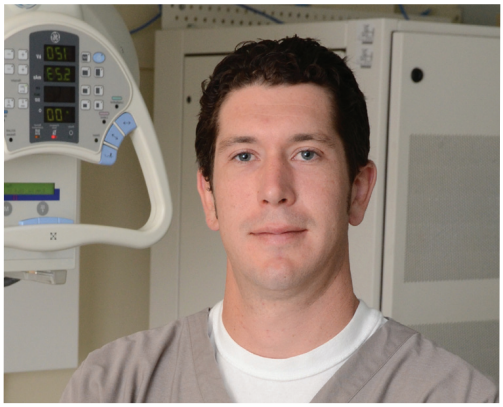

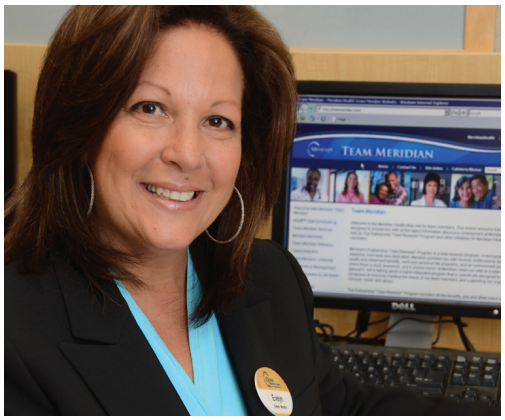

MERIDIAN HEALTH

Medical Plan

A Partnership "TOTAL REWARDS" Program

SUMMARY PLAN DESCRIPTION OF THE MERIDIAN HEALTH MEDICAL PLAN

Effective January 1, 2015

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INTRODUCTION

This document provides the terms and conditions for eligibility and benefits under the **Meridian Health** Team Member Medical Plan ("Plan"). It is intended to be a comprehensive description of the participation requirements and available benefits under the Plan. Please keep it for your reference. When it states "Plan" or "Summary Plan Description" (or SPD), it is referring to this document. The Medical Plan is a component plan under the Welfare Benefits Plan of Meridian Health, which governs in the case of any difference between it and this document. If you would like to review the official Plan documents, or to obtain a copy of any Plan document, please contact the Meridian HR Support Services Team.

Coverage under the Plan will take effect for an eligible Team Member and designated Dependents when the Team Member and such Dependents satisfy the Waiting Period and all the eligibility, enrollment and other requirements of the Plan.

While Meridian Health ("Employer") expects to continue the benefits described in this SPD, it reserves the right to terminate, suspend, discontinue or amend one or more of the benefits or other terms and conditions (including eligibility rules, cost sharing, benefit exclusions, and others) at any time and for any reason, as described in *Amending and Terminating the Plan*.

The Plan will pay benefits only for eligible expenses incurred during the time the Plan Participant or Dependent is covered by this Plan. No benefits are payable for expenses incurred before coverage began or after coverage terminated, even if the expenses were incurred as a result of an accident, injury or disease that occurred, began, or existed while the coverage was in force. For the purposes of this Plan, an expense for a service or supply is incurred on the date the service or supply is furnished.

ELIGIBILITY, FUNDING, EFFECTIVE DATE AND TERMINATION PROVISIONS

Eligibility Requirements for Team Member Coverage. A person is eligible for Team Member coverage if he or she meets the following requirements:

(1) is a Full-Time, Active Team Member of the Employer (a Team Member is considered Full-Time if he or she is scheduled to work at least **36** hours per week and is on the regular payroll of the Employer for that work) or is a Part-Time, Active Team Member of the Employer (a Team Member is considered Part-Time if he or she is regularly scheduled to work at least **20** hours per week and is on the regular payroll of the Employer for that work); and

(2) completes the Team Member Waiting Period, which ends on the first day of the calendar month following the date of hire or, if later, initial eligibility.

Team Members become eligible for coverage on:

(1) The effective date of the Plan if you were employed on that date; or

(2) The first of the month following their first day of employment or, if later, initial eligibility (subject to the conditions listed below).

However, Plan coverage is not automatic. The Team Member has to timely enroll in the Plan to be covered as an Active Team Member.

Notwithstanding the foregoing, the following Team Members are not eligible for coverage under the Plan:

(1) Part-Time Team Members at Meridian Nursing & Rehabilitation ("MNR") Ocean Grove;

(2) Quality Care Management Team Members;

(3) Meridian Health Resources doctors who are eligible for medical benefits directly through their practices;

(4) Part-Time Team Members at MNR Brick, except for certain grandfathered Team Members;

(5) Part-Time Team Members at MNR Shrewsbury, except for (i) certain grandfathered Team Members and (ii) Team Members covered by a collective bargaining agreement providing for coverage;

(6) Per Diem Team Members; and

(7) Team Members covered by a collective bargaining agreement, unless the terms of the collective bargaining agreement provide for eligibility under the Plan.

For purposes of eligibility for coverage, Full-Time and Part-Time Team Members who are absent because of health conditions are treated as if they are actively at work, and leaves of absence that qualify under the Family and Medical Leave Act (FMLA) or the Uniformed Services Employment and Reemployment Rights Act (USERRA) are treated as periods of active employment to the extent such treatment is required and applicable to the Employer under such laws. Notwithstanding the foregoing, a newly hired or newly eligible Team Member must report to work for the Employer in order for any coverage under the Plan to become effective.

Eligible Classes of Dependents

A Dependent is any one of the following persons:

(1) Legal Spouse. The term "*Spouse*" shall mean the person lawfully married to a Team Member under the laws of any domestic or foreign jurisdiction where such individual and Eligible Employee were married. The Plan Administrator requires a certified copy of a marriage certificate.

(2) Civil Union Partner. A same-sex Civil Union Partner under a Civil Union (see *Definitions* Section). The Plan Administrator may require documentation proving a legal Civil Union.

(3) Domestic Partner. A Domestic Partner (see *Definitions* Section) who (a) entered into a Domestic Partnership with a Team Member prior to January 1, 2014, (b) was enrolled in the Welfare Benefit Plan of Meridian Health (the "Welfare Benefit Plan") as of January 1, 2014, and (c) has provided the applicable proof requirements, is eligible for coverage under the Plan. It is required that you provide an Affidavit of Domestic Partnership and documents evidencing joint responsibility. The following documentation for coverage for a domestic partner is acceptable: joint mortgage or lease; designation of the Domestic Partner as a primary beneficiary for a life insurance or a retirement contract; designation of the Domestic Partner as a primary beneficiary in the Team Member's will; durable power of attorney for healthcare or financial management; joint ownership of a motor vehicle, a joint checking account or a joint credit account; a relation or cohabitation contract which obligates each of the parties to provide support for the other party.

A failure to elect to continue coverage under the Welfare Benefit Plan for your Domestic Partner during annual open enrollment for each Plan Year occurring on or after January 1, 2014, will result in a permanent loss of coverage under the Plan for your Domestic Partner, unless he or she thereafter becomes your Civil Union Partner or Spouse.

(4) Child(ren). Child(ren) who have not attained age 26 will be eligible for coverage under the Plan. The term "children" or "child" shall include your natural children, adopted children, step-children, foster children, children placed with you in anticipation of adoption or becoming your foster child, unmarried child for whom you are the court-appointed legal guardian, or your Domestic Partner's or Civil Union Partner's children. The phrase "child placed with you in anticipation of adoption" refers to a child who is lawfully placed with you for legal adoption by you.

Any child of a Plan Participant who is an alternate recipient under a qualified medical child support order shall be considered as having a right to Dependent coverage under this Plan. Coverage of these children is in accordance with the requirements of the federal Omnibus Budget Reconciliation Act of 1993. This Plan's qualified medical child support order procedures are available upon request, at no charge.

(5) Legal Guardianship. If you apply to enroll a child for whom you have a court-appointed legal guardianship within 30 days of the date legal guardianship is granted, coverage for the child becomes effective the date the legal guardianship is granted. A child for whom you acquire legal guardianship, but whom you do not apply to enroll until more than 30 days after the date legal guardianship is granted, will not be eligible until the next Annual Enrollment Period.

(6) Disabled Child. A covered Dependent child who reaches the limiting age and is unmarried, Totally Disabled, incapable of self-sustaining employment by reason of mental or physical handicap, and primarily dependent upon the covered Team Member for support and

maintenance; provided that the child became so incapacitated prior to reaching the limiting age and was enrolled in the Plan at that time. The Plan Administrator may require, at reasonable intervals during the two years following the Dependent's reaching the limiting age, subsequent proof of the child's Total Disability and dependency.

After such two-year period, Meridian Health may require subsequent proof not more than once each year. Meridian Health 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.

Special Note Regarding Tax Considerations
If you enroll an eligible dependent for medical coverage under the Plan, please keep in mind that if the dependent is not an IRS tax dependent for purposes of the Plan, the value of Meridian-provided medical coverage for the dependent will be treated as taxable income to you, a concept known as "imputed income." In addition, if an eligible dependent is not an IRS tax dependent for purposes of the Plan, you will not be able to pay for your share of his or her medical coverage premium on a pre-tax basis under the terms of the Flexible Benefits Plan. See the Section *Tax Treatment of Dependent Health Coverage* below.

ELIGIBILITY LIMITATIONS

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

If both parents are Team Members, their children will be covered as Dependents of one parent, but not on both.

Eligibility Requirements for Dependent Coverage. A family member of a Team Member will become eligible for Dependent coverage on the first day that the Team Member is eligible for Team Member coverage and the family member satisfies the requirements for Dependent coverage. Plan coverage is not automatic. The Team Member has to timely enroll an eligible Dependent in order for the Dependent to be covered.

At any time, the Plan may require proof that a Spouse or child qualifies or continues to qualify as a Dependent as defined by this Plan.

FUNDING

Cost of the Plan

Meridian Health shares the cost of Team Member and Dependent coverage under this Plan with the covered Team Members. Covered Active Team Members contribute their portion of the cost through pre-tax payroll deductions (subject to Plan terms and federal law requirements for pre-tax treatment of contributions), and **Meridian** Health bears the remaining cost of coverage from its general assets.

The enrollment application for coverage details the required Team Member contributions to be deducted from payroll. Rates may change from time to time. **Meridian** Health will notify you of changes in the cost of coverage before you enroll for the next year. When an Active Team Member completes the

benefit enrollment process and elects to participate in this Plan, the Team Member is providing payroll deduction authorization.

TAXATION

Tax Treatment of Dependent Health Coverage

Typically, the value of a dependent's coverage under an employer-sponsored group health plan, such as the Plan, is not included in the employee's income for tax purposes. However, if a dependent does not meet very specific requirements specified in the federal tax code, then the dependent's health coverage is taxable to the employee.

A dependent's Plan coverage will not result in imputed income if that dependent is your spouse or IRS tax dependent for health coverage purposes. For purposes of the Plan, a tax dependent for health coverage includes a child who has not attained the age of 27 as of the end of the taxable year.

For these purposes, your child is an individual who is:

- your son, daughter (your son or daughter includes your natural or legally adopted son or daughter or an individual who is lawfully placed with you for legal adoption),
- stepson, or stepdaughter, or
- your eligible foster child (that is, an individual who is placed with you by an authorized placement agency or by judgment, decree, or other order of any court of competent jurisdiction).

If an individual does not meet the above definition of child, he or she will still be your tax dependent for health coverage purposes if he or she is a U.S. citizen or resident who is either a Qualifying Child or a Qualifying Relative, as described below.

A Qualifying Child is a person who:

- is your child, grandchild, brother, sister, stepbrother, stepsister, or niece or nephew;
- is under the age of 19 (or 24 in the case of a student), or is any age and is permanently and totally disabled;
- does not provide over one-half of his or her own support for the calendar year;
- lives with you for over one-half of the calendar year; and
- is unmarried (that is, has not filed a joint tax return during the calendar year at issue).

If a person does not meet the definition of a Qualifying Child, he or she could be your tax dependent for purposes of the Plan by meeting the requirements to be a Qualifying Relative. A Qualifying Relative generally is a person who:

- receives over one-half of his or her support from you for the calendar year;
- is either related to you, or lives with you for the entire calendar year as a member of your household; and
- is not your Qualifying Child or any other taxpayer's Qualifying Child during the calendar year.

For example, your Civil Union Partner or Domestic Partner will be your IRS tax dependent for health coverage purposes if he or she is a U.S. citizen or resident, receives over one-half of his or her support from you, and lives with you for the entire calendar year as a member of your household. Even though a Civil Union Partner or Domestic Partner is not a "relative" in the traditional sense, he or she may meet the definition of a Qualifying Relative and could thereby be your tax dependent for Plan purposes. Your

Civil Union Partner's or Domestic Partner's child typically will not be your IRS tax dependent for Plan purposes unless your Civil Union Partner or Domestic Partner is also your IRS tax dependent for Plan purposes.

Meridian will calculate the value of Plan benefits related to your Civil Union Partner or Domestic Partner and his or her children, and any child for whom you are legal guardian, and add that to your regular pay as imputed income and you will pay your share of Plan coverage for your Civil Union Partner or Domestic Partner and his or her children, and any child for whom you are legal guardian, through after-tax payroll deductions, unless you complete and return a certification of federal tax dependent status, indicating that such individual qualifies as your federal tax dependent for medical coverage purposes.

A Special Note about Health Savings Accounts

HSA Benefits in General

The purpose of the HSA benefit is to help you save and pay for "qualified medical expenses," as defined under IRC Section 223, for you, your spouse, and any dependent (as defined in IRC Section 152, determined without regard to subsections (b)(1), (b)(2), and (d)(1)(B) thereof). The HSA is not a Company-sponsored employee benefit plan—it is a custodial account that you open with Wells Fargo to be used primarily for reimbursement of eligible medical expenses. Consequently, Wells Fargo, not the Company, will establish and maintain your HSA. Please note that the Company does not endorse Wells Fargo. The Company's role is limited to allowing you to contribute to your HSA on a pre-tax salary-reduction basis and making certain Company contributions to your HSA.

The Company has no authority or control over the funds deposited in your HSA. Neither your HSA nor the HSA component of the Flexible Benefits Plan that allows you to contribute to your HSA on a pre-tax basis is subject to the Employee Retirement Income Security Act of 1974, as amended ("ERISA").

Eligible Individual for HSA Benefits

To participate in the HSA benefits, you must be an HSA-eligible individual. This means that you are eligible to contribute to an HSA under the requirements of IRC Section 223 and that you have elected to participate in qualifying high deductible health plan coverage (*i.e.*, the CDHPlan) offered by Meridian and have not elected any disqualifying non-high deductible health plan coverage. (High deductible health plan means the CDHPlan offered by Meridian that is intended to qualify as a high deductible health plan under IRC Section 223(c)(2), as described in this SPD.)

If you elect HSA benefits, you will be required to certify that you meet all of the requirements under IRC Section 223 to be eligible to contribute to an HSA. You are eligible to contribute to an HSA if you meet the following criteria:

- You are enrolled in the CDHPlan option.
- You are not enrolled in Medicare.
- You are not claimed as a dependent on someone else's tax return.
- You are not covered by another health plan that is not a high deductible health plan. This includes coverage received through your spouse's medical plan, or participation in a full purpose health flexible spending account (including if your spouse participates in a full purpose health flexible spending account).

Your spouse is not eligible to enroll in the CDHPlan if he or she is:

- covered by another health plan, unless it is a qualified high deductible health plan;
- claimed as a dependent on another person's tax return; or
- enrolled in Medicare.

To find out more about HSA eligibility requirements and the consequences of making contributions to an HSA when you are not eligible (including possible excise taxes and other penalties), see the Flexible Benefits Plan SPD and IRS Publication 969 (Health Savings Accounts and Other Tax-Favored Health Plans).

Note about Dependent Coverage under the CDHPlan

You should carefully consider whether you want to enroll in the CDHPlan if you want to cover a dependent child who is not a qualifying child or qualifying relative as those terms are defined for health coverage purposes under the IRC. Although you may enroll such a dependent child in the CDHPlan option if he or she meets the Medical Plan eligibility requirements, you may be reimbursed from your HSA for medical expenses incurred on behalf of your child *only if* the child is a qualifying child or qualifying relative, as modified for health coverage purposes. This means that, depending on your specific circumstances, you could elect to enroll your child in the CDHPlan option for purposes of the high deductible health plan portion, but find that you are unable to be reimbursed from your HSA for medical expenses attributable to that child's treatment. For example, if you elect coverage under the CDHPlan option for a dependent child who is over age 19 and is neither a full-time student nor totally and permanently disabled, you will not be able to use money in your HSA for the child's medical expenses, unless the child meets the requirements to be a qualifying relative for health coverage purposes. See the Flexible Benefits Plan SPD for more details.

Maximum HSA Benefits

You elect to contribute to your HSA benefits under the Flexible Benefits Plan. The amount you elect (combined with any contributions Meridian makes on your behalf) must not exceed the statutory maximum amount for HSA contributions applicable to your CDHPlan coverage tier (i.e., single or family) for the calendar year in which the contribution is made. An additional catch-up contribution may be made if you are age 55 or older (you must certify your age to the Company).

For further details on contributions and applicable limitations, please go to www.TeamMeridian.com or see the Flexible Benefits Plan SPD.

For Additional Information

For details on paying for your HSA contributions, changing your HSA contribution election and taxation of HSA contributions, please see the Summary Plan Description for the Flexible Benefits Plan and other documentation associated with your HSA and provided to you by Meridian.

For details regarding your rights and responsibilities with respect to your HSA (including information regarding the terms of eligibility, what constitutes a qualifying high deductible health plan, contributions to the HSA, and distributions from the HSA), please refer to your HSA custodial account agreement and other documentation associated with your HSA and provided to you by Wells Fargo. You may also want to review IRS Publication 969 (Health Savings Accounts and Other Tax-Favored Health Plans).

ENROLLMENT

Enrollment Requirements. A Team Member must enroll for coverage by completing an enrollment application including the appropriate payroll deduction authorization. If Dependent coverage is desired, the covered Team Member is required to timely enroll for Dependent coverage also.

Enrollment Requirements for Newborn Children

Well baby charges for covered nursery care will be applied toward the Plan of the covered parent. After routine nursery charges, if the newborn child is not enrolled in this Plan on a timely basis, as defined in the Section *Timely or Late Enrollment*, there will be no payment from the Plan and the covered parent will be responsible for all costs.

A newborn child of a covered Team Member who has Dependent coverage is not automatically enrolled in this Plan, unless the covered Team Member notifies the Plan Administrator within (31) days of birth. Charges for covered nursery care and routine Physician care will be applied toward the Plan of the covered parent. If the newborn child is required to be enrolled and is not enrolled in this Plan on a timely basis, as described in the Section *Timely or Late Enrollment*, there will be no Plan coverage for the newborn child.

For coverage of Sickness or Injury, including Medically Necessary and Appropriate care and treatment of congenital defects, birth abnormalities or complications resulting from prematurity, the newborn child must be enrolled as a Dependent under this Plan within 31 days of the child's birth in order for non-routine coverage to take effect from the birth.

If the child is required to be enrolled and is not enrolled within 31 days of birth, the child will be considered a Late Enrollee (See Late Enrollment below.)

TIMELY OR LATE ENROLLMENT

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

If two Team Members (husband and wife) are covered under the Plan and the Team Member who is covering the Dependent children terminates coverage, the Dependent coverage may be continued by the other covered Team Member with no waiting period as long as coverage has been continuous.

(2) Late Enrollment - An enrollment is "late" if it is not made on a "timely basis" or during a Special Enrollment Period. Late Enrollees and their Dependents (if any) may enroll only during the next available open enrollment or if an applicable mid-year change event occurs and the employee elects coverage in a timely fashion as described in the Section *Change Events*.

If an individual loses eligibility for coverage as a result of terminating employment or a general suspension of coverage under the Plan, then upon becoming eligible again due to resumption of employment or due to resumption of Plan coverage, only the most recent period of eligibility will be considered for purposes of determining whether the individual is a Late Enrollee.

EFFECTIVE DATE

Effective Date of Team Member Coverage. A newly hired eligible Team Member will be covered under this Plan as of the first day of the calendar month following his or her date of hire, provided that the Team Member satisfies the enrollment requirements described above.

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

CHANGE EVENTS

Except with respect to HSA Benefits, which you may prospectively change, waive, or revoke at any time, your Plan elections will remain in effect until the end of the Plan Year for which they are made, and you will not be able to change your election until the next annual enrollment period. Outside of the annual enrollment period, you can only change your Plan elections if you have a "Qualified Change Event." Any election change on account of a Qualified Change Event must be consistent with that event. The Qualified Change Events recognized under the Plan include the following:

Special Enrollment - Under the Health Insurance Portability and Accountability Act (HIPAA), you are allowed to enroll yourself and your eligible Dependents outside of the annual enrollment period when certain events occur. Special enrollment rights exist when:

- You acquire a new Dependent due to marriage, entering into a Civil Union, birth, adoption or placement for adoption; or
- You declined coverage under the Plan during a previous enrollment period because you were covered under another group health plan (or group health insurance), but you subsequently lose your other coverage for any of the following reasons:
    - You or your Dependents exhaust COBRA continuation coverage under another employer's group health plan (other than due to failure to pay contributions or for cause);
    - Employer contributions toward the other group health plan coverage terminate; or
    - You or your Dependents lose eligibility under the other group health plan or health insurance coverage (other than due to your failure to pay contributions or for cause), including:
        - As a result of legal separation, divorce, dissolution of a civil union or domestic partnership, cessation of dependent status, death, termination or reduction in hours of employment;
        - In the case of an individual HMO policy, loss of coverage because you no longer reside or work in the service area;
        - In the case of a group HMO, loss of coverage because you no longer reside or work in the service area, provided that no other benefit package is available to you; or
        - When a plan no longer offers any benefits to your class of similarly situated individuals.
    - You or your Dependent becomes:
        - ineligible for coverage under a Medicaid plan or a state child health plan, and as a result coverage is terminated; or
        - eligible for a premium assistance subsidy for the Medical Plan under Medicaid or the state child health plan.

When your special enrollment right results from the fact that you acquire a new Dependent through marriage, entering into a Civil Union, birth, adoption, or placement for adoption, you can enroll your new

Dependent in the Plan. In addition, if you are not already enrolled in the Plan, you can enroll yourself during the special enrollment period. If your Spouse, Civil Union Partner, or Domestic Partner is not already enrolled in the Plan and you have special enrollment rights because you acquire a new Dependent, you can enroll your Spouse, Civil Union Partner, or Domestic Partner during the special enrollment period. However, you cannot enroll any other Dependents who were already eligible for benefits but not previously enrolled in the Plan.

Change in Status - You may make a change to your coverage elections when certain change in status events occur, but only if the change is consistent with the event. The coverage change must be on account of and correspond to a change in status event that affects your or your dependent's eligibility for coverage under the Medical Plan or another employer's plan. The following are change in status events:

- Your legal marital status changes (e.g., through marriage, divorce, legal separation or annulment), you enter a Civil Union, or you dissolve a Civil Union or Domestic Partnership;

- The number of your eligible Dependents changes (such as when a child becomes your Dependent through birth or adoption; a person's dependent status — as defined by the Internal Revenue Code — changes; or a Dependent dies);

- Your covered Dependent no longer satisfies the requirements for coverage under the Plan because the dependent reaches the limiting age, or any similar circumstance;

- A change in your or your Dependent's employment status, including termination or commencement of employment, change of worksite, or any other change resulting in you or your Dependent becoming eligible or ineligible for benefits under a benefit plan;

- A reduction or increase in your or your Dependent's hours of employment (e.g., due to a change from part-time to full-time status or vice versa, a strike or lockout, or an unpaid leave of absence); or

- A change in your or your Dependent's residence affects eligibility for coverage.

Significant Cost or Coverage Changes – You may also change your coverage elections outside of the annual enrollment period if:

- Coverage under the Plan is significantly reduced or ends (if the significant reduction results in a loss of coverage, you may revoke coverage under that option and elect coverage under a similar option, or if no similar option is available, drop coverage; if the significant reduction does not result in a loss of coverage, you may revoke coverage under that option and elect coverage under a similar option, but you may not drop coverage completely);

- The cost of a benefit option significantly increases (you may elect to pay the increased cost for your current option, select a new benefit option, or revoke your coverage if there is no similar option);

- The cost of a benefit option significantly decreases (you may select that option);

- A similar benefit option is added, significantly improved or eliminated, and you are eligible to elect the new or improved option; or

- There are significant changes under your Spouse's, Civil Union Partner's, or Domestic Partner's plan due to a mid-year election change that satisfies the Internal Revenue Code regulations, or a change during an open enrollment period where your Spouse's, Civil Union Partner's or Domestic Partner's plan has a different plan year or enrollment period than the Plan.

Qualified Medical Child Support Order - Your election under the Plan may be changed as necessary to comply with a judgment, decree, or order resulting from a divorce, legal separation, annulment, or change in legal custody (including a qualified medical child support order) requiring you to provide coverage for a dependent child. In addition, if such a judgment, decree, or order requires your former spouse to provide coverage to a dependent child and such coverage is provided, you may elect to terminate coverage for such child.

Upon receipt of an order (from a court or from an administrative agency) requiring enrollment of an eligible dependent child, the Member will be notified if the order constitutes a Qualified Medical Child Support Order (QMCSO) as required under federal law. QMCSO procedures, under which the Plan administers medical child support orders, are available, at no charge, upon request to the Plan Administrator.

Entitlement to Medicare or Medicaid - You may make a corresponding election change under the Plan if you or your Dependent becomes entitled to Medicare or Medicaid coverage, other than coverage relating solely to the distribution of pediatric vaccines, or loses eligibility for such coverage.

How to Change Your Election and/or Participation during the Year

If you have a Qualified Change Event—for example, if you get married—you can make certain mid-year changes to your contribution amounts under the Plan.

You can make coverage changes by completing a Benefit Enrollment/Change Form located on the Meridian Health Intranet or at www.TeamMeridian.com.

If you have a Qualified Change Event during the year and need to change your coverage outside of the annual enrollment period, you must do so within 31 days of the Qualified Change Event (or within 60 days in the case of a special enrollment right due to loss of eligibility for Medicaid or CHIP coverage or eligibility for a state premium assistance subsidy from a Medicaid plan or through CHIP). Otherwise, you are not eligible to make a coverage change before the next annual enrollment period, unless you or your eligible family member has another Qualified Change in Status.

Your new election will be effective as of the first day of the month following the date on which such Plan Election is received, provided such election is received by the Plan Administrator (or the representative of the Plan Administrator) within 31 days after the event, except as follows:

- A change election on account of the birth, adoption, or placement of adoption of a new dependent shall be retroactive to the effective date of the event; and

- In the case of an enrollment due to marriage, coverage shall commence on the first day of the month following the date of the marriage.

Please note that you are not permitted to add a new Civil Union Partner (or the children of such individual) if you dissolved a Civil Union at any time during the prior 12 months (note that effective January 1, 2014, new Domestic Partners are not eligible under the Plan).

TERMINATION OF COVERAGE

When a Team Member's Coverage Terminates. Except as otherwise described in the Section entitled *Continuation Coverage Rights under COBRA*, Team Member coverage will terminate on the earliest of these dates:

(1) Termination of Active Employment or change in employment status, resulting in loss of eligibility (that is, you cease to be an eligible Team Member). Terminations occurring between the 1st of the month and 15th of the month will end coverage as of the 15th. Terminations occurring after the 15th of the month will end coverage as of the last day of the month;

(2) The last day of the calendar month for which any required Team Member contribution has been paid if the charge for the next period is not paid when due;

(3) Upon a finding, by the Plan Administrator, that the Team Member attempted to defraud the Plan or intentionally misrepresented material fact to the Plan. Termination of coverage in such circumstances may take effect on a retroactive basis (i.e., rescission);

(4) The date you effectively elect to cancel your coverage;

(5) The date the Plan is amended, resulting in your loss of eligibility;

(6) The date the Plan is terminated; or

(7) The date you die.

When Dependent Coverage Terminates. Except as described in the Section *Continuation Coverage Rights under COBRA*, a Dependent's coverage will terminate on the earliest of these dates:

(1) The date that the Team Member's coverage under the Plan terminates for any reason with the exception of death. Dependent coverage ends on the last day of the calendar month next following the month of the Team Member's death;

(2) The last day of the calendar month a covered Spouse, Civil Union Partner, or Domestic Partner ceases to be a Dependent as defined under this Plan;

(3) The last day of the calendar month that a Dependent child ceases to be a Dependent as defined by the Plan (subject to any extension for a Totally Disabled Dependent child as described above);

(4) The last day of the calendar month for which any required Team Member contribution for the Dependent's coverage has been paid if the Team Member contribution for the next period is not paid when due;

(5) Upon a finding, by the Plan Administrator, that the Dependent (or purported Dependent) attempted to defraud the Plan or intentionally misrepresented material fact to the Plan. Termination of coverage in such circumstances may take effect on a retroactive basis (i.e., rescission);

(6) The date you effectively elect to cancel your Dependent's Plan coverage;

(7) The date the Plan is amended, resulting in your Dependent's loss of eligibility;

(8) The date the Plan is terminated; or

(9) In the case of a Dependent enrolled pursuant to a QMCSO, the date as of which the Plan Administrator receives written evidence that the QMCSO is no longer in effect or that the dependent is enrolled in comparable health coverage.

RESCISSION OF COVERAGE

Your Plan coverage may be cancelled or discontinued retroactively only if: (1) the cancellation or discontinuance of coverage is effective retroactively to the extent it is attributable to a failure to timely pay required contributions for coverage, or (2) the cancellation or discontinuance of coverage is not considered to be a prohibited rescission under the Patient Protection and Affordable Care Act and applicable guidance. Your Plan coverage may be rescinded if you perform an act, practice or omission that constitutes fraud in an enrollment form or in a claim for benefits, or if you make an intentional misrepresentation of material fact to the Plan Administrator regarding any information material to your eligibility for benefits. The Plan Administrator will provide you with written notice at least 30 days in advance of the rescission of your coverage. Any rescission of coverage is treated as a denial of benefits for purposes of the Plan claims procedures. A retroactive termination due to your non-payment of contributions is not considered a rescission.

