

**College of Southern Maryland
Group Benefits Plan**

**Plan Document and
Summary Plan Description**

As Amended and Restated
Effective July 1, 2007

**COLLEGE OF SOUTHERN MARYLAND
GROUP BENEFITS PLAN**

**SUMMARY PLAN DESCRIPTION
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PREFACE

PLAN DOCUMENT FOR COLLEGE OF SOUTHERN MARYLAND GROUP BENEFITS PLAN

College of Southern Maryland Group Benefits Plan (hereafter called the "Plan") is a self-funded group benefit plan.

This Plan Document replaces all previous Plan Documents, Summary Plan Descriptions and their amendments.

The Plan is subject to all the terms, provisions and limitations stated on the following pages.

This revised Plan is effective as of 12:01 A.M. Eastern Standard Time on July 1, 2007.

INTRODUCTION

The College of Southern Maryland Group Benefits Plan (hereafter called the "Plan") is a self-funded group health plan and is designed to assist you and your family with the payment of medical and dental expenses.

This booklet is a Summary Plan Description. Using non-technical language, it describes your benefits under the Plan and will answer most of your questions. It contains a Schedule of Benefits, descriptions of the benefits listed in the Schedule, a list of the limitations of the Plan, definitions, instructions for filing claims and procedures on what to do if you have any problems with a claim.

The benefits and provisions of the Plan have been described as carefully as possible. A Table of Contents has been included to help you find the answers to your questions quickly. No one, including NCAS, can orally modify any Plan benefits or limitations. In order to fully understand your benefits and to avoid confusion, you and your family should read this booklet carefully and completely.

The Plan includes a Preferred Provider Organization (PPO) option depending on the employee's location. A PPO is a network of Hospitals and Physicians who render health care services to Participants. Employees will have a choice of obtaining medical services from a PPO (In-Network) or Non-PPO (Out-of-Network) provider. The In and Out-of-Networks differ in their payment schedule and claims filing procedures. In most instances, there is a lower deductible and a higher rate of reimbursement for services rendered by PPO providers. To take advantage of the lower deductibles and higher reimbursement, you must use a PPO provider.

Please contact the provider or the applicable PPO prior to receiving services to confirm the provider's participation in the PPO. Providers drop out of the PPO on occasion. In order to receive the network discounts and higher reimbursement, your provider must be in the network at the time the services are rendered.

Your Plan has a pre-admission/admission review requirement. If you or any family member are going to be or are admitted to a hospital, hospice, extended care facility, residential rehabilitation facility, or receive home health care or infertility treatment, the Managed Care Vendor must be notified.

If you do not notify the Managed Care Vendor prior to an admission, Covered Services will be reduced by \$200. Refer to Chapter V for additional information. The Managed Care Vendor and their telephone number are:

Nationwide Better Health: (800) 315-2031

If you have any questions, contact the Claims Administrator, NCAS. NCAS handles the day-to-day business of the Plan and will be glad to answer your questions. Their telephone number is **(866) 219-9292**.

Note Regarding HIPAA Privacy:

NCAS complies with the privacy requirements outlined in the Health Insurance Portability and Accountability Act, otherwise known as HIPAA. The HIPAA Privacy Regulations are designed to provide protection against the unauthorized use and disclosure of a patient's health information.

If you call with a question about a member's claim, NCAS is required to confirm that the caller can identify several key pieces of information about the claimant. In addition to the member's name, the caller will be required to provide three (3) of the following forms of identity:

- Membership number
- Member date of birth
- Member address
- Member phone number
- Member zip code

Under certain circumstances, a completed Personal Representative or Authorization form will be required for an adult member. Adult members include the employee, spouse, and dependent child age 18 and over. To find out more about these new HIPAA regulations and obtain forms, go to www.ncas.com on the Internet.

CHAPTER I
ELIGIBILITY

WHO IS ELIGIBLE?

Employee - All Active Employees, hired to work 10 months or more per year and regularly scheduled to work at least 35 hours per week on a full-time basis as determined by the Employer, and part-time employees of the Employer, hired to work 10 months or more per year, on the regular payroll of the Employer for that work, and regularly scheduled to work at least 20 hours per week on or subsequent to the effective date of this Plan, are eligible for the benefits described in this Plan.

The term employee also includes a person who is totally disabled if he or she qualifies for Social Security disability benefits, participated in the College of Southern Maryland Group Benefits Plan for two (2) full years prior to the disabling event or the duration of employment, whichever is shorter, and he or she will qualify for Medicare benefits within three (3) years of disability. During the period of time the employee's application for Medicare is pending, the employee may extend health plan benefits at the employee rate, contingent on providing medical evidence that he or she is unable to perform any kind of work due to the disability.

Retiree – Effective July 1, 2007, a retiree, who has retired from College of Southern Maryland, who meets the state retirement system eligibility requirements for service retirement, has at least 10 years of continuous employment with the College of Southern Maryland in a non-temporary, budgeted position at the time of retirement, is drawing a monthly retirement benefit and has participated in the Plan for five (5) full years prior to retirement (if he or she has changed from single to family coverage during that 5-year period, he or she is eligible for single retirement coverage only) will be eligible for the benefits described in this Plan. So as not to adversely impact employees who plan to retire within five years of July 1, 2007, this new requirement will be phased in as follows:

Retirement Date	Required # of years as a Plan Participant
July 2008	2
July 2009	2
July 2010	3
July 2011	4
July 2012	5

Such retirees are eligible for medical and prescription benefits at the same premium rate applied to active employees. Dental and vision benefits are excluded. Retirees and/or dependents who become eligible for Medicare must enroll for parts A and B of Medicare coverage.

Leased workers, temporary employees, and independent contractors are not eligible for the Plan. An employee on an authorized leave-of-absence, as required by the Family and Medical Leave Act of 1993, shall be classified as eligible.

If an employee qualifies as both an employee and a Dependent, such person may be covered as an employee or Dependent, but not as both. If both husband and wife are Employees, their children will be covered as Dependents of the husband or wife, but not of both.

Dependents - Eligible dependents are your:

- a. Spouse – A husband or wife under a legal marriage (who is neither divorced nor legally separated).
- b. Domestic partner;

- c. Unmarried dependent children under age 19 who are primarily dependent on the Participant for support;
- d. Unmarried dependent children age 19 and over, but under age 23, who are enrolled as a student in high school, or an educational organization listed on the Oryx Press publication, *Accredited Institutions of Post-Secondary Education*. A Student Certification form indicating Full-Time Student status must be signed by the Employee and received each semester by NCAS. A Full-Time student's coverage continues only between semester/quarters if the student is enrolled as a full-time student in the next regular semester/quarter. If the student is not enrolled as a full-time student, coverage will be terminated retroactively to the last day of the attended school term.
- e. Unmarried dependent children age 19 and over who are incapable of self-support because of mental retardation, mental illness, or physical incapacity that began before the child reached age 19 or 23 (if a full-time student). Proof of incapacity must be received by the Employer within 30 days after coverage would otherwise terminate. Additional proof of disability may be required from time to time;
- f. Any child of a participant who does not qualify as a dependent under subsections b,c, or d above, solely because the child is not primarily dependent upon the participant for support so long as over half of the support of the child is received by the child from the participant pursuant to a multiple support agreement.

A Spouse, domestic partner, or child who is on active duty in the armed forces of any country is not eligible for coverage.

Domestic Partner – To be recognized as domestic partners, both individuals must meet all of the following criteria:

- a. Both domestic partners must be unmarried.
- b. Domestic partners must have been in a mutually exclusive relationship for the last six (6) months, intending to do so indefinitely, and must share the same primary residence.
- c. Domestic partners must meet the age requirements for marriage in Maryland and be mentally competent to consent to contract.
- d. Domestic partners must not be related by blood to the degree prohibited in a legal marriage in the State of Maryland.
- e. Domestic partners must be jointly responsible for the common welfare of each other and share financial obligations. An Affidavit of Domestic Partnership from signed to that effect and proof of three (3) of the following must be submitted to the Human Resources Office:
 - A joint mortgage or lease.
 - Joint ownership of a motor vehicle, joint bank account, or joint credit account.
 - Domestic partner named as beneficiary of life insurance.
 - Domestic partner named as primary beneficiary in the employee's will.
 - Domestic partner assigned durable property or health care power of attorney.

Employees and their partners will be required to sign an Affidavit of Committed Partnership available through Human Resources.

Cost of Coverage for Domestic Partnerships – The Employer portion of the premium allocable to coverage for a Domestic Partner is taxable income to the Employee and will be included as part of W-2 compensation and the Employee's Domestic Partner's portion of the premium will be paid with after tax dollars.

The term "**dependent children**" means any of a Participant's:

- a. Natural children;
- b. Child of a domestic partnership;

- c. Legally adopted children who are under age 18 at the time of the adoption, or children placed in the Employee's home pending final adoption (provided the child is under age 18 at the time of the placement);
- d. Stepchildren who depend on you for support (only as long as a natural parent remains married to the Employee and also resides in the Employee's household);
- e. Foster children (provided the foster child is not a ward of the state);
- f. Children who are under the legal guardianship of the employee;
- g. Children for whom the Employee is required to provide health care coverage under a recognized Qualified Medical Child Support Order.

ENROLLMENT

HOW DO I ENROLL?

Employee - To become covered by the Plan, you must complete an Election Form. You should return the completed form to the Personnel/Human Resources Department within 30 days from your eligibility date.

When you enroll, you may select coverage for yourself and your Dependents. If you have eligible Dependents whom you want to enroll, you must select one of the Employee and Dependent options when you complete your enrollment application.

Special Enrollment Period: If you are declining enrollment for yourself or your Dependents (including your Spouse and Domestic Partner) because of other health insurance coverage, you may in the future be able to enroll yourself or your Dependents in this plan, provided that you request enrollment within 30 days after your other coverage ends.

An Employee (or Dependent) who is eligible but not enrolled is allowed to enroll in the Plan at a date later than the initial enrollment period, if:

- a. The Employee was covered under a health plan (including COBRA coverage) at the time coverage was initially offered;
- b. If required by the Plan Administrator, the Employee states in writing that the other coverage is the reason for declining enrollment;
- c. The other coverage that the Employee had was COBRA coverage and the COBRA coverage was exhausted;
- d. The coverage is other health plan coverage and it is terminated due to loss of eligibility:
 - 1) As a result of legal separation, divorce, death, cessation of dependent status (such as attaining the maximum age to be eligible as a dependent child under the plan), termination of employment, or reduction in the number of hours of employment or termination of employer contributions to the coverage and not due to failure to pay or termination of coverage for cause (such as making a fraudulent claim or an intentional misrepresentation of a material fact in connection with coverage under the plan);
 - 2) The other coverage the Employee had was offered through an HMO, or other arrangement (in the group or individual market) that does not provide benefits to individuals who no longer reside, live, or work in a service area and (in the case of group coverage through an HMO) no other benefit package is available to the individual;
 - 3) An individual incurs a claim that would meet or exceed a lifetime limit on all benefits.
 - 4) A plan no longer offers any benefits to a class of similarly situated individuals.

NOTE: When a loss of eligibility occurs, the Employee must request enrollment in writing within 30 days of exhaustion, termination of coverage or (in the case of the lifetime limit) of the date a claim is denied due to satisfaction of the lifetime limit.

- e. In addition, if you have a new Dependent as a result of marriage, birth, adoption, or Placement for Adoption, you may enroll yourself and your Dependents, provided that you request enrollment within 30 days after the marriage, birth, adoption or Placement for Adoption. Coverage will be effective:
 - 1) In the case of a marriage, on a date specified by the Plan Administrator that is not later than the first day of the first month beginning after the date the Employee

- submits an election form electing coverage for the Employee and/or Dependent(s) under the Plan;
 - 2) In the case of a Dependent's birth, the date of such birth;
 - 3) In the case of a Dependent's adoption or Placement for Adoption, the date of such adoption, or Placement for Adoption.
- f. A child who becomes an alternate beneficiary because of a recognized Qualified Medical Child Support Order is eligible to be added to the Plan provided that you request enrollment within 30 days.

Changing Status - If your employment status changes so that you are eligible to participate in the Plan, you must complete an enrollment form within 30 days of the date of eligibility.

New Dependents – A newborn, an adopted child, a child placed for adoption and a previously ineligible dependent who meets the eligibility requirements (i.e. an over-age dependent child is not a full-time student and then becomes a full-time student) are eligible to be added to the Plan.

Coverage for the new Dependent becomes effective on the date of eligibility provided that you request enrollment within 30 days.

See the section entitled Special Enrollment Period for further information.

Open Enrollment - Before the Plan Year begins, an open enrollment period shall be authorized to allow eligible employees to change their participation elections, to obtain new participation for the employee and/or eligible dependents, The open enrollment period shall be held before the Plan Year begins with an effective date of the following July 1st.

Re-Enrollment Provision - If an eligible employee takes FMLA leave, as defined by the Family and Medical Leave Act (FMLA), due to one or more of the following:

- a. Because of the birth of a son or daughter of the employee and in order to care for such son or daughter;
- b. Because of the placement of a son or daughter with the employee for adoption or foster care;
- c. In order to care for the spouse, or a son, daughter, or parent, of the employee, if such spouse, son, daughter, or parent has a serious health condition;
- d. Because of a serious health condition that makes the employee unable to perform the functions of the position of such employee;

and terminates his or her coverage in the Plan, he will be able to re-enroll in the Plan upon return to active employment at the conclusion of a period not to exceed that defined by the FMLA. This employee will **not** be subject to Pre-existing Waiting Period provisions. Refer to the DEFINITIONS (Chapter VI) under Family Medical and Leave Act.

Enrollment forms are obtainable from your Personnel/Human Resources Department.

Changing Coverage - You may change your election during the Plan Year if you experience any of the following Life Events:

- a. There is a change in employment status, including termination or commencement of employment of the employee, spouse, domestic partner, or dependent.
- b. The employee, spouse, domestic partner or dependent has a significant change in health coverage or cost of coverage attributable to employment (example: dependent switches from hourly to salaried employment and the dependent's employer's medical plan covers only salaried employees);
- c. There is a reduction or increase in hours of employment by the employee, spouse, domestic partner, or dependent, including a switch between part-time and full-time, a strike or lockout,

- or commencement or return from an unpaid leave of absence.
- d. There is a change in coverage of the spouse, domestic partner or dependent under other plans. (example: your spouse's employer has a cafeteria plan with an election period that is different from this Plan's annual election period. You may change your benefit elections to correspond to the changes elected by your spouse during his or her annual election period. Also, if your spouse's employer has a cafeteria plan that allows participants to make changes during a Plan Year, such as the ones permitted by this Plan, and your spouse makes one of those permitted changes, you may elect changes to your coverage under this Plan, as long as your change corresponds with the change made by your spouse. For example, if your spouse revokes his or her benefit election for a health plan offered by her employer because of the increase in cost, you could change your election under a health plan offered by this Plan to elect coverage for your spouse.
 - e. There is a change in legal marital status, including marriage, death of spouse, divorce, legal separation or annulment; or your domestic partner status changes through completion of the Affidavit of Domestic Partnership (as determined by the Employer), the death of your partner or the termination of your domestic partner status (as determined by the Employer);
 - f. There is a change in the number of dependents, including birth, adoption, placement for adoption, or death of a dependent.
 - g. Your dependent satisfies or ceases to satisfy the requirements for unmarried dependents, due to attainment of age, student status, or any similar circumstances as provided in the accident or health plan under which the employee receives coverage.
 - h. There is a change in the place of residence or work of the employee, spouse, domestic partner, or dependent.
 - i. There is a judgment, decree or order resulting from a divorce, legal separation, annulment, or change in legal custody (including a qualified medical child support order) that requires accident or health coverage for an employee's child. The employee can change his election to provide coverage for the child if the order requires coverage under the employee's plan; or, the employee can make an election change to cancel coverage for the child if the order requires the former spouse to provide coverage.
 - j. Eligibility for Medicare or Medicaid (other than pediatric vaccines).

