Registered Nurse (R.N.), Licensed Physical Therapist, Midwife, Physician Assistant, Occupational Therapist, Speech Language Pathologist, Physiotherapist, Psychiatrist, Psychologist (Ph.D.), Licensed Acupuncturist, Licensed Naturopathic Physician, Master of Arts, Certified Dietitian/Nutritionist, Licensed Professional Counselor or Licensed Social Worker. 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 must be pre-approved by the Plan Administrator.

**Plan** – Lourdes Health Network Health Care Plan Associates Benefits Plan, which is a benefits plan for certain associates of Lourdes Health Network and is described in this document.

**Plan Sponsor** – Distinguished from Health Plan for privacy purposes. Defined at section 3(16)(B) of ERISA, 29 U.S.C. 1002 (16)(B).

**Plan Year** – The 12-month period beginning on either the effective date of the Plan or on the day following the end of the first plan year, which is a short plan year.

**Preferred Provider Organization (PPO)** – A company that contracts with a selected group of Hospitals and physicians (preferred providers) offering quality care. Utilization management techniques are applied to covered services. The Plan pays network providers on a fee-for-service basis, usually at discounted rates. The Plan is designed to provide financial incentives in the form of increased benefits to members utilizing preferred providers.

**Pregnancy** – Childbirth and conditions associated with pregnancy, including complications.

**Prescription Drug** – Any of the following: a drug or medicine which, under federal law, is required to bear the legend: "Caution: federal law prohibits dispensing without prescription"; injectable insulin; hypodermic needles or syringes, but only when dispensed upon a written prescription of a licensed physician. Such drug must be medically necessary in the treatment of a sickness or injury.

**Preventive/Wellness Care** – This includes services and supplies for screening procedures used to establish a baseline and regularly scheduled exams performed for the purpose of promoting good health and early detection of disease.

**Protected Health Information** – Information that is created or received by Plan, or a Business Associate of the Plan, whether oral, written, or in electronic form, and relates to the past, present, or future physical or mental health or condition of a member; the provision of health care to a member; or the past, present, or future payment for the provision of health care to a member; and that identifies the member or for which there is a reasonable basis to believe the information can be used to identify the member. Individually Identifiable Health Information includes information of persons living or deceased.

**Qualified Medical Child Support Order** – An issued order, judgment, decree or settlement agreement by a court of competent jurisdiction that requires a non-custodial parent to provide medical coverage for his or her child who might not otherwise be eligible for coverage. A qualified order includes information regarding: 1) The Covered Person's name and address; 2) The name and last known mailing address of the alternate recipient (i.e., the child); 3) The name of the Plan the child will be covered by; 4) A reasonable description of the type and scope of health coverage provided under the Plan; 5) The period of time to which the order applies; and 6) The order must be signed by the Judge, Commissioner or Magistrate who is presiding over the divorce. The enacted Omnibus Budget Reconciliation Act of 1993 (OBRA '93) provides for the recognition of qualified medical child support orders (QMCSO) by group health plans.

**Recovery** – Monies paid to the Covered Person by way of judgment, settlement or otherwise to compensate for all losses caused by the injuries or sickness whether or not said losses reflect medical, dental or other charges covered by the Plan.

Recovery from another plan under which the Covered Person is covered. This right of refund also applies when a Covered Person recovers under an uninsured or underinsured motorist plan, homeowner's plan, renter's plan or any liability plan.

**Rehabilitation Inpatient** – Inpatient Rehabilitative Admission for physical therapy, speech therapy and occupational therapy when medically necessary to restore and improve function that was previously normal but lost following an accidental injury or illness. The Covered Person must have

been covered under this or a prior medical plan with the Company when the injury or illness occurred and must have been continuously covered by the Company since that time.

**Reimbursement** – Repayment to the Plan for medical or dental benefits that it has advanced toward care and treatment of the injury or sickness.

**Routine Care** – The medical treatment or services neither directly related nor medically necessary for the diagnosis or treatment of a specific Injury, Sickness or pregnancy-related condition, which is known or reasonably suspected.

**Sickness/Illness** – Disease or medical condition and pregnancy diagnosed and requiring treatment by a physician.

**Subrogation** – The Plan’s right to pursue the Covered Person’s claims for medical or dental charges against the person causing injury.