CONTINUATION OF COVERAGE

In addition to COBRA continuation coverage (discussed later in this Plan in the Section entitled *Continuation Coverage Rights under COBRA*), coverage may be continued in the following circumstances:

Continuation During Periods of Employer-Certified Disability or Leave of Absence. Individuals who would otherwise lose coverage under the Plan as a result of losing Team Member status (for example, as a result of disability, leave of absence, layoff, etc.) may, to the extent permitted under the Employer's employment policies and procedures, temporarily continue Plan coverage in accordance with such policies and procedures; provided, however, that such coverage continuation is subject to other terms and conditions under the Plan (including timely payment of required contributions) and any subsequent changes to Plan terms and conditions.

Continuation During Family and Medical Leave. This Plan shall at all times comply with the Family and Medical Leave Act of 1993 as promulgated in regulations issued by the Department of Labor.

During any leave that is a qualifying leave under the federal Family and Medical Leave Act (FMLA) (if applicable), Plan coverage will remain available to the extent required by FMLA.

To the extent Plan coverage terminates during the FMLA leave due to nonpayment of required contributions, coverage will resume as and to the extent required under FMLA (as applicable). Waiting periods will not apply for purposes of resuming coverage under the Plan, but all accumulated maximums (if any, such as visit limits, overall annual limit) will be reinstated.

Rehiring a Terminated Team Member. A terminated Team Member who is rehired will be treated as a new hire and be required to satisfy all Eligibility and Enrollment requirements, with the exception of a Team Member returning to work directly from COBRA coverage, who then will have no break in coverage. Notwithstanding the foregoing, if a terminated Team Member is rehired within 30 days and in the same calendar year, coverage as previously elected will be automatically reinstated upon reporting to work and the Team Member will not be able to make changes to your election.

Team Members on Military Leave. For Team Member covered under this Plan immediately prior to being called to active duty by any of the armed forces of the United States of America, coverage may continue for up to 24 months or the period of uniformed services leave, whichever is shorter, if the Team Member pays any required contributions toward the cost of the coverage during the leave. If the leave is 30 days or less, the contribution rate will be the same as for Active Team Member. If the leave is longer than 30 days, the required contribution will be higher, but will not exceed 102% of the cost of coverage. Coverage continued under this provision runs concurrently with coverage available under COBRA Continuation Coverage.

Whether or not the Team Member elects continuation coverage under the Uniformed Services Employment and Reemployment Rights Act (USERRA), coverage will be reinstated on the first day of his or her return to active employment with the Employer if he or she released under honorable conditions and returns to employment:

- On the first full business day following completion of military service for a leave of 30 days or less;
- Within 14 days of completing military service for a leave of 31 to 180 days; or
- Within 90 days of completing military service for a leave of more than 180 days (a reasonable amount of travel time or recovery time for an Illness or Injury determined by the Veterans Administration to be service connected will be allowed).

When coverage under this Plan is reinstated, all provisions and limitations of this Plan will apply to the extent that they would have applied if the Team Member had not taken military leave and coverage had been continuous under this Plan. Any waiting period will be waived. (This waiver of limitations does not provide coverage for any Illness or Injury caused or aggravated by military service, as determined by the Veterans Administration.) For complete information regarding your rights under USERRA, contact the Meridian HR Support Services Team.

CERTIFICATES OF CREDITABLE COVERAGE

Until December 31, 2014 (or such other applicability date that develops through regulations or other sub-regulatory guidance) and to the extent required under the Health Insurance Portability and Accountability Act of 1996 (HIPAA), each Covered Person will be provided a certificate of creditable coverage (i) when Plan coverage is lost (or would be lost in the absence of COBRA coverage or other coverage elected instead of COBRA; and (ii) when COBRA continuation coverage (if elected) ceases. In addition, a certificate of creditable coverage will be provided upon request to the Meridian HR Support Services Team by any Covered Person, or by any former Covered Person within 24 months after the date coverage ceases (including COBRA continuation coverage, if elected). A certificate of creditable coverage, which proves that the individual was covered under this Plan and indicates the period of coverage, may help reduce any pre-existing condition exclusion period under another health plan.

OPEN ENROLLMENT

During the annual open enrollment period, covered Team Members and their covered Dependents will be able to change their current benefit elections based on which benefits and coverage levels are right for them. In addition, Team Members and their Dependents who are Late Enrollees will also be able to enroll in the Plan during this period.

Benefit choices made during the open enrollment period will become effective the following January 1st and remain in effect through December 31st of the same calendar year unless earlier terminated or modified under terms of this Plan (See the Section *Change Events*). To the extent previously satisfied, coverage Waiting Periods will be considered satisfied when changing from one plan coverage option to another plan coverage option.

A covered Team Member who fails to make an election during Open Enrollment will automatically retain his or her current coverage election under the Plan or comparable coverage if a coverage option is eliminated (note that elections for flexible spending accounts under the Meridian Health Flexible Spending Accounts Plan do not automatically roll over; you must reelect flexible spending accounts coverage each year).

Team Members will receive detailed information regarding Open Enrollment from their Employer.

YOUR BENEFITS

Verification of Eligibility 1-800-992-6613

You should call the above number to verify eligibility for Plan benefits **before** the charge is incurred.

WHAT ARE THE BENEFITS?

All benefits described in this Schedule are subject to the exclusions and limitations described in this Summary Plan Description including, but not limited to, exclusions of charges for services or products that are (i) not Medically Necessary and Appropriate; (ii) not based on the QualCare Plan Allowable Charges; and (iii) Experimental and/or Investigational. The meanings of these capitalized terms are in the *Definitions* Section of this document.

Participating Providers

This Plan has entered into an agreement with certain Hospitals, Physicians and other health care providers, which in this Summary Plan Description are called Participating Providers. Because these Participating Providers have agreed to charge reduced fees to persons covered under the Plan, the Plan can afford to reimburse a higher percentage of their fees.

Therefore when a Covered Person uses a Participating Provider, that Covered Person will have a lower liability than when a Non-participating Provider is used.

It is the Covered Person's choice as to which Provider to use. However, some services are not covered by the Plan (or are reimbursed at a lower level) when provided by a Non-participating Provider. Review the schedule and remainder of this document carefully to ensure that your Provider selection makes sense for you.

HOW TO IDENTIFY PARTICIPATING PROVIDERS:

All **Meridian Health** members can access the **Meridian Health Inner Circle Directory** at the **www.teammeridian.com.**

You can find a listing of the Plan's Participating Providers and provider information on QualCare's website at www.qualcareinc.com or by calling the QualCare hotline at 1-800-992-6613.

Under the **Plan offerings** you have freedom of choice. Your level of benefits, covered services, Deductibles and Co-insurance amounts are based on the providers you select:

(1) **Inner Circle Providers** are those Physicians designated as **Inner Circle** Physicians for the Plan (see **Inner Circle** Directory). Using **Inner Circle** providers provides you with the highest level of coverage and will keep out of pocket expenses at their lowest. Your maximum benefit from the Plan is through use of the **Inner Circle** Providers. These providers are referred to as Inner Circle Providers throughout the SPD.

(2) **QualCare Network Providers** are Hospitals, Physicians, and other Providers who are participating in the QualCare **POS or PPO** Networks (refer to the Schedule of Benefits for your Plan). With the QualCare **POS and PPO** Networks, you will still maintain a generous

level of coverage, however, your Co-payment, Deductible and Co-insurance levels will be higher than the **Inner Circle** Providers.

(3) **PHCS/Multiplan Network Providers** are Hospitals, Physicians, and other Providers who are participating in the PHCS/Multiplan Network. This network is available for **any covered Team Member residing outside of New Jersey and Pennsylvania**, who can utilize these Providers at the In Network benefit level. This network is also available for Dependents who permanently reside outside of New Jersey and Pennsylvania. With the PHCS/Multiplan Network you will still maintain a generous level of coverage, however, your Copayment, Deductible and Coinsurance levels will be higher than the Inner Circle Providers. PHCS/Multiplan Network providers can be located at www.**multiplan**.com.

(4) **InterGroup Network Providers** are Hospitals, Physicians, and other Providers who are participating in the InterGroup Network. This network is available for **any covered Team Member residing in Pennsylvania**, who can utilize these Providers at the In Network benefit level. With the InterGroup Network you will still maintain a generous level of coverage, however, your Copayment, Deductible and Coinsurance levels will be higher than the Inner Circle Providers. InterGroup Network providers can be located at www.igs-ppo.com.

The Providers described in (2) – (4) are referred to as Network or In Network Providers throughout the SPD.

(5) **Out-of-Network Providers** are Hospitals, Physicians and other Providers who are not participating in the networks offered under your plan. When you select a Provider who is not a member of one of the Networks, you face the highest amount of out-of-pocket expenses (i.e., Deductibles, Copayments, Coinsurance and expenses for non-covered services) and are responsible for any amounts over QualCare Plan Allowable Charges. Please note, the QualCare Inner Circle plan does not have Out-of-Network benefits, except for Medical Emergencies.

BASIS OF PLAN PAYMENTS:

(1) **Inner Circle and Network Providers:** Plan payments are based on the charge determined by QualCare, to be reasonable for the type of Covered Services or Supplies you receive. This amount is referred to in this booklet as the "QualCare Plan Allowable Charges." **Inner Circle** and Network providers have agreed to accept this amount as payment in full for their services. This means if the provider's normal charges are more than the QualCare Plan Allowable Charges, you will not be billed for the difference between the provider's regular fee and the QualCare Plan Allowable Charges.

(2) **Out-of-Network Providers:** Plan payment for Out-of-Network Provider services are based on the QualCare Plan Allowable Charges for the Covered Service or Supplies you receive. Charges in excess of the QualCare Plan Allowable Charges are not considered covered charges under this Plan and therefore do not accrue toward your Out-of-Pocket Maximum. In addition to your responsibility for cost-sharing, Out-of-Network providers may bill you for amounts in excess of the Allowable Charge.

Under the provisions of the **Meridian Health** Plan, you have the freedom to choose which Hospitals and Physicians you utilize for your health care. The Plan will cover charges for the type of care, service and treatment described in this booklet wherever you receive them (the QualCare Inner Circle plan does not cover benefits provided by Out-of-Network Providers, except for Medical Emergencies), however, you

receive your highest level of benefits when you utilize one of the **Meridian Health** Hospitals and your **Inner Circle** providers. The need for elevation of benefits may arise for certain, specific circumstances:

- If a Member has a service performed at one of the **Meridian Health** Hospitals, and has services performed by a Provider that is not within the **Meridian Health Inner Circle**, the services will be paid at the network participation status of the Physician. For Hospital based Physicians, including but not limited to anesthesiologists, radiologists, and pathologists, who provide services at one of the **Meridian Health** facilities, the services will be paid at **Inner Circle** benefit level.
- Laboratories in the QualCare **POS and PPO** Networks, which are limited to Quest Diagnostics, will only be approved at the Network benefit. It is the Team Member's, not the provider's, responsibility to direct any lab work to an **Inner Circle**, POS, or PPO lab.
- If a Member has a service performed at one of the **Meridian Health** Hospitals, and it is determined by QualCare's Utilization Management Department that there are no **Inner Circle** Physicians that can provide the service, the Physician who provides the service(s) at the Hospital will be paid at the **Inner Circle** benefit level. For Hospital based Physicians, including but not limited to anesthesiologists, radiologists, and pathologists who provide services at one of the Meridian Health facilities, the services will be paid at the **Inner Circle** benefit level.
- When a facility service is deemed by QualCare to not to be available at one of the Meridian Health **Inner Circle** facilities, and a Member is redirected by QualCare's Utilization Management Department to an In-Network or out-of-network facility, both the facility and Physician bills for the services will be reimbursed at the **Inner Circle** benefit level. Any out-of-network Providers will be reimbursed at billed charges at the **Inner Circle** benefit level.
- True Medical Emergency services at an out-of-network facility and associated out-of-network Physician charges will be paid at the billed charges at the **Inner Circle benefit level**. Refer to the Schedule of Benefits.
- **Out-of-Network assistant surgeon's** charges if the operating surgeon is an **In-Network** Provider shall be payable at the **In-Network** Provider level. When the operating surgeon is an **Inner Circle** provider, covered expenses shall be payable at the **Inner Circle** provider level.
- In the event the covered person is confined to an **Inner Circle** provider hospital and the **Inner Circle** provider physician requests a consultation from **an In-Network** or **Out-of-Network** Provider or a newborn visit is performed by an **In-Network** or **Out-of-Network** Provider, covered expenses shall be payable at the **Inner Circle** provider level. In the event the covered person is confined to **an In-Network** Provider hospital and the **In-Network** Provider physician requests a consultation from an **Out-of-Network** Provider or a newborn visit is performed by an **Out-of-Network** Provider, covered expenses shall be payable at **the In-Network** Provider level.
- Students who attend college out of the area, and who need non-Wellness care that cannot be delayed until they are home, will have claims paid at the In Network level at a QualCare negotiated rate or at charges, if QualCare is unable to negotiate a rate.

If issues arise with payment of claims, please contact QualCare's Customer Service Department at 1-800-992-6613 or you can file an appeal. See Section *Appeal Procedure* on how to file an appeal.

HOW YOU PAY FOR SERVICES:

How you pay for services depends on whether you receive care from a Network Provider (including **Inner Circle** providers) or an Out-of-Network Provider.

QualCare Inner Circle and PPO Plans:

- **Inner Circle Providers** — this is your highest level of benefits. There is no Deductible to pay, and office visits are covered under a Copayment.
- **Network Providers** – You will be required to meet the Benefit Year In-Network Deductible. Simply show your Plan identification card to your Network provider and pay the required Copayment. Your provider will bill the Plan directly for services rendered.
- **Out-of-Network Providers** — Note that the Inner Circle Plan does not cover Out-of-Network Providers, except for Medical Emergencies. Under the PPO Plan, when you choose to use providers that are not part of the network, you will be required to meet the Benefit Year Deductible before the Plan pays benefits. In general, the plan will pay **50%** of the QualCare Plan Allowable Charges after you meet your Benefit Year Deductible. Please note that when using Out-of-Network Providers your out-of-pocket expense will be higher as Out-of-Network providers can bill you for any charges that exceed the QualCare Plan Allowable Charges.

CDHPlan:

- **Inner Circle Providers** — this is your highest level of benefits. Please note, a Deductible applies for all services except Preventive Care.
- **Network Providers** – You will be required to meet the Benefit Year In-Network Deductible before the Plan pays benefits. Simply show your Plan identification card to your Network provider and pay the required 30% Coinsurance. Your provider will bill the Plan directly for services rendered.
- **Out-of-Network Providers** — When you choose to use providers that are not part of the network, you will be required to meet the Benefit Year Deductible before the Plan pays benefits. In general, the plan will pay **50%** of the QualCare Plan Allowable Charges after you meet your Benefit Year Deductible. Please note that when using Out-of-Network Providers your out-of-pocket expense will be higher as Out-of-Network providers can bill you for any charges that exceed the QualCare Plan Allowable Charges.

Deductibles Payable by Plan Participants

Typically, there is one Deductible amount per Plan option that must be paid by a Covered Person before any money is paid by the Plan for any covered services. A new deductible amount is required at the start of each new Plan year.

PPO Plan:

Under the PPO Plan, amounts you pay towards your QualCare Network and Out-of-Network Deductible will be combined. For example, if you pay $1,000 for covered services you receive for QualCare Network Providers, you will be credited with $1,000 towards your Out of Network Deductible. Likewise, if you pay $2,000 for Out-of-Network Services, you will have satisfied your QualCare Network Deductible as well. Each January 1st a new Deductible is required.

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.

One (1) family member will have to satisfy the individual calendar year Deductible. The second half of the family Deductible can be satisfied by another individual or by any combination of covered family

members. However, no more than the individual amount will be credited to the family Deductible on behalf of any one covered person. After members of the family have satisfied the family Deductible, the Plan will pay covered charges for all covered family members as if each one of them had satisfied the individual Deductible.

CDHPlan:

Under the CDHPlan, amounts you pay towards your QualCare Network and Out-of-Network Deductible will be combined. For example, if you pay $1,000 for covered services you receive for QualCare Network Providers, you will be credited with $1,000 towards your Out of Network Deductible. Likewise, if you pay $2,000 for Out-of-Network Services, you will have satisfied your QualCare Network Deductible as well. Each January 1st a new Deductible is required.

If you have Family Coverage, the Deductible may be met by any combination of covered family members. The Individual Deductible does not apply. No member in the family is eligible for benefits subject to the Deductible until the Family Coverage Deductible is met. Once a Deductible is met, coverage by the Plan is subject to any other Member Cost sharing that may apply.

SCHEDULE OF BENEFITS

QualCare Inner Circle

Plan Provision	Inner Circle [2]	In- Network [2]
Annual Deductible • Individual • Family	None	$1,000 $2,000
HOW IS THE DEDUCTIBLE MET	*Once two covered family members have met the individual Deductible, the Deductible will be considered satisfied for all family members. Deductible applies for In Network services.*	
Coinsurance	100% of fee schedule	70% of fee schedule
COINSURANCE EXPLANATION	*The Plan will pay the designated percentage of Covered Charges until out-of-pocket amounts are reached, at which time the Plan will pay 100% of the remainder of Covered Charges for the rest of the Calendar Year unless stated otherwise.*	
In-Network Out-of-Pocket Maximum • Individual • Family	None	$4,000 $6,700
INCLUSION / EXCLUSION CONDITIONS:	*The In-Network Out-of-Pocket Maximum excludes Deductibles and copayments, and any amounts providers may charge that exceed the QualCare Plan Allowable Charges. Once two family members have reached the In-Network Out-of-Pocket Maximum, the Plan pays 100% for all family members for the remainder of the year. See the Combined Inner Circle and In-Network Out-of-Pocket Maximum below.*	
Combined Inner Circle and In-Network Out-of-Pocket Maximum • Individual • Family	$6,350 $12,700	
INCLUSION / EXCLUSION CONDITIONS:	*Combined Inner Circle and In-Network annual Out-Of-Pocket Maximum includes the Inner Circle and In-Network deductible, coinsurance, copayments, or similar charges, and Out-of-Network deductible for Medical Emergency services. It does not include premiums, balance billing, or spending for non-covered services. If this limit is reached, the Plan will pay 100% of the remainder of Allowable Charges for Inner Circle and In-Network providers without regard to whether the In-Network Out-of-Pocket Maximum is also met.*	
Lifetime Maximum	Unlimited	
PRE-CERTIFICATION	***For network services, your physician should obtain Pre-certification for you, as required, however, you are ultimately responsible for Pre-certification for all services, as required (in or out-of-network). There will be a $400 penalty applied for each failure to pre-certify.***	

Hospital Services		
In-patient Admissions [1]		
• Hospital	100%	$750 copay, then 70% after deductible
• Physician Charges	100%	70% after deductible
Outpatient Services and Ambulatory Surgery [1]		
• Hospital	100%	$500 copay, then 70% after deductible

• Free-Standing Surgical Center	100%	$300 copay, then 70% after deductible
• Office based Surgery	100%	$300 copay, then 70% after deductible
• Physician Charges	100%	70% after deductible

(1) Pre-certification: These services require Pre-certification. For network services, your physician should obtain Pre-certification for you, however, you are ultimately responsible for Pre-certification for all services (Inner Circle, In-Network or out-of-network).

(2) Reimbursement to all providers is based on the QualCare Plan Allowable Charges. Any Out-of-Network provider can balance bill the patient for any amounts in excess of the QualCare Plan Allowable Charges. This excess amount is considered a non-covered amount and does not accrue towards the Out-of-Pocket maximum.

Emergency Services		
Emergency Room Service:		
• Hospital	$50 copay applies to non-emergency care with 100% coverage after copay	$100 copay applies to non-emergency care with 70% coverage after copay
• Physician		
**Note: Copay Waived if admitted*		
Emergency Admission:		
• Hospital	100%	100%
• Physician	100%	100%
• Ancillary Charges	100%	100%
Diagnostic Services related to ER Visit	100%	100%
**Note: Copay Waived if admitted*	Out-of-Network Services and Supplies for Medical Emergencies are covered at the same rate described for Inner Circle and In-Network providers	

Physician Services		
Surgeon, Assistant Surgeon		
• Inpatient	100%	70% after deductible
• Outpatient	100%	70% after deductible
• Office	100%	70% after deductible
Anesthesiologist	100%	70% after deductible
Office visits		
• PCP	$30 copay	70% after deductible
• Specialist	$40 copay	70% after deductible
Urgent Care Center	$30 copay	$40 copay
Allergy Treatment		
• With Office Visit	$40 copay	70% after deductible
• Without Office Visit	100%	70% after deductible
Pre-Natal Care(1) (Obstetrical Ultrasounds greater than **3** per pregnancy require pre-certification)	100%	100%
Chiropractic Services **20 Visit MAXIMUM per calendar year**	$40 copay	70% after deductible

(1) Pre-certification: These services require Pre-certification. For network services, your physician should obtain Pre-certification for you, however, you are ultimately responsible for Pre-certification for all services (Inner Circle, In-Network or out-of-network).

Wellness Services		
The Plan covers "preventive health services," as that term is defined by the Patient Protection and Affordable Care Act of 2010, as amended, and implementing regulations thereunder. For more information about the specific preventive health services that are covered, visit https://www.healthcare.gov/what-are-my-preventive-care-benefits/#part=1. *Wellness coverage includes reimbursement for routine physical examinations, including related lab tests and x-rays, routine gynecological examination, mammography, pap smear, routine prostate screening & antigen test, glaucoma tests and recommended immunizations as shown in the Routine* ***Wellness Schedule.***		
Immunizations	100%	100%
Influenza Vaccine	100%	100%
HPV Vaccine	100%	100%
Routine Child Exams	100%	100%
Routine Adult Exams	100%	100%
Routine Gynecological Exams	100%	100%
Routine Mammograms	100%	100%
Prostate Exams	100%	100%
Routine Hearing Exam	$40 copay	70% after deductible

Diagnostic Services: Lab & X-ray		
Laboratory		
• Hospital	100%	70% after deductible
• Free Standing Facility	100%	70% after deductible
• Physician's Office	100%	70% after deductible
Radiology		
• Hospital	100%	70% after deductible
• Free Standing Facility	100%	70% after deductible
• Physician's Office	100%	70% after deductible
Professional Fees	100%	70% after deductible
Pre-admission Testing	100%	70% after deductible
High Tech Scans (1) **CT / CTA / PET / MRI / MRA / Dexa / Bone Density**		
• Hospital	100%	70% after deductible
• Free Standing Facility	100%	70% after deductible
(1) Pre-certification: These services require Pre-certification. For network services, your physician should obtain Pre-certification for you, however, you are ultimately responsible for Pre-certification for all services (Inner Circle, In-Network or out-of-network).		

Therapy Services		
Cardiac Rehab (1)		
• Outpatient Hospital	100%	70% after deductible
• Free Standing Facility	100%	70% after deductible
• Office	100%	70% after deductible

Respiratory Rehab [(1)] • Outpatient Hospital • Free Standing Facility • Office	 100% 100% 100%	 70% after deductible 70% after deductible 70% after deductible
Radiation / Chemotherapy [(1)] • Outpatient Hospital • Free Standing Facility • Office	 100% 100% 100%	 70% after deductible 70% after deductible 70% after deductible
Dialysis • Outpatient Hospital • Free Standing Facility • Office	 100% 100% 100%	 Not Covered
Infusion Therapy [(1)] • In-patient • Outpatient Hospital • Free Standing Facility • Office • Home	 100% 100% 100% 100% 100%	 $750 copay, then 70% after deductible, 70% after deductible 70% after deductible 70% after deductible 70% after deductible
Cognitive Therapy [(1)] • Outpatient Hospital • Office / Other Facility **60 Visit MAXIMUM per calendar year**	 100% $40 copay	 Not Covered
Physical Therapy Services [(1)] • Outpatient Hospital • Office / Other Facility **60 Visit MAXIMUM per calendar year**	 100% $40 copay	 Not Covered
Occupational Therapy Services [(1)] • Outpatient Hospital • Office / Other Facility **60 Visit MAXIMUM per calendar year**	 100% $40 copay	 Not Covered
Speech Therapy Services [(1)] • Outpatient Hospital • Office / Other Facility **30 Visit MAXIMUM per calendar year**	 100% $40 copay	 Not Covered
Acupuncture	$40 copay	Not Covered
Pain Management	100%	70% after deductible

[(1)] Pre-certification: These services require Pre-certification. For network services, your physician should obtain Pre-certification for you, however, you are ultimately responsible for Pre-certification for all services (Inner Circle, In-Network or out-of-network).

Other Covered Services		
Hospice [(1)] • In-patient • Home **181 day MAXIMUM per calendar year**	 100% 100%	 70% after deductible 70% after deductible
Home Health Care [(1)] **120 day MAXIMUM per calendar year**	100%	70% after deductible
Private Duty Nursing [(1)]	100%	70% after deductible

Durable Medical Equipment [1] *** Repairs / Replacements**	100%	70% after deductible
Diabetic Supplies	100%	70% after deductible
Diabetic Counseling	100%	70% after deductible
Nutritional Counseling	100%	70% after deductible
Breast Pump	100%	100%
Lactation Consultant	100%	100%
Ambulance Transportation [1] • Emergent • Hosp to Hosp • Acute to Rehab • Nursing to Dialysis Facility	 100% 100% 100% 100%	 70% of billed charges after deductible 70% of billed charges after deductible 70% of billed charges after deductible 70% of billed charges after deductible
Prosthesis [1]	100%	70% after deductible
Orthotics [1] *Braces custom fitted (support of body part)*	100%	70% after deductible
Foot Orthotics/Diabetic Shoes [1]	100%	70% after deductible
Orthotripsy • Hospital • Physicial Plan only covers for a diagnosis of plantar fasciitis	 100% 100%	 Not Covered 100%* *Only covered 100% when performed by a QualCare physician at a Meridian Facility
Blood/Blood Products	100%	70% after deductible
Contraception • Insertion / Removal • Device* • Other *When provided at physician's office	 100% 100% Covered under Rx	 100% 100% Covered under Rx
Family Planning Procedures[1] ***(Vasectomies, Tubal Ligations & Voluntary Abortions)*** • Outpatient • Office Reversal of sterilization is not covered	 100% 100%	 70% after deductible 70% after deductible
Wigs after Chemo *1 per lifetime initial purchase* *$500 maximum benefit*	100%	70% after deductible
Infertility Treatment [1] *$10,000 lifetime medical maximum*	100%	70% after deductible
Hearing Aid • Insertion • Device • Cochlear Implants • Repair	 Not Covered	 Not Covered
Optical Benefit (Hardware)	Not Covered	Not Covered

Glasses / Lenses *after* Cataract Surgery (1 pair maximum)	100%	70% after deductible

(1) Pre-certification: These services require Pre-certification. For network services, your physician should obtain Pre-certification for you, however, you are ultimately responsible for Pre-certification for all services (Inner Circle, In-Network or out-of-network).

Mental Health / Substance Abuse Services		
In-patient (1)		
• Hospital / Facility	100%	$750 copay, then 70% after deductible
• Physician Charges	100%	70% after deductible
Outpatient*		
• Hospital / Facility	$40 copay	70% after deductible
• Physician Charges	$40 copay	70% after deductible
Biofeedback	$40 copay	70% after deductible
Marriage Counseling	Not Covered	Not Covered
Bereavement Counseling	Not Covered	Not Covered

(1) Pre-certification: These services require Pre-certification. For network services, your physician should obtain Pre-certification for you, however, you are ultimately responsible for Pre-certification for all services (Inner Circle, In-Network or out-of-network).

Dental Services / Vendor Info		
Oral Surgery *Note: Only covered if related to an accident and/ or damage to perfect health teeth*	100%	70% after deductible
Full / Partial Bony Impacted	100%	70% after deductible
TMJ • Surgical • Non – Surgical	Not Covered	Not Covered

Pharmacy Services / Vendor Info		
Pharmacy	**Envision Rx Options (800) 361-4542 – See the Section Prescription Plan for payment levels**	
Self-Injectable Medication	Covered under Rx	Covered under Rx

SCHEDULE OF BENEFITS

QualCare PPO

Plan Provision	Inner Circle	In-Network	Out-of-Network (2)
Annual Deductible • Individual • Family	None None	$1,000 $2,000	$2,000 $4,000
HOW IS THE DEDUCTIBLE MET	*Once two covered family members have met the individual Deductible, the Deductible will be considered satisfied for all family members. Deductibles accumulate between In Network and Out of Network*		
Coinsurance	100% of fee schedule	70% of fee schedule	50% of fee schedule
COINSURANCE EXPLANATION	*The Plan will pay the designated percentage of Covered Charges until out-of-pocket amounts are reached, at which time the Plan will pay 100% of the remainder of Covered Charges for the rest of the Calendar Year unless stated otherwise.*		
In-Network Out-of-Pocket Maximum • Individual • Family	N/A	$4,000 $6,700	No annual maximum
INCLUSION / EXCLUSION CONDITIONS	*The In-Network Out-of-Pocket Maximum excludes Deductibles, copayments, and any amounts out-of-network providers may charge that exceed the QualCare Plan Allowable Charges. Once two family members have reached the In-Network Out-of-Pocket Maximum, the Plan pays 100% for all family members for the remainder of the year. Balance bill charges would still apply for out-of-Network providers. See the Combined Inner Circle and In-Network Out-of-Pocket Maximum below.*		
Combined Inner Circle and In-Network Out-of-Pocket Maximum • Individual • Family	$6,350 $12,700		No annual maximum
INCLUSION / EXCLUSION CONDITIONS	*Combined Inner Circle and In-Network annual Out-Of-Pocket Maximum includes the Inner Circle and In-Network deductible, coinsurance, copayments, or similar charges, and Out-of-Network deductible for Medical Emergency services. It does not include premiums, balance billing, or spending for non-covered services. If this limit is reached, the Plan will pay 100% of the remainder of Allowable Charges for Inner Circle and In-Network providers without regard to whether the In-Network Out-of-Pocket Maximum is also met.*		
Lifetime Maximum	Unlimited		
PRE-CERTIFICATION	***For network services, your physician should obtain Pre-certification for you, as required, however, you are ultimately responsible for Pre-certification for all services (in or out-of-network). There will be a $400 penalty applied for each failure to pre-certify.***		

Hospital Services			
In-patient Admissions [(1)]			
• Hospital	100%	70% after deductible	50% after deductible
• Physician Charges	100%	70% after deductible	50% after deductible
Outpatient Services and Ambulatory Surgery [(1)]			
• Hospital	100%	70% after deductible	50% after deductible
• Free-Standing Surgical Center*	100%	70% after deductible	50% after deductible
• Office based Surgery*	100%	70% after deductible	50% after deductible
• Physician Charges	100%	70% after deductible	50% after deductible
**$1,200 max per surgery done at an out of network same day surgery center including all related services*			
[(1)] Pre-certification: These services require Pre-certification. For network services, your physician should obtain Pre-certification for you, however, you are ultimately responsible for Pre-certification for all services (Inner Circle, In-Network or out-of-network).			
[(2)] Reimbursement to all providers is based on the QualCare Plan Allowable Charges. Any Out-of-Network provider can balance bill the patient for any amounts in excess of the QualCare Plan Allowable Charges. This excess amount is considered a non-covered amount and does not accrue towards the Out-of-Pocket maximum.			