The consistency rule requires that the change in status results in the employee, spouse, or dependent gaining or losing eligibility for accident or health coverage under either the cafeteria plan or an accident or health plan of the spouse's or dependent's employer; and that the election change corresponds with that gain or loss of coverage.

In addition to the above-noted Life Events, any other Life Events may be considered if permitted under a Flexible Benefit Plan (Section 125) and agreed to by the Plan Administrator.

When Can I Change or Cancel Enrollment? – You may change or cancel coverage in the Plan if you have an eligible Life Event change or during Open Enrollment. The Life Event must be permitted under a Flexible Benefit Plan (Section 125) and agreed to by the Plan Administrator.

You must contact the Human Resources Department to verify eligibility to change or cancel coverage and fill out the appropriate paperwork within 30 days.

Uniformed Service under USERRA – A Participant who is absent from employment with the Employer on account of being in “uniformed service” as that term is defined by the Uniformed Services Employment and Reemployment Rights Act of 1994 (“USERRA”) may elect to continue participation in the Plan. The coverage period shall extend for the lesser of 24 months or until the Participant fails to apply for reinstatement or to return to employment with the Employer. The Participant shall be responsible for making the required contributions during the period in which he is in “uniformed service.” The manner in which such payments are made shall be determined by the Plan Administrator in a manner similar to that of FMLA leave.

Military Leave Act – Notwithstanding anything in this Plan to the contrary, with respect to any Employee or Dependent who loses coverage under this Plan during the Employee's absence from employment by reason of military service, no Pre-Existing Condition exclusion or Waiting Period may be imposed upon the reinstatement of such Employee's or Dependent's coverage upon reemployment of the Employee unless such Pre-Existing Condition exclusion or Waiting Period would have otherwise applied to such Employee or Dependent had the Employee not been on military leave of absence.

EFFECTIVE DATE OF COVERAGE

WHEN DOES MY COVERAGE BECOME EFFECTIVE?

Employees and Their Eligible Dependents - The effective date of the eligible employee is on the **later** of the following dates:

- a. The Plan's effective date, July 1, 2007;
- b. The date the Waiting Period concludes.

The Waiting Period is the period from the date of employment until the first day of the month following the date of employment.

New Employees: New full-time employees who enroll in the Plan are eligible for coverage as indicated above. If you elect coverage for your Dependents when you enroll, their effective date will be the same as your effective date. Employees, who, because of an employment status change, are now eligible for coverage and who enroll in the Plan, are effective on the first day of eligibility.

New Dependents - If you acquire a new Dependent (birth, marriage or adoption) refer to the section entitled Special Enrollment Period. If a previously ineligible Dependent meets the eligibility requirements, refer to the section entitled How Do I Enroll.

If your current enrollment election already provides coverage for the Dependent without a change, coverage is in effect from the date of eligibility upon receipt of a new enrollment application.

Changing Coverage - If you qualify to add or drop a Dependent, you must complete a new enrollment application. Please contact the Personnel/Human Resources Department for the form. Coverage will become effective as explained above.

After your new enrollment application is received, processed and approved, you will receive a new identification card.

Pre-existing Waiting Period - A pre-existing condition is any condition (whether physical or mental), regardless of the cause of the condition, for which medical advice, diagnosis, care or treatment was recommended or received within the 3-month period ending on the Enrollment Date. Participants must satisfy a 12-month waiting period from the Enrollment Date before becoming eligible to receive benefits for pre-existing conditions.

This provision will not apply to newborns or children who are adopted or placed for adoption and enrolled in the plan within 30 days. Pregnancy is not considered a pre-existing condition.

If an employee or dependent has not satisfied the pre-existing condition waiting period of the Employer's plan in effect immediately prior to the effective date of this Plan, credit will be given for the period of time which elapsed while the Participant was covered by the prior plan.

The period of pre-existing condition exclusion will be reduced by prior periods of Creditable Coverage under another plan or health coverage applicable to the Participant as of the Enrollment Date, if such coverage was earned without a Significant Break in Coverage. The Participant must show proof of prior creditable coverage. A Certificate of Coverage may be used for this purpose.

TERMINATION

WHEN DOES MY COVERAGE TERMINATE?

Employee - Employee coverage shall automatically terminate immediately upon the earliest of the following dates, unless the covered Employee elects Continuation of Coverage:

- a. The last day of the month in which employment terminates;
- b. Except in the case of certain leaves of absence, the last day of the month in which the employee ceases to be eligible;
- c. The date this Plan is terminated (if Continuation of Coverage not available);
- d. The date the employee receives the maximum lifetime benefits provided by the Plan;
- e. With respect to any coverage requiring Participant contributions, and with respect to which Participant contributions are discontinued, the period for which the employee fails to make any required contribution;
- f. Except to the extent required by law, the day the covered employee enters the military of any country or international organization on a full-time active duty basis other than scheduled drills or other training not exceeding 1 month in any calendar year.

Dependent - Dependent coverage shall automatically terminate immediately upon the earliest of the following dates, unless the Employee or covered Dependent elects Continuation of Coverage:

- a. The day on which the Dependent ceases to be an eligible Dependent as defined in the Plan. When coverage ceases due to a dependent reaching a limiting age, coverage will end on the last day of the calendar year. A dependent whose coverage has been extended due to student status who graduates will be covered until the end of the calendar year during which the graduation occurs;
- b. The last day of the month in which the Employee's coverage under the Plan is terminated;
- c. The last day of the month in which the Employee terminates employment;
- d. With respect to any coverage requiring Participant contributions, and with respect to which Participant contributions are discontinued, the period for which the Employee fails to make any required contribution;
- e. The date the Plan is terminated (Continuation of Coverage not available);
- f. The date the Dependent receives the maximum lifetime benefits provided by the Plan;
- g. Except to the extent required by law, the day such Dependent enters the military of any country or international organization on a full-time active duty basis other than scheduled drills or other training not exceeding 1 month in any calendar year;
- h. If coverage terminates due to the death of (i) an employee who participated in the college's health care plan with dependent coverage for at least two (2) years prior to death; or (ii) a retiree who participated in the plan with dependent coverage, then those surviving dependents who were Covered Dependents on the day immediately preceding the death shall remain covered, provided that such dependents do not become eligible for coverage under another group plan (except Medicare) and otherwise remain Eligible Dependents and continue to pay the required premium.

CONTINUATION OF COVERAGE

A covered person may continue coverage for a period of 18, 29 or 36 months, at his/her own expense, pursuant to the provisions of the Consolidated Omnibus Budget Reconciliation Act (COBRA), as amended, if coverage under the Plan would otherwise terminate because of a life event known as a "qualifying event". After a qualifying event, COBRA continuation coverage must be offered to each person who is a "qualified beneficiary" as follows:

1. **Termination of Employment:** A covered employee, spouse, domestic partner, and dependent child (qualified beneficiary) may elect to continue coverage under this Plan for up to 18 months, if their eligibility ends due to one of the following qualifying events:
 - a. The covered employee is terminated (for reasons other than Gross Misconduct*);
 - b. The covered employee's number of hours of employment is reduced.

* Gross Misconduct is defined as the deliberate and willful violation of a reasonable rule or policy of the Employer, governing the employee's behavior in performance of his or her work, provided such violation has harmed the Employer or other employees or has been repeated by the employee despite warning or other explicit instruction from the Employer. Employees may also be terminated for cause, such as fraudulent claims submission.

Disability Extension: A qualified beneficiary may elect to extend coverage an additional 11 months, up to a maximum of 29 months, for himself/herself and nondisabled family members who are entitled to COBRA continuation coverage, if he is disabled (as defined by Title II or XVI of the Social Security Act) at the time of the qualifying event or at any time during the first 60 days of COBRA continuation coverage and is covered for Social Security Disability Income benefits.

The Qualified Beneficiary must send **the COBRA Administrator** a copy of the Social Security office's disability determination letter within 60 days after the latest of (and in no event later than the end of the 18th month of COBRA coverage):

- a. The date of the Social Security Administration's disability determination
- b. The date on which the qualifying event occurs
- c. The date on which the qualified beneficiary loses coverage; or
- d. The date on which the qualified beneficiary is informed of the obligation to provide the disability notice.

If the Social Security office determines that the qualified beneficiary is no longer disabled, the COBRA Administrator must receive a copy of the Social Security office's letter within 30 days after it determines that he is no longer disabled. Please send the required documentation to the COBRA Administrator at the address shown at the end of this Section.

2. **Loss of Dependent Eligibility:** A covered Dependent (spouse, domestic partner or child) may elect to continue coverage under this Plan for up to 36 months, if his or her eligibility ends due to any of the following qualifying events:
 - a. The covered employee dies
 - b. The covered employee is divorced, legally separated, or there is a termination of domestic partnership (as determined by the Employer)
 - c. The covered employee becomes eligible for and elects Medicare benefits
 - d. A Dependent child ceases to be a Dependent (as defined by the Plan).

The Employee or covered Dependent must notify the Plan Sponsor as follows:

Notice Obligations

A covered employee, spouse, domestic partner, or dependent is responsible for notifying the College of Southern Maryland of the employee's divorce or legal separation, or of the employee's child losing dependent status. The qualified beneficiary must notify the Plan Sponsor within 60 days of the date of the event or the date on which coverage would terminate, whichever is later. Written notification must be provided to:

**SUSAN NEEDHAM
COLLEGE OF SOUTHERN MARYLAND DEPARTMENT OF HUMAN RESOURCES
(301) 934-7895**

The qualified beneficiary may be required to complete a "COBRA Qualifying Event Notification Form" and attach official documentation which substantiates the event. If you do not have access to a form, please provide the College of Southern Maryland with the following information in writing and attach a copy of official documentation: employee name, identification number, beneficiary name, address, telephone number, date of event, and description of event.

Failure to give notice within 60 days of the event can result in COBRA coverage being forfeited.

Multiple Event Extension: If a covered Dependent elects the 18 month continuation following an event shown in Part 1 and later becomes entitled to a 36 month continuation due to an event shown in Part 2, then that covered Dependent may continue coverage for up to 36 continuous months from the date of the first qualifying event.

For example, because the Employee is terminated, an 18-month continuation is elected for a covered Dependent. Before the 18 month period has ended, the covered Dependent reaches the maximum age to be covered under the Plan. This is a second qualifying event. In order to extend continuation of coverage up to 36 months from the original continuation of coverage effective date, the Dependent must notify the COBRA Administrator in writing, within 60 days of the second event or the date coverage ends (whichever is later). Written notification must include: beneficiary's name, identification number, address, telephone number, date of event, description of event and a copy of official documentation substantiating the event (if divorce or legal separation.) The COBRA Administrator's contact and address can be found at the end of this section.

- 3. Retirees and Bankruptcy**– Covered retirees of an employer that declares Chapter XI bankruptcy are eligible for continuation coverage if they lose coverage within one year before or after the bankruptcy proceedings begin. Retirees may continue their coverage until their death. The Spouse and Dependent children of the retiree are eligible for continuation coverage until the retiree's death plus an additional thirty-six months of coverage after the date of the retiree's death.

Election - A covered Employee can elect COBRA coverage for himself or herself and/or his or her covered Dependents. In the event that an Employee with family coverage does not elect COBRA coverage for his or her Dependents, such coverage may be elected by the Dependents. No Spouse or child is entitled to continuation coverage unless that individual was a covered Dependent under the Plan on the date before any of the above qualifying events except for the following: A Qualified Beneficiary includes a child born to or placed for adoption with a covered Employee during the period of COBRA coverage. An election on behalf of a minor child can be made by the child's

parent or legal guardian.

To continue coverage, the Employee or Dependent, hereinafter called a continuee, affected by the qualifying event must make written election by the 60th day following: (a) the last day of coverage; or (b) the date he is sent notice of the right to continue coverage; whichever is later.

Within 45 days of the election date, the continuee must pay the required monthly premium for the COBRA coverage period prior to the election. The 18 or 36 month continuation period will begin on the earliest of the above qualifying events.

Monthly Premium - The due date for the monthly premium is the first day of each coverage month and COBRA allows 30 days from the due date to send the premium to the COBRA Administrator. The monthly premium will not exceed 102% of the total monthly cost (determined by the Plan on an actuarial basis) for coverage of a similarly situated active employee. However, when a disabled continuee extends coverage beyond 18 months, the monthly premium will increase to 150% of that total average monthly premium. The monthly premium is subject to change at the beginning of each Plan Year.

Payment of Claims - No claim will be payable under this COBRA provision, until the COBRA Administrator receives the applicable monthly premium for the continuee's coverage.

Termination - Coverage under the COBRA provision will terminate on the earliest of the following:

- a. The date on which the Employer ceases to provide a group health plan to employees;
- b. The date the continuee first becomes, after the date of the election, covered under any other group health plan (unless the plan contains pre-existing condition exclusions or limitations that are not reduced by creditable coverage);
- c. The date the continuee first becomes, after the date of the election, covered for Medicare benefits;
- d. The date the continuee fails to make timely payment of the monthly premium under the Plan;
- e. For a disabled continuee who extends coverage beyond 18 months, the first of the month which begins 30 days after the continuee is no longer considered disabled as defined by Social Security regulations;
- f. The end of the applicable 18, 29 or 36 month period. In no case will coverage continue beyond 36 months from the original qualifying event, even if a second qualifying event occurs during the COBRA coverage period;
- g. For cause, such as fraudulent claims submission, on the same basis that coverage could be terminated for similarly situated active employees.

Conversion Privileges – At the end of the continuation coverage period, the employee, spouse or dependent must be allowed the option to enroll in an individual conversion health plan provided by the College of Southern Maryland if such conversion plan is available.