**Substance Abuse** – The condition caused by regular excessive compulsive drinking of alcohol and/or physical habitual dependence on drugs that results in a chronic disorder affecting physical health and/or personal or social functioning. 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. Care and treatment shall include, but are not limited to orthodontics, crowns, inlays, physical therapy and any appliance that is attached to or rests on the teeth.

**Third Party Administrative Functions** – Activities are limited to activities that would meet the definition of payment or health care operations, but do not include functions to modify, amend, or terminate the plan or solicit bids from prospective issuers. Plan administration functions include quality assurance, claims processing, auditing, monitoring, and management of carve-out plans – such as vision and dental. Protected Health Information for these purposes may not be used by or between Covered Entities or Business Associates of a Covered Entity in a manner inconsistent with HIPAA’s Privacy Regulation, absent an authorization from the individual. Plan administration specifically does not include any employment-related functions.

**Total Disability** – Associate's complete inability to perform any and every duty of his or her regular or customary occupation or similar occupation for which the associate is reasonably capable due to education and training, as a result of illness or injury, or a dependent's inability to perform the normal activities of a person of like age and sex who is in good health.

**Treatment Center** – A facility licensed as a psychiatric, alcohol or substance abuse treatment facility by the state in which it is located that provides a planned program of treatment for mental and nervous disorders, or alcohol or substance abuse based on a written plan established and supervised by a physician.

**Urgent Care** – Medical treatment which if the regular time periods observed for claims were adhered to: (a) Could seriously jeopardize the life or health of the plan participant or their ability to regain maximum function; or (b) Would in the opinion of a physician with knowledge of the plan participant’s medical condition, subject the patient to severe pain that cannot be adequately managed without the care or treatment that is the subject of the claim.

**Usual, Customary and Reasonable (UCR)** – **Usual** means the provider's most frequent charge for the service or treatment. **Customary** means the charge made, for the same service in the same area, by other physicians or medical service providers with similar training and experience. **Reasonable** means the medical care or supplies; usually given and the fee usually charged for

the cases in that area. The Plan will reimburse the actual charge billed if it is lesser than the usual and reasonable charge. The Plan Administrator has the discretionary authority to decide whether a charge is usual, customary and reasonable.

## GENERAL PROVISIONS

**Administration** – This plan of benefits is administered through the Human Resources Department of Lourdes Health Network. As Plan Administrator, Lourdes Health Network shall have the discretionary power and authority to: determine eligibility for benefits; interpret or construe the terms of the Plan and any other writing affecting the establishment or operation of the Plan; determine questions of fact which arise in connection with the Plan; and decide all matter arising under the Plan, based on the applicable facts and circumstances. The Loomis Company has been retained to provide independent services in the area of claims processing.

**Assignment of Benefits** – In the event a Plan participant has executed an Assignment of Benefits, the Plan shall direct amounts payable under the terms of this Plan to the provider of service. If the Plan receives notification from a provider that the provider has the Plan participant's authorization to assign benefits on file, then that shall be acceptable notice to the Plan that an Assignment of Benefits has been executed. Benefits may not, however, be assigned to anyone other than the provider of service without the approval of Lourdes Health Network.

**Funding** – The benefits outlined in this booklet are paid directly from the required associate contributions and the assets of the Company. The Company may purchase insurance to reimburse itself if claims paid during a Plan Year exceed expected total amounts, expected individual amounts, or both.

**Plan Amendment or Termination** – Lourdes Health Network reserves the full, absolute and discretionary right to amend, modify, suspend, withdraw, discontinue or terminate the Plan in whole or in part at any time for any and all participants of the Plan by formal action taken by the Board of Directors, or by the execution of a written amendment by the Plan Sponsor. If the Plan is amended, modified, suspended, withdrawn, discontinued or terminated, covered associates and covered dependents will be entitled to benefits for claims incurred prior to the date of such action. Such changes may include, but are not limited to, the right to (1) Change or eliminate benefits, (2) Increase or decrease participant contributions, (3) Increase or decrease deductibles and/or co-payments, and (4) Change the class of associates or dependents covered by the Plan.

**Medical Care Decision** – The benefits under the Plan provide solely for the payment of certain health care expenses. All decisions regarding health care are solely the responsibility of each Covered Person in consultation with the health care providers selected. The Plan contains rules for determining the percentage of allowable health care expenses that will be reimbursed, and whether particular treatments or health care expenses are eligible for reimbursement. The Covered Person in accordance with the Plan's appeal procedures may dispute any decision with respect to the level of health care reimbursements, or the coverage of a particular health care expense. Each Covered Person may use any source of care for health treatment and health coverage as selected, and neither the Plan nor the employer shall have any obligation for the cost or legal liability for the outcome of such care, or as a result of a decision by a Covered Person not to seek or obtain such care, other than the liability of the Plan for the payments of benefits as outlined herein.