Emergency Services			
Emergency Room Service:			
• Hospital	$50 copay applies to non-emergency care	$100 copay applies to non-emergency care with 70% coverage after copay	Non-emergency care not covered
• Physician			
• Ancillary Charges			
**Note: Copay Waived if admitted*			
Emergency Admission:			
• Hospital	100%	100%	100%
• Physician	100%	100%	100%
• Ancillary Charges	100%	100%	100%
Diagnostic Services related to ER Visit			
**Note: Copay Waived if admitted*			

Physician Services			
Surgeon, Assistant Surgeon • Inpatient • Outpatient • Office	 100% 100% 100%	 70% after deductible 70% after deductible 70% after deductible	 50% after deductible 50% after deductible 50% after deductible
Anesthesiologist	100%	70% after deductible	50% after deductible
Office visits • PCP • Specialist	 $30 copay $40 copay	 $40 copay $50 copay	 50% after deductible 50% after deductible
Urgent Care Center	$30 copay	$40 copay	$40 copay
Allergy Treatment • With Office Visit • Without Office Visit	 $40 copay 100%	 $50 copay 100%	 50% after deductible 50% after deductible
Pre-Natal Care [(1)] (Obstetrical Ultrasounds greater than **3** per pregnancy require pre-certification)	100%	100%	50% after deductible
Chiropractic Services **$1,800 MAXIMUM per calendar year**	$40 copay	$50 copay	50% after deductible

[(1)] Pre-certification: These services require Pre-certification. For network services, your physician should obtain Pre-certification for you, however, you are ultimately responsible for Pre-certification for all services (Inner Circle, In-Network or out-of-network).

Wellness Services			
The Plan covers "preventive health services," as that term is defined by the Patient Protection and Affordable Care Act of 2010, as amended, and implementing regulations thereunder. For more information about the specific preventive health services that are covered, visit https://www.healthcare.gov/what-are-my-preventive-care-benefits/#part=1. *Wellness coverage includes reimbursement for routine physical examinations, including related lab tests and x-rays, routine gynecological examination, mammography, pap smear, routine prostate screening & antigen test, glaucoma tests and recommended immunizations as shown in the* ***Routine Wellness Schedule.***			
Immunizations	100%	100%	Not Covered
Influenza Vaccine	100%	100%	Not Covered
HPV Vaccine	100%	100%	Not Covered
Routine Child Exams	100%	100%	Not Covered
Routine Adult Exams	100%	100%	Not Covered
Routine Gynecological Exams	100%	100%	Not Covered
Routine Mammograms	100%	100%	Not Covered
Prostate Exams	100%	100%	Not Covered
Routine Hearing Exam	$40 copay	$50 copay	50% after deductible

Diagnostic Services: Lab & X-ray			
Laboratory • Hospital • Free Standing Facility • Office	 100% 100% 100%	 70% after deductible 70% after deductible 70% after deductible	 50% after deductible 50% after deductible 50% after deductible
Radiology • Outpatient Hospital • Free Standing Facility • Office	 100% 100% 100%	 70% after deductible 70% after deductible 70% after deductible	 50% after deductible 50% after deductible 50% after deductible

Professional Fees	100%	70% after deductible	50% after deductible
Pre-admission Testing	100%	70% after deductible	50% after deductible
High Tech Scans [(1)] **CT / CTA / PET / MRI / MRA / Dexa / Bone Density**			
• Hospital	100%	70% after deductible	50% after deductible
• Free Standing Facility	100%	70% after deductible	50% after deductible
[(1)] **Pre-certification: These services require Pre-certification. For network services, your physician should obtain Pre-certification for you, however, you are ultimately responsible for Pre-certification for all services (Inner Circle, In-Network or out-of-network).**			

Therapy Services			
Cardiac Rehab [(1)]			
• Outpatient Hospital	100%	70% after deductible	50% after deductible
• Free Standing Facility	100%	70% after deductible	50% after deductible
• Office	100%	70% after deductible	50% after deductible
Respiratory Rehab [(1)]			
• Outpatient Hospital	100%	70% after deductible	50% after deductible
• Free Standing Facility	100%	70% after deductible	50% after deductible
• Office	100%	70% after deductible	50% after deductible
Radiation / Chemotherapy [(1)]			
• Outpatient Hospital	100%	70% after deductible	50% after deductible
• Free Standing Facility	100%	70% after deductible	50% after deductible
• Office	100%	70% after deductible	50% after deductible
Dialysis			
• Outpatient Hospital	100%	Not Covered	Not Covered
• Free Standing Facility	100%		
• Office	100%		
Infusion Therapy [(1)]			
• In-patient	100%	70% after deductible	50% after deductible
• Outpatient Hospital	100%	70% after deductible	50% after deductible
• Free Standing Facility	100%	70% after deductible	50% after deductible
• Office	100%	70% after deductible	50% after deductible
• Home	100%	70% after deductible	50% after deductible
Cognitive Therapy [(1)]			
• Outpatient Hospital	100%	70% after deductible	50% after deductible
• Office / Other Facility	100%	70% after deductible	50% after deductible
60 Visit MAXIMUM per calendar year			
Physical Therapy Services [(1)]			
• Outpatient Hospital	100%	70% after deductible	50% after deductible
• Office / Other Facility	$40 copay	70% after deductible	50% after deductible
60 visit MAXIMUM per calendar year			
Occupational Therapy Services [(1)]			
• Outpatient Hospital	100%	70% after deductible	50% after deductible
• Office / Other Facility	$40 copay	70% after deductible	50% after deductible
60 visit MAXIMUM per calendar year			
Speech Therapy Services [(1)]			

• Outpatient Hospital • Office / Other Facility **30 visit MAXIMUM per calendar year**	100% $40 copay	70% after deductible 70% after deductible	50% after deductible 50% after deductible
Acupuncture	$40 copay	Not Covered	Not Covered
Pain Management	100%	70% after deductible	50% after deductible

(1) Pre-certification: These services require Pre-certification. For network services, your physician should obtain Pre-certification for you, however, you are ultimately responsible for Pre-certification for all services (Inner Circle, In-Network or out-of-network).

Other Covered Services			
Hospice *(181 day maximum)*(1) • In-patient • Home	 100% 100%	 70% after deductible 70% after deductible	 50% after deductible 50% after deductible
Home Health Care (1) **120 day maximum per year**	100%	70% after deductible	50% after deductible
Private Duty Nursing (1)	100%	70% after deductible	50% after deductible
Durable Medical Equipment (1) *** Repairs / Replacements**	100%	70% after deductible	50% after deductible
Diabetic Supplies	100%	70% after deductible	50% after deductible
Diabetic Counseling	100%	70% after deductible	50% after deductible
Nutritional Counseling	100%	70% after deductible	50% after deductible
Breast Pump	100%	100%	100%
Lactation Consultant	100%	100%	100%
Ambulance Transportation (1) • Emergent • Hosp to Hosp • Acute to Rehab • Nursing to Dialysis Facility	 100% 100% 100% 100%	 100% after deductible 100% after deductible 100% after deductible 100% after deductible	 100% of billed charges 100% of billed charges 100% of billed charges 100% of billed charges
Prosthesis (1)	100%	70% after deductible	50% after deductible
Orthotics (1) *Braces custom fitted (support of body part)*	100%	70% after deductible	50% after deductible
Foot Orthotics/ Diabetic Shoes (1)	100%	70% after deductible	50% after deductible
Orthotripsy • Hospital • Physician Plan only covers for a diagnosis of plantar fasciitis	 100% 100%	 Not Covered 100%* *Only covered 100% when performed by a QualCare physician at a Meridian Facility	 Not Covered Not Covered
Blood/Blood Products	100%	70% after deductible	50% after deductible
Contraception • Insertion / Removal • Device* • Other *When provided at a physician's office	 100% 100% Covered under Rx	 100% 100% Covered under Rx	 100% Not Covered Covered under Rx
Family Planning Procedures(1) ***(Vasectomies, Tubal Ligations & Voluntary Abortions)*** • Outpatient • Office Reversal of sterilization is not covered	 100% 100%	 70% after deductible 70% after deductible	 50% after deductible 50% after deductible
Wigs after Chemo	100%	70% after deductible	50% after deductible

1 wig per lifetime *$500 maximum benefit*			
Infertility Treatment [(1)] *$10,000 lifetime medical maximum*	100%	70% after deductible	50% after deductible
Hearing Aid[(1)] • Insertion • Device • Cochlear Implants • Repair	Not Covered	Not Covered	Not Covered
Optical Benefit (Hardware)	Not Covered	Not Covered	Not Covered
Glasses / Lenses after Cataract Surgery (1 pair maximum)	100%	100%	100%

[(1)] Pre-certification: These services require Pre-certification. For network services, your physician should obtain Pre-certification for you, however, you are ultimately responsible for Pre-certification for all services (Inner Circle, In-Network or out-of-network).

Mental Health / Substance Abuse Services			
In-patient [(1)] • Hospital / Facility • Physician Charges	 100% 100%	 70% after deductible 70% after deductible	 50% after deductible 50% after deductible
Outpatient • Hospital / Facility • Physician Charges	 $40 copay $40 copay	 $50 copay $50 copay	 50% after deductible 50% after deductible
Biofeedback	$40 copay	$50 copay	50% after deductible
Marriage Counseling	Not Covered	Not Covered	Not Covered
Bereavement Counseling	Not Covered	Not Covered	Not Covered

[(1)] Pre-certification: These services require Pre-certification. For network services, your physician should obtain Pre-certification for you, however, you are ultimately responsible for Pre-certification for all services (Inner Circle, In-Network or out-of-network).

Dental Services / Vendor Info			
Oral Surgery *Note: Only covered if related to an accident and/ or damage to perfect health teeth*	100%	70% after deductible	50% after deductible
Full / Partial Bony Impacted	100%	70% after deductible	50% after deductible
TMJ [(1)] • Surgical • Non – Surgical	Not Covered	Not Covered	Not Covered

[(1)] Pre-certification: These services require Pre-certification. For network services, your physician should obtain Pre-certification for you, however, you are ultimately responsible for Pre-certification for all services (Inner Circle, In-Network or out-of-network).

Pharmacy Services / Vendor Info			
Pharmacy	**Envision Rx Options (800) 361-4542 - See the Section Prescription Plan for payment levels**		
Self-Injectable Medication	Covered under Rx	Covered under Rx	Covered under Rx

SCHEDULE OF BENEFITS

Meridian CDHPlan

Plan Provision	Inner Circle	In-Network	Out-of-Network (2)
Annual Deductible	The dollars in your Health Savings Account are used for the first $1,500 /$3,000 of health care expenses; you must meet the deductible before any expenses are covered (other than preventive services) under the Plan		
HOW IS THE DEDUCTIBLE MET	*If you have Family Coverage, the $3,000 Deductible must be met by two or more covered family members. For individuals a $1,500 Deductible must be met. Deductibles accumulate between In Network and Out of Network*		
Coinsurance	100% of fee schedule	70% of fee schedule	50% of fee schedule
COINSURANCE EXPLANATION	***The Plan will pay the designated percentage of Covered Charge, after the deductible is met (for all services other than preventive services)****, until out-of-pocket amounts are reached, at which time the Plan will pay 100% of the remainder of Covered Charges for the rest of the Calendar Year unless stated otherwise.*		
In-Network Out-of-Pocket Maximum • Individual • Family	N/A	$4,000 $6,700	No annual maximum
INCLUSION / EXCLUSION CONDITIONS	*The In-Network Out-of-Pocket Maximum excludes Deductibles, copayments, and any amounts out-of-network providers may charge that exceed the QualCare Plan Allowable Charges. Once two family members have reached the In-Network Out-of-Pocket Maximum, the Plan pays 100% for all family members for the remainder of the year. Balance bill charges would still apply for out-of-Network providers. See the Combined Inner Circle and In-Network Out-of-Pocket Maximum below.*		
Combined Inner Circle and In-Network Out-of-Pocket Maximum • Individual • Family	$6,350 $12,700		No annual maximum
INCLUSION / EXCLUSION CONDITIONS	*Combined Inner Circle and In-Network annual Out-Of-Pocket Maximum includes the Inner Circle and In-Network deductible, coinsurance, copayments, or similar charges, and Out-of-Network deductible for Medical Emergency services. It does not include premiums, balance billing, or spending for non-covered services. If this limit is reached, the Plan will pay 100% of the remainder of Allowable Charges for Inner Circle and In-Network providers without regard to whether the In-Network Out-of-Pocket Maximum is also met.*		
Lifetime Maximum	Unlimited		
PRE-CERTIFICATION	***For network services, your physician should obtain Pre-certification for you, however, you are ultimately responsible for Pre-certification for all services (in or out-of-network). There will be a $400 penalty applied for each failure.***		

Hospital Services			
In-patient Admissions [1]			
• Hospital	100% after deductible	70% after deductible	50% after deductible
• Physician Charges	100% after deductible	70% after deductible	50% after deductible
Outpatient Services and Ambulatory Surgery [1]			
• Hospital	100% after deductible	70% after deductible	50% after deductible
• Free-Standing Surgical Center*	100% after deductible	70% after deductible	50% after deductible
• Office based Surgery*	100% after deductible	70% after deductible	50% after deductible
• Physician Charges	100% after deductible	70% after deductible	50% after deductible
**$1,200 max per surgery done at an out-of-network same day surgery centers including all related services*			
[1] Pre-certification: These services require Pre-certification. For network services, your physician should obtain Pre-certification for you, however, you are ultimately responsible for Pre-certification for all services (Inner Circle, In-Network or out-of-network).			
[2] Reimbursement to all providers is based on the QualCare Plan Allowable Charges. Any Out-of-Network provider can balance bill the patient for any amounts in excess of the QualCare Plan Allowable Charges. This excess amount is considered a non-covered amount and does not accrue towards the Out-of-Pocket maximum.			

Emergency Services			
Emergency Room Service:			
• Hospital	100% after deductible coverage for non-emergency care	70% after deductible coverage for non-emergency care	50% after deductible coverage for non-emergency care
• Physician			
• Ancillary Charges			
**Note: Copay Waived if admitted*			
Emergency Admission:			
• Hospital	100% after deductible	100% after deductible	100% after deductible
• Physician	100% after deductible	100% after deductible	100% after deductible
• Ancillary Charges	100% after deductible	100% after deductible	100% after deductible
Diagnostic Services related to ER Visit	100% after deductible	100% after deductible	100% after deductible
**Note: Copay Waived if admitted*			

Physician Services			
Surgeon, Assistant Surgeon			
• Inpatient	100% after deductible	70% after deductible	50% after deductible
• Outpatient	100% after deductible	70% after deductible	50% after deductible
• Office	100% after deductible	70% after deductible	50% after deductible
Anesthesiologist	100% after deductible	70% after deductible	50% after deductible

Office visits • PCP • Specialist	 100% after deductible 100% after deductible	 70% after deductible 70% after deductible	 50% after deductible 50% after deductible
Urgent Care Center	100% after deductible	100% after deductible	100% after deductible
Allergy Treatment	100% after deductible	70% after deductible	50% after deductible
Pre-Natal Care (Obstetrical Ultrasounds greater than **3** per pregnancy require pre-certification)	100% after deductible	100% after deductible	50% after deductible
Chiropractic Services [(1)] **$1,800 MAXIMUM per calendar year**	100% after deductible	100% after deductible	Not Covered

[(1)] Pre-certification: These services require Pre-certification. For network services, your physician should obtain Pre-certification for you, however, you are ultimately responsible for Pre-certification for all services (Inner Circle, In-Network or out-of-network).

Wellness Services

The Plan covers "preventive health services," as that term is defined by the Patient Protection and Affordable Care Act of 2010, as amended, and implementing regulations thereunder. For more information about the specific preventive health services that are covered, visit https://www.healthcare.gov/what-are-my-preventive-care-benefits/#part=1. *Wellness coverage includes reimbursement for routine physical examinations, including related lab tests and x-rays, routine gynecological examination, mammography, pap smear, routine prostate screening & antigen test, glaucoma tests and recommended immunizations as shown in the* ***Routine Wellness Schedule.***

Immunizations	100%	100%	Not Covered
Influenza Vaccine	100%	100%	Not Covered
HPV Vaccine	100%	100%	Not Covered
Routine Child Exams	100%	100%	Not Covered
Routine Adult Exams	100%	100%	Not Covered
Routine Gynecological Exams	100%	100%	Not Covered
Routine Mammograms	100%	100%	Not Covered
Prostate Exams	100%	100%	Not Covered
Routine Hearing Exam	100% after deductible	70% after deductible	50% after deductible

Diagnostic Services: Lab & X-ray

Laboratory • Hospital • Free Standing Facility • Office	 100% after deductible 100% after deductible 100% after deductible	 70% after deductible 70% after deductible 70% after deductible	 50% after deductible 50% after deductible 50% after deductible
Radiology • Outpatient Hospital • Free Standing Facility • Office	100% after deductible 100% after deductible 100% after deductible 100% after deductible	70% after deductible 70% after deductible 70% after deductible 70% after deductible	50% after deductible 50% after deductible 50% after deductible 50% after deductible
Professional Fees	100% after deductible	70% after deductible	50% after deductible
Pre-admission Testing	100% after deductible	70% after deductible	50% after deductible
High Tech Scans [(1)] **CT / CTA / PET / MRI / MRA / Dexa / Bone Density** • Hospital • Free Standing Facility	 100% after deductible 100% after deductible	 70% after deductible 70% after deductible	 50% after deductible 50% after deductible

(1) Pre-certification: These services require Pre-certification. For network services, your physician should obtain Pre-certification for you, however, you are ultimately responsible for Pre-certification for all services (Inner Circle, In-

Network or out-of-network).			
Therapy Services			
Cardiac Rehab [(1)] • Outpatient Hospital • Free Standing Facility • Office	 100% after deductible 100% after deductible 100% after deductible	 70% after deductible 70% after deductible 70% after deductible	 50% after deductible 50% after deductible 50% after deductible
Respiratory Rehab [(1)] • Outpatient Hospital • Free Standing Facility • Office	 100% after deductible 100% after deductible 100% after deductible	 70% after deductible 70% after deductible 70% after deductible	 50% after deductible 50% after deductible 50% after deductible
Radiation / Chemotherapy [(1)] • Outpatient Hospital • Free Standing Facility • Office	 100% after deductible 100% after deductible 100% after deductible	 70% after deductible 70% after deductible 70% after deductible	 50% after deductible 50% after deductible 50% after deductible
Dialysis [(1)] • Outpatient Hospital • Free Standing Facility • Office	 100% after deductible 100% after deductible 100% after deductible	Not Covered	Not Covered
Infusion Therapy [(1)] • In-patient • Outpatient Hospital • Free Standing Facility • Office • Home	 100% after deductible 100% after deductible 100% after deductible 100% after deductible 100% after deductible	 70% after deductible 70% after deductible 70% after deductible 70% after deductible 70% after deductible	 50% after deductible 50% after deductible 50% after deductible 50% after deductible 50% after deductible
Cognitive Therapy [(1)] • Outpatient Hospital • Office / Other Facility **60 day MAXIMUM per incident.**	 100% after deductible 100% after deductible	 70% after deductible 70% after deductible	 50% after deductible 50% after deductible
Physical Therapy Services [(1)] • Outpatient Hospital • Office / Other Facility **$4,000 MAXIMUM per person per calendar year**	 100% after deductible 100% after deductible	 70% after deductible 70% after deductible	 50% after deductible 50% after deductible
Occupational Therapy Services [(1)] • Outpatient Hospital • Office / Other Facility **$4,000 MAXIMUM per person per calendar year**	 100% after deductible 100% after deductible	 70% after deductible 70% after deductible	 50% after deductible 50% after deductible
Speech Therapy Services [(1)] • Outpatient Hospital • Office / Other Facility **$2,500 MAXIMUM per person per calendar year**	 100% after deductible 100% after deductible	 70% after deductible 70% after deductible	 50% after deductible 50% after deductible
Acupuncture	100% after deductible	70% after deductible	Not Covered
Pain Management	100% after deductible	70% after deductible	50% after deductible
[(1)] Pre-certification: These services require Pre-certification. For network services, your physician should obtain Pre-certification for you, however, you are ultimately responsible for Pre-certification for all services (Inner Circle, In-Network or out-of-network).			

Other Covered Services			
Hospice *(181 day maximum)*[1] • In-patient • Home	 100% after deductible 100% after deductible	 70% after deductible 70% after deductible	 50% after deductible 50% after deductible
Home Health Care [1] **120 day maximum per year**	100% after deductible	70% after deductible	50% after deductible
Private Duty Nursing [1] **120 day maximum per year**	100% after deductible	70% after deductible	50% after deductible
Durable Medical Equipment [1] *** Replacements**	100% after deductible	70% after deductible	50% after deductible
Diabetic Supplies	100% after deductible	70% after deductible	50% after deductible
Diabetic Counseling	100% after deductible	70% after deductible	50% after deductible
Nutritional Counseling	100% after deductible	70% after deductible	50% after deductible
Breast Pump	100%	100%	100%
Lactation Consultant	100%	100%	100%
Ambulance Transportation [1] • Emergent • Hosp to Hosp • Acute to Rehab • Nursing to Dialysis Facility	 100% after deductible 100% after deductible 100% after deductible 100% after deductible	 100% after deductible 100% after deductible 100% after deductible 100% after deductible	 100% after deductible 100% after deductible 100% after deductible 100% after deductible
Prosthesis [1] $2,500 maximum per year per person	100% after deductible	70% after deductible	50% after deductible
Orthotics [1] *Braces custom fitted (support of body part)*	100% after deductible	70% after deductible	50% after deductible
Foot Orthotics/ Diabetic Shoes [1]	100% after deductible	70% after deductible	50% after deductible
Orthotripsy • Hospital • Physician Plan only covers for a diagnosis of plantar fasciitis	 100% 100%	 Not Covered 100%* *Only covered 100% when performed by a QualCare physician at a Meridian Facility	 Not Covered Not Covered
Blood/Blood Products	100% after deductible	70% after deductible	50% after deductible
Contraception • Insertion / Removal • Device* • Other *When provided at Physician's office	 100% 100% Covered under Rx	 100% 100% Covered under Rx	 100% Not Covered Covered under Rx
Family Planning Procedures[1] ***(Vasectomies, Tubal Ligations & Voluntary Abortions)*** • Outpatient • Office Reversal of sterilization is not covered	 100% after deductible 100% after deductible	 70% after deductible 70% after deductible	 50% after deductible 50% after deductible
Wigs after Chemo *1 wig per lifetime* *$500 maximum benefit*	100% after deductible	70% after deductible	50% after deductible

Infertility Treatment [(1)] ***$10,000 lifetime medical maximum***	100% after deductible	70% after deductible	50% after deductible
Hearing Aid[(1)] • Insertion • Device • Cochlear Implants • Repair	Not Covered	Not Covered	Not Covered
Optical Benefit (Hardware)	Not Covered	Not Covered	Not Covered
Glasses / Lenses after Cataract Surgery	100%	100%	100%

[(1)] Pre-certification: Certain services require Pre-certification. For network services, your physician should obtain Pre-certification for you, however, you are ultimately responsible for Pre-certification for all services (Inner Circle, In-Network or out-of-network).

Mental Health / Substance Abuse Services			
In-patient [(1)]			
• Hospital / Facility	100% after deductible	70% after deductible	50% after deductible
• Physician Charges	100% after deductible	70% after deductible	50% after deductible
Outpatient			
• Hospital / Facility	100% after deductible	70% after deductible	50% after deductible
• Physician Charges	100% after deductible	70% after deductible	50% after deductible
Biofeedback	100% after deductible	70% after deductible	50% after deductible
Marriage Counseling	Not Covered	Not Covered	Not Covered
Bereavement Counseling	Not Covered	Not Covered	Not Covered

[(1)] Pre-certification: Certain services require Pre-certification. For network services, your physician should obtain Pre-certification for you, however, you are ultimately responsible for Pre-certification for all services (Inner Circle, In-Network or out-of-network).

Dental Services / Vendor Info			
Oral Surgery *Note: Only covered if related to an accident and/ or damage to perfect health teeth*	100% after deductible	70% after deductible	50% after deductible
Full / Partial Bony Impacted	100% after deductible	70% after deductible	50% after deductible
TMJ [(1)] • Surgical • Non – Surgical	Not Covered	Not Covered	Not Covered

[(1)] Pre-certification: Certain services require Pre-certification. For network services, your physician should obtain Pre-certification for you, however, you are ultimately responsible for Pre-certification for all services (Inner Circle, In-Network or out-of-network).

Pharmacy Services / Vendor Info			
Pharmacy	**Envision Rx Options (800) 361-4542 -See the Section Prescription Plan for payment levels**		
Self-Injectable Medication	Covered under Rx	Covered under Rx	Covered under Rx

Wellness Schedule

ROUTINE WELLNESS SCHEDULE - ALL AGES

(Including Immunizations)

The Plan covers "preventive health services," as that term is defined by the Patient Protection and Affordable Care Act of 2010, as amended, and implementing regulations thereunder. For more information about the specific preventive health services that are covered, visit https://www.healthcare.gov/what-are-my-preventive-care-benefits/#part=1.

Childhood, Adolescent, and Young Adult Health Supervision Visits are covered by the Plan at the ages listed in Table 1.

Table 1. Ages at Which Childhood Health Supervision Visits Are Covered

Newborn	9 months
First week of life	12 months
1 month	15 months
2 months	18 months
4 months	2 years
6 months	2 ½ years
Annually from age 3 years through age 21 years	

Vaccines given to children, adolescents, and young adults through age 21, alone or in combination, are covered under this Plan within the designated age ranges and up to the specified number of doses as shown in Table 2:

Table 2. Covered Childhood Vaccinations

Updated regularly by the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention.

Vaccine	Doses in Series	Primary Age Range	Catch Up Range
Hepatitis B	3	Birth – 18 months	19 months – 21 years
Rotavirus	3	6 weeks – 32 weeks	None
DtaP*	5	2 months – 6 months	4 – 6 years
Tdap	1	10 years	Through age 21 years And postpartum
Haemophius influenzae b (Hib)*	4	2 months – 15 months	18 months – 6 years
Pneumococcal conjugate	4	2 months – 6 years	None
Pneumococcal polysaccharide	1	None	7 – 21 years if medically necessary and appropriate
Inactivated Polio*	4	2 months – 6 years	Through age 21 years
Influenza	Annual	6 months – 21 years	Not applicable
Measles**	2	12 – 15 months	Through age 21 years
Mumps**	2	12 – 15 months	Through age 21 years
Rubella**	2	12 – 15 months	Through age 21 years
Varicella**	2	12 months – 6 years	Through age 21 years
Hepatitis A	2	12 – 18 months	Through age 21 years
Meningococcal	1 – 2	2 years	Through age 21 years
Human papillomavirus (HPV) - *(Cervical cancer vaccine)*	3	9 – 12 years	Through age 21 years

*Vaccines marked with single asterisk (*) are covered whether given singly or in combination with each other.
**Vaccines marked with double asterisk (**) are covered whether given singly or in combination with each other.

Tests or interventions during Childhood Health Supervision Visits covered separately by the Plan, in addition to the Health Supervision Visits covered separately by the plan, in addition to the Health Supervision Visits, are shown in Table 3.

Table 3. Tests or Interventions Covered in Addition to Childhood Health Supervision Visit

Age/Age Range	Test or Intervention
Newborn – 2 months	Vision Screen (Visual Evoked Potential) Hearing Screen (Auditory Evoked Potential)
Newborn – 2 months	Hemoglobin and Metabolic Screening (PKU, Hypothyroidism)
9 months, 18 months, 30 months	Autism Screening
12 months (earlier and more often if indicated by history)	Hemoglobin
12 months and 24 months	Lead screening
At any visit after 1 month, if indicated by history	Tuberculin Skin Test
3 – 5 years	Baseline Urinalysis
11 – 18 years	One dipstick urinalysis annually for male and female adolescents who are sexually active
18 – 21 years (earlier if indicated by history and/or physical examination)	Dyslipidemia Screening (cholesterol, lipid panel)
11 years – 21 years (if indicated by history and/or physical examination)	Sexually Transmitted Infection Screening (e.g., Cervical or Urethral Culture)
11 years – 21 years (if indicated by history and/or physical examination)	Cervical Dysplasia Screening (e.g. Pap Smear)

Adult wellness evaluations and interventions covered under this Plan are listed in Table 4.

Table 4. Covered Adult Wellness Evaluations or Interventions

Age/Age Range	Frequency	Evaluation or Intervention
From age 22	Annually	History and Physical Examination
From age 22 years	Annually	Multiphasic chemistry screening, to include cholesterol and high-density lipoprotein (HDL) level (or lipid panel, if indicated by history)
From age 22 years	Annually	Hemoglobin
From age 22 years	Annually	Urinalysis
From age 22 years	Annually	Screen for cervical dysplasia (Pap Smear)
From age 22 years	Annually	Electrocardiogram
Women between age 35 years and 39 years (if indicated by family history)	Once	Baseline Mammogram
Women from age 40 years	Annually	Mammogram
From age 45 years	Annually	Stool Examination for Presence of Blood
From age 50 years (for average risk individual)	Every 10 years	Colonoscopy
Males from age 40 years through age 75 years	Annually	Prostate-Specific Antigen (PSA)
From age 35 years	Every 2 years	Intraocular Pressure (Glaucoma) Test
Women within 3 – 5 years after menopause or age 65 years or older (if never screened)	Once	Bone Densitometry (Osteoporosis Screening)
Men age 70 years or older	Once	Bone Densitometry (Osteoporosis Screening)
From age 22 years	Annually	Influenza vaccine
Women between age 22 years and 26 years (if not yet immunized)	Once	Three-dose series of human papilloma virus (HPV [cervical cancer]) vaccine
From age 22 years (if not immune or previously immunized)	Once	One- to two-dose series of varicella (chickenpox) vaccine
From age 22 years (if not immune or previously immunized)	Once	Two-dose series of measles-mumps-rubella vaccine
From age 22 years (but not prior to 10 years since last tetanus booster)	Once	Tetanus-diphtheria (Td) booster vaccination (with pertussis-containing vaccine [Tdap] the first time, if less than 65 years of age)

MEDICAL BENEFITS
WHAT'S COVERED

COVERED CHARGES FOR THE FOLLOWING

The following Covered Services and Supplies are reimbursed based on the QualCare Plan Allowable Charges and may be subject to Plan Deductibles, Coinsurance, Copayment, or day/visit limitations. Please refer to the Schedule of Benefits for more detailed benefit information.