COBRA Administrator – If you have any questions about the law or your obligations, you may contact the COBRA Administrator:

COLLEGE OF SOUTHERN MARYLAND
8730 Mitchell Road
La Plata, MD 20646
(301) 934-1860

CHAPTER II
MEDICAL BENEFITS

College of Southern Maryland Medical Plan Schedule of Benefits	
<p>You are entitled to the Covered Services described in this booklet. In-Network payments are based on the allowable amount as contracted between the provider and the PPO Network in the amounts specified in the schedule shown below. See the Notes section below for information on how benefits are applied when a PPO Provider refers you to an Out-of-Network Provider or facility. Payments to Out-of-Network providers are based on the Reasonable and Customary allowance, in the amounts specified in the schedule shown below. Covered Services are subject to the Plan Year Deductible as indicated. Any service with a maximum benefit level applies toward both the In-Network and the Out-of-Network maximum limits.</p>	
<p>Pre-Admission Certification: The services identified below with a (*) require precertification by the Managed Care Vendor. Failure to comply may result in reduced benefits. Please refer to Chapter V for those requirements.</p>	
Individual Lifetime Maximum:	
Overall Medical Maximum	\$1,000,000
Infertility Treatment	\$100,000
Individual Calendar Year Maximums	
Extended Care Facility	60 days
Routine Well Adult Care	\$300
Acupuncture	15 visits
Private Duty Nursing	40 visits
Mental Health and Substance Abuse - Inpatient	30 days (combined)
Orthotics	\$750
Wig – when hair loss is due to chemotherapy	One
Vision – eye exam, frames/lenses, contacts	\$100 (combined)
Other Individual Maximums	
Screening Mammogram - Ages 35 to 40 - Ages 40 to 50 - Ages 50 and over	One per 5 year period One every 2 years One per calendar year

	IN-NETWORK	OUT-OF-NETWORK
Medical Deductible, Per Calendar Year:		
Individual	\$250	\$500
Per Family	\$500	\$1,000
Out-of-Pocket Maximum, Per Calendar Year:		
Individual	\$1,500	\$3,000
Per Family	\$3,000	\$6,000
Any coinsurance (the 10% or 30% patient responsibility) satisfied applies toward both the In-Network and the Out-of Network out-of pocket limits. Expenses applied to the deductible, for the treatment of nervous/mental disorders, alcoholism and substance abuse, penalties for non-certified hospital admissions, non-covered services, copay amounts, prescription copays, and charges in excess of reasonable and customary do not apply toward the out-of pocket limit.		
TYPE OF EXPENSE	IN-NETWORK	OUT-OF-NETWORK
Hospital and Other Facility Expenses:		
Inpatient Hospital * (Semi-private)	90% ¹	70% ¹
Inpatient Medical Rehabilitation*	90% ¹	70% ¹
Nursery Room Charges	90% ¹	70% ¹
Freestanding Birthing Facility	90% ¹	70% ¹
Emergency Room (Accident and Sudden/ Serious Illness)	\$50 copay, then 90% ¹ , copay waived if admitted	\$50 copay, then 70% ¹ , copay waived if admitted
Pre-admission Testing	90% ¹	70% ¹
Outpatient Surgery	90% ¹	70% ¹
Outpatient Diagnostic X-ray and Laboratory	90% ¹	70% ¹
Extended Care Facility * (Semi-private) (Maximum of 60 days per calendar year)	90% ¹	70% ¹
Inpatient Hospice Care*	90% ¹	70% ¹
Outpatient Hospice Care	90% ¹	70% ¹
Outpatient Therapy - Chemotherapy - Radiation - Physical - Speech - Occupational - Renal dialysis	90% ¹	70% ¹

* Pre-certification required

1 Subject to deductible

TYPE OF EXPENSE	IN-NETWORK	OUT-OF-NETWORK
Professional Expenses		
Emergency Room Physician	90% ¹	70% ¹
Second Surgical Opinion	90% ¹	70% ¹
Inpatient Surgery	90% ¹	70% ¹
Outpatient Surgery	90% ¹	70% ¹
Outpatient Surgery, in physician's office (PCP)	\$20 copay per visit, then 100%	70% ¹
Outpatient Surgery, in physician's office (Specialist)	\$30 copay per visit, then 100%	70% ¹
Inpatient assistant surgeon	90% ¹	70% ¹
Outpatient assistant surgeon	90% ¹	70% ¹
Inpatient hospital visits by physician	90% ¹	70% ¹
Inpatient hospital consultations by physician	90% ¹	70% ¹
Outpatient Therapy <ul style="list-style-type: none"> - Chemotherapy - Radiation - Physical - Speech - Occupational - Renal dialysis 	90% ¹	70% ¹
Inpatient anesthesia	90% ¹	70% ¹
Outpatient anesthesia	90% ¹	70% ¹
Physician's Office Visits – Primary Care Physician (PCP)	\$20 copay per visit, then 100%	70% ¹
Physician's Office Visits - Specialist	\$30 copay per visit, then 100%	70% ¹
Injection - Allergens, serums, toxins and vaccines	90% ¹	70% ¹
Chiropractor	\$30 copay per visit, then 100%	70% ¹
Podiatrist Office Visits	\$30 copay per visit, then 100%	70% ¹
Outpatient x-ray, laboratory, and diagnostic tests	90% ¹	70% ¹
Professional Component <ul style="list-style-type: none"> - Inpatient x-ray or lab interpretation - Outpatient x-ray or lab interpretation 	90% ¹	70% ¹

* Pre-certification required

1 Subject to deductible

TYPE OF EXPENSE	IN-NETWORK	OUT-OF-NETWORK
Wellness Care		
Routine Well Adult Care (Children and Adults age 13 and over)– includes office visits, prostate screening, gynecological exam, routine physical examination (Maximum of \$300 per calendar year)	\$20 copay per visit, then 100%	70% ¹
Routine Well Adult X-ray and Lab (Charges do not apply to the \$300 Well Adult Care maximum)	90%	70% ¹
Screening Mammogram Ages 35 through 39 – one baseline Ages 40 through 49 – one every two years Ages 50 and over – one per calendar year	90%	70% ¹
Routine Well Child Care (Age 2 to 13) – includes office visits, routine physical exams, laboratory tests, x-rays and immunizations	\$20 copay per visit, then 100%	70% ¹
Routine Well Newborn Care (Newborn to age 2)	\$20 copay per visit, then 100%	70% ¹
Other Facility and/or Professional Expenses:		
Acupuncture – limited to 15 visits per calendar year	90% ¹	70% ¹
Home Infusion	90% ¹	70% ¹
In Vitro Fertilization* (limited to 3 attempts per live birth)	90% ¹	70% ¹
Artificial Insemination* (limited to 6 cycles per lifetime)	90% ¹	70% ¹
Home Health Care	90% ¹ for the first 40 visits, 70% thereafter	70% ¹ for the first 40 visits, then 50%
Orthotics (Calendar Year max of \$750)	90% ¹	70% ¹
Non-experimental Organ Transplants*	90% ¹	70% ¹
Durable Medical Equipment/Prosthetic Devices	90% ¹	70% ¹
Private Duty Nursing – outpatient only (maximum of 40 visits per Calendar Year)	90% ¹	70% ¹
Disposable Medical Devices	90% ¹	70% ¹
Ambulance Service	90% ¹	70% ¹
Urgent Care	90% ¹	70% ¹
Wigs (after chemotherapy)	90% ¹	70% ¹

* Pre-certification required

1 Subject to deductible

TYPE OF EXPENSE	IN-NETWORK	OUT-OF-NETWORK
Mental Health Benefits:		
Inpatient Mental Health* – semiprivate (30 day maximum per Calendar Year, combined with inpatient Substance Abuse)	90% ¹	70% ¹
Psychiatric Day Care (30 day maximum per Calendar Year, combined with inpatient. Each day of care will count as one half day toward the inpatient maximum)	90% ¹	70% ¹
Inpatient Hospital Visits by physician	90% ¹	70% ¹
Outpatient Mental Health Therapy	75% ¹ for first 20 visits, then 60%	65% ¹ for first 20 visits, then 50%
Psychological Testing	90% ¹	70% ¹
Substance Abuse (Drug and Alcohol) Benefits:		
Detoxification/Residential Rehabilitation* (Maximum of 30 days per Calendar Year, combined with inpatient Mental Health)	90% ¹	70% ¹
Detoxification – Inpatient Hospital visits	90% ¹	70% ¹
Outpatient Alcohol and Substance Abuse Therapy	75% ¹ for first 20 visits, then 60%	65% ¹ for first 20 visits, then 50%
Routine Vision Benefits:		
Eye exam, frames, lenses and contact lenses. (Combined maximum of \$100 per calendar year)	100% No deductible	100% No deductible

* Pre-certification required

1 Subject to deductible

Notes on PPO and Non-PPO Benefits:

- a. Benefits for services provided by a participating provider (PPO) are payable as shown in the Schedule of Benefits as In-Network services. Verify that the provider participates with the PPO before you receive services to obtain In-Network benefits. To determine whether a physician or facility participates in the PPO, contact your health care provider, the Claims Administrator at 703-934-6227 or 800-888-6227, or link to the PPO website at www.ncas.com.
- b. Anesthesia, x-rays, laboratory, and other diagnostic services rendered at a PPO facility and provided and billed by a Non-PPO provider, will be paid at the In-Network benefit level.
- c. When services are rendered in an emergency room, and In-Network benefits are being applied, the Plan will also consider related charges for the emergency room physician services at the In-Network benefit level, regardless of whether the Physician participates in the PPO Network.
- d. A Primary Care Physician (PCP) is any duly licensed doctor who is engaged in the practice of family medicine, general practice, internal medicine, pediatric medicine OB/GYN and geriatric medicine and/or who is classified as a Primary Care Physician by the Plan.

COMPREHENSIVE MEDICAL BENEFITS

PLAN PROVISIONS

Individual Deductible - Each Participant's annual deductible is shown in the Schedule of Benefits. This deductible must be met once each calendar year and applies to Covered Services indicated in the Schedule of Benefits.

Family Deductible - Under Family Coverage, when the deductible amounts accumulated by 2 or more members of a family reach the total of shown in the Schedule of Benefits during a calendar year, no further deductibles will apply to any family members for the rest of that calendar year. (When calculating the Family Deductible, a family member's expenses cannot exceed the individual Deductible amount.)

Deductible Carryover Provision - Although a new deductible will apply each calendar year, charges incurred during October, November, and December which are applied to that year's deductible will also be applied toward the deductible for the next year and thus reduce or eliminate the next year's deductible.

Out-of-Pocket Limit - After you have met the deductible expense, the Plan will pay the amount specified in the Schedule of Benefits. The remaining percentage, for which you are responsible, is called coinsurance. When your (or your family's) coinsurance expense reaches the Out-of-Pocket Limit shown in the Schedule of Benefits for claims incurred during a calendar year, the Plan will pay 100% of the Reasonable and Customary or Network allowance of that individual's (or family's) eligible expenses for the remainder of that calendar year. Expenses applied to your deductible or for the treatment of nervous/mental disorders, alcoholism, substance abuse, penalties for non-certified hospital admissions, non-covered services, In-Network copay amounts, Prescription copays, and charges in excess of Reasonable and Customary allowance do not apply toward the Out-of-Pocket Limit. All copays, including office visit copays, continue to be due, after the out-of-pocket maximum is met.

Copay - The dollar amount (shown in the Schedule of Benefits) a Participant is required to pay for a covered service. A copay is expressed as a flat dollar amount and does not apply toward the Deductible or Out-of-Pocket limit.

Lifetime Maximum - The lifetime maximum represents the maximum amount of benefits a Participant is eligible to receive during the entire time he is covered under the Plan and includes all Covered Services described in the Plan.

COVERED MEDICAL SERVICES

COVERED SERVICES - A Participant is entitled to the following benefits for Medically Necessary Care only when services are rendered by a certified or Licensed Provider. All benefits are subject to the General Exclusions and Limitations and other provisions of this Plan. Payments to Out-of-Network providers are based on the Reasonable and Customary allowance. In-Network payments are based on the allowable amount as contracted between the provider and the PPO Network.

Acupuncture – Benefits are available for services provided by an acupuncturist, who has been licensed by the State Acupuncture Board.

Alcoholism and Substance Abuse Services - Benefits are available for inpatient (including a licensed or certified alcoholism or substance/drug abuse treatment facility) or outpatient care for alcohol and/or substance abuse disorders including individual and group therapy, individual, group and family counseling, psychological testing, and other expenses related to the diagnosis when rendered by a:

- a. Doctor of Medicine (MD);
- b. Licensed Clinical Psychologist (PhD);
- c. Licensed Clinical Social Worker (LCSW);
- d. Licensed Professional Counselor (LPC);
- e. Registered Nurse Clinical Specialist (RNCS).

Outpatient rehabilitation (4 or more hours) is covered as outpatient therapy. Refer to the Schedule of Benefits for coverage limits.

Alcoholism and Substance Abuse disorders are identified by the International Classification of Diseases, 9th Edition codes 291 through 292.9, except for 292.8, and 303 through 305.9.

No benefits for the treatment of alcoholism and/or substance abuse will be provided under any other service or provision of the Plan.

Ambulance Service – Benefits are provided for local ambulance service (ground or air) to and from the nearest Hospital where necessary care and treatment can be provided.

Anesthesia - Benefits are provided for the cost and administration of anesthesia.

Birthing Center - Benefits are provided for a licensed or certified institution which meets the following criteria:

- a. It provides 24-hour-a-day nursing service by or under the direction of Registered Nurses and Certified Nurse Midwives;
- b. It is staffed, equipped and operated to provide care for patients during an uncomplicated pregnancy, delivery and the immediate post-partum period;
- c. It provides care for obstetrical patients and infants born in the center who require emergency and immediate life support measures to sustain life pending transfer to a hospital.

Cardiac Rehabilitation Program - The Plan provides benefits for Cardiac Rehabilitation Programs for a heart attack, heart surgery, or diagnosis of angina pectoris when services are rendered by a hospital-based Cardiac Rehabilitation Program or a program that is coordinated with a Hospital. Services must be initiated within 12 weeks after other treatment for the medical conditions ends.

Care Management - In cases where the patient's condition is expected to be or is of a serious

nature, the Claims Administrator may arrange for review and/or care management services from a professional qualified to perform such services, usually the Managed Care Vendor. The Managed Care Vendor or other professional approved by the Claims Administrator shall have the right to alter or waive, in writing, the normal provisions of this Plan to achieve the most efficient use of medical resources and the best patient outcome.

Benefits provided under this provision are subject to all other Plan provisions. Alternative care will be determined on the merits of each individual case and any care or treatment provided will not be considered as setting a precedent or creating any future liability, with respect to that or any other Participant.

Chiropractic Care - Benefits are provided for detecting and correcting structural imbalance, distortion, misalignment or incomplete or partial dislocation of or in the vertebral column. Eligible expenses do not include maintenance and palliative treatment.

Contraceptives - Benefits are available for FDA approved contraceptive drugs and contraceptive devices which require a physician's prescription and administration. The associated office visit is also covered. Over-the-counter devices are not covered. Oral contraceptives are covered under the Prescription Card Plan.

Cosmetic Surgery - Benefits are **ONLY** provided to correct a condition resulting from non-cosmetic surgery or an accidental bodily injury or to correct a congenital anomaly that results in a functional defect of an eligible dependent child.

Note: Reconstructive surgery is covered, only if such surgery is to restore bodily function or correct deformity resulting from non-cosmetic surgery, an accidental bodily injury, or a congenital defect. This includes reconstruction of the breast on which a mastectomy has been performed. Following surgery of the breast for cancer, benefits are provided for surgery and reconstruction of the other breast to produce a symmetrical appearance. There is also coverage for prostheses and physical complications of all stages of mastectomy, including lymphedemas; in a manner determined in consultation with the attending physician and the patient.