## **RIGHTS AND PROTECTIONS**

As a Plan participant, you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA). ERISA provides that all Covered Persons shall be entitled to:

- Examine, without charge, at the Plan Administrator's office and at other specified locations, such as worksites and union halls, all plan documents, including insurance contracts, collective bargaining agreements and a copy of the latest annual report (Form 5500 Series) filed by the Plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Pension and Welfare Benefit Administration.
- Obtain copies of all plan documents such as the form 5500, insurance contracts, collective bargaining agreements, updated summary plan descriptions, and other plan information upon written request to the Plan Administrator. The Administrator may make a reasonable charge for the copies.
- Receive a summary of the Plan's annual financial report. The Plan Administrator is required by law to furnish each participant with a copy of this summary annual report.
- Continue health care coverage for yourself, spouse or dependents if there is a loss of coverage under the Plan as a result of a qualifying event. You or your dependents may have to pay for such coverage. Review this summary plan description and the documents governing the plan or the rules governing your COBRA continuation coverage rights.
- Reduction or elimination of exclusionary periods of coverage for preexisting conditions under your group health plan, if you have creditable coverage from another plan. You should be provided a certificate of creditable coverage, free of charge, from your group health plan or health insurance issuer when you lose coverage under the plan, when you become entitled to elect COBRA continuation coverage, when your COBRA continuation coverage ceases, if you request it before losing coverage, or if you request it up to 24 months after losing coverage. Without evidence of creditable coverage, you may be subject to the preexisting condition exclusion for 12 months (18 months for late enrollees) after your enrollment date.

In addition to creating rights for Covered Persons, ERISA imposes duties upon the people who are responsible for the operation of this plan. The people who operate your plan, called "fiduciaries" of the Plan, have a duty to do so prudently and in the interest of you and the other Covered Persons and beneficiaries.

No one, including your employer or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a welfare benefit or exercising your rights under ERISA. If a claim for a welfare benefit is denied in whole or in part, you have a right to know why this was done, to obtain copies of documents relating to the decision without charge, and to appeal any denial, all within certain time schedules.

Under ERISA, there are steps a Covered Person can take to enforce the above rights. For instance, if a Covered Person requests information from the Plan and does not receive it within 30 days, they may file suit in a federal court. In such a case, the court may require the Plan Administrator to provide the materials and pay up to \$110 a day until the Covered Person receives the materials, unless the materials were not sent because of reasons beyond the control of the administrators. If anyone has a claim for benefits, which is denied or ignored, in whole or in part, they may file suit in a state or federal court. In addition, if a Covered Person disagrees with the Plan's decision or lack thereof concerning the qualified status of a domestic relations order or a medical child support order, you may file suit in a federal court. If it should happen that plan fiduciaries misuse the Plan's money, or if anyone is discriminated against for asserting their rights, they may seek assistance from the

U.S. Department of Labor, or file suit in a federal court. The court will decide who should pay court costs and legal fees. If the individual is successful, the court may order the persons sued to pay these costs and fees. If the individual loses, the court may order that person to pay these costs and fees, for example if it finds the claim is frivolous.

If there are any questions about the Plan, contact the Plan Administrator. If there are any questions about this statement or about ERISA rights, or if you need assistance in obtaining documents from the plan administrator, you should contact the nearest Area Office of the Pension and Welfare Benefits Administration, U.S. Department of Labor, listed in your telephone directory or the Division of Technical Assistance and Inquiries, Pension and Welfare Benefits Administration, U.S. Department of Labor, 200 Constitution Avenue, NW, Washington, D.C. 20210. You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Pension and Welfare Benefits Administration.

### **LEGISLATIVE COMPLIANCE**

All provisions of the Plan shall at all times be in compliance with the Health Insurance Portability and Accountability Act of 1996 (HIPAA), ERISA and other applicable governmental laws, statutes, regulations, or rules promulgated by any governing unit having appropriate jurisdiction. The Plan Administrator shall administer the Plan accordingly, as well as complying with any changes to such statutes, regulations or rules affecting these provisions.