Members are entitled to receive benefits as described below when Medically Necessary and Appropriate, subject to the provisions of this Plan, including (but not limited to) the Member's payment of the applicable Copayments or Coinsurance as stated in the Schedule of Benefits and subject to the Requirements specified as Pre-Certification.

The Claims Administrator determines whether any service or supply provided and/or arranged for under the Plan was Medically Necessary and Appropriate for purposes of coverage under the Plan.

DEDUCTIBLE AMOUNT

This is an amount of covered charges for which no benefits will be paid. Before benefits can be paid in a Plan Year a Covered Person must meet the Deductible shown in the Schedule of Benefits.

When the maximum amount shown in the Schedule of Benefits has been incurred by members of a Family Unit toward their Plan Year Deductibles, the Deductibles of all members of that Family Unit will be considered satisfied for that year.

BENEFIT PAYMENT

Each Plan Year, benefits will be paid for the covered charges of a Covered Person that are in excess of the Deductible. Payment will be made at the rate shown under Reimbursement rate in the Schedule of Benefits. No benefits will be paid in excess of the applicable limit (if any) under the Plan.

OUT-OF-POCKET LIMIT

Two out-of-pocket limits apply under the Plan:

In-Network Out-of-Pocket Maximum. Covered Services and Supplies are payable at the percentages shown each Plan Year until the Out-of-Pocket Maximum shown in the Schedule of Benefits is reached for that year. Then, **In-Network** Covered Services and Supplies incurred by a Covered Person will be payable at 100% of the QualCare Plan Allowable Charge (except for the charges excluded) for the rest of the Plan Year, except for office visits and other care for which Copayments are required.

When a Family Unit reaches the Out-of-Pocket Maximum, **In-Network** Covered Services and Supplies for that Family Unit will be payable at 100% of the QualCare Plan Allowable Charge (except for the charges excluded) for the rest of the Plan Year.

Combined Inner Circle and In-Network Out-of-Pocket Maximum. In addition to the In-Network Out-of-Pocket Maximum, an aggregated Out-of-Pocket Maximum applies to your benefits provided by Inner Circle and In-Network providers. For this combined out-of-pocket maximum, cost-sharing amounts that count toward the out-of-pocket maximum include Inner Circle and In-Network deductibles, coinsurance, copayments, or similar charges, and the Out-of-Network deductible for Medical Emergency services,

but not premiums, balance billing amounts, or spending for non-covered services. When the combined out-of-pocket maximum is reached, the Plan will pay 100% of all of the QualCare Plan Allowable Charges for Covered Services and Supplies provided by Inner Circle and In-Network providers for the remainder of the Plan year, regardless of whether you have satisfied the In-Network Out-of-Pocket maximum described above.

MAXIMUM BENEFIT AMOUNT

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

WHAT'S COVERED:

ABORTION

Charges incurred for an elective abortion are considered covered services under this Plan.

ACUPUNCTURE

Acupuncture is reimbursable only when provided by an individual licensed as an acupuncturist in the State in which he/she practices and is provided by an Inner Circle provider for Inner Circle and PPO plans

Conditions for which acupuncture is reimbursable include, but are not limited to, the following:

- Postoperative nausea and/or vomiting
- Post-chemotherapy nausea and/or vomiting
- Postoperative pain
- Myofascial pain
- Musculoskeletal pain
- Pain caused by local or metastatic malignancy
- Headache
- As part or all of the anesthesia administered in connection with surgical procedure(s)

ALLERGY TESTS/TREATMENT

Charges incurred for allergy tests and allergy treatments are considered covered services under this Plan.

AMBULANCE SERVICES

The Plan covers ground and/or air ambulance services when medically necessary and appropriate. Services must be pre-approved in advance by the Plan (except in a medical emergency). Prior approval for a non-emergency ambulance is required.

Medically necessary and appropriate charges for transporting you to:

- a local hospital if needed care and treatment can be provided by a local hospital,
- the nearest hospital where needed care and treatment can be given, if a local hospital cannot provide such care and treatment (it must be in connection with an inpatient confinement), or
- another inpatient health care facility.

Ground Ambulance

Covered expenses include charges for transportation:

- To the first hospital where treatment is given in a medical emergency.

- From one hospital to another hospital in a medical emergency when the first hospital does not have the required services or facilities to treat your condition.
- From hospital to home or to another facility when other means of transportation would be considered unsafe due to your medical condition.
- From home to hospital for covered inpatient or outpatient treatment when other means of transportation would be considered unsafe due to your medical condition.
- When during a covered inpatient stay at a hospital, skilled nursing facility or acute rehabilitation hospital, an ambulance is required to safely and adequately transport you to or from inpatient or outpatient medically necessary and appropriate treatment.

Air or Water Ambulance
Covered expenses include charges for transportation to a hospital by air or water ambulance when:

- Ground ambulance transportation is not available; and
- Your condition is unstable, and requires medical supervision and rapid transport; and
- In a medical emergency, transportation from one hospital to another hospital; when the first hospital does not have the required services or facilities to treat your condition and you need to be transported to another hospital; and the two conditions above are met.

Note: *The Plan does not pay for chartered air flights, or any other travel or communication expenses of patients, practitioners, nurses or family members inside or outside the United States*

AMBULATORY SURGICAL CENTER CHARGES

The Plan covers ambulatory surgical center charges in connection with covered surgery. Services must be pre-approved in advance by the Plan when required.

ANESTHETICS AND OTHER SERVICES AND SUPPLIES

The following anesthetic and other services and supplies are covered:

- anesthetics and their administration, hemodialysis, casts, splints, prosthetics, surgical dressings and the initial fitting and purchase of braces, trusses and crutches. Replacements or repairs are not covered;
- blood, blood products, blood transfusions and the cost of testing and processing blood, except for blood that has been donated or replaced on behalf of the covered person. Blood storage is not covered by the Plan;
- medically necessary and appropriate supplies, other than those excluded by the Plan

BIRTHING CENTER

Covered expenses shall include services, supplies and treatments rendered at a birthing center provided the physician in charge is acting within the scope of his license and the birthing center meets all legal requirements. Services of a midwife acting within the scope of his license or registration are a covered expense if the state in which such service is performed has legally recognized midwife delivery. Coverage is provided for prenatal care, delivery, and postpartum care within 48 hours after a vaginal delivery and 96 hours after a cesarean delivery

CARDIAC REHABILITATION

Cardiac rehabilitation as deemed Medically Necessary and Appropriate provided services are rendered

(a) under the supervision of a Physician;
(b) in connection with a myocardial infarction, coronary occlusion or coronary bypass surgery;
(c) initiated within 12 weeks after other treatment for the medical condition ends; and

(d) in a Medical Care Facility as defined by this Plan.

CHIROPRACTIC CARE/SPINAL MANIPULATION

Spinal Manipulation/Chiropractic services by a licensed M.D., D.O. or D.C. for covered members age 18 and older only. Members under 18 years of age require pre-certification from the plan.

COVERED NEWBORN CHILD

The following charges are covered in association with a newborn child under the mother's admission for the following services:

- routine nursery care while the child is in the hospital;
- charges for routine examinations and tests;
- charges for routine procedures, such as circumcision.

Note: Newborn children must be enrolled in the Plan within 31 days of birth in order to be covered by the Plan for any non-routine services.

DENTAL SERVICES

Injury to, or care of **mouth, teeth and gums**. Charges for injury to or care of the mouth, teeth, gums and alveolar processes will be covered charges under Medical Benefits only if that care is for the following oral surgical procedures:

- Excision of tumors and cysts of the jaws, cheeks, lips, tongue, roof and floor of the mouth.
- Emergency repair due to injury to sound natural teeth. This repair must be made within 12 months from the date of an accident.
- Surgery needed to correct accidental injuries to the jaws, cheeks, lips, tongue, floor and roof of the mouth.
- Excision of benign bony growths of the jaw and hard palate.
- External incision and drainage of cellulitis.
- Incision of sensory sinuses, salivary glands or ducts.
- Removal of impacted teeth.
- Hospital and general anesthesia/twilight services provided to a severely disabled or child five (5) or under for dental services.
- A medical condition eligible under this Plan which requires Hospital and general anesthesia for dental services rendered by a Dentist.

No charge will be covered under Medical Benefits for dental and oral surgical procedures involving orthodontic care of the teeth, periodontal disease, preparing the mouth for the fitting of or continued use of dentures, crowns and/or routine dental care with the exception of dental bridge work when the services are required for the management of a congenital anomaly.

DIABETIC SERVICES, SUPPLIES AND TRAINING

Charges for the treatment of diabetes must be recommended or prescribed by a Physician, Nurse Practitioner or Clinical Nurse in order to be considered as covered charges under this Plan.

The following equipment and supplies are covered charges when recommended or prescribed by a Physician, Nurse Practitioner or Clinical Nurse:

- blood glucose monitors;
- blood glucose monitors for the legally blind;
- cartridges for the legally blind;

- test strips for glucose monitors;
- visual reading and urine testing strips;
- insulin;
- insulin pumps and necessary accessories;
- insulin infusion devices;
- injection aids;
- lancets;
- needles and syringes; and
- oral agents for controlling blood sugar levels.
- diabetic shoes

The following services and training are eligible charges:

(a) routine diabetes foot care;
(b) self-management education which is provided by a health care professional recognized as a Certified Diabetes Educator, a Registered Dietician or a state licensed Pharmacist; and
(c) nutritional counseling.

Note: Benefits for self-management and nutritional counseling and education will be provided for any of the following three (3) reasons:

- ✓ when diabetes is diagnosed;
- ✓ when a change in self-management occurs through a significant change in a Covered Person's conditions or symptoms; or
- ✓ re-education is required

DURABLE MEDICAL EQUIPMENT AND PROSTHETIC DEVICES

The Plan covers medically necessary and appropriate charges for the rental of durable medical equipment needed for therapeutic use, when pre-certified by the Plan up to the maximum shown in the Schedule of Benefits. At the option of the Plan, the purchase of such items may be covered when it is less costly and more practical than rental.

The Plan does not pay for:

- the rental or purchase of items such as, but not limited to, air conditioners, exercise equipment, saunas or air humidifiers that do not fully meet the definition of durable medical equipment; or
- adjustable and/or supportive chairs or orthopedic mattresses.

The Plan also covers the initial fitting and purchase of artificial limbs and eyes, and other prosthetic devices that take the place of a natural part of a covered person's body, or are needed due to a functional birth defect in a covered Dependent child.

The Plan will cover these replacements if there is a sufficient change in a covered person's physical condition to make the original devices no longer functional.

The Plan covers dental prosthetics or devices only when resulting from accidental injury to sound, natural teeth within six months of an accidental injury. Orthotic devices must correct a defect of body form or function. Only the basic device is covered, and any medically necessary and appropriate special features must be approved in advance.

EMERGENCY CARE

Do not delay getting medical care in the event of an emergency. If a hospital admission and/or surgery is required due to a life-threatening illness or injury, get the immediate care you need. Then, you or your physician may need to call the Plan as soon as possible after the admission occurs. In addition, you or your doctor must request a continued stay review for any emergency admission.

Coverage if You Are Out of Town
If you require medical attention while you are traveling or your covered Dependent child requires care while away at school, the Plan will pay benefits as follows if an Out-of-Network provider is utilized: **Emergency care** will be reimbursed at the network level. Emergency care includes conditions that require immediate treatment, such as bone fractures, wounds requiring sutures, poisoning and loss of consciousness. **Elective care** will be reimbursed at the out-of-network level, if you have out-of-network benefits. You should always try to find a participating provider for these services to lessen your out of pocket expenses.

GENETIC COUNSELING

Genetic counseling can occur before conception (i.e. when one or two of the parents are carriers of a certain trait), during pregnancy (i.e. if the woman will be over 35 at delivery, if a woman wants prenatal testing, or if an abnormality is noted on an ultrasound, or in a test result), after birth (if a birth defect is seen), during childhood (i.e. if the child has developmental delay, or a genetic syndrome), or adulthood (for adult onset genetic conditions such as Huntington's disease or hereditary cancer syndromes).

A **genetic counselor** is a medical genetics expert with a master of science degree. They are certified by the American Board of Genetic Counseling. Genetic counselors work as members of a health care team and act as a patient advocate as well as a genetic resource to physicians. Genetic counselors provide information and support to families who have members with birth defects or genetic disorders, and to families who may be at risk for a variety of inherited conditions. They identify families at risk, investigate the problems present in the family, interpret information about the disorder, analyze inheritance patterns and risks of recurrence and review available testing options with the family.

HOME HEALTH CARE

Home health care services may include alternatives to hospitalization, such as a participating home health agency, as long as services and treatment are pre-certified by the Plan and medically necessary and appropriate.

In general, the following services are covered but limited to **120** visits every Calendar Year:

- Skilled nursing services, provided by or under the supervision of a registered professional nurse.
- Services of a home health aide, under the supervision of a registered professional nurse, or if appropriate, a qualified speech or physical therapist. These benefits are covered only when the primary purpose of the Home Health Services rendered to a Member is skilled in nature.
- Medical Social Services by or under the supervision of a qualified medical or psychiatric social worker, in conjunction with other Home Health Services, if the services are certified as essential for the effective treatment of a Member's medical condition.

- Therapy Services as set forth.
- Infusion Therapy.

The following conditions also apply:

- Your physician must certify that home health care is needed in place of inpatient care in a recognized facility. The services and supplies must be ordered by your physician, included in the home health care Plan, and provided by — or coordinated by — a home health care agency according to the written home health care Plan.
- The services and supplies must be provided by recognized health care professionals on a part-time or intermittent basis, except when full-time or 24-hour service is needed on a short-term basis.
- The home health care Plan must be provided in writing by your physician within 14 days after home health care starts. It must be reviewed by your physician at least once every 60 days.
- Each visit by a home health aide, nurse or other recognized provider whose services are pre-certified under the home health care Plan can last up to four hours.

The Plan does not cover:

- ✓ services provided to family members, other than the patient, or
- ✓ services and supplies not included in the home health care Plan, and
- ✓ charges by a nurse for medically necessary and appropriate private duty nursing care, unless it is pre-certified as part of a home health care Plan, coordinated by a home health care agency and covered under home health care charges.

***Note**: The Plan is not required to provide home health benefits if it determines that the treatment setting is not appropriate, or when a more cost-effective setting in which to provide medically necessary and appropriate care is available.*

All Treatment for a Covered Person's care is subject to the Benefit Payment maximums/limitations shown in the Schedule of Benefits.

HOSPICE CARE

Charges made by a hospice for *palliative and supportive care* provided to a *terminally ill* or *terminally injured* member under a hospice care program inpatient and home are covered. *Palliative and supportive care* means care and support aimed mainly at lessening or controlling pain or symptoms; it makes no attempt to cure the terminal illness or terminal injury. *Terminally ill* or *terminally injured* means that a physician has certified, in writing, that the covered person's life expectancy is six months or less. Hospice care must be pre-certified by the Plan. Under a hospice care program, any eligible services and supplies, including prescription drugs, are covered by the Plan. Services and supplies may be provided on an inpatient or outpatient basis.

Maximum benefit 181 days inpatient and/or outpatient per year.

The services and supplies must be:

- needed for palliative and supportive care;
- ordered by the covered person's physician;
- included in the hospice care plan; and
- provided by, or coordinated by, a hospice.

The Plan does not pay for:

- services and supplies provided by volunteers or others who do not regularly charge for their services;
- funeral services and arrangements;
- legal or financial counseling or services;
- treatment not included in the hospice care Plan.

Note: *Hospice care must be provided according to a written hospice care plan. This is a coordinated program with an interdisciplinary team designed to meet the special needs of the terminally ill or terminally injured member. It must be set up and reviewed periodically by your physician.*

INFERTILITY SERVICES

Charges for services rendered by a reproductive endocrinologist will be covered for the diagnosis and treatment of infertility, including in-vitro fertilization. The plan has a $10,000 lifetime maximum benefit for these services (both testing and treatment). The covered services include, but are not limited to:

- Diagnosis and diagnostic testing
- Medications
- Surgery, including microsurgical sperm aspiration
- Ovulation induction
- Artificial insemination including intrauterine insemination with no limit as to the number of cycles
- Medical costs of sperm donors

The definition of infertility does not include a person who has been voluntarily sterilized regardless of whether the person has attempted to reverse the sterilization. Services will not be covered for a person who has successfully reversed sterilization yet is diagnosed as medically infertile (or cannot carry a pregnancy to live birth). However, if the partner of such person is infertile, and is covered under this Plan, that partner is eligible for coverage.

In addition to services that require precertification, the following services must be pre-certified:

- Injectable infertility drugs

All Treatment for a Covered Person's care is subject to the Benefit Payment maximums/limitations shown in the Schedule of Benefits. These Services require Pre-certification.

INHERITED METABOLIC DISEASE

The Plan covers charges incurred for the therapeutic treatment of inherited metabolic diseases, including the purchase of medical foods and low protein modified food products as determined to be medically necessary and appropriate by the covered person's physician.

INPATIENT HOSPITAL SERVICES

The Plan covers the following inpatient services when pre-certified (as required) by the Plan.

(1) Semi-private room and board accommodations, see Schedule of Benefits for any daily limits that may apply;

(2) Hospital charges related to labor and delivery, in accordance with the Newborns' and Mothers' Health Protection Act:

- a minimum of 48 hours of inpatient care in a hospital following a vaginal delivery, and

- a minimum of 96 hours of inpatient care in a hospital following a cesarean section, provided that the attending physician determines that inpatient care is medically necessary and appropriate, or the mother requests the inpatient care, but an exception can be made to the 48-hour and 96-hour rules if the attending provider decides, in consultation with the mother, to discharge the mother or newborn earlier

(3) Private accommodations only when medically necessary and appropriate, is approved in advance. Otherwise, you are liable to the facility for the difference in payment covered by the Plan and the private-room rate;

(4) Pre-admission testing**,** provided the tests are performed on an outpatient basis within seven days of the planned admission and surgery.

(5) routine nursing care;

(6) use of intensive or special care facilities- daily limits apply;

(7) X-ray examinations including CAT scans, but not dental X-rays unless related to covered services;

(8) use of operating room and related facilities;

(9) magnetic resonance imaging (MRI);

(10) drugs, medications and biologicals;

(11) cardiography/encephalography;

(12) laboratory testing and services;

(13) pre-operative and post-operative care;

(14) special tests;

(15) nuclear medicine;

(16) therapy services;

(17) oxygen and oxygen therapy;

(18) anesthesia and anesthesia services;

(19) blood processing and administration; and

(20) intravenous injections and solutions.

(21) Medically Necessary and Appropriate Hospital services and supplies provided to the Covered Person during the Inpatient confinement.

LABORATORY TESTS AND X-RAYS

X-rays and laboratory tests that are medically necessary and appropriate to treat an illness or injury are covered by the Plan. However, the Plan does not pay for X-rays and tests performed as part of a routine physical checkup, unless specifically listed in the Wellness Schedule. Plan covers costs for services including Magnetic Resonance Imaging (MRI) and CAT scans, but not dental x-rays unless related to covered services.

MAMMOGRAMS — ROUTINE SCREENING

The Plan covers network charges for:

- Baseline mammography between 35 and 39 years of age

- Annual Mammography and cytologic screening (annual exams age 40 and over)
- More frequent Mammography if recommended by your physician

MENTAL HEALTH AND SUBSTANCE ABUSE

The Plan covers the following mental health and substance abuse services. To receive the network level of benefits, services must be provided by a participating physician at the provider's office or at a participating substance abuse center.

Mental and Nervous Conditions

- Outpatient Services**.** Benefits include diagnosis, medical, psychiatric and psychological treatment for Mental and Nervous Conditions. Payment for non-medical ancillary services (such as vocational rehabilitation or employment counseling) is not provided, but information regarding appropriate agencies will be provided if available.
- Inpatient. The following services shall be covered under inpatient treatment: (1) lodging and dietary services; (2) physician, psychologist, nurse and trained staff services; (3) diagnostic X-ray; (4) psychiatric, psychological and medical laboratory testing; (5) drugs, medicines, equipment use and supplies.
- Partial Hospitalization Services. Members are eligible for a partial hospitalization treatment program.
- Court ordered admissions are not covered.

Note: You must receive Pre-certification for Inpatient Mental and Nervous admissions.

Substance Abuse

- Outpatient Services. Benefits include diagnosis, medical, psychiatric and psychological treatment for the abuse or addiction to drugs or alcohol. Payment for non-medical ancillary services (such as vocational rehabilitation or employment counseling) is not provided, but information regarding appropriate agencies will be provided if available. Members are entitled to unlimited outpatient care benefits for detoxification.
- Inpatient. Members are entitled to receive inpatient rehabilitation for the treatment of medical conditions resulting from substance abuse and referral services for substance abuse or addiction. The following services shall be covered under inpatient rehabilitation: (1) lodging and dietary services; (2) physician, psychologist, nurse, certified addictions counselor and trained staff services; (3) diagnostic X-ray; (4) psychiatric, psychological and medical laboratory testing; (5) drugs, medicines, equipment use and supplies.
- Partial Hospitalization Treatment. Members are eligible for a partial hospitalization treatment program for alcohol or substance abuse or addiction.
- Special Note For Chemical Dependency Admissions. Court ordered chemical dependency admissions are not covered.

All Treatment for a Covered Person's care is subject to the benefits shown in the Schedule of Benefits.

NUTRITIONAL COUNSELING

The Plan covers charges for nutritional counseling for the management of disease entities that have a specific diagnostic criterion that can be verified. The nutritional counseling must be prescribed and provided by a physician, physician assistant, nurse, or registered dietician.

ORTHOTICS

Orthotic devices and appliances (a rigid or semi-rigid supportive device that restricts or eliminates motion for a weak or diseased body part), including initial purchase, fitting and repair shall be a covered expense. Orthopedic shoes or corrective shoes (unless they are an integral part of a leg brace) and other supportive devices for the feet shall not be covered. Replacement will be covered only when a physiological change in the patient's condition necessitates replacement.

ORTHOTRIPSY

This procedure will only be covered for a diagnosis of plantar fasciitis. Team Member must complete at least (6) months of conservative treatment before surgical intervention. All orthotripsy cases will be reviewed on a case by case basis by QualCare's Medical Director.

OSTOMY SUPPLIES

The following equipment and supplies are covered charges when recommended or prescribed by a Physician, Nurse Practitioner or Clinical Nurse:

- Pouch
- Ostomy Belts
- Appliance Cleaners
- Irrigators
- Adhesives/Removers
- Skin Barriers/Wafers
- Closures
- Dressings

OUTPATIENT HOSPITAL SERVICES

The Plan covers outpatient hospital services, including services provided by a hospital outpatient clinic. Services must be pre-approved in advance by the Plan when required.

PHYSICIAN SERVICES

Covered expenses shall include:

- Charges made by a physician during a visit to treat illness or injury. The visit may be at the physician's office, in your home, or in a hospital or other facility during your stay or in an outpatient facility.
- Surgical treatment.
- Surgical assistance provided by a physician if it is determined that the condition of the covered person or the type of surgical procedure requires such assistance.
- Furnishing or administering anesthetics, other than local infiltration anesthesia, by other than the surgeon or his assistant.
- Consultations requested by the attending physician during a hospital confinement. Consultations do not include staff consultations that are required by a hospital's rules and regulations.
- Radiologist or pathologist services for interpretation of x-rays and laboratory tests necessary for diagnosis and treatment.
- Radiologist or pathologist services for diagnosis or treatment, including radiation therapy and chemotherapy.
- Allergy testing consisting of percutaneous, intracutaneous and patch tests and allergy injections.

PODIATRY SERVICES

Covered expenses shall include surgical podiatry services, including incision and drainage of infected tissues of the foot, removal of lesions of the foot, removal or debridement of infected toenails, surgical removal of nail root, and treatment of fractures or dislocations of bones of the foot.

PREGNANCY BENEFITS

You'll need to obtain one Pre-certification for the pregnancy. You or your physician must call and request a pre-hospital review at least 60 days before the expected date of delivery, or as soon as reasonably possible.

Group health plans may not, under Federal law, restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a cesarean section. However, Federal law generally does not prohibit the mother's or newborn's attending provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours as applicable). In any case, plans and issuers may not, under Federal law, require that a provider obtain pre-certification from the plan or the issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours).

PRESCRIPTIONS

Prescription Drugs (when provided as part of a covered inpatient admission). See *Prescription Plan* Section of this document for more information on your Prescription Drug Card Program.

PRIVATE DUTY NURSING CARE

Private duty nursing care by a licensed nurse (R.N., L.P.N. or L.V.N.). Covered charges for this service will be included to this extent:

Outpatient Nursing Care. Charges are covered only when care is Medically Necessary and Appropriate, and not Custodial in nature. The only charges covered for Outpatient nursing care are those shown above, under Home Health Care. Outpatient private duty nursing care on a 24-hour-shift basis is covered when medically necessary and appropriate, for a short time period (not to exceed a two week period). Please refer to the Schedule of Benefits.

PROSTHESES

The initial purchase of a prosthesis (other than dental) provided for functional reasons when replacing all or part of a missing body part (including contiguous tissue) or to replace all or part of the function of a permanently inoperative or malfunctioning body organ shall be a covered expense.

A charge for the purchase of prosthesis is considered incurred on the date the prosthesis is received/delivered. A prosthesis that is received/delivered after the termination date of a covered person's coverage under this Plan is not covered.

Repair or replacement of a prosthesis, which is, medically necessary and appropriate due a physiological change in the patient's condition will be considered a covered expense.

RECONSTRUCTIVE / COSMETIC SURGERY

Cosmetic surgery or reconstructive surgery shall only be a covered expense in the event:

- A covered person receives an injury because of an accident and as a result requires surgery. Cosmetic or reconstructive surgery and treatment must be for the purpose of restoring the covered person to his normal function immediately prior to the accident; or,
- It is required to correct a congenital anomaly, for example, a birth defect for a child.

Mastectomy
Correction of abnormal congenital conditions and reconstructive mammoplasties will be considered covered charges. This mammoplasty coverage will include reimbursement for:

- reconstruction of the breast on which a mastectomy has been performed,
- surgery and reconstruction of the other breast to produce a symmetrical appearance, and
- coverage of prostheses and physical complications during all stages of mastectomy, including lymphedemas and two (2) post mastectomy bras per year, in a manner determined in consultation with your physician.

ROUTINE COSTS ASSOCIATED WITH CLINICAL TRIALS

Coverage for routine costs of clinical trials conducted in relation to the prevention, detection or treatment of cancer or other life-threatening disease or condition for qualified individuals. Covered benefits under this subsection will be provided only as required under PPACA. Coverage includes items or services typically provided under the Plan for a participant not enrolled in a clinical trial. Routine patient costs do not include:

- the Experimental or investigational items, devices or services used in the clinical trial;
- items or services not included in the direct clinical management of the patient, but instead are provided in connection with data collection and analysis; or
- a service clearly inconsistent with widely accepted and established standards of care for a particular diagnosis.

The Plan Administrator may limit coverage of the costs described herein to those routine costs associated with clinical trials conducted by an in-network provider, to the extent permitted under PPACA.

ROUTINE PREVENTIVE CARE

Covered charges are payable for "preventive health services," as that term is defined by PPACA. Specific preventive health services that are covered are described at http://www.healthcare.gov/center/regulations/prevention/recommendations.html, and in the Wellness Services Section in the **Schedule of Benefits** and in the **Wellness Schedule.**

SKILLED NURSING CARE, EXTENDED CARE OR REHABILITATION SERVICES

The Plan covers the following for Skilled Nursing, Extended Care and Rehabilitation Facilities:

- medically necessary and appropriate charges provided in a skilled nursing, extended care center or rehabilitation center. The Plan does not cover charges above Plan limitations.
- all other medically necessary and appropriate services and supplies provided during a confinement. However, the confinement must meet the following criteria:
    - the patient is confined as a bed patient in the facility;
    - the confinement starts within fourteen (14) days of discharge from a Hospital confinement or directly from home;
    - the Attending Physician certifies that the confinement is needed for further care of the condition that caused the Hospital confinement; and

- the Attending Physician completes a treatment plan that includes a diagnosis, the proposed course of treatment and the projected date of discharge from the skilled facility.

See the Schedule of Benefits for limitations on coverage for skilled care, extended care and rehabilitation services. The Plan does not cover charges for any additional days above those limitations.

Charges which are in excess of the limitations outlined in the Schedule of Benefits will not be considered as covered charges.

SLEEP DISORDERS

Covered expenses shall include charges for sleep studies and treatment of sleep apnea and other sleep disorders, including charges for sleep apnea monitors.

SPECIALIZED NON-STANDARD FORMULAS

Special enteral and/or oral feeding formulas are reimbursable if all of the following conditions are met:

- A special enteral or oral feeding formula is medically necessary and appropriate to sustain life or health
- No retail regular over-the-counter enteral or oral feeding formula can be used for the individual
- The special enteral or oral feeding formula is the sole source of nutrition or the source of at least 50% of the daily caloric intake
- Nutritional management of the individual must include ongoing evaluation and management by a physician, physician assistant, or advance practice nurse
- Diagnoses or conditions for which a special enteral or oral feeding formula is considered medically necessary and appropriate include but are not limited to:
    - Severe, potentially life-threatening or life-threatening allergy to proteins such as soy or milk
    - Short gut syndrome
    - Inborn errors of metabolism, including but not limited to phenylketonuria and maple syrup urine disease

Products considered a reimbursable special enteral or oral feeding formula include but are not limited to:

- Elecare®
- Alimentum®
- Neocate®

SURGICAL/MEDICAL SERVICES

The professional services of a Physician for surgical or medical services. Charges for **multiple surgical procedures** will be a covered expense subject to the following provisions:

(a) If bilateral or multiple surgical procedures are performed by one (1) surgeon, benefits will be determined based on the QualCare Plan Allowable Charge that is allowed for the primary procedures; 50% of the QualCare Plan Allowable Charge will be allowed for each additional procedure performed through the same incision. Any procedure that would not be an integral part of the primary procedure or is unrelated to the diagnosis will be considered "incidental" and no benefits will be provided for such procedures;

(b) If multiple unrelated surgical procedures are performed by two (2) or more surgeons on separate operative fields, benefits will be based on the QualCare Plan Allowable Charge for each surgeon's primary procedure. If two (2) or more surgeons perform a procedure that is normally performed by one (1) surgeon, benefits for all surgeons will not exceed the QualCare Plan Allowable Charge allowed for that procedure; and

(c) If an assistant surgeon is required, the assistant surgeon's covered charge will not exceed 20% of the QualCare Plan Allowable Charges.