Dental Services - Benefits for procedures pertaining to the treatment of the teeth and/or support structures of the teeth are not covered with the following exceptions:

- a. Services and related supplies resulting from an accidental injury, including hospitalization, when the patient's condition warrants such care, will be provided if treatment is received while the individual is a Participant. All treatment must be received within 1 year from the date of accident. An injury to the natural teeth or damage to a dental appliance as the result of the biting, chewing of a foreign object, or in the course of ingesting food is not considered an accidental injury;
- b. General anesthesia and associated Hospital or Ambulatory Surgical Facility services and related supplies for dental procedures will be covered when such medically necessary services are required for a:
 - Participant who has a non-dental physical or mental impairment; or
 - Participants who are seven years of age or younger; or
 - Participants who are between eight years and seventeen years and who are extremely uncooperative, fearful, or uncommunicative.

Diagnostic Services - Benefits are provided for diagnostic services obtained on an inpatient or outpatient basis. They are tests or procedures ordered by a Physician or other professional provider because of specific symptoms. Diagnostic services must be directed toward determining a definite condition or disease and can include:

- a. X-ray and other radiology services;
- b. Laboratory and pathology services;
- c. Cardiographic, encephalographic and radioisotope tests.

Durable Medical Equipment (DME) - Any equipment designed for repeated use and which is medically necessary for the treatment of an illness or injury, to improve the functioning of a malformed body member, or to prevent further deterioration of the patient's medical condition. DME shall also include wheelchairs, hospital beds, respirators and other such items as determined by the Claims Administrator:

Benefits for DME are provided for the lesser of the rental charges or the purchase price, up to the PPO or UCR allowance, and are paid as specified in the Schedule of Benefits. The DME must be:

- a. Primarily and customarily used to serve a medical purpose and generally is not useful to a person in the absence of illness or injury;
- b. Appropriate for use in the home;
- c. Prescribed by a Physician;
- d. Consistent with the diagnosis.

Standard DME is equipment including braces, devices or supplies which provides the basic therapeutic or functional purpose necessary for the Participant's condition. Deluxe DME is equipment which has features not necessitated by the patient's medical condition.

Benefits for the initial services or supplies for hearing aids and the fitting thereof, may be provided when such services or supplies are required as a result of an illness occurring while the patient is covered under this Plan.

In addition, benefits may be provided for 1 pair of eyeglasses or contact lenses required as a result of and directly related to intraocular surgery. Examples of surgeries for which such benefits may be allowed include cataract surgery, cornea transplant and scleral buckling. Benefits would not be provided in cases such as strabismus surgery in which extraocular muscle work is performed.

Extended Care Facility - Any hospital services and supplies available on an inpatient basis are available for a confinement in an Extended Care Facility or Skilled Nursing Facility for the maximum period of time shown in the Schedule of Benefits. To be eligible for benefits, the patient must enter the Extended Care Facility immediately following a Hospital confinement or a period of Home Health Care Utilization, be confined for the same or related condition, be under the continuous care of a doctor and require 24-hour nursing care. Confinements separated by less than 7 days are considered one confinement.

Home Health Care - To receive Home Health Care benefits, the Participant's condition must necessitate Skilled Care such that he would have required hospital or extended care facility confinement if Home Health Care benefits had not been available. The patient must be under the direct care of a Physician and the patient's Physician must develop a plan of treatment with a hospital or Home Health Care agency which defines the services the patient is to receive at home.

The Home Health Care agency must be licensed to provide nursing and other therapeutic services. Any single visit up to 4 hours by a member of a Home Health Care Provider team will equal 1 Home Health Care visit.

Covered Home Health Care services provided by the Home Health Care agency include:

- a. Part-time or intermittent nursing care, by a Registered Nurse (RN) or a Licensed Practical or Vocational Nurse (LPN/LVN);
- b. Part-time or intermittent home health aide or homemaker services for the patient only;
- c. Occupational, speech, audiological, physical, and respiratory therapies provided by a Home Health Care agency;
- d. Social work, performed by a certified or licensed Social Worker (if licensing is not required by the state in which the work is performed, the Social Worker must have at least a masters degree in social work) to help the patient and family cope with the illness;
- e. Nutrition services by a Registered Dietician.

Home Health Care Exclusions:

- a. Custodial care;
- b. Services or supplies not included in the home health care plan;
- c. Home Health Care visits for the treatment of nervous or mental conditions;
- d. Any period during which the Participant is not under the care of a Physician;
- e. Those services or supplies listed under the General Exclusions and Limitations section.

Home Infusion Therapy - Medically referred treatment for parenteral infusion of antibiotics, chemotherapy, total parenteral nutrition, and other infusion therapies in the Participant's residence. Covered services include:

- a. Medical care for the patient receiving home infusion therapy via central venous line or standard intra-venous route;
- b. Nutritional and other infusion therapies, including hydration, antibiotics, chemotherapy, pain management, and certain blood products;
- c. Related nursing care and supplies.

Hospice Care - Benefits are available to terminally ill patients with a life expectancy of 6 months or less.

Inpatient Hospice Care - All inpatient services covered while a Participant is confined in a hospital are also covered under the Hospice Care coverage. All treatment rendered to a Participant admitted to a Hospice Care Program must be under the direction of a Physician.

Outpatient Hospice Care - Benefits will be provided for Hospice Care services rendered in the patient's home by members of the Hospice Care team when the services are billed by a Hospice Provider. The following outpatient Hospice Care services are covered when rendered by members of a Hospice Care team:

- a. Nursing care by a Registered Nurse (RN) or Licensed Practical/Vocational Nurse (LPN/LVN);
- b. Patient care provided by home health aides or homemaker services;
- c. Visits by Medical Social Workers;
- d. Visits by Physical and Respiratory Therapists;
- e. Rental of durable medical equipment such as hospital beds, respirators, oxygen tents, crutches and wheelchairs when billed by the Hospice Provider;
- f. Medically necessary surgical and medical supplies;
- g. Drugs and medicines billed by the Hospice Provider;
- h. Nutritional counseling by a Registered Dietician;
- i. Group or individual bereavement counseling for family members for a maximum of 6 visits during the 90 day period following the patient's death.

Hospital Inpatient - Your Plan provides benefits for the following services when a member is

admitted to a hospital:

- a. Room and board and general nursing care in a semi-private room (2 or more beds), and a special care unit;
- b. Private room accommodations, if medically necessary;
- c. Use of operating, delivery, and treatment rooms and equipment;
- d. Prescribed drugs and medications administered in the hospital;
- e. Charges related to unreplaced blood, blood plasma and expanders including the processing, collection, and storage of blood;
- f. Anesthesia and its administration;
- g. Oxygen and its administration;
- h. Dressings, supplies, casts and splints;
- i. Diagnostic services;
- j. Therapy services.

Hospital Outpatient - Any hospital services and supplies available on an inpatient basis are also available on an outpatient basis for:

- a. X-rays and laboratory services;
- b. Outpatient surgery and anesthesia;
- c. Emergency care.

Infertility – Benefits are provided for the covered Participant or Participant’s Spouse for fertility procedures, including infertility drugs.

Artificial insemination is eligible when the oocytes (eggs) are naturally produced by the Participant and fertilized with sperm naturally produced by the Spouse. Artificial insemination is limited to 6 sessions per lifetime.

In-Vitro Fertilization is eligible when the Participant or the Participant’s spouse has a history of infertility for 2 years (this includes 2 years’ duration following a reversal of an elective sterilization); the infertility is associated with endometriosis, exposure to DES, or blockage or removal of fallopian tubes; abnormal male factors; and the patient has been unable to attain a successful pregnancy through artificial insemination. The oocytes (eggs) must be naturally produced by the Participant and fertilized with sperm naturally produced by the Spouse. The benefit is limited to 3 in-vitro fertilization attempts per live birth.

All fertility services, including infertility drugs, are limited to a maximum lifetime benefit of \$100,000.

Maternity Services - Benefits for maternity care and services are available to all covered Employees and covered Dependents. Hospital, surgical and medical benefits are available on an inpatient or outpatient basis for the following maternity services:

- a. Delivery;
- b. Routine prenatal and postnatal care;
- c. Treatment for complications of a pregnancy;
- d. Post-partum home visit to assess mother and baby by a Home Health Care agency.

Statement of Rights Under the Newborns’ and Mothers’ Health Protection Act

Under federal law, group health plans and health insurance issuers offering group health insurance coverage generally may not restrict benefits for any hospital length of stay in connection with

childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a cesarean section. However, the plan or issuer may pay for a shorter stay if the attending provider (e.g., your physician, nurse, midwife, or physician assistant), after consultation with the mother, discharges the mother or newborn earlier.

Also, under federal law, plans and issuers may not set the level of benefits or out-of-pocket costs so that any later portion of the 48-hour (or 96-hour) stay is treated in a manner less favorable to the mother or newborn than any earlier portion of the stay.

In addition, a plan or issuer may not, under federal law, require that a physician or other health care provider obtain authorization for prescribing a length of stay of up to 48 hours (or 96 hours). *However, if your or your newborn's medical condition requires you to stay more than 48 hours after a vaginal delivery or 96 hours after a cesarean section, then your physician or the hospital must contact the Managed Care Vendor for precertification of additional days.*

Medical Services and Supplies - Medical care is the non-surgical treatment a Participant receives from a Physician or other Approved Provider for an illness or injury, including:

- a. Physician's inpatient visits;
- b. Care by a surgeon and, at the same time, care by another Physician, provided the Physicians are treating 2 separate conditions;
- c. Consultations, excluding routine staff consultations required by hospital rules;
- d. Home and office visits;
- e. Charges related to unreplaced blood, blood plasma and expanders including the processing, collection, and storage of blood;
- f. Allergy tests and shots;
- g. Second Surgical Opinions;
- h. Oxygen;
- i. Growth Hormone and supplies with a physician's letter of medical necessity;
- j. Diabetic equipment and supplies, except supplies covered by the Prescription Drug Plan;
- k. Casts, splints, jobst garments, orthotics.

Nervous and Mental Disorders - Benefits are available for inpatient or outpatient care for nervous or mental conditions including individual and group therapy, marital and family counseling, psychiatric tests, and expenses related to the diagnosis when rendered by a:

- a. Doctor of Medicine (MD);
- b. Licensed Clinical Psychologist (PhD);
- c. Licensed Clinical Psychiatric Social Worker (LCSW);
- d. Licensed Professional Counselor (LPC);
- e. Registered Nurse Clinical Specialist (RNCS).

Psychiatric day care is covered as an inpatient day. Two days of day care count as one inpatient day. Nervous and mental disorders are identified by the International Classification of Diseases, 9th Edition codes 290 through 290.9, 292.8 through 302.9, and 306 through 316. Refer to the Schedule of Benefits for coverage limits.

Other services for the treatment of nervous and mental disorders, such as medical management and related laboratory services are covered as any other medical service.

Newborn Services - Benefits are provided for inpatient newborn care, including expenses related to circumcision of the newborn, on the same basis as for any other eligible expense, provided the baby is enrolled as a Participant within 30 days of birth.

Oral Surgery - Benefits are provided only for the following procedures:

- a. Surgical procedures required to correct injuries of the jaw, cheeks, lips, tongue, roof and floor of the mouth;
- b. Surgery involving accessory sinuses, salivary glands, or ducts;
- c. Excision of tumors and cysts of the jaw, cheeks, roof and floor of the mouth when pathological examination is required;
- d. Excision of exostosis of the jaw and hard palate when not related to the fitting of dentures;
- e. Extraoral incision and drainage of abscesses;
- f. Maxillomandibular dysfunction;
- g. Extraction of teeth due to a medical diagnosis related to radiation therapy.

Organ Transplants – Covered Services for Participants receiving medically necessary human-to-human organ or tissue transplants include all related services and supplies:

- a. Charges incurred for selective testing of potential donors from an organ registry. Benefits are not provided for screening of the general population;
- b. Charges incurred for organ transplantation;
- c. Charges for organ procurement, including donor expenses not covered under the donor's benefit plan including:
 - 1) Coverage for organ procurement from a non-living donor will be provided for costs involved in removing, preserving and transporting the organ;
 - 2) Coverage for organ procurement from a live donor will be provided for the costs involved in screening the potential donor, transporting the donor to and from the site of the transplant (see Travel Allowance), as well as for medical expenses associated with removal of the donated organ and the medical services provided to the donor in the interim and for the follow-up care;
 - 3) If the transplant procedure is a bone marrow transplant, coverage will be provided for the cost involved in the removal of the patient's bone marrow (autologous) or donated marrow (allogeneic). Coverage will also be provided for treatment and storage costs of the marrow, up to the time of reinfusion;
- d. Charges incurred for follow-up care, including immuno-suppressant therapy.

Travel Allowance: While traveling to and from the Transplant Program Provider, and if the Transplant Program Provider is located 50 or more miles from the recipient's home, the following benefits are covered expenses:

- a. Transportation is limited to a maximum of the cost of a round-trip coach airfare to the Transplant Program Provider for you and your travel companion;
- b. Transportation using a motor vehicle will be paid in accordance with the current IRS allowance per mile for medical travel;
- c. Hotel accommodations up to \$75 per day at hotels should you be released to an outpatient facility for medically necessary post-surgical care from the Transplant Program Provider;
- d. Hotel accommodations up to \$75 per day at hotels for your travel companion to remain in the immediate area during all or a portion of the duration of your treatment plan;
- e. Daily meals and other reasonable and necessary services or supplies for you and your travel companion up to an allowance of \$75 per person per day.

Transplant Program Provider is the Physician performing the transplant and/or the Hospital in which the transplant is performed.

Organ transplant procedures, including complications from any such procedure, services or supplies related to any such procedure, such as, but not limited to, high dose chemotherapy, radiation therapy or any other form of therapy, or immunosuppressive drugs are not covered, **except** for the following procedures:

- a. Heart; combined heart and lung; single lung; double lung; lobar lung; kidney, kidney/pancreas; pancreas; cornea; liver; bone; small bowel in pediatric patients; small bowel/liver; multivisceral; skin (for grafting or for any other medically necessary purposes);
- b. Autologous bone marrow for:
 - 1) Non-Hodgkin's lymphoma;
 - 2) Hodgkin's lymphoma;
 - 3) Neuroblastoma;
 - 4) Acute lymphocytic leukemia in first or subsequent remission;
 - 5) Acute non-lymphocytic leukemia in first or subsequent remission;
 - 6) Germ cell tumors;
 - 7) High Dose Chemotherapy for breast cancer, Stage III and Stage IV;
 - 8) Multiple myeloma;
 - 9) Medulloblastoma in high risk children.
- c. Allogeneic bone marrow for:
 - 1) Aplastic anemia;
 - 2) Acute leukemia;
 - 3) Severe combined immunodeficiency;
 - 4) Wiskott-Aldrich syndrome;
 - 5) Infantile malignant osteopetrosis (Albers-Schonberg disease or marble bone disease);
 - 6) Chronic myelogenous leukemia (CML);
 - 7) Neuroblastoma Stage III or IV in children over 1 year of age;
 - 8) Homozygous beta thalassemia (thalassemia major);
 - 9) Hodgkin's lymphoma;
 - 10) Non-Hodgkin's lymphoma;
 - 11) Myelodysplastic syndromes;
 - 12) Lysosomal storage disorders (mucopolysaccharidosis, Gaucher's disease, Hunter's syndrome, Hurler's syndrome, Sanfilippo syndrome, Maroteaux-Lamy syndrome, mucopolipidosis, lipidosis, metachromatic leukodystrophy);
 - 13) Multiple myeloma.