Pursuant to HIPAA, the Plan will at no time take into consideration any health status related factors, (physical or mental illnesses, prior receipt of health care, prior medical history, genetic information, evidence of insurability, conditions arising out of acts of domestic violence, or disability) which exist in relation to a person who is eligible for coverage under the Plan for purposes of determining the initial or continued eligibility of coverage under the Plan, for determining the level of contribution to Plan funding, or to determine the level of benefits which will be made available to a person. All Plan participants will be given written notice of any material reduction in benefits provided by the plan within 60 days of the adoption of such material reduction.

No provision contained in this booklet nor any portion of the Plan shall give a Plan participant or entity acting on their behalf any right or cause of action, either at law or in equity against the Plan Administrator, the Third Party Administrator, the Plan Sponsor, or the Utilization Review Administrator for the acts of any Hospital where care is received, for the acts of any physician, or other provider from whom services are received and benefits are provided under this Plan.

## **NOTICE OF PRIVACY PRACTICES**

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

We are required by law to maintain the privacy of your protected health information (PHI). We are obligated to provide you with a copy of this Notice of our legal duties and of our privacy practices with respect to PHI and we must abide by the terms of this Notice. We reserve the right to change the provisions of our Notice and make the new provisions effective for all PHI we maintain. If we make a material change to our Notice, we will mail a revised Notice to the address that we have on record for the policyholder.

If you have any questions or want additional information about this Notice or the policies and procedures described in this Notice, please contact the Plan Administrator.

**Effective Date:** This Notice of Privacy Practices became effective on April 14, 2004.

### **PRIMARY USES AND DISCLOSURES OF PROTECTED HEALTH INFORMATION**

**Payment:** We may use or disclose your PHI to pay claims for services provided to you and to fulfill our responsibilities for plan coverage and providing plan benefits. For example, we may disclose your PHI when a provider (doctor, Hospital, clinic, etc.) requests information regarding your eligibility for coverage under our health plan, or we may use your information to determine if a treatment that you received was medically necessary.

**Health Care Operations:** We may use or disclose your PHI to support our business functions. These functions include, but are not limited to: medical care, quality assessment and improvement, stop-loss insurance underwriting, business planning, and business development. For example, we may use or disclose your PHI: (i) To provide you with information about one of our health management programs; (ii) To respond to a customer service inquiry from you; or (iii) In connection with fraud and abuse detection and compliance programs.

**Business Associates:** We contract with individuals and entities (Business Associates) to perform various functions on our behalf or to provide certain types of services. To perform these functions or to provide their services, our Business Associates will receive, create, maintain, use, or disclose PHI, but only after we require the Business Associates to agree in writing to contract terms designed to appropriately safeguard your information. For example, we may disclose your PHI to a Business Associate to administer claims or to provide service support, utilization management, subrogation, or pharmacy benefit management.

**Other Covered Entities:** We may use or disclose your PHI to assist other covered entities in connection with payment activities and certain health care operations. For example, we may disclose or share your PHI with other insurance carriers in order to coordinate benefits, if you or your family members have coverage through another carrier.

## **PERMITTED USES AND DISCLOSURES OF PROTECTED HEALTH INFORMATION**

**Personal Representatives:** We may disclose PHI to the patient or the patient's personal representative. A personal representative is a legal guardian, or a person designated by you to act on your behalf in making decisions related to your health care.

**Public Health Activities:** We may disclose PHI to report health information to public health authorities for the purpose of preventing or controlling disease, injury or disability.

**Abuse or Neglect:** If we believe you are the victim of abuse or neglect, we may disclose PHI to a government authority such as social services or protective services agency.

**Health Oversight Activities:** We may disclose PHI to a health oversight agency that oversees the health care system and is charged with responsibility for ensuring compliance.

**Legal Proceedings:** We may disclose PHI in the course of a judicial or administrative proceeding in response to legal order or other lawful process.

**Law Enforcement Officials:** We may disclose PHI to the police or other officials in compliance with a court order or subpoena.

**Organ & Tissue Procurement:** We may disclose PHI to organizations that facilitate organ, eye or tissue procurement, banking or transplantation.

**Coroners:** We may disclose PHI to a medical examiner as authorized by law.

**Specialized Government Functions:** We may use and disclose PHI to units of the government with special functions such as the U.S. military or the U.S. Department of State.

**Workers' Compensation:** We may disclose PHI as authorized by and to the extent necessary to comply with laws relating to workers' compensation or other similar programs.