SURGICAL TREATMENT OF MORBID OBESITY

Covered expenses shall include charges for surgical treatment of morbid obesity for covered persons with health problems that are aggravated by or related to the morbid obesity.
All services must be pre-certified.

THERAPY SERVICES

The following are covered services or supplies ordered by a Physician and used to treat, or promote recovery from, an Injury or Illness:

1. **Cardiac Rehabilitation Therapy -** program of structured outpatient supervised exercise that occurs subsequent to a major cardiac event.
2. **Chemotherapy –**treatment of malignant disease by chemical or biological antineoplastic agents. The materials and services of technicians are included.
3. **Cognitive Rehabilitation Therapy -** retraining the brain to perform intellectual skills that it was able to perform prior to disease, trauma, surgery, or previous therapeutic processes. Therapy must be by a licensed psychologist, neurologist, physiatrist, or clinical neuro-psychologist. Therapy must be in accordance with a licensed psychologist, neurologist, physiatrist, or clinical neuro-psychologist's exact orders as to type, frequency, and duration to improve cognitive skills.
4. **Dialysis Treatment -** treatment of acute renal failure or chronic irreversible renal insufficiency by removing waste products from the body. This includes hemodialysis, peritoneal dialysis and home hemodialysis. Dialysis center charges for covered dialysis services are covered through coordination of benefits with Medicare and this Plan. These services and supplies must be pre-certified by the Plan.
5. **Infusion Therapy -** administration of antibiotic, nutrients or other therapeutic agents by direct infusion.
6. **Occupational Therapy -** treatment to restore a physically disabled person's ability to perform the ordinary tasks of daily living. Therapy must be by a licensed occupational therapist. Therapy must be ordered by a Physician, result from an Injury or Sickness and improve a body function. Covered expenses do not include recreational programs, maintenance therapy or supplies used in occupational therapy.
7. **Physical Therapy -** treatment by physical means to relieve pain, restore maximum function, and prevent disability following disease, injury, or loss of a limb. Treatment is covered by a licensed physical therapist. The therapy must be in accordance with a Physician's exact orders as to type, frequency and duration and to improve a body function.
8. **Radiation Therapy -** treatment of disease by X-ray, radium, cobalt, or high-energy particle sources. Radiation Therapy includes rental or cost of radioactive materials. Diagnostic Services requiring the use of radioactive materials are not Radiation Therapy. The materials and services of technicians are included.

9. **Speech Therapy** - treatment by a licensed speech therapist. Therapy must be ordered by a Physician and follow either: (i) surgery for correction of a congenital condition of the oral cavity, throat or nasal complex (other than a frenectomy of a person; (ii) an Injury; or (iii) a Sickness that is other than a learning or Mental Disorder.

TRANSPLANT BENEFITS

Organ and tissue transplants are covered except those that are classified as "Experimental and/or Investigational" and performed by an institution approved by the National Cancer Institute or pursuant to protocols consistent with the guidelines of the American Society of Clinical Oncologists. Pre-certification is required.

The Plan covers medically necessary and appropriate, pre-certified services and supplies for the following types of organ and tissue transplants:

- cornea, kidney, lung, liver, heart and pancreas;
- allogeneic bone marrow;
- autologous bone marrow transplant and associated dose-intensive chemotherapy; and
- peripheral blood stem cell transplants and associated dose-intensive chemotherapy.

Charges for the care and treatment due to an organ or tissue transplant are covered, subject to the following limits:

(1) The transplant must be performed to replace an organ or tissue.

(2) Charges for obtaining donor organs are covered charges under this Plan when the recipient is a Covered Person. When the donor has medical coverage, his or her plan will pay first. The benefits under this Plan will be reduced by those payable under the donor's plan. Donor charges include those for:

   a. evaluating the organ;
   b. removing the organ from the donor; and
   c. transportation and storage costs directly related to the donation of the organ and billed by the Hospital.

(3) If the organ donor is a Covered Person and the recipient is not, then this Plan will cover donor organ charges for:

   a. evaluating the organ, and
   b. removing the organ from the donor.

This Plan will always pay benefits secondary to any other benefit plan.

VISION CARE BENEFITS

The Plan does not provide coverage for radial keratotomy or other eye surgery to correct near-sightedness. The Plan covers the following services and supplies:

- Non-routine eye-care, provided that it is deemed medically necessary and appropriate.

WELL NEWBORN CARE

The Plan shall cover well newborn care as part of the mother's claim while the mother is confined for delivery. Such care shall include, but is not limited to:

- Physician services
- Hospital services
- Circumcision

WIGS

The plan will allow for the coverage of a wig or hairpiece prescribed by a physician as a prosthetic for hair loss due to injury, disease, or treatment of a disease.

Examples of covered illnesses are:

- Burns – 2nd degree full thickness and 3rd degree burns with resulting permanent alopecia
- Lupus
- Alopecia areata with near complete or complete cranial hair loss
- Alopecia totalis
- Alopecia universalis
- Fungal infections not responsive to an appropriate (typically 6 week) course of antifungal treatment resulting in near complete or complete cranial hair loss
- Chemotherapy
- Radiation therapy

WILM'S TUMOR

The Plan covers charges incurred for the treatment of Wilm's Tumor, even if it is deemed experimental or investigational. Treatment can include, but is not limited to, autologous bone marrow transplants when standard chemotherapy treatment is unsuccessful.

WOMEN'S PREVENTIVE CARE

Well-woman visits such as annual health care visits, preconception and prenatal care will be covered under the HHS Guidelines. When appropriate these well-women visits will include other preventive services listed in the guidelines, Section 2713 of the PHSA (such as some routine immunizations). In addition to the above mentioned, the following services are also covered:

- Gestational diabetes screening
- HPV DNA testing
- STI counseling, and HIV screening and counseling
- Contraception and contraceptive counseling
- Breastfeeding support, supplies and counseling
- Domestic violence screening

Please refer to the *Schedule of Benefits* and *Wellness Schedule* for details.

PLAN EXCLUSIONS

THE FOLLOWING ARE NOT COVERED SERVICES UNDER THE MERIDIAN HEALTH PLAN.

For all Medical Benefits shown in the Schedule of Benefits, a charge for the following is not covered:

(1) **Alcohol.** Services, supplies, care or treatment to a Covered Person for an Injury or Sickness which occurred as a result of that Covered Person's illegal use of alcohol. The arresting officer's determination of inebriation will be sufficient for this exclusion. Expenses will be covered for Injured Covered Persons other than the person illegally using alcohol and expenses will be covered for Substance Abuse treatment as specified in this Plan.

(2) **Ambulance services** for transportation from a hospital or other health facility, including ambulance service to home or after discharge, unless you are being transferred to another inpatient health care facility, including ambulance service to home or after discharge.

(3) **Armed Forces.** Condition which results from participation in a civil insurrection, riot, duty as a member of the armed forces of any country or state of war (whether the war is declared or undeclared).

(4) **Blood or blood plasma** that is replaced by or for a covered person.

(5) **Childbirth classes** are not a covered benefit under the Plan.

(6) **Completion of claim forms.**

(7) **Complications of non-covered treatments.** Care, services or treatment required as a result of complication from a treatment not covered under the Plan.

(8) **Cosmetic Surgery.** Services or supplies for cosmetic purposes, that is, for the primary purpose of changing or improving appearance rather than to restore bodily function or to repair damage caused by an accidental injury (surgery must take place in the calendar year of or the calendar year following the accident), disease, birth defects or prior therapeutic treatment.

(9) **Court Ordered Treatment**, unless it meets medical necessity and appropriateness criteria.

(10) **Counseling.** Counseling services that are not medically necessary and appropriate in the treatment of a diagnosed medical condition, including, but not limited to: educational counseling, vocational counseling, nutritional counseling, counseling for social or social-economic purposes, diabetic self-education programs, stress management and lifestyle modification;

(11) **Covered under another law.** Services provided for the treatment of any condition, disease, illness or injury that's covered under any Workers' Compensation Law, Occupational Law, Occupational Disease Law, or any similar law.

(12) **Custodial Care.** Services or supplies provided mainly as rest care, maintenance or Custodial Care.

(13) **Dental Service.** Charges for dental services except as described in the Section *Medical Benefits – What's Covered*.

(14) **Diagnostic Testing.** Diagnostic testing in connection with school exams, athletic exams, pre-marital exams or employment physicals are not covered unless specifically listed in the *Preventive Care* Section.

(15) **Education or training.** Charges for educational, special education, or job training, whether or not given in a facility providing medical or psychiatric care.

(16) **Educational or vocational testing.** Services for educational or vocational testing or training. However, diabetic education is covered.

(17) **Elective Ambulance.** Including ambulance service to home or after discharge.

(18) **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/or QualCare Plan Allowable Charges.

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

(20) **Experimental or not Medically Necessary and Appropriate.** Care and treatment that is either Experimental/Investigational, Research, Screening or not Medically Necessary and appropriate unless specified as a covered service in the Section *Medical Benefits – What's Covered*. If any Experimental or Investigational services or supplies are provided in the course of a clinical trial, some routine patient costs for items and services furnished in connection with participation in a clinical trial may be covered, but only if those items and services would otherwise be provided under the Plan (see the Section *Routine Costs Associated with Clinical Trials*).

(21) **Extraction of Teeth.** Except for bony impacted teeth.

(22) **Eye Care.** Radial keratotomy or other eye surgery to correct near-sightedness. Also, routine eye examinations, including refractions, lenses for the eyes and exams for their fitting, unless such care is specifically covered in the Schedule of Benefits. This exclusion does not apply to aphakic patients and soft lenses or sclera shells intended for use as corneal bandages.

(23) **Financial Counseling Services.** Services for or in connection with financial counseling services.

(24) **Foot Care.** Treatment of weak, strained, flat, unstable or unbalanced feet, metatarsalgia or bunions (except open cutting operations), and treatment of corns, calluses or toenails (unless needed in treatment of a metabolic or peripheral-vascular disease).

(25) **Foreign Travel.** Care, treatment or supplies outside the United States if travel is for the sole purpose of obtaining medical services.

(26) **Gastric Bypass or Lap Band Surgery** unless deemed Medically Necessary and Appropriate, meets medical criteria for morbid obesity.

(27) **Government Coverage.** Care, treatment or supplies furnished by a program or agency funded by any government. This does not apply to Medicaid or when otherwise prohibited by law.

(28) **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, except for wigs due to injury, disease or treatment of a disease.

(29) **Hearing aids and exams.** Charges for services or supplies in connection with hearing aids or exams for their fitting.

(30) **Health Awareness.** Dietary instruction, educational services, behavior modification, literature, membership in health clubs, exercise equipment, and preventive programs other than those specifically listed as covered.

(31) **Herbal Medicine.**

(32) **Hospital Team Members.** Professional services billed by a Physician or nurse who is a Team Member of a Hospital or Skilled Nursing Facility and paid by the Hospital or facility for the service.

(33) **Housekeeping.** Charges for housekeeping services.

(34) **Hypnotism.**

(35) **Illegal Acts.** Charges for services received as a result of Injury or Sickness caused by or contributed to by 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.

(36) **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.

(37) **Inpatient Nursing Care**. Charges are covered only when care is Medically Necessary and Appropriate or not Custodial in nature and the Hospital's Intensive Care Unit is filled or the Hospital has no Intensive Care Unit.

(38) **Impotence.** Care, treatment, services, supplies or medication to treat sexual inadequacies or dysfunction.

(39) **Megavitamin Therapy and orthomolecular psychiatric therapy.**

(40) **Methadone Maintenance.**

(41) **Military Duty.** Services for any illness or injury occurring during military service.

(42) **No charge.** Care and treatment for which there would not have been a charge if no coverage had been in force.

(43) **No obligation to pay.** Charges incurred for which the Plan has no legal obligation to pay.

(44) **No Physician recommendation.** Care, treatment, services or supplies not recommended and approved by a 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 which is appropriate care for the Injury or Sickness.

(45) **Non-Mental Illness.** Services for or in connection with the following when not specifically the result of mental illness: Social maladjustment, Behavior, Lack of discipline or other antisocial action

(46) **Obesity.** Charges for weight reduction surgery (unless medically necessary and appropriate due to morbid obesity) or weight control programs, charges for nutritional supplements, special diets (unless for medical food and low protein modified food products for inherited metabolic diseases when diagnosed and determined to be medically necessary and appropriate by the treating physician), vitamins, charges for drugs or supplements for weight gain or loss.

(47) **Occupational.** Care and treatment of an Injury or Sickness that is occupational-that is, arises from work for wage or profit including self-employment.

(48) **Orthoptics, Vision training, low vision aids or supplemental training.**

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

(50) **Physical Examinations.** For routine physical examinations not required for health reasons including but not related to, employment, insurance, government license, and court-ordered forensic or custodial evaluations.

(51) **Plan design excludes.** Charges excluded by the Plan design as mentioned in this document.

(52) **Primal Therapy**. Environmental ecological treatments, primal therapy, bioenergetic therapy, carbon dioxide therapy.

(53) **Psychodrama.**

(54) **Relative giving services.** Professional services performed by a person who ordinarily resides in the Covered Person's home or is related to the Covered Person as a Spouse, parent, child, brother or sister, whether the relationship is by blood or exists in law.

(55) **Replacement braces.** Replacement of braces of the leg, arm, back, neck, or artificial arms or legs, unless there is sufficient change in the Covered Person's physical condition to make the original device no longer functional.

(56) **Rest cures, sanatorium or convalescent care.**

(57) **Routine Care.** Charges for routine or periodic examinations, screening examinations, evaluation procedures, preventive medical care, or treatment or services not directly related to the diagnosis or treatment of a specific Injury, Sickness, or pregnancy- related condition which is known or reasonably suspected, unless such care is specifically covered in the Schedule of Benefits.

(58) **Alternative Medicine Services, such as Rolfing.**

(59) **School System Coverage.** Services or items any school system is required to provide.

(60) **Services before or after coverage.** Care, treatment or supplies for which a charge was incurred before a person was Covered under this Plan or after coverage ceased under this Plan.

(61) **Services a covered individual has been charged only because coverage exists or those a covered individual is not obligated to pay.**

(62) **Services not specified as covered.** Services, treatments and supplies which are **not specified as covered** under this Plan would be covered if determined to be Medically Necessary and Appropriate, and not specifically excluded.

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

(64) **Separately Billed Anesthesia, or Local Anesthesia.** If charges are included in the surgical fee.

(65) **Skilled Nursing Facility, Extended Care Facility, Home Health Care.** In connection with treatment of mental, Psychoneurotic or personality disorders.

(66) **Smoking Cessation.** Care and treatment for smoking cessation programs unless Medically Necessary and Appropriate due to severe active lung illness such as emphysema or asthma.

(67) **Supplements.** Vitamins, minerals, food supplements or substitutes.

(68) **Surgical sterilization reversal.** Care and treatment for reversal of surgical sterilization.

(69) **Surrogate pregnancy**. Any charges resulting from or incurred in connection with surrogate pregnancy.

(70) **Telephone consultations.**

(71) **Temporomandibular Joint Syndrome.** All diagnostic and treatment services related to the treatment of jaw joint problems including TMJ syndrome.

(72) **Timely Filing of Claims.** Claims submitted after one year following the date of service will not be considered eligible for coverage under this Plan and will be the responsibility of the Plan Participant.

(73) **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.

(74) **Umbilical Cord Preservation.**

(75) **Wigs, toupees, hair transplants**, **hair weaving or any drug**, if such drug is used in connection with baldness, except for wigs after chemotherapy, burns, alopecia, lupus, etc., limited to 1 wig per lifetime up to $500 maximum benefit.

(76) **War.** Any loss that is due to a declared or undeclared act of war.

(77) **Workers' Compensation Benefits.** Any sickness or injury for which the covered person is paid benefits, or may be paid benefits if claimed, if the covered person is covered or required to be covered by Workers' Compensation. In addition, if the covered person enters into a settlement giving up rights to recover past or future medical benefits under a Workers' Compensation law, the Plan shall not cover past or future Medical Services that are the subject of or related to that settlement. Furthermore, if the covered person is covered by a Worker's Compensation program that limits benefits if other than specified health care providers are used and the covered person receives care or services from a health care provider not specified by the program, the Plan shall not cover the balance of any costs remaining after the program has paid.

(78) **Veterans' Administration Hospitals.** Coverage for Veterans' Administration Hospitals are covered only when services or treatment are for a non-service related injury or non-service emergency. Benefits will be payable based on the provider's participation.

(79) **Modification to a home or automobile** to make it accessible and drivable by an individual with a disability.

PRESCRIPTION PLAN

PRESCRIPTION DRUG BENEFITS

(This service provided by Envision Rx Options)

The following Prescription Benefit Guidelines apply for all Plans and are all identical benefits.
If you have questions you may call **EnvisionRxOptions** at:
General Inquiries: 1-800-361-4542
Walgreens Specialty Pharmacy Services: 1-800-823-2712
Online: **www.envisionrx.com**

DEFINITION YOU NEED TO KNOW

Prescription Drugs – drugs, biologicals and compound prescriptions that are sold only by prescription and are required to show on the manufacturer's label the words "Caution-Federal Law Prohibits Dispensing Without a Prescription," or other drugs and devices as determined by the Plan, such as insulin. The Plan does not pay for drugs that are limited by federal law for investigational use, or any use which the FDA determines to be contraindicated for the specific treatment for which the drug is prescribed.

Prescription Drug Plan - Participating EnvisionRxOptions

When you enroll in the **Meridian Health Plan**, you will be automatically provided with prescription benefits. The **Meridian Health** prescription program is provided by **EnvisionRxOptions**. The prescription benefits available to you are built around different pricing structures or "tiers" that enable you to control cost based on the types of medications you select (see Generic vs. Preferred vs. Non-*Preferred Drugs* Section below).

Meridian Health Ambulatory Pharmacy (Inner Circle and PPO plans only)

Retail Pharmacy (limited to a 30-day supply)

Generic	$0 copay
Preferred Brand	$25 copay
NonPreferred & Other Brand	$35 copay
Specialty	$70 copay

Maintenance Drugs (limited to a 30-day supply for specialty medications; 90-day supply for maintenance medications)

Generic	$0 copay
Preferred Brand	$50 copay
NonPreferred & Other Brand	$70 copay
Specialty	$70 copay (30-day supply)

Meridian Health Prescription Program – Provided by EnvisionRxOptions (Inner Circle and PPO plans only)

Retail Pharmacy (limited to a 30-day supply)	
Generic	$7 copay
Preferred Brand	$35 copay
NonPreferred & Other Brand	$50 copay
Specialty	$90 copay

Mail Order Program (limited to a 30-day supply for specialty medications; 90-day supply for maintenance medications)	
Generic	$17.50 copay
Preferred Brand	$87.50 copay
NonPreferred & Other Brand	$125 copay

Meridian Health CDHPlan – Provided by EnvisionRxOptions

Retail Pharmacy (limited to a 30-day supply)	
Generic	80% of fee schedule after deductible
Preferred Brand	80% of fee schedule after deductible
NonPreferred & Other Brand	80% of fee schedule after deductible
Specialty	80% of fee schedule after deductible
Preventive	100%

Mail Order Program (limited to a 30-day supply for specialty medications; 90-day supply for maintenance medications)	
Generic	80% of fee schedule after deductible
Preferred Brand	80% of fee schedule after deductible
NonPreferred & Other Brand	80% of fee schedule after deductible
Specialty	80% of fee schedule after deductible
Preventive	100%

The **EnvisionRxOptions** website – **www.envisionrx.com** – can help you manage your prescription drug program. The website includes tools that enable participants to locate a pharmacy, order mail service refills, track mail service orders, ask questions and find answers concerning specialty medications.

Generic vs. Preferred vs. Non-Preferred Drugs

When you obtain your medications at a pharmacy, you will be responsible for satisfying a copay that is built around different prices. In all instances, your copay amount is the lowest when you select a generic version of a prescription. In most cases, you are required to select a generic prescription unless no generic equivalent is available.

Preferred brand drugs identified on the **EnvisionRxOptions** Performance Drug List can be obtained at the next highest copay amount. The copays for these brand name drugs are chosen for their clinical value and cost-effectiveness. In most cases, more than one drug is available to treat the same medical conditions. The medications on the Performance Drug List will cost you less.

Choosing brand name drugs not on the **EnvisionRxOptions** Performance Drug List can result in higher copayment. Many of these drugs are covered under your plan, but will generally cost you the most.

Specialty Medications

Specialty medications are drugs that are used to treat complex conditions, such as cancer, growth hormone deficiency, hemophilia, hepatitis C, immune deficiency, multiple sclerosis, and rheumatoid arthritis. Whether they're administered by a healthcare professional, self-injected, or taken by mouth, specialty medications require an enhanced level of service.

EnvisionRxOptions is available to assist those with specialty medication needs manage their overall health care. This program allows you to obtain expensive injectable and/or oral specialty medications at a better cost through mail order and provides you with various personalized pharmacy care management services. These services include, but are not limited to:

- Personal attention from a pharmacist-led Care Team that provides condition-specific education, medication administration instruction and expert advice to help manage your therapy;
- Simplified ordering process through a dedicated toll-free number
- Claims assistance to help determine your individual coverage and file the necessary paperwork
- Confidential and convenient delivery of medications (including ancillary supplies such as needles, syringes, disposable containers, alcohol swabs, etc.) to the location of your choice, and
- Helpful follow-up care calls to remind you when it's time to refill your prescription, check on your therapy progress and answer any questions you may have.

For general questions concerning **EnvisionRxOptions**, call **1-800-361-4542**.

Coverage Determination, Redetermination (Internal Appeal) and Independent Review (External Appeal) Program

EnvisionRxOptions maintains a process for coverage determinations (including clinical prior authorizations), redeterminations, and external reviews (independent review organization ("IRO") submissions). EnvisionRxOptions utilizes a claim adjudication platform to determine real-time coverage/non-coverage status for Claims submitted electronically at the point-of-sale. Claims failing one or more Plan coverage rules are rejected at the point-of-sale and information regarding the reject reason(s) is conveyed to the dispensing pharmacy at the point-of-sale. Pharmacy personnel may contact EnvisionRxOptions' Customer Service Department to begin the coverage determination process or they may inform the Member of the reason(s) for the rejection and provide the Member with instructions to contact the Customer Service Department in the event the Member would like to initiate a coverage determination.

Coverage Determinations (or Clinical Prior Authorizations)

When a coverage determination request is initiated, the information connected with the rejected prescription is conveyed by EnvisionRxOptions to the prescriber via fax with a request for specific information regarding the Member's medication history and disease diagnosis. The prescriber completes the form and returns it to EnvisionRxOptions where the information provided by the prescriber is evaluated by an EnvisionRxOptions clinical pharmacist. Expedited coverage determinations occur as soon

as possible, taking into account medical exigencies, but no later than 24 hours of receipt of the request and standard determinations occur within 72 hours of receipt of the request.

If the information provided meets the criteria to allow an override of the initial rejection, an override will be configured in the adjudication system that will allow the claim to process. If the clinical review determines the prescription fails to meet the coverage criteria, the prescription will remain in rejected status.

The result of the coverage determination is communicated to the Member by written letter, the prescriber by fax, and the dispensing pharmacy by fax. In the event the coverage determination results in an adverse benefit determination, as defined below, the notice to the Member will include:

- information sufficient to identify the claim involved, including the date of service, the prescriber, the claim amount (if applicable), and a statement describing the availability, upon request, of the diagnoses and treatment codes (along with the corresponding meaning of those codes);
- the specific reasons for denial, including a description of the Plan's standard, if any, used in denying the claim;
- reference to the specific Plan provisions on which the decision is based;
- a description of any additional material or information needed for the Member to perfect the claim and an explanation of why the material or information is needed;
- any specific rule, guideline, protocol or other similar criterion the decision-maker relied upon in making the adverse benefit determination, and that a copy of the rule, guideline, etc., will be provided free, if the Member requests a copy;
- if the decision is based on a medical necessity and appropriate or experimental treatment or similar exclusion or limitation, an explanation of the scientific or clinical judgment, or a statement that the explanation will be provided free, if the Member requests a copy;
- if the request involves an urgent care decision, a description of the applicable expedited review process;
- provide the code assigned to the reason for the denial and the meaning of the code;
- describe the internal appeals procedures and external review processes for prescription benefits, including information about how to initiate an appeal; and
- include contact information for any applicable office of health insurance consumer assistance or ombudsman that is available to help the Member with the appeals process.

An "adverse benefit determination" is a denial, reduction, or termination of, or a failure to provide or make payment (in whole or in part) for, a benefit, including any such denial, reduction, termination, or failure to provide or make payment for a benefit resulting from the application of any utilization review, as well as a failure to cover an item or service for which benefits are otherwise provided because it is determined to be experimental or investigational or not medically necessary or appropriate. An adverse benefit determination also includes any rescission of coverage as defined in the regulations restricting rescissions, whether or not there is an adverse effect on any particular benefit at that time.

The availability and contact information of an agency offering assistance to the Member with the appeals and external review processes can be found at: www.healthcare.gov/using-insurance/managing/consumer-help/index.html.

Redetermination (Internal Appeal)

Upon initiation of a redetermination by the Member (or the Member's appointed representative), additional supporting documentation may be requested by EnvisionRxOptions. Expedited redetermination request evaluations occur as soon as possible, taking into account medical exigencies, but no later than 72 hours of receipt of the request to allow the Member to submit additional information for consideration, and standard evaluations occur within 72 hours of receipt of the request. The evaluation is performed by a clinical pharmacist or pharmacists other than the pharmacist or pharmacists that reviewed the original coverage determination request, to maintain impartiality within the review process.

EnvisionRxOptions will allow a Member to review the claim file and to present evidence and testimony as part of the internal appeals process. EnvisionRxOptions will provide the Member, free of charge, with any new or additional evidence considered, relied upon, or generated by the redetermination as soon as possible and sufficiently in advance of the date on which the notice of an adverse benefit determination is required to be provided, to give the Member a reasonable opportunity to respond prior to that date.

If the redetermination information supports an override of an adverse benefit determination, an override will be configured in the adjudication system which will allow the claim to process. If evaluation determines the redetermination request fails to meet the coverage criteria, the claim will remain in rejected status.

The result of the redetermination is communicated to the Member by written letter. In the event the redetermination results in an adverse benefit determination, the notice to the Member will include:

- the specific reason or reasons for such adverse determination;
- reference to the specific Plan provisions on which the determination is based;
- subject to privacy laws and other restrictions, if any, the identification of the claim, date of service, prescriber, claim amount (if applicable), and information about how to obtain diagnosis, treatment and denial codes with their meanings;
- an explanation of the Plan's external review processes (and how to initiate an external review) and a statement of the Member's right to bring a civil action under Section 502(a) of ERISA following a final denial on external review;
- in certain situations, a statement in non-English language(s) that future notices of claim denials and certain other benefit information may be available in such non-English language(s);
- a statement that the Member is entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the claim;
- any internal rule relied upon in making the adverse determination, or a statement that a copy of this information will be provided free of charge to the Member upon request;
- if the adverse benefit determination was based on medical necessity or experimental treatment, either an explanation of the scientific judgment for the adverse determination, applying the terms of the Plan to the Member's circumstances, or a statement that such explanation will be provided free of charge upon request;
- a description of the standard that was used in denying the claim and a discussion of the decision; and
- contact information for any applicable office of health insurance consumer assistance or ombudsman.

The Member may, upon request and free of charge, receive reasonable access to and copies of all documents, records, and other information used in the coverage determination

The availability and contact information of an agency offering assistance to the Member with the appeals and external review processes can be found at: www.healthcare.gov/using-insurance/managing/consumer-help/index.html.

External Appeal (Independent Review Organization)

A Member may file a request for an external review with the Plan within four months after the date of receipt of notice of a final adverse benefit determination. The redetermination (internal appeal) process must be exhausted before an external appeal is requested; however a simultaneous request for a redetermination and an external appeal may be made in an urgent care situation. When a Member (or the Member's duly appointed representative) initiates an external appeal request, whether standard or expedited, EnvisionRxOptions will complete a preliminary review of the request within five business days of receipt of the request. This preliminary review will determine (i) if the Member was covered under the Plan on the date of service, (ii) if the rejection does not relate to the Member's failure to meet the requirements for eligibility, (iii) if the Member has exhausted the internal appeal process, and (iv) if the Member has provided all information required to process an external review.

Within one business day after the preliminary review is complete, EnvisionRxOptions will issue a notification in writing to the Member. If the request is complete, but determined to be ineligible for external review, the Member notification will include the reason the claim has been determined to be ineligible and contact information for the Employee Benefits Security Administration. If the request is incomplete, the Member notification will specify the information needed to make the request complete. The Member will have an opportunity to provide the needed information within the four-month filing period, or within 48 hours of receiving the notification, whichever is later.

Once the preliminary review has been determined to be complete for an external review, EnvisionRxOptions will provide the claim information, Plan exclusion and coverage criteria documentation, and clinical review criteria to an IRO. EnvisionRxOptions has contracted with three IROs. External appeal requests are assigned to the IROs by rotation to avoid selection bias. Each contracted IRO holds URAC accreditation status to conduct external reviews. The IRO is not bound by the previous redetermination decision and reviews each case in accordance with the terms of the Plan and coverage documentation.

The IRO will notify the Member once it receives the Member's claim information and the Member will have 10 business days to submit any additional information for the IRO to consider in its external appeal.

The IRO will convey a final decision to EnvisionRxOptions and the Member within 45 days for standard reviews and within 72 hours for expedited reviews. Expedited reviews are permitted when standard review timeframes would seriously jeopardize the life or health of the Member.