Under the Organ Transplant benefit, the following services are not provided:

- a. Travel, lodging and other charges for your travel companion other than to accompany you to and from the Transplant Program Provider;
- b. Charges in connection with the Travel Allowance that are not related to your travel to and from the Transplant Program Provider except for charges for your treatment while at the Transplant Program Provider;
- c. Charges for the repair or maintenance of a motor vehicle;
- d. Personal expenses incurred for the maintenance of your or your travel companion's residence. Examples of these are childcare costs, house-sitting costs, or kennel charges;
- e. Reimbursement of any wages lost by you or your travel companion;
- f. The services and medical expenses incurred by a donor (except as specified above) as a result of such transplant procedure.

Orthotics - Benefits are included for the initial purchase and fitting of orthotic inserts and devices (rigid or semi-rigid supportive device which restricts or eliminates motion for a weak or diseased body part). This does not include orthopedic shoes, unless they are an integral part of a leg brace. Please refer to the Schedule of Benefits for benefit maximums.

Pre-admission Testing - The Plan pays the reasonable and customary fees for pre-admission x-rays and laboratory tests required in connection with a scheduled hospital admission or out-patient procedure. Benefits will be provided if the hospital or physician postpone or cancel the admission out-patient procedure but no benefits are payable if the Participant postpones or cancels the hospital admission or out-patient procedure.

Prescription Drugs - See Chapter III.

Private Duty Nursing Services - When recommended by a Physician, coverage is available for the services of a private duty nurse (RN, LPN and LVN).

Covered expenses do not include charges by:

- a. The same nurse for more than one shift during any day;
- b. A nurse who is a member of the patient's family or normally resides in the patient's home.

Prosthetics – Benefits are provided for prosthetic devices, including replacement of original prosthetic devices if such devices break and cannot be repaired.

Routine Mammogram – Benefits are provided for a screening mammogram. Please refer to the Schedule of Benefits for frequency limits.

Routine Well Adult Care – Routine well adult care are services rendered in the absence of any indication of an injury or sickness.

Benefits will be paid for the office visit, GYN exam, pap smear, prostate screening, x-rays, laboratory tests, and other tests given or ordered at the time of the examination; routine hearing screening; routine vision screening; immunizations given by a Physician for an infectious disease; and testing for tuberculosis. The physical examination may include a review and written record of the patient's complete medical history, a check of all bodily systems, and a review and discussion of the examination results with the patient or, for a child, with the parent/guardian.

In addition to the General Limitations and Exclusions, the following charges are not eligible:

- a. Services or supplies for the diagnosis or treatment of a suspected or identified disease;
- b. Examinations while hospital confined;
- c. Services not identified and billed as part of a routine physical examination;
- d. Services not performed by a Physician or under his or her direct supervision;
- e. Pre-marital or employment examinations, vision or dental services.

Second Surgical Opinion - A second opinion on the necessity of a specific surgical procedure. The second opinion is voluntary, but if elected, must be given by a board-certified specialist who, by reason of the Physician's specialty, qualifies the Physician to make such an opinion.

Surgery - Inpatient or Outpatient surgical services are covered for the following procedures:

- a. Surgery, when performed by a Physician or other professional provider;
- b. Assistant at surgery;;
- c. Treatment of fractured or dislocated bones;

- d. Reconstructive (non-cosmetic) surgery;
- e. Sterilizations;
- f. Abortion.

The following guidelines apply to surgical procedures:

Assistant Surgeon Fees – The amount eligible will be based on 20% of the PPO or UCR allowance for the covered surgical procedure.

Co-Surgery Fees – If two or more surgeons work together as primary surgeons for the same surgical procedure, benefits for all surgeons will not exceed the PPO or UCR allowance for that procedure.

Multiple Surgical Procedures – If two or more surgical procedures are performed through the same incision, benefits for the primary procedure will be based on 100% of the PPO or UCR allowance and all other eligible procedures will be based on 50% of the PPO or UCR allowance.

Note: Reconstructive surgery is covered, only if such surgery is to restore bodily function or correct deformity resulting from non-cosmetic surgery, an accidental bodily injury, or a congenital defect of a dependent child.

In accordance with the Women's Health and Cancer Rights Act, this includes reconstruction of the breast on which a mastectomy has been performed. Following surgery of the breast for cancer, benefits are provided for surgery and reconstruction of the other breast to produce a symmetrical appearance. There is also coverage for prostheses and physical complications of all stages of mastectomy, including lymphedemas; in a manner determined in consultation with the attending physician and the patient.

Therapy Services - Services for individual therapy are covered on an inpatient or outpatient basis. They are services or supplies used for the treatment of an illness or injury and include:

- a. Chemotherapy;
- b. Radiation therapy;
- c. Renal dialysis treatments;
- d. Respiratory therapy;
- e. Speech therapy – to restore speech lost or impaired due to an illness, injury, surgical procedure, or major congenital anomalies that affect speech. Speech therapy is not covered for language dysfunctions or articulation errors such as stuttering, lisps or tongue thrust, abnormal speech development, to change an accent, diplexia or hearing loss;
- f. Occupational therapy - to restore bodily function lost due to an illness, injury, or surgical procedure. Eligible expenses do not include maintenance and palliative treatment;
- g. Physical therapy – Eligible expenses do not include maintenance and palliative treatment.

Urgent Care Centers – A facility licensed to provide medical services for unexpected illnesses or injuries that require prompt medical attention but are not life-threatening.

Vision Care – Benefits are provided for a routine exam, lenses/frames and contact lenses up to the maximum shown in the Schedule of Benefits.

Well-Child Care - The Plan will provide benefits for well-child care in the 12-year period immediately following birth. Eligible expenses include health maintenance services, immunizations, routine hearing and vision screening, and routine preventative tests and services that monitor the child's physical and mental development.

Wigs – Benefits are provided for wigs when hair loss is the result of chemotherapy. Please refer to the Schedule of Benefits for benefit maximum.

GENERAL LIMITATIONS AND EXCLUSIONS

Pre-existing Waiting Period - A pre-existing condition is any condition (whether physical or mental), regardless of the cause of the condition, for which medical advice, diagnosis, care or treatment was recommended or received within the 3-month period ending on the Enrollment Date. Participants must satisfy a 12-month waiting period from the Enrollment Date before becoming eligible to receive benefits for pre-existing conditions.

This provision will not apply to newborns or children who are adopted or placed for adoption and enrolled in the plan within 30 days. Pregnancy is not considered a pre-existing condition.

If an Employee or Dependent has not satisfied the pre-existing condition waiting period of the Employer's plan in effect immediately prior to the effective date of this Plan, credit will be given for the period of time which elapsed while the Participant was covered by the prior plan.

The period of pre-existing condition exclusion will be reduced by prior periods of Creditable Coverage under another plan or health coverage applicable to the Participant as of the Enrollment Date, if such coverage was earned without a Significant Break in Coverage. The Participant must show proof of prior creditable coverage. A Certificate of Coverage may be used for this purpose.

Exclusions: Benefits are not provided under your Medical plan for:

1. **Adoption** – Charges in connection with the adoption of a child;
2. **Blood Processing** – Charges related to the processing, collection and storage of blood billed by an independent laboratory.
3. **Commission of a Crime** - Charges resulting from or occurring (a) during the commission of a crime by the Participant, or (b) while engaged in an illegal act, illegal occupation, or aggravated assault. Charges are eligible if they result from a medical condition or domestic violence;
4. **Complications** – Charges for complications resulting from a non-covered treatment or surgical procedure;
5. **Contraceptives** – Charges for oral contraceptives (see Prescription Drug Plan);
6. **Cosmetic Surgery** – Charges for cosmetic surgery and related services, except as specified under Cosmetic Surgery and Surgery;
7. **Dental** – Charges for treatment on or to the teeth, the nerves or roots of the teeth, gingival tissue or alveolar processes. However, treatment will be provided for reasons listed under Dental Covered Services.
8. **Diagnostic Inpatient Care** – Inpatient care primarily for diagnostic purposes, speech or occupational therapy, or while the participant is confined primarily for rest, custodial or domiciliary care. This exclusion does not apply to Hospice Care.
9. **Durable Medical Equipment** – Charges for the difference in cost between the standard and deluxe models of durable medical equipment;
10. **Excess Charges** – Excess of Reasonable and Customary allowance;
11. **Experimental or Investigational** – Services which are determined to be for research or experimental or investigational, except as specified under Organ Transplants;
12. **Foot Care** – Charges for routine care of feet, including removal of corns, calluses, toenails (except the partial removal of a nail with removal of part or all of its matrix);
13. **Government Facility** – Treatment in a facility owned or operated by the United States or any state or local government unless the Participant is legally obligated to pay;
14. **Hair Loss** – Charges for 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 after chemotherapy;

15. **Hazardous Activities** – Treatment or services received as a result of an accidental injury incurred while the participant is engaged in a hazardous activity or professional sporting event (on an individual or group basis for wage or profit). Such hazardous activities include, hang gliding, sky diving, use of all terrain vehicles, rock climbing, use of explosives, racing in an automobile, motorcycle or boat, travel to countries with advisory warnings, river running and bungee jumping;
16. **Hearing** – Hearing aids and their fitting, except as specified under Durable Medical Equipment;
17. **Holistic or Homeopathic Medicine** – Holistic or homeopathic medicine including services or supplies provided in connection with the treatment;
18. **Insertion of Breast Implants** – Charges for the insertion of breast implants (unless in connection with a mastectomy), and any procedure or related series of procedures whereby breast implants are removed and replaced with new implants;
19. **Insurance or Employment** – Charges for or related to examinations for insurance or employment;
20. **Maternity Care** – Charges for maternity care for persons other than the covered employee and his or her eligible dependents;
21. **Motor Vehicle** - For expenses in connection with an Injury arising out of or relating to an Accident involving the maintenance or use of a motor vehicle (other than a recreational vehicle not intended for highway use, motorcycle, motor-driven cycle, motorized pedal cycle or like type vehicle). This exclusion shall apply to those expenses up to the minimum amount required by law in the state of residence for any Injury arising out of an Accident of the type for which benefits are or would be payable under automobile insurance, regardless of whether or not automobile insurance is in force and regardless of any benefit limits under such insurance. However, this exclusion does not apply to a Covered Person who is a non-driver when involved in an uninsured motor vehicle.
22. **Myotherapy** – Charges for myotherapy by a massage therapist;
23. **Newborn Care** – Charges for newborn care for dependent children of a dependent child;
24. **No-fault** – Charges reimbursable by no-fault auto insurance, or any other federal or state mandated law;
25. **Not Legally Required to Pay** – Charges which the Participant is not legally required to pay or which would not have been made if no coverage had existed. This exclusion does not apply if a claim is from the Veterans Administration under Title 38 of the US Code for treatment of a veteran not having a service connected disability;
26. **Not Medically Necessary or Recommended** – Charges which are determined not to be medically necessary for the medical care diagnosis or treatment of an injury or illness; or charges for any service, treatment or supply not recommended by a physician;
27. **Nutritional Counseling** – Charges for nutritional counseling and oral nutritional supplements , except as specified under Home Health Care and Hospice Care;
28. **Obesity** – Charges for the treatment of obesity, weight loss or dietary control whether or not it is, in any case, a part of the treatment plan for another sickness, with the exception of medically necessary charges for the treatment for morbid obesity;
29. **Organ Donor** – Charges incurred by the donor of an organ or tissue for transplant to a recipient who is not a covered person under this Plan;
30. **Orthotic shoes** – Charges for orthotic shoes, unless attached to a brace;
31. **Personal Hygiene** – Charges for personal hygiene, convenience or personal comfort items, such as, but not limited to, vaporizers, air conditioners, humidifiers, air filters, first aid items, bathing/toilet accessories, elevators, stair and van lifts, whirlpools, and physical fitness equipment or programs, and other non-medical supplies or equipment;
32. **Personal Injury Protection** – Charges for services or supplies rendered to a Participant to the extent that the benefits are available in whole or part under a personal injury protection or a compulsory medical payments provision of any motor vehicle insurance contract required under federal or state no-fault motor vehicle insurance, whether or not

- the Participant properly asserts his rights under such motor vehicle insurance contract;
33. **Private Duty Nursing** – Charges for private duty nursing when rendered on an inpatient basis; when requested by or for the convenience of the patient's family; when such services are rendered by a nurse who resides in the Participant's home or who is related by blood or marriage to the Participant;
 34. **Private Room** – Charges for a private room, beyond the amount normally paid for a semiprivate room;
 35. **Relative Giving Services** – Services or supplies rendered by the employee, employee's spouse and the children, brothers, sisters, parents, or grandparents of either the employee or employee's spouse;
 36. **Reversal of Sterilizations;**
 37. **Self-help** – Charges for educational services, hypnotism, biofeedback, or any type of self-help or goal oriented or behavior modification therapy, such as to lose weight or quit smoking, except as specified under Nutritional Counseling;
 38. **Self-inflicted Injuries** – Services or supplies furnished in connection with intentionally self-inflicted injuries, whether committed while sane or insane; treatment of or related to a drug overdose if such overdose is intentional, the result of illegal drugs, or results from the intentional improper use of drugs and medicines, whether or not the drugs or medicines are prescribed. Charges for self-inflicted injuries are eligible if they result from a medical condition or domestic violence;
 39. **Services Before or After Coverage** - Charges incurred prior to the date an Employee or a Dependent of an Employee becomes a Participant under this Plan; or charges incurred after the date an Employee or a Dependent of an Employee is no longer a Participant under this Plan;
 40. **Sexual Change or Impairment** - Treatment of sexual impairment or inadequacies which are not related to organic disease, sex transformations; or treatment leading to or in connection with transsexual surgery;
 41. **Smoking Cessation** – Charges for smoking cessation expenses, including smoking deterrents;
 42. **Surrogacy** - A third-party's expenses in connection with infertility treatment; and sperm or egg storage fees incurred in connection with planning for future treatment;
 43. **Telephone Consultations** – Charges for telephone or electronic consultations, failure to keep scheduled appointments, completion of claim forms, stand-by, set-up or other charges for services not rendered;
 44. **Temporo-mandibular Joint Disorders** – Charges for treatment of temporo-mandibular joint dysfunction, oral rehabilitation, oral splints, orthotics and appliances (See Dental Plan);
 45. **Timely Filing** - Charges for services received by the Claims Administrator or the PPO later than 1 year from the date the services were rendered or otherwise provided;
 46. **Transportation or travel** - Charges for transportation or travel, except as specified under ambulance and organ transplants;
 47. **Vision** – Charges routine vision services in excess of the amount shown in the Schedule of Benefits, vision therapy, orthoptics, replacement eyewear (if eyewear is lost or stolen), safety glasses and surgery performed to eliminate the need for eyeglasses for refractive errors (i.e. radial keratotomy or LASIK), except as specified under Durable Medical Equipment;
 48. **War or Act of War** – Charges for treatment of a condition resulting from war or an act of war, riot, rebellion, civil disobedience, or an injury sustained or illness contracted while on duty with any military service for any country;
 49. **Weekend Admission** – Charges for any inpatient hospital admission occurring on a Friday or Saturday in conjunction with a surgical procedure scheduled to be performed during the following week. A Sunday admission will be eligible only for procedures scheduled to be performed early Monday morning. This limitation will not apply to

necessary medical admissions requiring immediate attention or to emergency surgical admissions;

50. **Workers' Compensation Law** - Illness or injury charges which arises out of or in the course of any employment for wage or profit for which the covered person is entitled to indemnify under the terms of any Workers' Compensation Law or similar law. This applies whether or not the Participant has declined participation under such law, except if the Participant is a proprietor, partner, or executive corporate officer Employee.