**Health & Safety:** We may use and disclose PHI, if in good faith, we believe it is necessary to prevent or lessen a serious and imminent threat to the health & safety of a person or the public.

**As Required by Law:** We may use and disclose PHI when required to do so by any other law not already referred to in the preceding categories.

**To the Plan Sponsor:** We may disclose your PHI to the plan sponsors of the group health plan for purposes of plan administration.

**Others Involved in Your Care:** We may disclose your PHI known to a family member, relative or close personal friend that you identify. Such a use will be based on how involved the person is in your care. If you are not present or able to agree to these disclosures of your PHI, then, using our professional judgment, we may determine whether the disclosure is in your best interest.

## **YOUR RIGHTS**

**Right to Request a Restriction:** You have the right to request a restriction on the PHI we use or disclose about you for claim payment or healthcare operations. We are not required to agree to any restriction that you may request. If we do agree to the restriction, we will comply with the restriction unless the information is needed to provide emergency treatment to you.

**Right to Request Confidential Communications:** If you believe that a disclosure of your PHI may endanger you, you may request that we communicate with you regarding your information in an alternative manner or at an alternative location. For example, you may ask that we only contact you at your work address or via your work e-mail.

**Right to Inspect and Copy:** You have the right to inspect and copy your PHI that is contained in a “designated record set.” A “designated record set” contains your medical and billing records, as well as other records that are used to make decisions about your health care benefits. However, you may not inspect or copy psychotherapy notes or certain other information that may be contained in a designated record set.

**Right to Amend:** If you believe that your PHI is incorrect or incomplete, you may request that we amend your information. In certain cases, we may deny your request for an amendment. For example, we may deny your request if the information you want to amend is not maintained by us, but by another entity.

**Right of an Accounting:** You have a right to an accounting of certain disclosures of your PHI that are made for reasons other than claim payment or health care operations. No accounting of disclosures is required for disclosures you authorized. You should know that most disclosures of your PHI will be for purposes of claim payment or health care operations, and, therefore, will not be subject to your right to an accounting.

**Right to a Paper Copy of this Notice:** You have the right to a paper copy of this Notice, even if you may have agreed to accept this Notice electronically.

## **COMPLAINTS**

You may complain to us if you believe that we have violated your privacy rights. You may file a complaint with us by contacting the Privacy Officer.

You also may file a complaint with the Secretary of the U.S. Department of Health and Human Services. You may submit this complaint to:

Department of Health and Human Services  
200 Independence Avenue, S.W.  
Room 509F HHH Building  
Washington, DC 20201

We will not penalize or in any other way retaliate against you for filing a complaint with the Secretary or with us.

## HIPAA SECURITY REGULATIONS

We are required to:

- Implement administrative, physical, and technical standards that reasonably and appropriately protect the confidentiality, integrity, and availability of electronic PHI;
- Ensure that the firewall required by the HIPAA privacy rule is supported by reasonable and appropriate security measures;
- Ensure that any agent or subcontractor to whom the Plan Sponsor provides electronic PHI agrees to implement reasonable and appropriate security measures; and
- Report to the Plan any security incident of which the Plan Sponsor becomes aware.

### **NO VERBAL MODIFICATIONS**

The Covered Person shall not rely on any oral statement from any employee of The Loomis Company which modifies or otherwise affects the benefits, general limitations and exclusions, or other provisions of this Plan and increases, reduces, waives or voids any coverage or benefits under this Plan.

In addition, such oral statement shall not be used in the prosecution or defense of a claim under this Plan.

Any written or oral verification received from Lourdes Health Network is based upon eligibility information and Plan benefits, which are subject to change. Therefore, any verification should not be interpreted as a guarantee of coverage or payment for any services rendered or otherwise provided to a participant.

### **MISSTATEMENTS**

In the event of any misstatement of any fact(s) affecting coverage under the Plan, the true facts will be used to determine the proper coverage. Coverage means eligibility as well as the amount of any benefits herein.

**This booklet is not a contract.** It explains in non-technical language the essential features of your Associate Benefit Program. Contact the Human Resources Department if there are any questions concerning coverage.

**ACCEPTANCE  
SUMMARY PLAN DESCRIPTION  
EXECUTION**

It is agreed that the provisions set forth in this document and properly executed amendments will be the basis for the administration of Lourdes Health Network Group Health Plan effective January 1, 2011.

**On Behalf of Lourdes Health Network**

\_\_\_\_\_  
**Name and Title**

\_\_\_\_\_  
**Date**

Version 2011