If the IRO reverses EnvisionRxOptions' adverse redetermination decision, then EnvisionRxOptions will provide coverage and/or payment of the claim within 24 hours of notification of the IRO decision. If the IRO upholds EnvisionRxOptions' adverse benefit redetermination decision, the IRO will communicate the decision to EnvisionRxOptions and the Member. The Member is provided letters with the specific reasons including:

- a general description of the reason for the request for external review, including information sufficient to identify the claim (including the date or dates of service, the prescriber, the claim amount (if applicable), the diagnosis code and its corresponding meaning, the treatment code and its corresponding meaning, and the reason for the previous denial);

- the date the IRO received the assignment to conduct the external review and the date of the IRO decision;
- references to the evidence or documentation, including the specific coverage provisions and evidence-based standards, considered in reaching its decision;
- a discussion of the principal reason or reasons for its decision, including the rationale for its decision and any evidence—based standards that were relied on in making its decision;
- a statement that the determination is binding except to the extent that other remedies may be available under State or Federal law to either the Member or EnvisionRxOptions;
- a statement that judicial review may be available to the Member; and
- current contact information, including phone number, for any applicable office of health insurance consumer assistance or ombudsman that may be available to assist the Member.

The IRO's decision is binding, except to the extent that other remedies (including judicial review of the decision) may be available under applicable law to either the Plan or the Member.

UTILIZATION MANAGEMENT SERVICES

Utilization Management Services Phone Number
QualCare, Inc.
(800)-992-6613

Members can also refer to their Medical ID card for the Utilization Management Services phone number.

The patient or family member must call this number to receive certification of certain Utilization Management Services. This call must be made at least 5 days in advance of services being rendered or within 48 hours after a non-elective admission.

Note: **Any reduction in reimbursement due to failure to follow Utilization Management procedures will not be credited toward the Out-of-Pocket Maximum.**

UTILIZATION REVIEW

Utilization review is a program designed to help ensure that the Plan provides coverage for necessary appropriate and cost-effective services and supplies.

The program consists of:

- **(a)** Pre-certification of the Medical Necessity and Appropriateness for non-emergency services listed under "Pre-Certification List;"
- **(b)** Retrospective review of the Medical Necessity and Appropriateness of the listed services provided on an emergency basis;
- **(c)** Concurrent review, based on the admitting diagnosis, of the listed services requested by the attending Physician; and
- **(d)** Certification of services and planning for discharge from a Medical Care Facility or cessation of medical treatment.

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

If a particular course of treatment or medical service is not certified, it means that the Plan will not consider that course of treatment as appropriate for the maximum reimbursement under the Plan.

The attending Physician does not have to obtain precertification from the Plan for prescribing a maternity length of stay that is 48 hours or less for a vaginal delivery or 96 hours or less for a cesarean delivery.

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

Here's how the program works

Pre-certification. Before a Covered Person enters a Medical Care Facility on a non-emergency basis or receives other listed medical services, the utilization review administrator will, in conjunction with the attending Physician, certify the care as appropriate for the purposes of Plan reimbursement. A non-emergency stay in a Medical Care Facility is one that can be scheduled in advance.

The utilization review program is set in motion by a telephone call from the Covered Person. Contact the utilization review administrator at the telephone number on your ID card **at least 48 hours before** services are scheduled to be rendered with the following information:

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

If there is an **emergency** admission to the Medical Care Facility, the patient, patient's family member, Medical Care Facility or attending Physician must contact the utilization review administrator **within 48 hours** of the first business day after the admission.

The utilization review administrator will determine the number of days of Medical Care Facility confinement or use of other listed medical services pre-authorized for payment. **Failure to follow this procedure will reduce reimbursement received from the Plan by $400 per occurrence.**

PRE-CERTIFICATION LIST

Coverage for the following services require Pre-Certification from the QualCare Utilization Management Department prior to receiving services. Your Primary Care Physician or Specialist must contact the Utilization Management Department for Pre-certification at 1-800-992-6613.

As a result of new technologies, pre-certifications include, but may not be limited to the following list:

▪ **All inpatient admissions including:**
Acute Care (notification for all obstetrical admissions required) Sub acute Care Skilled Nursing Rehabilitation Hospice Mental Health and Substance Abuse **Note:** Elective inpatient admissions require pre-certification at least five (5) days before the admission Urgent or emergency admissions require notification within two (2) business days of admission
▪ **Outpatient and ambulatory surgery, regardless of the location, for only the procedures listed below:**
Blepharoplasty (eyelid surgery) Cardiac catheterization (procedure to look into blood vessels) Dialysis Endoscopic nasal sinus surgery (procedure to look into facial cavities) Keloid revisions (removal of scar tissue) Foot Surgery using CPT Codes 28008 through 28360 and 28705 through 28760 Mammoplasty, reduction (breast reduction) Mastopexy (surgical revision of a breast or other breast surgery, whether female or male) Gynecomastia Surgical Procedures (removal of excess tissue from the male breast) Otoplasty (external ear surgery) Rhinoplasty (plastic surgery of the nose) Septoplasty (reconstruction of the partition between the nasal cavities) Spinal Surgical Procedure (i.e.: Microdiscectomy, Percutaneous Discectomy, Laminectomy) Turbinectomy (removal of nasal walls) Uvuloplasty (surgery of the soft palate of mouth) Varicose Vein Interventions (a procedure on the veins of the legs)
▪ **Pain Management Programs/Treatment including:**
Epidurals (anesthesia into the spinal canal for pain relief) Cryodenervation (freezing of nerves for pain relief) Facet Injections (injections into a spinal joint) Radiofrequency denervation (procedure to destroy a nerve for relief of pain) Sacroiliac joint injections (injection into lower back for pain relief) Intrathecal (spinal canal) Pumps Spinal cord stimulators
▪ **Other outpatient services:**
Ankle Foot Orthotics, Foot Orthotics, Custom fitted (those custom braces made for support above the foot) Braces, Custom fitted (support of a body part) Durable Medical Equipment (purchases greater than $500) Durable Medical Equipment All Rentals Homecare, Hospice, Home Infusion Infertility (treatment for those that are unable to conceive, must have coverage under the Plan Benefits) Investigational/Experimental Services MRA (Imaging test of blood vessel and the flowing of blood through them) Obstetrical Ultrasounds greater than three (3) per pregnancy (test to visualize a fetus in the uterus) Outpatient Infusion therapy, excluding Cancer Chemotherapy (medicine or fluids into veins) PET Scans (3-D image or picture of functional processes in the body) Prosthetics (artificial body parts) Rehabilitation (cardiac, cognitive, occupational, physical, pulmonary, speech therapy) Transplant evaluations Transportation Elective (non-emergency only)

To pre-certify a service, please call the Plan hotline 800-992-6613. This phone number is also provided on your Plan identification card.

PRE-CERTIFICATION PENALTY: If the Covered Person does not receive pre-certification as explained in this section, the benefit payment will be reduced by $400 per occurrence.

Concurrent review, discharge planning

Concurrent review of a course of treatment and discharge planning from a Medical Care Facility are parts of the utilization review program. The utilization review administrator will, solely for the purposes of Plan coverage, monitor the Covered Person's Medical Care Facility stay or use of other medical services and coordinate with the attending Physician, Medical Care Facilities and Covered Person either the scheduled release or an extension of the Medical Care Facility stay or extension or cessation of the use of other medical services.

If the attending Physician feels that it is Medically Necessary and Appropriate for a Covered Person to receive additional services or to stay in the Medical Care Facility for a greater length of time than has been pre-certified, the attending Physician must request coverage for the additional services or days.

Second and/or Third Opinion Program

Certain surgical procedures are performed either inappropriately or unnecessarily. In some cases, surgery is only one of several treatment options.

The second and/or third opinion program fulfills the dual purpose encouraging Covered Persons to make informed decisions and protecting the financial integrity and viability of the Plan.

Benefits will be provided for a second (and third, if necessary) opinion consultation to determine the Medical Necessity and Appropriateness of an elective surgical procedure. An elective surgical procedure is one that can be scheduled in advance; that is, it is not an emergency or of a life-threatening nature.

The patient may choose any board-certified specialist who is not an associate of the attending Physician and who is affiliated in the appropriate specialty.

While any surgical treatment is allowed a second opinion, the following procedures are ones for which surgery is often performed when other treatments may be available.

Appendectomy	Hernia surgery	Spinal surgery
Cataract surgery	Hysterectomy	Surgery to knee, shoulder, or elt toe
Cholecystectomy (gall bladder removal)	Mastectomy surgery	Tonsillectomy and Adenoidectomy
Deviated septum (nose surgery)	Prostate surgery	Tympanotomy (inner ear)
Hemorrhoidectomy	Salpingo-oophorectomy (removal of tubes/ovaries)	Varicose vein ligation

Case Management

If a Covered Person has a medical condition with special needs or one that extends beyond the acute care setting, case management helps ensure that coverage is provided for care that is both appropriate and efficient. Case management professionals work closely with the patient, the patient's family, and the attending Physician to help determine appropriate treatment options that best meet the patient's needs and manage costs. The case manager will help coordinate the treatment program and arrange for necessary resources. Case managers are also available to answer questions and provide ongoing support for the family in times of medical crisis.

In addition, case managers are supported by a panel of Physician advisors who offer guidance on up-to-date treatment programs and medical technology. While the case manager recommends alternative treatment programs and helps coordinate needed resources, the patient's attending Physician remains responsible for the actual medical care.

Here's how case management services work:

1. The patient (or his/her authorized representative) or an attending physician can request case management services by calling the toll-free number shown on the back of your medical ID card. In addition, the claim office may refer an individual for case management.
2. The case management provider will assess each case to determine whether case management is appropriate.
3. The patient (or his/her authorized representative) will be contacted by an assigned case manager who will explain in detail how the program works.
4. Following an initial assessment, the case manager will work with the patient, his/her family and the attending Physician to determine the needs of the patient and to identify what alternative treatment programs are available. (For example, in-home medical care in lieu of extended hospital convalescence.) There are no penalties if the alternative treatment program is not followed.
5. The case manager will arrange for alternative treatment services and supplies, as needed. (For example, nursing services or a hospital bed and other durable medical equipment for the home.)
6. The case manager also acts as a liaison between the Plan, the patient (or his/her representative), his/her family, and the Physician as needed. (For example, by helping you understand a complex medical diagnosis or treatment plan.)
7. Once the alternative treatment program is in place, the case manager continues to manage the case to ensure the treatment program remains appropriate to the patient's needs.

Note: Case Management is a voluntary service. There are no reductions of benefits or penalties if the patient and family choose not to participate. Case management professionals can, however, offer coverage for quality, cost-effective treatment alternatives, as well as provide assistance in obtaining needed medical resources and ongoing family support in a time of need.

NOTE: Failure to comply with case management may result in benefit penalties. Examples of benefit penalties may include claims not being processed, a denial of benefit payment, and/or restricted authorization, and/or termination from the plan with no access to COBRA.

Each treatment plan is individually tailored to a specific patient and should not be seen as appropriate or recommended for any other patient, even one with the same diagnosis.

DEFINITIONS

The words shown below have specific meanings when used in this Summary Plan Description. Please read these definitions carefully. They will help Members understand what services are provided.

ACTIVE TEAM MEMBER – A Team Member who is employed on the regular payroll of the Employer as an employee and who is scheduled to perform the duties of his or her job with the Employer on a full-time or part-time basis, at the Employer's place of business, or at another place to which a Team Member must travel to perform his or her regular duties.

ALCOHOL ABUSE - Abuse of or addiction to alcohol.

AMBULANCE - A certified transportation vehicle for transporting ill or injured people that contains all life-saving equipment and staff as required by applicable state and local law.

AMBULATORY SURGICAL CENTER - A Facility mainly engaged in performing Outpatient Surgery. It must be staffed by Physicians and Nurses, under the supervision of a Physician, have operating and recovery rooms, be staffed and equipped to give emergency care, and have written backup arrangements with a local Hospital for emergency care. It must carry out its stated purpose under all relevant state and local laws and be either: accredited for its stated purpose by either The Joint Commission or the Accreditation for Ambulatory Care, or approved for its stated purpose by Medicare. A Facility is not an Ambulatory Surgical Center, for the purpose of this document, if it is part of a Hospital.

BASELINE – The initial test results to which the results in future years will be compared in order to detect abnormalities.

BIRTHING CENTER - Any free-standing 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, or be approved for its stated purpose by the Accreditation Association for Ambulatory Care or Medicare.

The Birthing Center must provide facilities for obstetrical delivery and short-term recovery after delivery; 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.

BRAND NAME DRUGS – Drugs as determined by the Food and Drug Administration and listed in the Formulary of the state in which they are dispensed; these drugs are protected by the trademark registration of the pharmaceutical company which produced them.

CALENDAR YEAR - Each successive twelve-month period starting on January 1st and ending on December 31st.

CIVIL UNION – A same-sex civil union that is either established pursuant to New Jersey law or recognized by the State of New Jersey as a civil union.

CIVIL UNION PARTNER – A person who has established and is in a Civil Union. **Meridian Health** may require that the Team Member provide a Civil Union Certificate or Civil Union License.

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

COINSURANCE – The benefit percentage of covered expenses payable by the Plan for benefits that are provided under the Plan. The coinsurance is applied to covered expenses after the deductible(s) have been met, if applicable.

COPAYMENT - A specified dollar amount which a Member must pay for certain Covered Services or Supplies.

COSMETIC SURGERY OR PROCEDURE - Any surgery or procedure that involves physical appearance, but which does not correct or materially improve a physiological function and is not Medically Necessary and Appropriate.

COVERED PERSON – A Team Member or Dependent who is covered under this Plan.

COVERED SERVICES OR SUPPLIES - The types of services and supplies described in the *Schedule of Benefits* Section of this Summary Plan Description. Read the entire Summary Plan Description to find out what benefits are limited or excluded.

CREDITABLE COVERAGE – With respect to a Team Member or Dependent, coverage of the Team Member or Dependent under any of the following: a Group Health Plan; a group or individual Health Benefits Plan; Part A or Part B of Title XVIII of the federal Social Security Act (Medicare); Title XIX of the federal Social Security Act (Medicaid), other than coverage consisting solely of benefits under section 1928 of Title XIX of the federal Social Security Act (the program for distribution of pediatric vaccines); chapter 55 of Title 10, United States Code (medical and dental care for members and certain former members of the uniformed services and their dependents); a medical care program of the Indian Health Service or of a tribal organization; a state health benefits risk pool; a health plan offered under chapter 89 of Title 5, United States Code; a public health plan as defined by federal regulation; a health benefits plan under section 5(e) of the "Peace Corps Act"; or coverage under any other type of plan as set forth by the Commissioner of Banking and Insurance by regulation.

Creditable Coverage does not include coverage which consists solely of the following: coverage only for accident or disability income insurance, or any combination thereof; coverage issued as a supplement to liability insurance; liability insurance, including general liability insurance and automobile liability insurance; workers' compensation or similar insurance; automobile medical payment insurance; credit only insurance; coverage for on-site medical clinics, coverage as specified in federal regulation, under which benefits for medical care are secondary or incidental to the insurance benefits; and other coverage expressly excluded from the definition of Health Benefits Plan.

CUSTODIAL CARE - Any service or supply, including room and board, which:

(a) is furnished mainly to help a Member meet his or her routine daily needs; or
(b) can be furnished by someone who has no professional health care training or skills.

Examples of Custodial Care are help walking and getting out of bed; assistance in bathing, dressing, feeding, or supervision over medication which could normally be self-administered.

DEDUCTIBLES – Annual amount of covered charges for which no benefits will be paid under the Plan. Before benefits can be paid in a **Calendar Year** a Covered Person must meet the Deductible shown in the Schedule of Benefits.

DEPENDENT – Any individual who is related to the Team Member by being:

a. a Spouse of the Team Member;
b. a Civil Union Partner of the Team Member;
c. a same-sex Domestic Partner of the Team Member who (i) entered into the Domestic Partnership with the Team Member prior to January 1, 2014 and (ii) has been continuously enrolled in the Welfare Benefit Plan since January 1, 2014;
d. a Dependent child of the Team Member;

Your "Dependent child" includes your natural child, adopted child, step-child, foster child, or Domestic Partner's or Civil Union Partner's child. The Plan treats a child as adopted or as a foster child from the time the child is placed in the home of the Team Member for the purpose of adoption or of becoming a foster child. The term also includes an unmarried child for whom you are Legal Guardian. Please refer to the *Eligibility* Section of this Summary Plan Description.

A Dependent is not a person who is covered by the Group Health Care Plan as a Team Member.

At the Plan's discretion, the Plan can require proof that a person meets the definition of a Dependent.

DIABETES DRUGS AND SUPPLIES - Test strips for glucose monitors and visual reading and urine test strips; insulin; injection aids; cartridges for the legally blind; syringes; insulin infusion devices; diabetic shoes; and oral agents for controlling blood sugar.

DIAGNOSTIC SERVICES - Procedures ordered by a recognized Provider because of specific symptoms to diagnose a specific condition or disease. Some examples include, but are not limited to:

a. radiology, ultrasound, diagnostic mammography and nuclear medicine;
b. laboratory and pathology; and
c. EKG's, EEG's, MRI's, sleep apnea testing and other electronic diagnostic tests.

DOMESTIC PARTNERS - An eligible Team Member and one other person who:

- have been living in a committed exclusive relationship of mutual caring and support for a period of at least twelve (12) months;
- intend for the Domestic Partnership to be permanent;
- are financially interdependent and jointly responsible for the common welfare and financial obligations of the household;
- is not legally or ceremonially married to any other individual, and, if previously married, a legal divorce or annulment has been obtained or the former spouse is deceased;
- are mentally competent to enter into a contract according to the laws of the state in which they reside;
- are 18 years of age or older;
- are the same gender;
- do not have a blood relationship that would bar marriage under applicable laws of the state in which they reside, if all other applicable marriage requirements of such state law were met;
- are not in the relationship solely for purposes of obtaining benefits; and

- if you live in a municipality or state that registers same sex domestic partners, you must be registered and provide the Plan Administrator with a copy of the registration.

Meridian Health requires that the Team Member submit an Affidavit of Same Sex Domestic Partnership, Civil Union Certificate or Civil Union License to be signed and dated by the Team Member certifying that a Domestic Partnership exists as defined within the Human Resources Policies and Procedures. Please refer to the Affidavit of Same Sex Domestic Partnership for additional information that may be required. Individuals who enter a domestic partnership with a Team Member on or after January 1, 2014 are not eligible under the Plan.

DURABLE MEDICAL EQUIPMENT - Equipment the Plan Determines to be:

a. designed and able to withstand repeated use;
b. used primarily and customarily for a medical purpose;
c. is generally not useful to a Member in the absence of an Illness or Injury; and
d. is suitable for use in the home.

Durable Medical Equipment includes, but is not limited to, apnea monitors, blood glucose monitors, insulin pumps, breathing equipment, oxygen, hospital type beds, walkers, wheelchairs, wigs following chemotherapy treatment in connection with Oncology Services.

Among other things, Durable Medical Equipment does not include: adjustments made to vehicles, air conditioners, air purifiers, humidifiers, dehumidifiers, elevators, ramps, stair glides, Emergency Alert equipment, handrails, heat appliances, improvements made to a Member's home or place of business, waterbeds, whirlpool baths, exercise and massage equipment.

EFFECTIVE DATE - The date on which coverage begins for a Member.

EMPLOYER – Meridian or any Participating Employers.

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

EXPERIMENTAL or INVESTIGATIONAL - Services or supplies which the Plan determines are:

a. not of proven benefit for the particular diagnosis or treatment of a Member's particular condition; or
b. not generally recognized by the medical community as effective or appropriate for the particular diagnosis or treatment of a Member's particular condition; or
c. provided or performed in special settings for research purposes or under a controlled environment or clinical protocol.

Unless otherwise required by applicable law with respect to drugs which have been prescribed for the treatment of a type of cancer for which the drug has not been approved by the United States Food and Drug Administration (FDA), the Plan will not cover any services or supplies, including treatment, procedures, drugs, biological products or medical devices or any hospitalizations in connection with Experimental or Investigational services or supplies.

The Plan will also not cover any technology or any hospitalization in connection with such technology if such technology is obsolete or ineffective and is not used generally by the medical community for the particular diagnosis or treatment of a Member's particular condition.

Governmental approval of a technology is not necessarily sufficient to render it of proven benefit or appropriate or effective for a particular diagnosis or treatment of a Member's particular condition, as explained below. A service or supply will generally not be considered Experimental or Investigational if it meets any of the following criteria, as determined by the Plan:

1. Any medical device, drug or biological product must have received final approval to market by the United States Food and Drug Administration (FDA) for the particular diagnosis or condition. Any other approval granted as an interim step in the FDA regulatory process, e.g., an Investigational Device Exemption or an Investigational New Drug Exemption, is not sufficient. Once FDA approval has been granted for a particular diagnosis or condition, use of the medical device, drug or biological product for another diagnosis or condition will require that one or more of the following established reference compendia recognize the usage as appropriate medical treatment:

    (a) The American Medical Association Drug Evaluations;
    (b) The American Hospital Formulary Service Drug Information; or
    (c) The United States Pharmacopoeia Drug Information

    As an alternative to such recognition in one or more of the compendia, the usage of the drug will be recognized as appropriate if it is recommended by a clinical study and recommended by a review article in a major peer-reviewed professional journal. A medical device, drug, or biological product that meets the above tests will not be considered Experimental or Investigational.

    In any event, any drug which the FDA has determined to be contraindicated for the specific treatment for which the drug has been prescribed will be considered Experimental or Investigational.

2. Conclusive evidence from the published peer-reviewed medical literature must exist that the technology has a definite positive effect on health outcomes; such evidence must include well-designed investigations that have been reproduced by non-affiliated authoritative sources, with measurable results, backed up by the positive endorsements of national medical bodies or panels regarding scientific efficacy and rationale;

3. Demonstrated evidence as reflected in the published peer-reviewed medical literature must exist that over time the technology leads to improvement in health outcomes, i.e., the beneficial effects outweigh any harmful effects;

4. Proof as reflected in the published peer-reviewed medical literature must exist that the technology is at least as effective in improving health outcomes as established technology, or is usable in appropriate clinical contexts in which established technology is not employable; and

5. Proof as reflected in the published peer-reviewed medical literature must exist that improvements in health outcomes, as defined in paragraph 3, is possible in standard conditions of medical practice, outside clinical investigatory settings.

EXTENDED CARE CENTER - See Skilled Nursing Center.

FACILITY - A place that is licensed, certified, or accredited to provide health care under the laws of the state in which it operates and provides health care services that are within the scope of its license, certification or accreditation.

FAMILY UNIT- The Covered Team Member and family members who are covered as Dependents under the Plan.

FULL-TIME - A normal work week of at least **36** regularly scheduled hours.

GENERIC DRUGS – A Prescription Drug which 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.

GENETIC INFORMATION – Information about genes, gene products and inherited characteristics that may derive from an individual of a family member. This includes information regarding carrier status and information derived from laboratory tests that identify mutations in specific genes or chromosomes, physical medical examinations, family histories and direct analysis of genes or chromosomes.

GROUP HEALTH PLAN – A Team Member welfare benefit plan, as defined in Title I of section 3 of ERISA (29 U.S.C. & 1002(1) to the extent that the plan provides medical care and includes items and services paid for as medical care to Team Members or their dependents directly or through insurance, reimbursement or otherwise.

HEALTH BENEFITS PLAN - Any hospital and medical expense insurance policy or certificate; health, hospital, or medical service corporation contract or certificate; or health maintenance organization subscriber contract or certificate delivered or issued for delivery in New Jersey by any carrier or any other similar contract, policy, or plan issued to an employer, not explicitly excluded from the definition of a health benefits plan. Health Benefits Plan does not include one or more, or any combination of the following: coverage only for accident or disability income insurance, or any combination thereof; coverage issued as a supplement to liability insurance; liability insurance, including general liability insurance and automobile liability insurance; workers' compensation or similar insurance; automobile medical payment insurance; credit-only insurance; coverage for on-site medical clinics; and other similar insurance coverage, as specified in federal regulations, under which benefits for medical care are secondary or incidental to other insurance benefits. Health Benefits Plans shall not include the following benefits if they are provided under a separate policy, certificate or contract of insurance or are otherwise not an integral part of the plan: limited scope dental or vision benefits; benefits for long term care, nursing home care, home health care, community based care, or any combination thereof; and such other similar, limited benefits as are specified in federal regulations. Health Benefits Plan shall not include hospital confinement indemnity coverage if the benefits are provided under a separate policy, certificate or contract of insurance, there is no coordination between the provision of the benefits and any exclusion of benefits under any group Health Benefits Plan maintained by the same plan sponsor, and those benefits are paid with respect to an event without regard to whether benefits are provided with respect to such an event under any Group Health Plan maintained by the same plan sponsor. Health Benefits Plan shall not include the following if it is offered as a separate policy, certificate or contract of insurance: Medicare supplemental health insurance as defined under section 1882(g)(1) of the federal Social Security Act; and coverage supplemental to the coverage provided under chapter 55 of Title 10, United States Code; and similar supplemental coverage provided to coverage under a Group Health plan.

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.

HOME HEALTH CARE PLAN - The plan must meet the following tests: it must be a formal written plan made by the patient's attending Physician which is reviewed at least every 30 days; it must state the diagnosis; it must certify that the Home Health Care is in place of Hospital confinement; and it must specify the type and extent of Home Health Care required for the treatment of the patient.

HOME HEALTH CARE - Home health care services may include alternatives to hospitalization, such as a participating home health agency, as long as services and treatment are pre-authorized by the plan and medically necessary and appropriate.

HOSPICE - A Provider that provides palliative and supportive care for terminally ill or injured people. It must carry out its stated purpose under all relevant state and local laws, and it must either:

a. be approved for its stated purpose by Medicare; or
b. be accredited for its stated purpose by either The Joint Commission or the National Hospice Organization.

HOSPITAL - An institution that is engaged primarily in providing medical care and treatment of sick and injured persons on an inpatient basis at the patient's expense and that fully meets 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.

ILLNESS - A bodily disorder, disease, physical sickness or Mental or Nervous condition. Illness includes Pregnancy, childbirth, miscarriage or Complications of Pregnancy.

INFERTILITY – Condition that results in the abnormal function of the reproductive system such that a person is unable to:

a. impregnate another person;
b. conceive after unprotected intercourse; or
c. carry a pregnancy to live birth.

INJURY - Damage to a Member’s body and all complications arising from that damage.

INPATIENT - Member is physically confined as a registered bed patient in a Hospital or other recognized health care facility.

INTENSIVE CARE UNIT- A separate, clearly designated service area that is maintained within a Hospital solely for the care and treatment of patients who are critically ill. 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 lifesaving equipment that 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.

JOINT COMMISSION - The Joint Commission accredits health care organizations and programs in the United States.

LATE ENROLLEE - An eligible Team Member or Dependent who enrolls under the Plan other than during the first 31-day period in which the individual is eligible to enroll under the Plan or during a Special Enrollment Period.

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

LIFETIME - A word that appears in this Plan in reference to benefit maximums and limitations. Lifetime is understood to mean while covered under this Plan. Under no circumstances does Lifetime mean during the lifetime of the Covered Person.

MEDICAID - The health care program for the needy provided by Title XIX of the United States Social Security Act, as amended from time to time.

MEDICAL EMERGENCY - A medical condition manifesting itself by acute symptoms of sufficient severity including, but not limited to, severe pain, psychiatric disturbances and/or symptoms of substance abuse such that a prudent layperson, who possesses an average knowledge of health and medicine, could expect, in the absence of immediate attention to result in placing the health of the 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; or serious dysfunction of a bodily organ or part.

With respect to a pregnant woman who is having contractions, a Medical Emergency exists where: there is inadequate time to affect a safe transfer to another Hospital before delivery; or the transfer may pose a threat to the health or safety of the woman or the unborn child. Examples of Medical Emergencies include, but are not limited to: heart attacks, strokes, convulsions, serious burns, obvious bone fractures, wounds requiring sutures, poisoning, and loss of consciousness or respiration.

MEDICAL NECESSITY AND APPROPRIATENESS - Services or supplies, provided by a recognized Health Care Provider that are determined to be:

a. necessary for the symptoms and diagnosis or treatment of the condition, Illness or Injury;
b. provided for the diagnosis or the direct care and treatment of the condition, Illness or Injury;
c. in accordance with generally accepted medical practice;
d. not for the convenience of the Member or Provider of medical services;
e. the most appropriate level of medical care that a Member needs; and
f. furnished within the framework of generally accepted methods of medical management currently used in the United States. In the instance of a Medical Emergency, the fact that a Provider prescribes, orders, recommends or approves the care, the level of care, or the length of time care is to be received, does not necessarily make the services Medically Necessary and Appropriate.

Not all Medically Necessary and Appropriate services or supplies are covered. Please refer to the *Plan Exclusions* Section of this Summary Plan Description.

MEDICARE - Parts A, B, and D of the health care program for the aged and disabled provided by Title XVIII of the United States Social Security Act, as amended from time to time.

MEMBER - An eligible person who is covered under this Plan (includes Covered Team Member and covered Dependents, if any).

MENTAL OR NERVOUS CONDITION - A condition which manifests symptoms which are primarily mental or nervous, regardless of any underlying physical cause. A Mental or Nervous Condition includes, but is not limited to: psychoses, neurotic and anxiety disorders, schizophrenic disorders, affective disorders, personality disorders, and psychological or behavioral abnormalities associated with transient or permanent dysfunction of the brain or related neurohormonal systems.

In determining whether or not a particular condition is a Mental or Nervous Condition, the Plan may refer to the current edition of the Diagnostic and Statistical Manual of Mental Conditions of the American Psychiatric Association.

MORBID OBESITY – A diagnosed condition in which the body mass index exceeds the medically recommended weight.

NON-COVERED SERVICES - Services or supplies that are not included within this Plan's definition of Covered Services or Supplies, are included in the list of Plan Exclusions, or which exceed any of the limitations shown in this Summary Plan Description.

NON-PARTICIPATING PROVIDER - A Provider that is not a QualCare Participating Provider.

NURSE - A registered nurse or licensed practical nurse, including a nursing specialist such as a nurse mid-wife, nurse practitioner or nurse anesthetist, who:

a. is properly licensed or certified to provide medical care under the laws of the state where the nurse practices; and
b. provides medical services which are within the scope of the nurse's license or certificate and are covered by the Group Health Care Plan.