CHAPTER III

PRESCRIPTION DRUG BENEFITS

Benefits are provided for brand name and generic prescription drugs. The Prescription Drug Plan co-payment amounts are as follows:

Prescription Drug Card	Co-payment per Prescription			
	34 day supply Retail		90 day supply Mail Order	
	Active Employee	Retiree	Active Employee	Retiree
Generic drugs	\$7	20%	\$14	20%
Preferred Brand Name (Formulary)	\$20	20%	\$40	20%
Non-preferred Brand (Non-Formulary)	\$35	20%	\$70	20%

Note: There is a mandatory generic requirement, unless a generic drug is not available or the physician prescribes, "dispense as written". If you choose a brand name drug and a generic is available, you will have to pay the difference between the generic drug and the brand name drug, unless the physician specifies dispense as written.

Generic versions of brand name drugs are reviewed and approved by the FDA (Food & Drug Administration). Generic drugs have the same active ingredients and come in the same strength and dosage form as the brand name drug. If you choose the generic drug, you will always pay the lowest copay.

The patient should discuss the prescription alternatives with his doctor to determine if a lower cost alternative is available and appropriate for his condition. The patient and the doctor should determine the treatment plan that is most appropriate for the condition. In some cases, this may mean the patient will pay the higher copay.

The administrator of the Prescription Drug Plan is PharmaCare (formally EHS). The Prescription Plan's network of participating pharmacies is nationwide and they display a decal in their window or near the pharmacy department. If you have questions regarding your Prescription Drug Plan you may contact PharmaCare at: (888) 645-9303 or access their website at: www.pharmacare.com.

When you present your identification card to a participating pharmacy, your cost for a prescription or a refill will be the brand name or generic prescription co-payment as indicated in the Schedule of Benefits. For maintenance prescription drugs you can obtain a larger quantity saving you trips to the pharmacy and prescription co-payment expenses by using the Mail Service Prescription Drug Program below.

The Mail Service Prescription Drug Program is mandatory for maintenance prescription drugs after 2 fills at the retail pharmacy.

HOW TO FILE A CLAIM

Member Pharmacies - Many pharmacies participate in the Prescription Plan program. When you go to a participating pharmacy, show your Prescription Plan identification card. It provides the pharmacy with important information about your coverage. The pharmacy will collect your co-payment and fill your prescription(s).

Non-Member Pharmacies or Member Pharmacies When the Participant Does Not Use the Prescription Plan Card - You must submit a claim directly to the Prescription Plan when you purchase a prescription from a non-member pharmacy or do not use your card at a member pharmacy. The Prescription Plan will only pay the maximum contracted price for each prescription, less your co-payment. The maximum contracted price used for reimbursement will probably be less than the amount you are charged. Reimbursement will be sent directly to you. To submit a claim, please request a claim form from your Personnel/Human Resources Department or access PharmaCare's website at: www.pharmacare.com.

Mail Service Prescription Drug Program - The Mail Service Prescription Drug Program provides benefits for maintenance drugs which require a prescription by law to purchase, and insulin. The Mail Service Prescription Drug Program is mandatory after 2 fills at the retail pharmacy. The maximum quantity which can be claimed is a 90-day supply which is more than can be obtained under the regular Prescription Drug Plan. Use of the Mail Service Prescription Drug Program will save you trips to the pharmacy and minimizes the prescription co-payments. Please contact your Personnel/Human Resources Department for the forms needed to order maintenance drugs via mail order or access PharmaCare's website at: www.pharmacare.com.

Participants Who Continue Coverage Under COBRA – Follow the directions given above.

CHAPTER IV

DENTAL CARE BENEFITS

Individual Maximums:	
Calendar Year Maximums: Levels I-III	\$1,500
Individual Deductible: Levels I and II Services Level III Services	\$50 per lifetime \$100 per calendar year
Covered Services:	
Level I – Preventive Services	1 st year in Plan – 70% 2 nd year in Plan – 80% 3 rd year in Plan – 90% 4 th year in Plan – 100%
Level II – Basic Services	1 st year in Plan – 70% 2 nd year in Plan – 80% 3 rd year in Plan – 90% 4 th year in Plan – 100%
Level III – Major Services	50%

ELIGIBILITY - The eligibility, enrollment, and effective date of coverage provisions described in Chapter I pertain to Dental Care Benefits.

DENTAL PLAN PROVISIONS

Individual Deductible - Each Participant's deductible is shown in the Schedule of Benefits. Each Participant must satisfy a lifetime deductible for Preventive and Basic Services and a calendar year deductible for Major Services.

Dental Care Covered Services - The Plan will pay the percentage indicated in the Schedule of Benefits based on the Reasonable and Customary allowances for the services rendered.

Maximum Dental Care Benefit - The calendar year maximum payable for Covered Services in Levels I through III is shown in the Schedule of Benefits.

DENTAL COVERED SERVICES

A Participant is entitled to benefits for the following services. All benefits are subject to the exclusions, limitations, and provisions of this Plan. Payments are based on the Reasonable and Customary allowance.

LEVEL I and II (Preventive and Basic Services)

Anesthesia – General anesthesia in conjunction with covered dental procedures and oral surgery.

Endodontic Services - Diagnosis and treatment of the pulp chambers and pulp canals. Covered endodontic services include pulpotomies, pulp capping, root canal therapy (if tooth is “opened” while covered by the Plan).

Extractions – Simple tooth extractions.

Fillings or Restorations - Fillings or restorations consisting of amalgam or composite material once per year per tooth surface.

Injection – Injection of antibiotic drugs in conjunction with a covered dental procedure.

Oral Examinations - Two oral examinations per calendar year.

Oral Prophylaxis - Cleaning of teeth, including scaling and polishing, twice a calendar year.

Oral Surgery (including post-operative care) - Alveoplasties, stomatoplasties, the excision and drainage of abscesses involving the teeth and/or support structures of the teeth, the removal of exostosis and hyperplastic tissue and the removal of impacted teeth.

Palliative Treatment - Emergency treatment for the relief of pain.

Periodontic Services - Prevention, detection and treatment of diseases of the tissues and bones supporting the teeth including gingival curettage, root planning and scaling (limited to once per year per quadrant), gingivectomy or gingivoplasty and osseous surgery and grafts. Periodontic services only apply to areas where natural teeth are present.

Repair of Crowns and Dentures - Recementation for any crown, bridge, facing or inlay. Repair of facings of a removable denture; repairs are limited to a maximum of 1 repair of each removable denture per calendar year. Denture adjustments and relinings.

Sealants – Sealants for permanent molars only, for dependent children up to age 15, limited to once in any 36 consecutive month period.

Space Maintainers – When used to replace premature loss of extracted teeth, for Dependent children up to age 19;

Topical Fluoride Applications - One topical fluoride application per person per calendar year.

X-rays - A complete series of full-mouth x-rays every 3 consecutive years and 1 set of bitewing x-rays per calendar year.

LEVEL III (Major Services)

Prosthodontic Services include the following:

- a. Inlays, onlays, gold fillings, or crown restorations;
- b. Initial installation of partial or full removable dentures, including adjustments for the six month period following installation;
- c. Replacement of an existing partial or full removable denture or fixed bridgework by a new denture or bridgework, the addition of teeth to existing fixed bridgework or partial removable denture (please refer to the Prosthesis Replacement Rule described below)
- d. Treatment by orthodontic means of temporomandibular joint dysfunction (TMJ) syndrome, internal derangement of the mandible, Costen-Syndrome or similar disorder.

Prosthesis Replacement Rule – The replacement of or additions to existing crowns, dentures or bridgework will be covered only if satisfactory evidence is furnished to the Claim Processor that one of the following applies:

- a. The replacement or addition of teeth is required to replace one or more teeth extracted or lost after the existing crown, denture or bridgework was installed, and while the individual is covered by the Plan;
- b. The existing crown, denture or bridgework cannot be made serviceable and was installed at least five years prior to its replacement; or
- c. The existing crown, bridgework, or denture is an immediate, temporary denture and replacement by a permanent denture is required within 12 months from the date of initial installation of the immediate temporary denture.

PRE-TREATMENT AUTHORIZATION

In order to determine appropriateness of treatment and reasonable and customary fees, a pre-treatment authorization is recommended from the Claims Administrator for any non-emergency treatment plan which exceeds \$300. An authorization with estimated benefits payable will be released after the dentist submits the treatment plan to the Claims Administrator (including the list of services to be performed) with dental codes, the itemized cost of each service, and the estimated duration of treatment.

Actual benefits are determined according to the Reasonable and Customary allowance which exists at the time the services are actually performed. Dental expenses may be denied if the treatment is not appropriate for the Participant's condition or any portion of fees charged may be denied which are in excess of Reasonable and Customary allowances for such procedures.

LIMITATIONS AND EXCLUSIONS ON YOUR DENTAL COVERAGE

Change of Dentist - If a Participant transfers from the care of a dentist to that of another dentist during the course of treatment, or if more than 1 dentist provides services for a dental procedure, benefits will be provided for no more than the amount allowed had only a single dentist provided the service.

Optional Techniques - Some dental conditions may be treated by 1 or more methods. This Plan will pay for the procedure that provides the proper treatment, according to accepted standards of dental practice, for the lowest Reasonable and Customary allowance.

Services Rendered Prior to Coverage - Under your dental coverage, the plan will exclude any dental services rendered prior to the effective date of coverage. Certain services which are begun

before the effective date will be considered as occurring prior to the effective date of coverage even if completed after the effective date. This applies to the following services:

- a. Fixed bridgework and full or partial dentures if the first impressions are taken and/or abutment teeth fully prepared prior to the effective date;
- b. A crown, inlay or onlay if the tooth is prepared prior to the effective date;
- c. Root canal therapy if the pulp chamber of the tooth is opened prior to the effective date.

Exclusions - In addition to the General Limitations and Exclusions, benefits will not be provided under your Dental Care Benefits for:

1. **Alterations** - Charges for altering vertical dimension, periodontal splinting or implantology;
2. **Cosmetic or Aesthetic** - Dental services for cosmetic or aesthetic purposes. However, charges are payable if the cosmetic dental work is needed because of an accidental injury received while covered if the cosmetic dental work is completed within 1 year from the date of the accident. The charges for the correction of a birth abnormality of a Participant are **not** considered to be cosmetic;
3. **Educational** – Charges for educational, research, or training programs, such as training in plaque control, dietary counseling or oral hygiene;
4. **Experimental** – Experimental services or services which do not meet the standards of dental practice accepted by the American Dental Association;
5. **Missed Appointments** – Charges made by a dentist for missed appointments or for completion of claim forms or filing of claims;
6. **Not Listed** - Charges for services not listed under Dental Covered Services;
7. **Not Necessary** - Dental services which are not necessary for the diagnosis or treatment of any dental disease, defect, or injury;
8. **Orthodontic treatment** – except as specified under TMJ covered services;
9. **Relative** - Charges incurred for services or supplies rendered by the Employee, Employee's Spouse and the children, brothers, sisters, parents, or grandparents of either the Employee or Employee's Spouse.
10. **Replacement of Appliance** - Replacement of lost missing, or stolen appliances and any appliance to be used as a spare;
11. **Replacement of Tooth** - Charges for replacement of teeth lost, or otherwise missing, prior to coverage under this Plan, for covered persons employed less than 2 years with the Employer;
12. **Timely Filing** – charges for services received by the Claims Administrator later than 1 year from the date the services were rendered;
13. **Veneers** – Charges for veneers on crowns or pontics other than the ten upper and lower anterior teeth;
14. **Workers' Compensation** - Dental services for which coverage is available to the Participant, in whole or in part, under any Workman's Compensation Law or similar legislation whether or not the Participant claims compensation or receives such benefits.

CHAPTER V

COST CONTAINMENT

Managed Care

Nationwide Better Health

The Managed Care provisions of this Plan are administered by Nationwide Better Health, the Managed Care Vendor (MCV). The staff at the Managed Care Vendor are Physicians and Registered Nurses who monitor the use of your health care benefits to ensure that you and your family:

- a. Receive the best medical care possible in the most appropriate health care setting;
- b. Avoid unnecessary surgery and excess hospital days;
- c. Receive medical advice on questions you have regarding medical care;
- d. Receive the maximum benefits from your health care treatment and benefit plan.

Components of the Managed Care program include:

- a. Pre-admission and Admission Review of all hospital admissions, including inpatient psychiatric and obstetrical admissions, fertility services and organ transplants;
- b. Continued Stay Review of all hospitalizations;
- c. Case management of potentially catastrophic cases;

Pre-admission, admission, and continued stay review decisions are based on the medical policy guidelines of the MCV. This may include, but is not limited to the following reviews:

- a. Cosmetic
- b. Investigational/Experimental
- c. Out patient services, e.g. speech therapy, physical therapy, chiropractic services

Otherwise, all medical necessity review will be performed at NCAS utilizing the CareFirst Medical Policy.

HOW THE MANAGED CARE PROGRAM WORKS

PRE-ADMISSION CERTIFICATION AND REVIEW:

- a. If your Physician recommends that you or a covered family member be hospitalized, you must contact the Managed Care Vendor for assistance with the certification process. Hospitalizations out of the country or when this Plan is the secondary payer do not require Pre-admission certification. All other hospitalizations require Pre-admission and Admission Review. Admission certification must occur prior to an elective or planned hospitalization or the next business day after an urgent or emergency admission. To obtain admission certification, call:

Nationwide Better Health: 800 315-2031

When you call, have your identification number, Employer name, patient name, home phone number, Physician name and phone number ready.

- b. Notification may be initiated by you, a family member, Physician, or representative from the hospital. The Managed Care Vendor will review your Physician's recommendations based on the medical information supplied and accepted standards and criteria for hospital admission. In most cases, the Managed Care Vendor will notify you, your doctor, and the hospital of your

certification approval within 24 hours. At that time the hospital will be advised of the number of approved days.