OPEN ENROLLMENT PERIOD - The period of time, at least once annually, designated by an Employer during which Team Members enroll in the Group Health Plan and agree to make required payments, if any.

OUT-OF-POCKET MAXIMUM – Your Out-of-Pocket Maximum is the annual limit you pay out of your own pocket for In Network Covered Services or Supplies, or for In-Network and Inner Circle Covered Services or Supplies combined, as described in the *Schedule of Benefits* and the Section *Out-of-Pocket Limit*.

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

PART-TIME - A normal work week of at least **20** but less than **36** regularly scheduled hours.

PARTIAL HOSPITALIZATION - An outpatient program specifically designed for the diagnosis or active treatment of a Mental or Nervous Condition or Substance Abuse when there is reasonable expectation for improvement or when it is necessary to maintain a patient's functional level and prevent relapse; this program shall be administered in a psychiatric facility that is accredited by The Joint Commission and shall be licensed to provide partial hospitalization services, if required, by the state in which the facility is providing these services. Treatment lasts less than 24 hours, but more than four hours a day, and no charge is made for room and board.

PARTICIPATING EMPLOYER – The Participating Employers that have adopted the Plan with Meridian Health's approval and make the Plan available to their eligible Team Members are described in the Section *General Plan Information.*

PARTICIPATING PROVIDER - A Provider which has an agreement with QualCare to provide Covered Services and Supplies.

PERIOD OF CONFINEMENT - Consecutive days of Inpatient services provided to an Inpatient, or successive Inpatient confinements due to the same or related causes, when discharge and re-admission to a recognized facility occurs within 90 days or less. The Plan determines if the cause(s) of the confinements are the same or related.

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

PLAN – **Meridian Health** Medical Plan, which is a benefit plan for certain Team Members of **Meridian Health** and is described in this Summary Plan Description.

PLAN PARTICIPANT - Any Team Member or Dependent who is covered under this Plan.

PLAN SPONSOR – Meridian Health

PLAN YEAR – The 12 month period beginning January 1 and ending December 31.

PRACTITIONER - A medical practitioner who:

a. is properly licensed or certified to provide medical care under the laws of the state where the practitioner practices; and
b. provides medical services that are within the scope of the practitioner's license or certificate and which are covered by the Group Health Care Plan.

PRE-CERTIFICATION – QualCare's approval for specified services and supplies prior to the date that charges are incurred. Services and supplies that are not pre-approved are subject to the penalties described within the *Utilization Management* Section of this Summary Plan Description.

PREGNANCY - Childbirth and conditions associated with Pregnancy, including complications.

PRESCRIPTION DRUGS - Any of the following: a Food and Drug Administration-approved 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 and Appropriate in the treatment of an Illness or Injury.

PREVENTIVE CARE - Services and supplies in connection with routine physical examinations, including laboratory tests and x-rays, immunizations and vaccines, well baby care, pap smears, mammography, and screening tests. Specific preventive health services that are covered are described at http://www.healthcare.gov/center/regulations/prevention/recommendations.html.

PRIMARY CARE PHYSICIAN (PCP) - A Participating Provider who is a doctor specializing in family practice, general practice, internal medicine, or pediatrics who supervises, coordinates, arranges and provides initial care and basic medical services to a Member, and is responsible for maintaining continuity of patient care.

PROVIDER - A person or other entity licensed where required and performing services within the scope of such license.

QUALCARE – QualCare, Inc.

QUALCARE FEE SCHEDULE – Any negotiated, discounted or per diem rate or fee that QualCare may have with a particular provider. See, also QualCare Plan Allowable Charges.

QUALCARE PLAN ALLOWABLE CHARGES – Charges that do not exceed the maximum dollar amount the Plan will recognize for a Covered Service or Supplies by other network Providers of similar profession. They are also referred to as "QualCare Fee Schedule." Charges in excess of the QualCare Plan Allowable Charges are not considered covered charges under the Plan and do not accrue toward your Out-of-Pocket Maximum.

ROUTINE FOOT CARE - The cutting, debridement, trimming, reduction, removal or other care of corns, calluses, flat feet, fallen arches, weak feet, chronic foot strain, dystrophic nails, excrescences, helomas, hyperkeratosis, hypertrophic nails, non-infected ingrown nails, deratomas, keratosis, onychauxis, onychocryptosis, tylomas or symptomatic complaints of the feet. Also includes orthopedic shoes, foot orthotics and supportive devices for the foot.

SERVICE AREA - A geographic area the Plan defines by county and/or zip code.

SKILLED NURSING CARE - Services that are more intensive than Custodial Care, are provided by a Registered Nurse (R.N.) or Licensed Practical Nurse (L.P.N.), and require the technical skills and professional training of an R.N. or L.P.N. and meet the requirements of Medicare.

SKILLED NURSING FACILITY - A facility that fully meets all of these tests:

(1) It is licensed to provide professional nursing services on an inpatient basis to persons convalescing from Injury or Illness. The service must be rendered by a registered nurse (R.N.) or by a licensed practical nurse (L.P.N.) under the direction of a registered nurse. Services to help restore patients to self-care in essential daily living activities must be provided.

(2) Its services are provided for compensation and under the full-time supervision of a Physician.
(3) It provides 24 hour per day nursing services by licensed nurses, under the direction of a full-time registered nurse.
(4) It maintains a complete medical record on each patient.
(5) It has an effective utilization review plan.
(6) It is not, other than incidentally, a place for rest, the aged, drug addicts, alcoholics, Custodial or educational care or care of Mental or Nervous Conditions.
(7) Be accredited for its stated purpose by The Joint Commission
(8) It is approved and licensed by Medicare.

This term also applies to charges incurred in a facility referring to itself as an extended care facility, convalescent nursing home, rehabilitation hospital or any other similar nomenclature.

SPECIALIST DOCTOR - A doctor who provides medical care in any generally accepted medical or surgical specialty or sub-specialty.

SPECIALIST SERVICES - Medical care in specialties other than family practice, general practice, internal medicine or pediatrics.

SPECIALTY PHARMACEUTICALS – Products that are processed through DNA technology or biological processes that target chronic disease states. Also known as Biotech Pharmaceuticals.

SPOUSE – The person lawfully married to a Team Member under the laws of any domestic or foreign jurisdiction where such individual and Eligible Employee were married. The Plan Administrator requires a certified copy of a marriage certificate.

SUBSCRIBER - A person who meets all applicable eligibility requirements, enrolls hereunder by making application, and for whom premium has been received.

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

SURGERY -

a. The performance of generally accepted operative and cutting procedures, including surgical diagnostic procedures, specialized instrumentations, endoscopic examinations, and other procedures; or
b. the correction of fractures and dislocations; or
c. pre-operative and post-operative care; or
d. any of the procedures designated by Current Procedural Terminology codes as surgery.

TEAM MEMBER – A person directly employed in the regular business of and compensated for services, as reported on the individual's annual W-2 form, by the employer. Team Member does not include an individual designated by Meridian to be an independent contractor (whether determined at a later date to be a common law employee or otherwise).

TEAM MEMBER ELIGIBILITY DATE -

a. the date of employment; and
b. the day after any applicable waiting period ends.

THERAPY SERVICES - The following services or supplies ordered by a Provider and used to treat, or promote recovery from, an Injury or Illness:

Cardiac Rehabilitation Therapy - program of structured outpatient supervised exercise that occurs subsequent to a major cardiac event.

Chelation Therapy - the administration of drugs or chemicals to remove toxic concentrations of metals from the body.

Chemotherapy – the treatment of malignant disease by chemical or biological antineoplastic agents.

Cognitive Rehabilitation Therapy - retraining the brain to perform intellectual skills that it was able to perform prior to disease, trauma, surgery, congenital anomaly or previous therapeutic processes.

Dialysis Treatment - the treatment of acute renal failure or chronic irreversible renal insufficiency by removing waste products from the body. This includes hemodialysis and peritoneal dialysis.

Infusion Therapy - the administration of antibiotic, nutrients or other therapeutic agents by direct infusion.

Occupational Therapy - treatment to restore a physically disabled person's ability to perform the ordinary tasks of daily living.

Physical Therapy - the treatment by physical means to relieve pain, restore maximum function, and prevent disability following disease, injury, or loss of a limb.

Radiation Therapy - the treatment of disease by X-ray, radium, cobalt, or high energy particle sources. Radiation Therapy includes rental or cost of radioactive materials. Diagnostic Services requiring the use of radioactive materials are not Radiation Therapy.

Respiration Therapy - the introduction of dry or moist gases into the lungs.

Speech Therapy - treatment for the correction of a speech impairment resulting from illness, surgery, injury, congenital anomaly, or previous therapeutic processes.

TOTAL DISABILITY OR TOTALLY DISABLED - A Dependent is totally disabled if he or she cannot engage in the normal activities of a person in good health and of like age and sex. The Dependent must be under the regular care of a Practitioner.

USUAL AND REASONABLE CHARGE - A charge that is not higher than the usual charge made by the provider of the care or supply and does not exceed the usual charge made by most providers of like service in the same area.

WAITING PERIOD – For a newly hired Active Full-Time or Part-Time Team Member, the time between the first day of employment and first day of coverage under the Plan.

YOU, YOUR, AND YOURS – Refers to the Team Member or Member.

CONFIDENTIALITY

FEDERAL PRIVACY REQUIREMENTS

Under federal law, special rules apply to the privacy of your health information. For more information about the confidentiality of your protected health information ("PHI") and how it may be used and disclosed, please refer to the Plan's Notice of Privacy Practices (the "Notice"). The Notice explains how you may access and amend your PHI, request an accounting of disclosures of your PHI, and request restrictions on disclosures of your PHI. You may request a copy of the Notice by contacting the Plan Administrator. Other policies adopted by the Plan contain standards designed to maintain the security of your PHI.

HOW TO SUBMIT A CLAIM - MEDICAL

HOW TO FILE A CLAIM

Be sure to refer to the following procedures when you need to file a claim. In the case of a claim for prescription drugs, please see the claims and appeals process described in the *Prescription Plan* Section of this SPD.

When you use a network provider, you will not have to complete any claim forms. Network providers are responsible for submitting claims directly to the Claims Administrator. Claim forms can be obtained by contacting the Claims Administrator.

Mail Claims to:
QualCare, Inc. **P.O. Box 249** **Piscataway, NJ 08855-0249** **Plan Hotline: 1-800-992-6613**

If you have a question about a claim, please call the Plan hotline at 1-800-992-6613. A representative will help you resolve your claim, including verifying that your claim is for a covered treatment.

CLAIMING YOUR BENEFITS (FILING A CLAIM)

When filing your claim, you must submit proof of each charge. It is extremely important that you secure copies of bills for all charges. All bills should be itemized.

Proof of claim must be furnished to the Claims Administrator within **180** days following the date services were provided. However, your claim will still be considered if it was not possible to furnish proof within that time and the proof was furnished as soon as reasonably possible, however, no later than **one year** from the original date services were provided.

All benefits provided by the Plan will be paid as soon as possible upon receipt of proof of claim. Benefits will be payable to the Team Member unless payment has been assigned.

No action at law or in equity may be brought against the Plan prior to the expiration of **90** days after proof of loss has been furnished, nor shall such action be brought within one year from the expiration of the time within which proof of loss is required to be furnished.

The Plan shall have the right to examine any person whose loss is the basis for the claim as often as it may reasonably require. The Plan is not in lieu of and does not affect any requirements for workers' compensation insurance.

IF YOUR CLAIM IS DENIED

If your health benefits claim is denied in whole or in part, the Claims Administrator will notify you in writing or electronically of its determination within the time frames written below. The Claims Administrator may determine that more time is needed, but will notify you in writing if that is the case before the end of the respective claim period. If your claim is not filed properly, you or your authorized representatives will be notified of that fact and of the procedures to be followed to properly file a claim.

Types of Claims

"Urgent Care Claims" - Claims with respect to which the application of the time periods for making non-urgent care determinations, either:

- could seriously jeopardize the patient's life or health or the ability to regain maximum function; or
- in the opinion of a physician with knowledge of the patient's medical condition, would subject the patient to severe pain that cannot be adequately managed without the care or treatment that is the subject of the claim.

An individual acting on behalf of the Plan, applying the judgment of a prudent layperson who has an average knowledge of health and medicine, can determine whether the urgent care definition has been satisfied. However, if a physician with knowledge of the patient's medical condition determines that the claim involves urgent care, it must be treated as such.

"Pre-Service Claims" – Any non-urgent request for benefits or for a determination, where the receipt of the benefit is conditioned, in whole or in part, on the Claim's Administrator's approval of the benefit in advance of obtaining medical care.

"Post-Service Claims" – Any claim for benefits that is not an urgent care claim or a pre-service claim. A post-service claim is considered to be filed when the Claims Administrator has been notified that a service has been rendered or furnished to you. Such notification must include full details of the service received, including your name, age, sex, identification number, the name and address of the provider, an itemized statement of the service rendered or furnished, the date of the service, the diagnosis, the claim charge, and any other information that the Claims Administrator may request in connection with services rendered to you.

Claim Notification Time-Frames

Urgent Care Claims (adverse or not) will be decided as soon as possible, but in no event later than 72 hours from receipt of the claim. The Plan will defer to the attending Physician or Provider with respect to the decision as to whether a claim constitutes "urgent care." If the claim is incomplete, so that a determination cannot be made of whether benefits are covered or payable under the Plan, the Claims Administrator will notify you within 24 hours of receipt of the claim of the information needed to complete the claim. You then have 48 hours to provide the information. Once the additional information is received by the Claims Administrator, the claim will be decided within 48 hours of the earlier of:

(1) the Plan's receipt of the specified information; or
(2) the end of the period afforded to you to provide the specified additional information.

Concurrent Care Decisions to reduce or terminate ongoing treatment will be communicated in writing or electronically to you far enough in advance to give you time to appeal and obtain a determination on review before the benefit is reduced. Any request that you may make to extend the treatment beyond the Plan-specified time or number of treatments will be decided within 24 hours of receipt of your request by the Plan. However, you must make the request to extend treatment at least 24 hours before the scheduled termination or reduction in treatment. Any decision by the Plan will be conveyed to you either in writing or electronically.

Pre-service Claims (adverse or not) will be decided within 15 days of receipt. This determination period may be extended one time for 15 days for reasons beyond the Plan's control, but the Plan will notify you in writing or electronically of the circumstances causing the delay and the date a determination is expected. If the extension is due to a faulty claim, the notice of extension will describe the needed information and provide you at least 45 days from receipt of the notice to provide the necessary information.

Post-service Claims Denials will be decided and communicated to you in writing or electronically within 30 business days of receipt of the claim. This determination period may be extended one time for 15 business days for reasons beyond the Plan's control, in which case the Plan will notify you in writing or electronically within the first 30-day period of the circumstances requiring an extension and the expected date of a decision. If the extension is due to a faulty claim, the notice of extension will describe the needed information and provide you at least 45 days from receipt of the notice to provide the necessary information.

NOTICE OF ADVERSE BENEFIT DETERMINATIONS

Adverse Benefit Determination

An "adverse benefit determination" is a denial, reduction, or termination of, or a failure to provide or make payment (in whole or in part) for, a benefit, including any such denial, reduction, termination, or failure to provide or make payment for a benefit resulting from the application of utilization review, as well as a failure to cover an item or service for which benefits are otherwise provided because it is determined to be experimental or investigational or not medically necessary or appropriate. If an ongoing course of treatment had been approved by the Claims Administrator and the Claims Administrator reduces or terminates such treatment before the end of the approved treatment period, that is also an adverse benefit determination. A rescission of coverage is also an adverse benefit determination; provided, however, that a rescission does not include a termination of coverage related to non-payment of premium. In addition, an adverse benefit determination includes a determination that an admission, availability of care, continued stay, or other health care service that is a covered service has been reviewed and, based upon the information provided, does not meet the Plan's requirements for medical necessity, appropriateness, health care setting, level of care, or effectiveness, and the requested service or payment for the service is therefore denied, reduced or terminated.

You will be given written or electronic notice of any adverse benefit determination on your claim. The notice will set forth:

- Information sufficient to identify the claim involved, including the date of service, the healthcare provider, the claim amount (if applicable), and a statement describing the availability, upon request, of the diagnoses and treatment codes (along with the corresponding meaning of those codes.)

- the specific reasons for denial, including a description of the Plan's standard, if any, used in denying the claim;
- reference to the specific plan provisions on which the decision is based;
- a description of any additional material or information needed for you to perfect the claim and an explanation of why the material or information is needed;
- any specific internal rule, guideline, protocol or other similar criterion the decision-maker relied upon in making the adverse benefit determination, and that a copy of the rule, guideline, etc., will be provided free, if you request a copy;
- if the decision is based on a medical necessity and appropriate or experimental treatment or similar exclusion or limitation, an explanation of the scientific or clinical judgment, or a statement that the explanation will be provided free, if you request a copy;
- if the request involves an urgent care decision, a description of the applicable expedited review process;
- provide the code assigned to the reason for the denial, the meaning of the code, and a description of the standard that was used in denying the claim (if any);
- describe the internal appeals procedures and external review processes for Medical Plan benefits, including information about how to initiate an appeal; and
- include contact information for any applicable office of health insurance consumer assistance or ombudsman that is available to help you with the appeals process.

When an urgent care decision is involved, information may be provided orally initially, but will be provided in writing or electronically within three days of the oral notice.

ASSIGNING PAYMENT OF HEALTH CARE BENEFITS

You may authorize the Claims Administrator to make payments directly to providers for covered services. However, the Claims Administrator reserves the right to make payments directly to you. Once a provider performs a covered service, the administrator will not honor a request to withhold payment of the claims submitted. Payments may also be made to an alternate recipient or that person's custodial parent or designated representative. Any payments made by the administrator fulfill all obligations of the Plan and/or the Plan sponsor to pay for covered services.

However, except as pursuant to an agreement between you and Meridian Health or as otherwise required by applicable law, your benefits under the Plan are not in any way subject to you or your dependents' debts and may not be voluntarily sold, transferred, alienated or assigned.

APPEAL PROCEDURE - MEDICAL

YOUR RIGHT TO APPEAL A CLAIM

The Plan maintains an appeal procedure for the resolution of disputes arising between covered persons and the Plan regarding adverse determinations.

Pursuant to your appeal, you are entitled to receive free, upon request, access to and copies of all documents, records and other information relevant to the claim. You also will receive a review that takes into account all comments, documents, records and other claim-related information. The review will be conducted by an individual(s) who is neither the individual who made the initial denial nor the subordinate of such individual.

If you wish to appeal an adverse determination, you have 180 days from the time you are notified to request a review. Problems as to claims between you and the Plan should generally be dealt with through the post-service appeal procedures listed below. If you have an urgent or pre-service appeal, refer to the appeals sections below for more detailed information on the types of appeals and the process for requesting a review.

Mail Stage 1 and Stage 2 Appeals to:
QualCare, Inc. **P.O. Box 249** **Piscataway, NJ 08855-0249** **Plan Hotline: 1-800-992-6613**

APPEAL OF AN ADVERSE BENEFIT DETERMINATION

Stage 1 Appeal: Internal. If you wish to appeal in writing an Adverse Benefit Determination decision, you may submit a Stage 1 claim appeal. The Claims Administrator or a representative of the Claims Administrator will consult with a health care professional, if necessary, who will neither be an individual who was consulted in connection with the initial decision nor the subordinate of any such individual. Upon request, you will be provided the identity of any medical or vocational experts whose advice was obtained on behalf of the Plan, regardless of whether the advice was relied on to make the initial decision. The Plan representative will review your appeal, make a determination on that appeal and communicate its decision to you or your representative as described below:

- **Urgent care claims**. The Plan will notify you as to its determination of a claim involving urgent care as soon as possible but not later than 72 hours after receipt of the claim by the Plan. This is so whether or not the determination is adverse and will take into account the medical exigencies. In the event that there is insufficient information to process the claim, you will be notified, no later than 24 hours after receipt of the claim, of the need for additional information to process it. You will have 48 hours from the date of such notice to provide the requested information. Failure to provide the necessary information within the 48-hour period described above may result in the denial of the claim. For urgent care benefit claims, there is only one level of appeal.

- **Pre-service claims**. Decisions on review of pre-service claims will be made and communicated as soon as reasonably possible, but in all cases within 15 days of the Plan's receipt of the claim.
- **Post-service claims**. Decisions on review of post-service claims will be made and communicated as soon as reasonably possible, but in all cases within 30 days of the Plan's receipt of the claim.

You will be permitted to review the claim file and to present evidence and written testimony as part of the internal claim appeal process. You will be provided, free of charge, any new or additional evidence or rationale considered, relied upon, or generated by the Plan in connection with the claim. Such evidence or rationale will be provided as soon as possible and sufficiently in advance of the date in which any notice of final internal adverse benefit determination is made in order to give you a reasonable opportunity to respond prior to such final determination.

The Plan will see to it that all claims/appeals are adjudicated in a manner designed to ensure the independence and impartiality of the persons involved in making the decisions.

Upon request, the Plan will provide you notice of available internal claims and appeals and external review procedures in a culturally and linguistically appropriate manner, if applicable. Any notice given subsequent to such request shall be made in the same manner.

The Plan will provide you with continued coverage pending the outcome of an internal appeal.

Stage 2 Appeal: Internal. If you wish to appeal the Stage 1 Appeal decision, you may do so in writing within 180 days of denial of your Stage 2 Appeal. The same process applicable to a Stage 1 Appeal applies. A decision will be sent to you or your representative in writing within 15 days for pre-service claims and 30 days for post-service claims from receipt of the Stage 2 Appeal. If the Stage 2 Appeal is denied, then you and/or your provider will be provided with written notification of the denial and the reasons for the denial and an explanation outlining your right to proceed to an External Review Process and a description of that process.

NOTIFICATION OF BENEFIT DETERMINATION ON APPEAL

The Claims Administrator's notice of an adverse benefit determination on appeal will include:

- Information sufficient to identify the claim involved, including the date of service, the healthcare provider, the claim amount (if applicable), and a statement describing the availability, upon request, of the diagnoses and treatment codes (along with the corresponding meaning of those codes.)

- the specific reason or reasons for such adverse determination;

- reference to the specific Plan (or medical coverage option) provisions on which the determination is based;

- a statement that you are entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the claim;

- any specific internal rule, guideline, protocol or other similar criterion the decision-maker relied upon in making the adverse benefit determination, and that a copy of the rule, guideline, etc., will be provided free, if you request a copy;

- if the adverse benefit determination was based on medical necessity or experimental treatment, either an explanation of the scientific judgment for the adverse determination, applying the terms of the Plan (or medical coverage option) to your circumstances, or a statement that such explanation will be provided free of charge upon request;

- a description of the standard that was used in denying the claim, including the denial code and its corresponding meaning, and a discussion of the decision;

- an explanation of the Plan's external review processes (and how to initiate an external review) and a statement of your right to bring a civil action under Section 502(a) of ERISA following a final denial; and

- contact information for any applicable office of health insurance consumer assistance or ombudsman.

If the Claims Administrator's decision is to continue to deny or partially deny your claim or you do not receive timely decision, you may be able to request an external review of your claim by an independent third party, who will review the denial and issue a final decision. Your external review rights are described in the Section *External Review Process* below.

If You Need Assistance

If you have any questions about the claims and appeals procedures, write or call the Claims Administrator at the numbers set forth in the Section *General Plan Information*.

If you need assistance with the internal claims and appeals or the external review processes that are described below, you may contact the health insurance consumer assistance office or ombudsman. For questions about your appeal rights or for assistance, you can contact the Employee Benefits Security Administration at 866-444-EBSA (3272).

EXTERNAL REVIEW PROCESS.

You may make a request to have an independent review organization ("IRO") conduct a standard external review or expedited external review of an adverse benefit determination or final internal adverse benefit determination. For purposes of the external review procedures described below, a "final internal adverse benefit determination" means an adverse benefit determination that has been upheld by the Claims Administrator at the completion of the internal claims and appeals process described above.

Standard External Review

- *Request for external review*. You may file a request for standard external review within four (4) months after the date of receipt of a notice of an adverse benefit determination or final internal adverse benefit determination from the Claims Administrator. If there is no corresponding date four (4) months after the date of receipt of such a notice, then the request must be filed by the first day of the fifth month following the receipt of the notice. For example, if the date of receipt of the notice is October 30, because there is no February 30, the request must be filed by March 1. If the last filing date would fall on a Saturday, Sunday, or Federal holiday, the last filing date is extended to the next day that is not a Saturday, Sunday, or Federal holiday.

- *Preliminary review*. Within five business days following the date of receipt of the external review request, the Claims Administrator will complete a preliminary review of the request to determine whether:

    - You are, or were, covered under the Plan at the time the health care item or service was requested or, in the case of a retrospective review, were covered under the Plan at the time the health care item or service was provided;

    - The adverse benefit determination or the final adverse benefit determination involves either medical judgment or a rescission of coverage (whether or not the rescission has any effect on any particular benefit at the time);

    - You have exhausted the internal appeals process, unless you are not required to exhaust the internal appeals process under the interim final regulations. Please refer to the Section *Exhaustion* below for additional information about exhaustion of the internal appeal process; and

    - You have provided all the information and forms required to process an external review.

      You will be notified within one (1) business day after the Claims Administrator completes the preliminary review if your request is eligible for external review, or if further information or documents are needed. You will have the remainder of the four-month period described above (or 48 hours following receipt of the notice, if later) to perfect your request for external review.

      If your claim is not eligible for external review, the Claims Administrator will outline the reasons it is ineligible in the notice and will provide contact information for the Department of Labor's Employee Benefits Security Administration.

- *Referral to Independent Review Organization*. If you submit your request for external review within the four-month time period described above and your claim is eligible for external review, the Claims Administrator will assign the matter to an IRO. The IRO assigned will be accredited by URAC or by a similar nationally-recognized accrediting organization, and the IRO will not be eligible for any financial incentives based on the likelihood that it will support the denial of benefits. In addition, the Claims Administrator has taken administrative steps to ensure independence in the external review process, such as using unbiased methods for selecting IROs to review claims.

  When your request for external review is eligible and assigned to an IRO, the following procedures will apply:

    - The IRO will utilize legal experts where appropriate to make coverage determinations under the Plan.

    - The IRO will timely notify you, in writing, that your request for external review is eligible and has been accepted for external review. This notice will include a statement that you may submit in writing to the assigned IRO additional information within 10 business days following the date of receipt of the notice, and that the IRO will be required to consider this additional information when conducting the external review. The IRO may, but is not required to, accept and consider additional information submitted after 10 business days.

- Within five business days after the date of assignment of the IRO, the Claims Administrator will provide to the assigned IRO the documents and any information considered in making the adverse benefit determination or final internal adverse benefit determination.

  Failure by the Claims Administrator to timely provide the documents and information will not delay the IRO from conducting the external review. If the Claims Administrator fails to timely provide the documents and information, the assigned IRO may terminate the external review and make a decision to reverse the adverse benefit determination or final internal adverse benefit determination. Within one business day after making such a decision, the IRO will notify you and the Claims Administrator.

- Within one (1) business day of receiving any information submitted by you, the assigned IRO will forward the information to the Claims Administrator. Upon receipt of any such information, the Claims Administrator may reconsider its adverse benefit determination or final internal adverse benefit determination that is the subject of the external review.

  Reconsideration by the Claims Administrator will not delay the external review. The external review may be terminated as a result of the reconsideration only if the Claims Administrator decides, upon completion of its reconsideration, to reverse its adverse benefit determination or final internal adverse benefit determination and provide coverage or payment. Within one (1) business day after making such a decision, the Claims Administrator must provide written notice of its decision to you and the assigned IRO. The assigned IRO will terminate its external review upon receipt of the notice from the Claims Administrator that the Claims Administrator has decided to reverse its adverse benefit determination or final internal adverse benefit determination.

- The IRO will review all of the information and documents timely received. In reaching a decision, the assigned IRO will review the claim de novo and not be bound by any decisions or conclusions reached during the Claims Administrator's internal claims and appeals process. In addition to the documents and information provided, the assigned IRO, to the extent the information or documents are available and the IRO considers them appropriate, will consider the following in reaching a decision:

  - Your medical records.

  - The attending health care professional's recommendation.

  - Reports from appropriate health care professionals and other documents submitted by the Claims Administrator, you, or your treating provider.

  - The terms of the Plan to ensure that the IRO's decision is not contrary to the terms of the Plan, unless the terms are inconsistent with applicable law.

  - Appropriate practice guidelines, which must include applicable evidence-based standards and may include any other practice guidelines developed by the Federal government, national or professional medical societies, boards, and associations.

- Any applicable clinical review criteria developed and used by the Claims Administrator, unless the criteria are inconsistent with the terms of the Plan or with applicable law.

- The opinion of the IRO's clinical reviewer or reviewers after considering the information described above, to the extent the information or documents are available and the clinical reviewer or reviewers consider appropriate.

o The IRO will provide you and the Claims Administrator with written notice of the final external review decision within 45 days after the IRO receives the request for the external review.

The notice of final external review decision will include the following information:

- A general description of the reason for the request for external review, including information sufficient to identify the claim (including the date or dates of service, the health care provider, the claim amount (if applicable), the diagnosis code and its corresponding meaning, the treatment code and its corresponding meaning, and the reason for the previous denial).

- The date the IRO received the assignment to conduct the external review and the date of the IRO decision.

- References to the evidence or documentation, including the specific coverage provisions and evidence-based standards, considered in reaching its decision.

- A discussion of the principal reason or reasons for its decision, including the rationale for its decision and any evidence—based standards that were relied on in making its decision.

- A statement that the determination is binding except to the extent that other remedies may be available under State or Federal law to either you or the Claims Administrator.

- A statement that judicial review may be available to you.

- Current contact information, including phone number, for any applicable office of health insurance consumer assistance or ombudsman that may be available to assist you.

o After a final external review decision, the IRO will maintain records of all claims and notices associated with the external review process for six (6) years. The IRO will make such records available for examination by you, the Claims Administrator, or State or Federal oversight agency upon request, except where such disclosure would violate State or Federal privacy laws.

▪ *Reversal of decision*. Upon receipt of a notice of a final external review decision reversing the adverse benefit determination or final internal adverse benefit determination, the Claims Administrator immediately must provide coverage or payment (including immediately authorizing or immediately paying benefits) for the claim.

Expedited External Review

- *Request for expedited external review*. You may make a request for an expedited external review with the Claims Administrator at the time you receive one of the following:

    - An adverse benefit determination that involves a medical condition for which the timeframe for completion of an expedited internal appeal would seriously jeopardize your life or health or would jeopardize your ability to regain maximum function, provided that you have already filed a request for an expedited internal appeal.

    - A final internal adverse benefit determination that involves a medical condition for which the timeframe for completion of a standard external review would seriously jeopardize your life or health or would jeopardize your ability to regain maximum function, or if the final internal adverse benefit determination concerns an admission, availability of care, continued stay, or health care item or service for which your received emergency services, but you have not been discharged from a facility.

- *Preliminary review*. Immediately upon receipt of the request for expedited external review, the Claims Administrator will complete a preliminary review to determine whether the request meets the reviewability requirements set forth in the Section *Standard External Review* above. The Claims Administrator will immediately send you a notice of its eligibility determination that meets the requirements set forth in the Section *Standard External Review* above.

- *Referral to Independent Review Organization*. Upon a determination that a request is eligible for external review following the preliminary review, the Claims Administrator will assign an IRO pursuant to the requirements set forth in the Section *Standard External Review* above.

  The Claims Administrator will provide or transmit all necessary documents and information considered in making the adverse benefit determination or final internal adverse benefit determination to the assigned IRO electronically or by telephone or facsimile or any other available expeditious method. The assigned IRO, to the extent the information or documents are available and the IRO considers them appropriate, will consider the information or documents described above under the procedures set forth in the Section *Standard External Review*. In reaching a decision, the assigned IRO will review the claim de novo and is not bound by any decisions or conclusions reached during the Claims Administrator's internal claims and appeals process.

- *Notice of final external review decision*. The IRO will provide notice of the final external review decision, in accordance with the content requirements set forth in the Section *Standard External Review*, as expeditiously as your medical condition or circumstances require, but in no event more than 72 hours after the IRO receives the request for an expedited external review. If the notice is not in writing, within 48 hours after the date of providing that notice, the assigned IRO will provide written confirmation of the decision to you and the Claims Administrator.

EXHAUSTION REQUIREMENT

For standard internal appeals, you have the right to request external review once the internal appeals process has been completed and you have received a final internal adverse benefit determination. For expedited internal appeals, you may request external review simultaneously with your request for an

expedited internal appeal. The IRO will determine whether or not your request is appropriate for expedited external review or if the expedited internal appeals process must be completed before external review may be requested.

External review may not be requested for an adverse benefit determination involving a post-service claim until the internal appeals process has been exhausted. You will be deemed to have exhausted the internal appeals process and may request external review if the Claims Administrator waives the internal appeals process or the Claims Administrator has failed to comply with the internal claims and appeals process.

You may not bring a lawsuit to recover benefits under the Plan until you have exhausted the internal administrative process described above. Any participant or beneficiary can bring an action in connection with the Plan only in the District of New Jersey. No legal action may be commenced at all unless commenced no later than one year following the issuance of a final decision on the claim for benefits, or the expiration of the appeal decision period if no decision is issued. This one-year statute of limitations on suits for all benefits will apply in any forum where you may initiate such a suit.

ADMINISTRATIVE (NON-BENEFIT) APPEALS

The Plan also has a procedure for resolving disputes between you and the Plan regarding administrative, i.e., non-benefit-related matters. An example of such matters is eligibility determinations. Direct your initial inquiry to the Plan Administrator. If you are dissatisfied with the response to your inquiry, you may appeal in writing to the Plan Administrator for an Administrative Appeal review. Presentation of a complaint should be in writing and may include written information from you or any other party in interest. This should be done as soon as possible but in no event later than 180 days from the date of the inquiry. A Plan representative will review your appeal/grievance and respond in writing within 30 days.

COORDINATION OF BENEFITS

Coordination of health benefit plans. This Plan was developed to provide necessary care for our Team Members and their dependents. Some of our Team Members, and/or their dependents may be covered by this Plan and another group health care plan. In this case, the Plan may pay only a portion of the expense. This is commonly referred to as Coordination of Benefits. Coordination of Benefits refers to the set of rules when two or more plans cover charges incurred by a Covered Person. This coordination of benefits provision does not apply under the Plan for outpatient prescription medications. Therefore this Plan will not coordinate benefits when a member has primary coverage under another plan for outpatient prescription medications. To be sure that all Plans covering you and your dependents are considered, please make sure to contact the Meridian HR Support Services Team when there is a change in your personal information.

When this Plan is Primary, benefits will be determined without regard to what any other plan covering you, or your dependent, will pay.

When this Plan is the secondary payor, it will pay the difference between the actual charge (less any provider discount or contracted amount*) and what the primary plan pays. However, the amount this Plan will pay as a secondary payor will never be more than it would pay if it were the primary payor. The combination of benefits paid by all of the plans covering any one person will not be more than the actual charge.

*In the case of a managed care plan, this Plan will not consider any charges in excess of what the contracted participating provider has agreed to accept as payment in full for either the primary or secondary plans.

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

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

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

In the case of a network plan: This Plan will not consider any charges in excess of what a network provider has agreed to accept as payment in full. Also, when a network plan is primary and the Covered Person does not use a network provider, this Plan will not consider as an allowable charge any charge that would have been covered by the network plan had the Covered Person used the services of a network provider.

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

Automobile limitations. When medical payments are available under vehicle insurance, the Plan will be secondary payor to your no-fault or other medical coverage through your auto insurance, unless you elect this plan as your primary payor. As a secondary payor, this plan will pay any deductible or co-insurance amounts. However, under no circumstances will this plan pay more as secondary payor than it would have paid as primary payor. Plan payments as secondary payor are subject to the rules and restrictions for all benefits as described in this booklet. See *Third Party Recovery Provision* Section for other rules that also apply.

Benefit plan payment order. When two or more plans provide benefits for the same allowable charge, benefit payment will follow these rules.

(1) Plans that do not have a coordination provision, or one like it, will pay first. Plans with such a provision will be considered after those without one.

(2) Plans with a coordination provision will pay their benefits up to the Allowable Charge:

(a) The benefits of the plan that covers the person other than as a dependent (that is, as a Team Member, member or subscriber) ("Plan A") are determined before those of the plan which covers the person as a dependent ("Plan B").

(b) When a child is covered as a Dependent and the parents are not separated or divorced, these rules will apply:

i. The benefits of the benefit plan of the parent whose birthday falls earlier in a year are determined before those of the benefit plan of the parent whose birthday falls later in that year;

ii. If both parents have the same birthday, the benefits of the benefit plan which has covered the patient for the longer time are determined before those of the benefit plan which covers the other parent.

(c) When a child's parents are divorced or legally separated, these rules will apply:

i. This rule applies when the parent with custody of the child has not remarried. The benefit plan of the parent with custody will be considered before the benefit plan of the parent without custody.

ii. This rule applies when the parent with custody of the child has remarried. The benefit plan of the parent with custody will be considered first. The benefit plan of the stepparent that covers the child as a Dependent will be considered next. The benefit plan of the parent without custody will be considered last.

iii. This rule will be in place of items (i) and (ii) above when it applies. A court decree may state which parent is financially responsible for medical and dental benefits of the child. In this case, the benefit plan of that parent will be considered before other plans that cover the child as a Dependent.

iv. If the specific terms of the court decree state that the parents shall share joint custody, without stating that one of the parents is responsible for the health care expenses of the child, the plans covering the child shall follow the order of benefit determination rules outlined above when a child is covered as a Dependent and the parents are not separated or divorced.

(d) The benefits of a benefit plan that covers a person as a Team Member who is neither laid off nor retired are determined before those of a benefit plan that covers that person as a laid-off or Retired Team Member. The benefits of a benefit plan that covers a

person as a Dependent of a Team Member who is neither laid off nor retired are determined before those of a benefit plan that covers a person as a Dependent of a laid off or Retired Team Member. If the other benefit plan does not have this rule, and if, as a result, the plans do not agree on the order of benefits, this rule does not apply.

(e) The benefits of a benefit plan that covers a person as a Team Member who is neither laid off nor retired or a Dependent of a Team Member who is neither laid off nor retired are determined before those of a plan which covers the person as a COBRA beneficiary.

(f) If the above order of benefits does not establish which plan is the primary plan, the benefits of the plan that covers the individual for a longer period of time shall be determined before the benefits of the plan(s) that covered the person for a shorter period of time.

Coordination of Benefits with Medicare

If you or your dependent is eligible for Medicare, the coordination of your benefits works differently from the above rules. In the case of Medicare, each individual who is eligible for Medicare will be assumed to have full Medicare coverage (Part A and Part B), whether or not the individual actually enrolls for full coverage. Generally, the following rules apply if you or your dependent is eligible for Medicare:

- If you have active employee coverage under the Plan and you or your dependent is eligible for Medicare, the Plan will be primary (so Meridian will pay benefits for the Medicare eligible person before Medicare pays).
- If you have coverage under the Plan for a reason other than active employment (*e.g.*, COBRA coverage, retiree coverage, or coverage after the sixth month that you receive disability benefits) and you or your dependent is eligible for Medicare, Medicare will be primary (so it will pay benefits for the Medicare eligible person before Meridian pays).
- If you or your dependent has end-stage renal disease (ESRD) (i.e., on kidney dialysis or needing a kidney transplant), the Plan will be primary for the first 30 months of ESRD treatment (i.e., the 30-month period beginning with the month in which eligibility for Medicare benefits for ESRD begins). After the first 30 months, Medicare will pay primary.

In order to assist Meridian in complying with Medicare Secondary Payer laws, it is very important that you promptly and accurately complete any requests for information from the claims administrator or Meridian regarding your Medicare eligibility, or the Medicare eligibility of your spouse or your covered dependent children. In addition, if you, your spouse or your covered dependent child becomes eligible for Medicare, or has Medicare eligibility terminated or changed, please contact Meridian promptly to ensure that your claims are processed in accordance with applicable coordination of benefits rules.

If you have any questions about which rules fit your situation, contact the Claims Administrator or the Meridian HR Support Services Team.

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

Right to receive or release necessary information. To make this provision work, this Plan may give or obtain needed information from another insurer or any other organization or person. This information may be given or obtained without the consent of or notice to any other person. A 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.

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

THIRD PARTY RECOVERY PROVISION

RIGHT OF SUBROGATION AND REIMBURSEMENT

When this provision applies. The Covered Person may incur medical or dental charges due to injuries that 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 that third party, or insurer, for payment of the medical or dental charges. Accepting benefits under this Plan for those 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:

(1) automatically assigns to the Plan his or her rights against any third party or insurer when this provision applies; and

(2) must repay to the Plan the benefits paid on his or her behalf out of the recovery made from the third party or insurer.

Amount subject to subrogation or refund. The Covered Person agrees to recognize the Plan's right to subrogation and reimbursement. These rights provide the Plan with a priority over any funds paid by a third 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, or other costs and expenses.

Notwithstanding its priority to funds, the Plan's subrogation and refund rights, as well as the rights assigned to it, are limited to the extent to which the Plan has made, or will make, payments for medical or dental charges as well as any costs and fees associated with the enforcement of its rights under the Plan. However, the Plan's right to subrogation still applies if the recovery received by the Covered Person is less than the claimed damage, and, as a result, the claimant is not made whole.

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 make payments. In addition, the Covered Person will do nothing to prejudice the right of the Plan to subrogate.

Defined terms: "Recovery" means 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 or dental charges covered by the Plan.

"Subrogation" means the Plan's right to pursue the Covered Person's claims for medical or dental charges against the other person.

"Reimbursement" means repayment to the Plan for medical or dental benefits that it has paid toward care and treatment of the Injury or Sickness.

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

CONTINUATION COVERAGE RIGHTS UNDER COBRA

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

The Plan Administrator has delegated responsibility for administering COBRA continuation coverage to the COBRA Administrator. Complete instructions on COBRA, as well as election forms and other information, will be provided by the COBRA Administrator to Plan Participants who become Qualified Beneficiaries under COBRA.

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

Who can become a Qualified Beneficiary? In general, a Qualified Beneficiary can be:

i. Any individual who, on the day before a Qualifying Event, is covered under a Plan by virtue of being on that day either a covered Team Member, the Spouse, Civil Union Partner, or Domestic Partner of a covered Team Member, or a Dependent child of a covered Team Member. If, however, an individual is denied or not offered coverage under the Plan under circumstances in which the denial or failure to offer constitutes a violation of applicable law, then the individual will be considered to have had the Plan coverage and will be considered a Qualified Beneficiary if that individual experiences a Qualifying Event.

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

iii. A covered Team Member who retired on or before the date of substantial elimination of Plan coverage which is the result of a bankruptcy proceeding under Title 11 of the U.S. Code with respect to the Employer, as is the Spouse, Civil Union Partner, or Domestic Partner, surviving Spouse, Civil Union Partner, or Domestic Partner or Dependent child of such a covered Team Member if, on the day before the bankruptcy Qualifying Event, the Spouse, Civil Union Partner, or Domestic Partner, surviving Spouse, Civil Union Partner, or Domestic Partner or Dependent child was a beneficiary under the Plan.

An individual is not a Qualified Beneficiary if the individual's status as a covered Team Member is attributable to a period in which the individual was a nonresident alien who received from the individual's Employer no earned income that constituted income from sources within the United States. If, on account of the preceding reason, an individual is not a Qualified Beneficiary, then a Spouse, Civil Union Partner, or Domestic Partner or Dependent child of the individual will also not be considered a Qualified Beneficiary by virtue of the relationship to the individual.

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

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

i. The death of a covered Team Member.

ii. The termination (other than by reason of the Team Member’s gross misconduct), or reduction of hours, of a covered Team Member’s employment.

iii. The divorce or legal separation of a covered Team Member from the Team Member’s Spouse or the dissolution of the Team Member’s Civil Union or Domestic Partnership.

iv. A covered Team Member becomes entitled to Medicare.

v. A Dependent child's ceasing to satisfy the Plan's requirements for a Dependent child (for example, attainment of the maximum age for dependency under the Plan).

vi. A proceeding in bankruptcy under Title 11 of the U.S. Code with respect to an Employer from whose employment a covered Team Member retired at any time.

If the Qualifying Event causes the covered Team Member, or the covered Spouse, Civil Union Partner, or Domestic Partner or a Dependent child of the covered Team Member, to cease to be covered under the Plan under the same terms and conditions as in effect immediately before the Qualifying Event (or in the case of the bankruptcy of the Employer, any substantial elimination of coverage under the Plan occurring within 12-months before or after the date the bankruptcy proceeding commences), the persons losing such coverage become Qualified Beneficiaries under COBRA if all the other conditions of COBRA are also met.

Taking leave under the Family and Medical Leave Act of 1993 ("FMLA") does not constitute a Qualifying Event. A Qualifying Event will occur, however, if a Team Member does not return to employment at the

end of the FMLA leave and all other COBRA continuation coverage conditions are present. If a Qualifying Event occurs, it occurs on the last day of FMLA leave and the applicable maximum coverage period is measured from this date (unless coverage is lost at a later date and the Plan provides for the extension of the required periods, in which case the maximum coverage date is measured from the date when the coverage is lost). Note that the covered Team Member and family members will be entitled to COBRA continuation coverage even if they failed to pay the Team Member portion of premiums for coverage under the Plan during the FMLA leave.

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

What is the election period and how long must it last? The election period is the time period within which the Qualified Beneficiary can elect COBRA continuation coverage under the Plan. The election period must begin not later than the date the Qualified Beneficiary would lose coverage on account of the Qualifying Event and must not end before the date that is 60 days after the later of the date the Qualified Beneficiary would lose coverage on account of the Qualifying Event or the date notice is provided to the Qualified Beneficiary of her or his right to elect COBRA continuation coverage.

Is a covered Team Member or Qualified Beneficiary responsible for informing the COBRA Administrator of the occurrence of a Qualifying Event?

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

- the end of employment or reduction of hours of employment,
- death of the Team Member,
- commencement of a proceeding in bankruptcy with respect to the employer, or
- enrollment of the Team Member in any part of Medicare.

IMPORTANT:

For the other Qualifying Events (divorce or legal separation of the Team Member and Spouse or dissolution of the Team Member's Civil Union or Domestic Partnership or a dependent child's losing eligibility for coverage as a dependent child), you or someone on your behalf must notify the Plan Administrator or its designee <u>in writing</u> within 60 days after the later of the date the Qualifying Event occurs or the date you would lose coverage due to the Qualifying Event, using the procedures specified below. If these procedures are not followed or if the notice is not provided <u>in writing</u> to the Meridian HR Support Services Team during the 60-day notice period, any Spouse, Civil Union Partner, or Domestic Partner or Dependent child who loses coverage will not be offered the option to elect continuation coverage. You must send this notice to HR Support Services or its designee.

NOTICE PROCEDURES:

Any notice that you provide must be ***in writing***. Oral notice, including notice by telephone, is not acceptable. You must mail, fax or hand-deliver your notice to the person, department or firm.

If mailed, your notice must be postmarked no later than the last day of the required notice period. Any notice you provide must state:

- the ***name of the plan or plans*** under which you lost or are losing coverage,
- the ***name and address of the Team Member*** covered under the plan,
- the ***name(s) and address(es) of the qualified beneficiary(ies)***, and
- the ***qualifying event*** and the ***date*** it happened.

If the qualifying event is a ***divorce or legal separation or dissolution of a Civil Union or Domestic Partnership***, your notice must include ***a copy of the divorce decree, the legal separation agreement, or other appropriate documentation***. There are other notice requirements in other contexts. See, for example, the discussion below under the heading entitled, *"**How does a Qualified Beneficiary become entitled to a disability extension?**"* That explanation describes other situations where notice from you or the qualified beneficiary is required in order to gain the right to COBRA coverage.

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

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

When may a Qualified Beneficiary's COBRA continuation coverage be terminated? During the election period, a Qualified Beneficiary may waive COBRA continuation coverage. Except for an interruption of coverage in connection with a waiver, COBRA continuation coverage that has been elected for a Qualified Beneficiary must extend for at least the period beginning on the date of the Qualifying Event and ending not before the earliest of the following dates:

i. The last day of the applicable maximum coverage period.

ii. The first day for which Timely Payment is not made to the Plan with respect to the Qualified Beneficiary.

iii. The date upon which the Employer ceases to provide any group health plan (including a successor plan) to any Team Member.

iv. The date, after the date of the election, that the Qualified Beneficiary first becomes covered under any other Plan that does not contain any exclusion or limitation with respect to any pre-existing condition, other than such an exclusion or limitation that does not apply to, or is satisfied by, the Qualified Beneficiary.

v. The date, after the date of the election that the Qualified Beneficiary first enrolls in the Medicare program (either part A or part B, whichever occurs earlier).

vi. In the case of a Qualified Beneficiary entitled to a disability extension, the later of:

a) 29-months after the date of the Qualifying Event, or the first day of the month that is more than 30 days after the date of a final determination under Title II or XVI of the Social Security Act that the disabled Qualified Beneficiary whose disability resulted in the Qualified Beneficiary's entitlement to the disability extension is no longer disabled, whichever is earlier; or

b) the end of the maximum coverage period that applies to the Qualified Beneficiary without regard to the disability extension.

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

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

What are the maximum coverage periods for COBRA continuation coverage? The maximum coverage periods are based on the type of the Qualifying Event and the status of the Qualified Beneficiary, as shown below.

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

ii. In the case of a covered Team Member’s enrollment in the Medicare program before experiencing a Qualifying Event that is a termination of employment or reduction of hours of employment, the maximum coverage period for Qualified Beneficiaries other than the covered Team Member ends on the later of:

a) 36-months after the date the covered Team Member becomes enrolled in the Medicare program; or

b) 18-months (or 29-months, if there is a disability extension) after the date of the covered Team Member's termination of employment or reduction of hours of employment.

iii. In the case of a bankruptcy Qualifying Event, the maximum coverage period for a Qualified Beneficiary who is the covered retiree ends on the date of the retiree's death. The maximum coverage period for a Qualified Beneficiary who is the covered Spouse, Civil Union Partner, or Domestic Partner, surviving Spouse, Civil Union Partner, or Domestic Partner or Dependent child of the retiree ends on the earlier of the Qualified Beneficiary's death or 36-months after the death of the retiree.

iv. In the case of a Qualified Beneficiary who is a child born to or placed for adoption with a covered Team Member during a period of COBRA continuation coverage, the maximum coverage period is the maximum coverage period applicable to the Qualifying Event giving rise to the period of COBRA continuation coverage during which the child was born or placed for adoption.

v. In the case of any other Qualifying Event than those described above, the maximum coverage period ends 36-months after the Qualifying Event.

Under what circumstances can the maximum coverage period be expanded? If a Qualifying Event that gives rise to an 18-month or 29-month maximum coverage period is followed by a second Qualifying Event that gives rise to a 36-month maximum coverage period within that 18- or 29-month period, the original period is expanded to 36-months, but only for individuals who are Qualified Beneficiaries at the time of both Qualifying Events. In no circumstance can the COBRA maximum coverage period be expanded to more than 36-months after the date of the first Qualifying Event. The Plan Administrator must be notified of the second Qualifying Event within 60 days of the second Qualifying Event. This notice must be sent to the **Meridian HR Support Services Team**.

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

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

Must the Plan allow payment for COBRA continuation coverage to be made in monthly installments? Yes. The Plan allows for payment only in monthly intervals.

What is Timely Payment for payment of COBRA continuation coverage? Timely Payment means a payment made no later than 30 days after the first day of the coverage period.

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

IF YOU HAVE QUESTIONS

If you have questions about your COBRA continuation coverage, you should contact **Meridian Health** 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 EBSA's Web site at www.dol.gov/ebsa.

KEEP YOUR PLAN ADMINISTRATOR INFORMED OF ADDRESS CHANGES

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

GENERAL PROVISIONS

PLAN ADMINISTRATOR. The Board of Trustees of Meridian Health, or its delegate, is responsible for designating the person, committee, or entity that will serve as the Plan Administrator. Currently, the Plan Administrator is the Senior Vice President of Human Resources. The Plan Administrator is the named fiduciary of the Plan for purposes of the Employee Retirement Income Security Act of 1974 ("ERISA"). The Plan Administrator may allocate or delegate certain functions as it deems appropriate. The day-to-day operation of the Plan is managed by QualCare, Inc., the Claims Administrator. The Claims Administrator has the discretionary authority to decide claims and appeals under the Plan.

Service of legal process may be made upon the Plan Administrator.

DUTIES AND AUTHORITY OF THE PLAN ADMINISTRATOR.

(1) To administer the Plan in accordance with its terms and consistent with applicable law. To establish, administer and enforce policies, interpretations, practices and procedures in connection with its duties.

(2) To make decisions and determinations regarding the interpretation or application of the Plan and Plan provisions, and to decide all other matters arising with respect to the Plan's administration and operation, including factual issues and the right to remedy possible ambiguities, inconsistencies or omissions.

(3) To determine the rights, eligibility, and benefits of Participants and beneficiaries under the Plan, including deciding disputes which may arise relative to a Plan Participant's rights. Benefits under this Plan will be paid only if the Plan Administrator, or its designee or delegate decides in its discretion that the applicant is entitled to them.

(4) To describe procedures for filing a claim for benefits and to review claim denials.

(5) To keep and maintain the Plan documents and all other records pertaining to the Plan.

(6) To appoint a Claims Administrator to pay claims.

(7) To perform all necessary reporting as required by ERISA.

(8) To establish and communicate procedures to determine whether a medical child support order is qualified under ERISA Sec. 609.

(9) To delegate to any person or entity such powers, duties and responsibilities as it deems appropriate.

PLAN ADMINISTRATOR COMPENSATION. The Plan Administrator serves **without** compensation; however, all expenses for plan administration, including compensation for hired services, will be paid by the Plan Sponsor.

AMENDING AND TERMINATING THE PLAN. The Employer expects to continue the Plan, but necessarily reserves the right at any time, by or pursuant to written action of its Board of Trustees, or its delegate, to amend or terminate the Plan in any and all respects including without limitation, the right to amend the Plan to reduce, change, eliminate and/or modify the type or amount of coverage or benefits

provided to any class of Covered Persons receiving or entitled to receive benefits, including the cost of benefits to such individual, without prior notice to such individuals. Upon termination of the Plan, all elections relating to the plan will terminate, and reimbursements and payments with respect to Plan benefits will be made only with respect to Claims for expenses incurred on or prior to the date of the Plan's termination.

PLAN FUNDING AND PAYMENT OF BENEFITS. Plan benefits are paid from the general assets of the Employer and contributions made by the covered Team Members. The level of any Team Member contributions will be set by the Plan Administrator. Benefits are generally paid through the Claims Administrator.

PLAN IS NOT AN EMPLOYMENT CONTRACT. The Plan is not to be construed as a contract for or of employment.

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

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

STATEMENT OF ERISA RIGHTS

YOUR RIGHTS UNDER ERISA

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

Receive Information about Your Plan and Benefits
Examine, without charge, at the Plan administrator's office and at the other specified locations, such as worksites, all documents governing the Plan, including insurance policies and contracts, if any, and collective bargaining agreements, if any, 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 Employee Benefits Security Administration.

Obtain, upon written request to the Plan administrator, copies of documents governing the operation of the Plan, including insurance contracts, if any, and copies of the latest annual report (Form 5500 Series) and updated Summary Plan Description. The Plan administrator may make 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 Group Health Plan Coverage
Continued health care coverage for yourself, your spouse or Dependents if there is a loss of coverage under the Plan 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 on 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 with 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 a preexisting condition exclusion for 12 months (18 months for Late Enrollees) after your enrollment date in your coverage.

Prudent Actions by Plan Fiduciaries
In addition to creating rights for Plan participants, ERISA imposes duties upon the people who are responsible for the operation of the benefit 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 other Plan participants and beneficiaries. No one, including your Employer, your union, if any, 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.

Enforce Your Rights
Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request materials from the Plan and do not receive then within 30 days, you may file suit in federal court. In such a case, the court may require the Plan administrator to provide the materials and pay you up to $110 a day until you receive the materials, unless the materials are not sent because of reasons beyond the control of the Plan administrator.

If you have a claim for the benefits that is denied or ignored, in whole or in part, you may file a suit in a state or federal court. In addition, if you disagree with the Plan's decision or lack thereof concerning the qualified status of a medical child support money order, you may file suit in federal court. If it should happen that Plan fiduciaries misuse the Plan's money, or if you discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in federal court. The court will decide who should pay court costs and legal fees. If you are successful the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, for example, if it finds your claim frivolous.

Assistance with Your Questions
If you have any questions about the Plan, you should contact the Plan administrator. If you have any questions about this statement or about your rights under ERISA, or if you need assistance in obtaining documents from the plan administrator, you should contact the nearest office of the Employee Benefits Security Administration, U.S. Department of Labor, listed in your telephone directory or:

The Division of Technical Assistance and Inquiries
Employee Benefits Security Administration
U.S. Department of Labor
200 Constitution Avenue, N.W.
Washington, DC 20210

You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefits Security Administration.

GENERAL PLAN INFORMATION

TYPE OF ADMINISTRATION

The Plan is a self-funded health plan and the administration is provided through a third party Claims Administrator. The funding for the benefits is derived from the funds of the Employer and contributions made by covered Team Members. The Plan is not insured.

PLAN NAME

The Medical Plan is a component plan of the Welfare Benefit Plan of Meridian Health

PLAN NUMBER

501

TAX ID NUMBER:

223471515

PLAN YEAR:

January 1 - December 31

TYPE OF PLAN

Group Health Plan

EMPLOYER PLAN SPONSOR INFORMATION

Meridian Health
1350 Campus Parkway
Neptune, New Jersey 07753

PARTICIPATING EMPLOYERS

See Appendix A

PLAN ADMINISTRATOR

Senior Vice President of Human Resources, Meridian Health
1350 Campus Parkway
Neptune, New Jersey 07753

NAMED FIDUCIARY

Meridian Health
1350 Campus Parkway
Neptune, New Jersey 07753

AGENT FOR SERVICE OF LEGAL PROCESS

Meridian Health
1350 Campus Parkway
Neptune, New Jersey 07753

TYPE OF ADMINISTRATION

Contract Administration

CLAIMS ADMINISTRATOR

QualCare, Inc.
30 Knightsbridge Road
Piscataway, New Jersey 08855
1-800-992-6613

EnvisionRxOptions (Prescription Drug Benefits)
2181 E. Aurora Rd.
Twinsburg, OH 44087
1-800-361-4542

COBRA ADMINISTRATOR

CONEXIS
1-877-722-2667

APPENDIX A
LIST OF PARTICIPATING EMPLOYERS

EIN	Participating Employer
22-3471515	Meridian Hospitals Corporation
52-1772578	Meridian Nursing & Rehabilitation, Inc.
22-2715789	Bayshore Health Care Center, Inc.
52-1772578	The Willows at Holmdel
30-0107825	Meridian Health Foundation, Inc.
22-2731440	Meridian Home Care Services, Inc.
22-2581430	Health Innovations Unlimited
06-1755230	Meridian Pediatric Associates, P.C.
06-1755239	Meridian Obstetrics & Gynecology Associates, P.C.
06-1755233	Meridian Medical Associates, P.C.
77-0720131	Meridian Pediatric Surgical Associates, P.C.
06-1755228	Meridian Surgical Associates, P.C.
14-1981651	Meridian Trauma Associates, P.C.
14-1981647	Northern Monmouth County Medical Associates, P.C.
14-1981653	Northern Ocean County Medical Associates, P.C.
27-1412183	SOMC Medical Group, P.C.
22-3200147	Meridian Health Realty
22-2519699	Meridian Health Resources
22-3274755	Shore Rehabilitation Institute, Inc.
20-3411350	Health Village Imaging, L.L.C.
22-3468694	Allergy & Pediatrics Associates of New Jersey Shore, P.C.
22-3522954	Ear, Nose, Throat & Facial Plastic Surgery Associates, P.C.
22-3566714	Jersey Shore Associates in Internal Medicine of Marlboro, P.C.
22-3554900	Jersey Shore Bethany Pediatrics, P.C.
22-1892659	Jersey Shore Internal Medicine & Family Practice Associates, P.C.
22-3318056	Jersey Shore Medical Associates, P.C.
22-3607249	Jersey Shore Monmouth County Associates
22-3802205	Jersey Shore Monmouth Family Medicine Group, P.C.
22-3554905	Jersey Shore Navesink Pediatrics, P.C.
22-3668383	Jersey Shore Tinton Falls Medical Associates, P.C.
54-2074684	WLB Medical Associates, P.C.