CONTINUED STAY REVIEW:

- a. If necessary, you, a family member, your Physician, or the hospital representative must call the Managed Care Vendor to request an extension of inpatient days beyond those originally assigned. The Managed Care Vendor will review your admission to determine if additional inpatient hospital days are medically necessary. This type of review is known as Continued Stay Review.
- b. If your admission or request for extension is denied; you may appeal the decision to the Managed Care Vendor and they will review your case and render a decision.

NOTE: In order to receive full benefits for a hospital admission, the admission must be certified by the Managed Care Vendor. If the Managed Care Vendor is not notified of the hospital admission, covered charges will be reduced by \$200, even if the admission is determined to be medically necessary. If the admission is not medically necessary, no benefits are payable for the entire Hospital stay. If the Participant stays in the Hospital longer than originally certified, and the extended stay is not certified through the Managed Care Vendor, no benefits are payable for the remainder of the Hospital stay.

Statement of Rights Under the Newborns' and Mothers' Health Protection Act

Under federal law, group health plans and health insurance issuers offering group health insurance coverage generally may not restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a cesarean section. However, the plan or issuer may pay for a shorter stay if the attending provider (e.g., your physician, nurse, midwife, or physician assistant), after consultation with the mother, discharges the mother or newborn earlier.

Also, under federal law, plans and issuers may not set the level of benefits or out-of-pocket costs so that any later portion of the 48-hour (or 96-hour) stay is treated in a manner less favorable to the mother or newborn than any earlier portion of the stay.

In addition, a plan or issuer may not, under federal law, require that a physician or other health care provider obtain authorization for prescribing a length of stay of up to 48 hours (or 96 hours).

LARGE CASE MANAGEMENT (CARE MANAGEMENT)

A "Large Case" is one resulting from a catastrophic illness or accident, which usually results in a lengthy stay or multiple hospital confinements. Large Case Management is the development of alternative treatment plans for Participants which meet the medical needs of the Participant, and achieve the most efficient use of medical resources.

By fully exploring treatment alternatives and, when appropriate, using a flexible approach to benefit administration, the case manager, Physicians, patients and families are able to work together to provide the patient with quality care which promotes the fullest recovery possible, in the most effective manner.

"A flexible approach to benefit administration" means that the case manager can approve treatment alternatives which usually are not covered under the Plan but will provide quality care to the patient and generate a savings over other covered options.

VI

GENERAL INFORMATION

DEFINITIONS

Active Employee - An employee hired to work 10 months or more per year and regularly scheduled to work at least 35 hours per week on a full-time basis as determined by the Employer, and part-time employees of the Employer, hired to work 10 months or more per year, on the regular payroll of the Employer for that work, and regularly scheduled to work at least 20 hours per week as determined by the Employer, either at his or her customary place of employment or at some location at which that employment requires him or her to travel, or if he is absent from work solely by reason of vacation, illness, or other excused absence.

Alcoholic Rehabilitation Facility - An institution licensed or certified to provide rehabilitative services for alcoholism, drug addiction, and/or substance abuse.

Ambulatory Surgical Facility - A licensed or certified institution which:

- a. Has permanent operating rooms and at least a recovery room, and all necessary equipment for use before, during and after surgery;
- b. Is operated under the supervision of a Licensed Physician with a medical staff including Registered Nurses (RNs) available for care in an operating or recovery room;
- c. Is other than a private office or clinic of 1 or more Physicians.

Approved Provider - A person or entity, other than a Hospital or Physician, which is a Licensed Provider. Other providers include:

Institutional

Alcohol Rehabilitation Facility
Ambulance Service
Ambulatory Surgical Facility
Birthing Center
Extended Care Facility
Free-Standing Laboratory Facility
Home Health Care Agency
Home Infusion Therapy Agency
Hospice
Pharmacy
Renal Dialysis Facility
Rehabilitation Facility
Residential Treatment Facility

Professional

Audiologist
Certified Nurse Midwife
Certified Registered Nurse Anesthetist
Licensed Clinical Social Worker
Licensed Practical or Vocational Nurse
Licensed Professional Counselor
Nurse Practitioner
Occupational Therapist
Physical Therapist
Registered Nurse
Registered Nurse Clinical Specialist
Respiratory Therapist
Speech Pathologist

Birthing Center - A licensed or certified institution which meets the following requirements:

- a. It provides 24-hour-a-day nursing service by or under the direction of Registered Nurses and Certified Nurse Midwives;
- b. It is staffed, equipped, and operated to provide:
 - 1) Care for patients during uncomplicated pregnancy, delivery, and the immediate postpartum period;
 - 2) Care for obstetrical patients and infants born in the center who require emergency and immediate life support measures to sustain life pending transfer to a hospital.

Calendar Year - The 12-month period from January 1 through December 31 of each year.

Certificate of Coverage – These are the primary means by which individuals will prove prior creditable coverage. You should have received a certificate of creditable coverage from your prior plan. You may request a certificate from your prior plan if you did not receive one. If necessary, your Human Resources Department will assist you in obtaining the certificate. You must present that certificate to the Employer in order for your creditable coverage to reduce your Pre-Existing Condition Waiting Period under this Plan.

Chemical Dependency, Alcoholism, or Substance Abuse - Physical and/or emotional addiction to drugs, narcotics, alcohol or other addictive substances to a debilitating degree. Dependence upon tobacco, nicotine, and caffeine are not included in this definition.

Claims Administrator - The person/organization providing consulting services to the Employer in connection with the operation of this Plan and performing such other functions, including processing and payment of claims, as may be delegated to it. The Claims Administrator is National Claims Administrative Services (NCAS).

Creditable Coverage - Coverage under almost any other type of medical plan, including group health plans, individual insurance, Medicare, Medicaid, Tricare, Indian Health Service medical care or care through a tribal organization, state health benefits risk pools, the Federal Employees Health Benefits Program, a public plan, the State Children's Health Insurance Program and a Peace Corps Plan. A public plan includes plans established or maintained by a state, the U.S. government, a foreign country, or any political subdivision of a state, the U.S. government, or a foreign country that provides health coverage to individuals who are enrolled in the plan. Creditable coverage is measured in days. Each day of creditable coverage reduces by one day any Pre-Existing Condition Waiting Period under this Plan. However, if the break in coverage between your old plan and this Plan is 63 days or longer, you will not receive any creditable coverage, and you will be subject to the full Pre-Existing Condition Waiting Period.

Custodial Care - The care provided primarily for maintenance of the patient. Custodial Care is designed essentially to assist the individual in meeting the activities of daily living and is not provided primarily for its therapeutic value in the treatment of an illness, accidental injury or condition. Custodial care includes, but is not limited to, helping in walking, bathing, dressing, feeding, or preparation of special diets.

Deductible - The amount of expenses for Covered Services that a Participant must pay for him or herself before the Plan will begin its payments.

Effective Date - The date on which coverage for an eligible Employee or an eligible Dependent begins.

Electronic Protected Health Information (EPHI) – The term "Electronic Protected Health Information" has the meaning set forth in 45 C.F.R. § 160.103, as amended from time to time, and generally means protected health information that is transmitted or maintained in any electronic media.

Emergency Care - Emergency service rendered for the sudden onset of a medical condition manifesting itself by acute symptoms of sufficient severity that the absence of immediate medical attention could reasonably result in

- a. Permanently placing the patient's health in jeopardy;
- b. Serious impairment to bodily functions;
- c. Serious and permanent dysfunction of any bodily organ or part;
- d. Sudden and unexpected onset of severe pain; or
- e. Other serious medical consequences.

Heart attacks, poisoning, loss of consciousness, severe breathing difficulties, convulsions, and other acute conditions may be considered medical emergencies. The symptoms and severity of the attack must require immediate medical care. Medical emergencies do not include less acute medical conditions which your own physician could treat during his regular hours.

Employer - The employer is the College of Southern Maryland.

Enrollment Date - The first day of coverage or, if there is a Waiting Period, the first day of the Waiting Period. The date of employment will usually be the enrollment date. However, the enrollment date for a late enrollee is the first day of coverage.

Exhaustion of COBRA Continuation Coverage - An individual's COBRA coverage ends for any reason other than either the failure of the individual to pay premiums on a timely basis or for cause (such as making a fraudulent claim or an intentional misrepresentation of a material fact in connection with the plan).

Experimental or Investigative - The use of any drug, device, supply, medical treatment or procedure not yet recognized by the Plan as acceptable medical practice. The Plan defines a drug, device, medical treatment or procedure as Experimental or Investigative if any of the following criteria apply:

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

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

Extended Care Facility - An institution operated pursuant to law and primarily engaged in providing room and board, together with 24-hour-a-day nursing service as needed to provide adequate medical care for persons convalescing from accident or illness and providing services under the supervision of a Physician or a Registered Nurse devoting full-time to such supervision. An Extended Care Facility must maintain adequate medical records and have available the services of a Physician under an established agreement if not supervised by a Physician. In no event shall such term include any institution which is:

- a. A Hospital;

- b. Primarily for the care of mental illness, drug addiction or alcoholism;
- c. Primarily engaged in providing domiciliary care, custodial care, educational care, or care for the aged.

Family and Medical Leave Act of 1993 (FMLA) - This applies to employers with 50 or more employees for at least 20 workweeks in the current or preceding calendar year. The following are some definitions identified by the FMLA:

Eligible Employee - An individual who has been employed by College of Southern Maryland for at least 12 months, has performed at least 1250 hours of service during the previous 12 month period, and has worked at a location where at least 50 employees are employed by the Employer within 75 miles.

Family Member - The (a) employee's biological, step, or foster parent or (b) a natural, adopted, foster, or step child, or a legal ward under 18 years of age, or 18 years and older and incapable of self-care because of a mental or physical disability or (c) spouse.

Serious Health Condition - An illness, injury, impairment, or physical or mental condition that involves; (a) inpatient care in a hospital, hospice or residential medical care facility, or (b) continuing treatment by a health provider.

These definitions are listed as a guide and the actual wording of the FMLA, as amended, shall supersede these definitions.

Fiduciary - The person or organization that has the authority to control and manage the operation and administration of the Plan. The fiduciary has discretionary authority to determine eligibility for benefits or to construe the terms of this Plan. The named fiduciary for this Plan is the Employer.

Full-Time Student - A Dependent child who is enrolled in and regularly attending an accredited college, university or other accredited school for the minimum number of credit hours required by that college or university in order to maintain full-time student status. A Dependent continues to be eligible for coverage for up to four months following the close of a school term only if enrolled as a full-time student for the following school term.

Home Health Care - Is care rendered to Participants who require active and skilled medical care at home. Home Health Care includes any array of professional, technical, and health related services usually provided by hospitals to inpatients.

Home Health Care Provider - A Hospital, skilled nursing facility, local or state governmental health department, a community Home Health Care agency or other health organization. A Home Health Care Provider must be licensed by the state or certified by the U.S. Health Care Financing Administration as a provider of Home Health Care services.

Hospice Care - The Provider-directed professional, technical, and related medical, palliative, and personal care services provided under a Hospice Care Program.

Hospice Care Program - A coordinated interdisciplinary program for meeting the special physical, psychological, and social needs of dying individuals and their immediate families; which provides palliative and supportive medical, nursing and other health services through home or inpatient care during the illness to Participants who have no reasonable prospect of a cure and, as estimated by a Physician, have a life expectancy of less than 6 months; and which provides bereavement counseling to the immediate families of such Participant.

Hospice Provider - Any Hospital, Home Health Care agency, Hospice or other facility or unit of such facility, which is licensed or certified (by the state in which services are rendered) to provide Hospice Care.

Hospital - A Licensed Provider, accredited as a Hospital by the Joint Commission on Accreditation of Healthcare Organizations or the American Osteopathic Association Healthcare Facilities Accreditation Program, which is an acute-care institution primarily engaged in providing diagnostic and therapeutic services for surgical or medical treatment by or under the supervision of Physicians and which provides 24-hour-a-day nursing services. An institution specializing in the care and treatment of a mental illness, which would qualify as a hospital, except that it lacks organized facilities on its premises for major surgery, shall nevertheless be deemed a hospital.

Illness - Sickness or disease, including mental infirmity, which requires treatment by a Physician. A recurrent illness shall be considered the same illness. Concurrent illnesses shall be deemed the same illness unless such illnesses are totally unrelated.

Infertility - Disease or condition that results in the abnormal function of the reproductive system such that a person is not able to conceive or produce conception during a period of one year.

Injury - An injury means a condition caused by accidental means which results in damage to the Participant's body from an external force. All injuries sustained by a Participant in connection with an accident shall be considered 1 injury.

Inpatient Care - Treatment as a registered bed patient.

Legend Drug - A pharmaceutical product that requires a physician's written prescription and cannot be obtained legally without a physician's prescription.

Licensed Provider - An Approved Provider, Hospital or Physician who is licensed or certified by the State in which he practices or the entity is located and provides Covered Services within the scope of their license. The Covered Services must be for Medically Necessary Care of an illness, injury or otherwise identified as a covered expense in the Schedule of Benefits.

Lifetime - The inception date in which coverage for you and your covered Dependents commences and continues throughout the period you and your covered Dependents meet the definition of a Participant under the Employer's Plan.

Maintenance Care – Any service or activity which seeks to prevent disease, prolong life, or promote health of an asymptomatic person who has reached the maximum level of improvement and whose condition is resolved or stable.

Managed Care Vendor - The Managed Care Vendor is Nationwide Better Health. Their telephone number is (800) 315-2031.

Medically Necessary Care – Any health care treatment, service or supply determined by the Plan Administrator to meet each of these requirements:

1. It is ordered by a Physician for the diagnosis or treatment of a Sickness or Injury;
2. The prevailing opinion within the appropriate specialty of the United States medical profession is that it is safe and effective for its intended use and that omission would adversely affect the person's medical condition; and
3. It is furnished by a provider with appropriate training and experience, acting within the scope of his or her license, and it is provided at the most appropriate level of care needed to treat the particular condition.

The Plan Administrator will determine whether these requirements have been met based on:

1. Published reports in authoritative medical and scientific literature;
2. Regulations, reports, publications or evaluations issued by government agencies such as the National Institute of Health, the Food and Drug Administration (FDA) and HCFA;
3. Listings in the following compendia: *The American Hospital Formulary Service Drug Information* and the *United States Pharmacopoeia Dispensing Information*; and
4. Other authoritative medical resources to the extent the Plan Administrator determines them to be necessary.

Service or supplies that are for the convenience of a Participant or provider are not considered medically necessary. When specifically applied to inpatient care, medically necessary also means the Participant's condition could not be treated safely on an outpatient basis.

Medicare - The programs established by Title XVIII of Public Law 89-97 (79 Statutes 291), as amended, entitled Health Insurance for the Aged Act.

Morbid Obesity – A diagnosed condition in which an individual's body weight exceeds the normal weight by 100 pounds or has a body mass index (BMI) of 40 or more (35 with certain co-morbid conditions). The excess weight must cause a condition such as physical trauma, pulmonary, and circulatory insufficiency, diabetes, or heart disease.

National Claims Administrative Services, Inc. (NCAS) - The Claims Administrator/Claims Administrator which provides claims payment services and customer service. Their telephone number is (866) 219-9292.

Outpatient - Anyone receiving services or supplies while not an inpatient.

Palliative Treatment – Relief of symptoms for a time but does not cure or end the cause of symptoms.

Participant - Any eligible employee or eligible Dependent who has elected coverage in this Plan and has fulfilled all requirements to continue participation.

Physician - A properly Licensed Provider holding a degree of Doctor of Medicine (MD), Osteopath (DO), Podiatrist (DPM), Psychologist (PhD), Dentist (DDS or DMD), or Chiropractor (DC).

Placement for Adoption - The assumption and retention of a legal obligation for total or partial support of a child by a person with whom the child has been placed in anticipation of the child's adoption. The child's placement for adoption with such person terminates upon the termination of such legal obligation.

Plan/This Plan - The plan of benefits as contained in the Summary Plan Description and Plan Document, and any agreements, schedules and amendments endorsed by the Plan Sponsor.

Plan Administrator - The person/organization responsible for the day-to-day functions and management of this Plan. The Plan Administrator may employ persons or firms to process claims and perform other Plan-connected services. If an Administrator is not appointed in the instrument which governs the Plan, then the Administrator is the Plan Sponsor. The Plan Administrator is College of Southern Maryland.

Plan Sponsor - The Plan Sponsor is the Employer who establishes a single employer plan. The Plan Sponsor is College of Southern Maryland.

Preferred Provider - A panel of Licensed Providers and/or a group of participating healthcare institutions which provide medical services to contracted groups of Participants. Savings received because of the contracted rates are not the responsibility of the Participant. Some Per-diem and discounted hospital rates can provide coverage for items usually not covered under the Plan (such as a private room which is not medically necessary). Contact NCAS or access the Preferred Provider Organization's (PPO) website, to determine if a provider participates.

Private Duty Nursing - Out of hospital Skilled Care ordered by a Physician and rendered by a Registered Nurse (RN) or Licensed Practical or Vocational Nurse (LPN/LVN).

Protected Health Information (PHI) - Individually identifiable health information which is maintained or transmitted by a health plan.

Qualified Beneficiary - Individuals who are entitled to COBRA continuation coverage. An individual who has been covered by the group health plan on the day before the event that caused a loss of coverage, and a child born to, or placed for adoption with, the covered employee during the period of COBRA coverage are Qualified Beneficiaries.

Qualified Medical Child Support Order (QMCSO) - A Medical Child Support Order:

- a. Creates or recognizes the existence of an alternate recipient's right to, or assigns to an alternate recipient the right to, receive benefits for which the Participant or beneficiary is eligible under a group health plan;
- b. Specifies the name and last known mailing address of the Participant and of each alternate recipient covered by the order;
- c. Specifies a reasonable description of the type of coverage to be provided by the Plan to each alternate recipient (or how it is determined);
- d. Specifies each plan to which the order applies and the period to which such order applies;
- e. Does not require a plan to provide any type or form of benefit not otherwise provided under the Plan.

Upon receipt of a Medical Child Support Order, the Plan Administrator or Claims Administrator shall follow these procedures:

- a. The Plan Administrator shall promptly notify in writing the Participant, each alternative recipient covered by the order, and each representative for these parties of the receipt of the Medical Child Support Order. Such notice shall include a copy of the order and these QMCSO procedures for determining whether such order is a QMCSO.
- b. The Plan Administrator shall permit the alternate recipient to designate a representative to receive copies of notices sent to the alternate recipient regarding the Medical Child Support Order.
- c. The Claims Administrator shall within a reasonable period after receiving a Medical Child Support Order, determine whether it is a qualified order and notify the parties indicated in subsection (a) above of such determination.
- d. The Plan Administrator shall ensure the alternate recipient is treated by the Plan as a beneficiary for reporting and disclosure purposes, such as by distributing to the alternate recipient a copy of the Summary Plan Description and any subsequent Plan amendments.

Reasonable and Customary Allowance - Plan allowances for treatment, services or supplies essential to the care of the individual as determined by the Claims Administrator. Charges by the Licensed Provider must be the amount usually charged for similar services and supplies when there is no insurance. Charges for Covered Services that do not exceed the amount in the fee schedule

used by the Plan will be reimbursed as specified in the Schedule of Benefits. The fee schedule published by Ingenix is used by the Plan to determine the Reasonable and Customary Allowance.

Rehabilitation Facility - A facility which mainly provides therapeutic and restorative services to sick or injured people to restore bodily function after an inpatient hospitalization for a debilitating illness or injury. Inpatient rehabilitation, provided by a licensed or certified facility in the jurisdiction in which care is rendered, must be medically necessary, that is the patient's condition must require supplementary skilled care in addition to physical therapy and/or occupational therapy. The expectation is to restore the Participant to enable him/her to live outside of an institution.

Residential Treatment Facility - A facility licensed or certified as such by the jurisdiction in which it is located to operate a program for the treatment and care of Participants diagnosed with alcohol, drug or substance abuse disorders or mental illness.

Security Incidents – The term "Security Incidents" has the meaning set forth in 45 C.F.R. § 164.304, as amended from time to time, and generally means the attempted or successful unauthorized access, use, disclosure, modification, or destruction of information or interference with systems operations in an information system.

Significant Break in Coverage - A break in coverage of 63 days or more. Waiting Periods are not considered breaks in coverage. Under HIPAA, if an individual has a break in coverage of at least 63 days, any Creditable Coverage before that break will be disregarded by the plan when evaluating whether to impose a pre-existing condition limitation period.

Skilled Care - Care which requires the technical proficiency and scientific skills of a Registered Nurse (RN) or Licensed Practical or Vocational Nurse (LPN/LVN). Skilled nursing services include, but are not limited to, the following:

- a. Intravenous or intramuscular injections;
- b. Administration of total parenteral nutrition, chemotherapy drugs, blood products, medications, and solutions via intravenous or central venous catheters;
- c. Levine tube and gastrostomy feedings (until a maintenance level is reached);
- d. Naso-pharyngeal and tracheostomy aspiration (until a maintenance level is reached);
- e. Insertion or replacement of catheters and sterile irrigations of catheters;
- f. Care of extensive decubitus ulcers, infected wounds or other severe skin disruptions requiring sterile technique and skilled application of dressings, and medications.

Surgery - The performance of generally accepted operative and cutting procedures, as well as the following:

- a. Specialized instrumentations, endoscopic examinations and other invasive procedures;
- b. Correction of fractures and dislocations;
- c. Usual and related pre-operative and post-operative care;
- d. Pregnancy, childbirth or miscarriage and complications thereof, and circumcision;
- e. Other procedures as reasonably approved by the Claims Administrator.

Total Disability - An employee is prevented solely because of an injury, illness or disease, from engaging in the substantial duties of any business or occupation for which he is qualified by education and experience and from performing any and all work for substantially similar compensation or profit; or if a Dependent of an employee is prevented, solely because of an injury or disease, from engaging in all of the normal activities of a person of like age and sex in good health. Certification of total disability must be made by a Physician.

Waiting Period - A waiting period is the period that must pass before an employee or Dependent is eligible to enroll under a group health plan. The waiting period does not count as prior creditable

coverage nor as days in a break in coverage.

Well-Child Care - Medical treatment, immunizations, services and supplies rendered to a child or newborn for the purpose of health maintenance and not for the treatment of an illness or injury.

CONDITIONS OF COVERAGE - The benefits described are available only when Covered Services are received after a Participant's effective date.

All Covered Services must be medically necessary, prescribed by a Physician or other professional provider, and rendered by a Physician (see Definitions).

Payment will be made for Covered Services according to the benefits in effect on the date the services are received.

A Participant has the right to select the provider of his choice. College of Southern Maryland has no responsibility for a provider's failure or refusal to render services to a Participant. Furthermore, College of Southern Maryland is not liable for anything the provider may or may not do.

COORDINATION OF BENEFITS - This Plan contains a non-profit provision coordinating it with other similar plans under which an individual may be covered so that the total benefits available during the calendar year will not exceed the benefits of this Plan that would have been provided in the absence of Coordination of Benefits.

If, in coordinating the benefits of this Plan with those of another plan, the rules set forth in the following Order of Benefit Determination paragraph would require this Plan to be the primary payer and the other plan, according to its rules, is the secondary payer, then the benefits of that other plan will be ignored for the purpose of determining the benefits of this Plan.

If, in coordinating the benefits of this Plan with those of another plan, the rules set forth in the following Order of Benefit Determination paragraph would require this Plan to be the secondary payer, and the other plan the primary payer, then benefits will be paid by this Plan to the extent of the difference between the dollar amount the primary plan will pay and the dollar amount of allowable expenses.

An "allowable expense" is a health care service or expense including deductibles, coinsurance or copayments, that is covered in full or in part by any of the plans involved.

"Plans" means these types of medical benefits:

- a. Group insurance and group subscribed contracts;
- b. Uninsured arrangements of group or group-type coverage;
- c. Group or group-type coverage through HMOs and other prepayment, group practice and individual practice plans;
- d. Group-type contracts (obtained and maintained only because of membership in a particular organization or group);
- e. Group, group-type or individual automobile "no fault" and traditional automobile "fault" type policies;
- f. Medicare or other government benefits;
- g. Group or group-type hospital indemnity benefits in excess of \$200 per day;
- h. Medical care portions of group long-term care contracts (such as skilled nursing care).

Order of Benefit Determination: When a claim is made, the primary plan pays its benefits without regard to any other plans. The secondary plans adjust their benefits so that the total benefits available will not exceed the allowable expenses.

A plan without a coordination provision similar to this Plan is always the primary plan. If all plans have such a provision:

- a. The plan covering the patient directly, rather than as an employee's dependent, is primary.

- b. If a child is covered under both parent's plans, the plan of the parent whose birthday (day and month only, without regard to the year of birth) comes earlier in the year is primary; however when the parents are separated or divorced, their plans pay in this order:
 - 1) If court decree has established financial responsibility for the child's health care expenses, the plan of the parent with this responsibility;
 - 2) The plan of the parent with custody of the child;
 - 3) The plan of the stepparent married to the parent with custody of the child;
 - 4) The plan of the parent not having custody of the child.
- c. Active/Inactive Employee: The plan covering a person as an employee who is neither laid off nor retired (or as that person's dependent) pays benefits first. The plan covering that person as a laid off or retired employee (or as that person's dependent) pays benefits second. If both plans do not have this rule and if, as a result, the plans do not agree on the order of benefits, this rule is ignored.
- d. If none of the above rules determine the order of benefits, the plan covering the patient longest is primary. The plan covering that person for the shorter time pays second.
- e. If none of the previously discussed rules apply, then the plans are to share the allowable expenses equally.

This Plan will always be primary for an expense incurred by a disabled Participant age 65 or under, other than a retired employee, for which Medicare benefits are available. This does not apply to charges incurred for End Stage Renal Disease.

With respect to a Participant's automobile insurance coverage, no fault and otherwise, where permitted by law, that coverage shall be primary to the coverage afforded by this Plan.

The Plan covering the individual as an Employee, retiree, or as a Dependent of an Employee will be primary, and the plan providing continuation coverage (COBRA) will be secondary. There are different rules for Medicare and COBRA. See that section below.

When the above rules reduce the total amount of benefits otherwise payable under this Plan, each benefit charge that would be payable shall be reduced proportionately.

EFFECT OF MEDICARE

Active Employees and Spouses Age 65 and Over - When an Employee in Active Service who is age 65 or over and when the covered dependent spouse of any such Employee who is age 65 or over becomes eligible for Medicare, the individual must choose either of the following options:

- a. Primary coverage under this Plan (under this option, benefits provided under this Plan will be paid without regard to Medicare);
- b. Sole coverage provided under Medicare (under this option, coverage under this Plan will terminate).

If the individual does not choose either of the above options in writing, this Plan will be primary.

Retirees and Spouses Age 65 and Over - Medicare is primary and the Plan will be secondary for the Participant if the individual is age 65 and over and retired. Medicare is primary and the Plan will be secondary for the dependent spouse if both the Participant and their covered dependent spouse are age 65 and over and retired.

If the retiree (or spouse) is eligible for Medicare and does not choose to enroll, this Plan will pay as

if Medicare were Primary.

Disability Due to End Stage Renal Disease (ESRD) - If a Participant becomes eligible for benefits under Medicare as a result of disability due to End Stage Renal Disease and chooses to remain covered under this Plan, this Plan will pay its benefits first and Medicare will be the secondary payer for the first 30 months of disability, in addition to the 3 month waiting period or a maximum of 33 months, when applicable. After the initial 30 or 33 months, Medicare will be the primary payer as determined by the Social Security Act and the Omnibus Reconciliation Acts, as amended.

Disability (other than End Stage Renal Disease) and Medicare - Medicare is the primary payer for individuals entitled to Medicare due to disability (other than End Stage Renal Disease) and under age 65 who have coverage under a plan covering 100 or more employees. However, if the coverage under the group health plan is by virtue of the "current employment status" of the individual or a family member then Medicare is the secondary payer.

For purposes of this provision, the term "disabled" will be the definition given by Social Security.

COBRA and MEDICARE

Medicare due to ESRD at the time of COBRA election – Medicare is the secondary payer for individuals entitled to Medicare due to ESRD who have coverage under another group health plan for the first 30 months of Medicare entitlement. After 30 months, Medicare becomes the primary payer.

Medicare due to Age at the time of COBRA election – Medicare is the primary payer and the COBRA plan the secondary payer. However, if the coverage under the group health plan is by virtue of the "current employment status" of the individual or a spouse of any age then Medicare is the secondary payer.

Medicare due to Disability at the time of COBRA election - Medicare is the primary payer for individuals entitled to Medicare due to disability and under age 65 who have COBRA coverage under a plan covering 100 or more employees. However, if the coverage under the group health plan is by virtue of the "current employment status" of the individual or a family member then Medicare is the secondary payer.

SUBROGATION/REIMBURSEMENT

1. The Plan may elect, but is not required, to advance payment of medical or dental benefits in those situations where an injury, sickness, disease or disability is caused in whole or in part by, or results from, the acts or omissions of a third party, or from the acts or omissions of a covered person where other insurance (such as auto or homeowners) is available. As a condition of providing benefits in such situations, the Plan and its agents shall have the right to recoup all benefits paid, either:
 - a) by subrogation directly from the responsible party (whether an unrelated third party or another covered person) or its insurer, without regard to whether the covered person is pursuing a claim against that responsible party, or
 - b) by reimbursement from the covered person, when the covered person has recovered compensation for such injury from any source described below.

The Plan shall be entitled to recover 100% of the benefits paid, without deduction for attorneys' fees and costs or other deductions, without regard to whether the covered person

is fully compensated by his/her net recovery from all the sources described in subsection 2, and without regard to allocation or designation of the recovery. **The Plan explicitly has the right of first recovery, even where a participant or beneficiary is not made whole.** If the covered person's net recovery is less than the benefits paid, then the Plan is entitled to be paid all of the net recovery achieved. All funds received by or for any covered person, up to and including the amount of claims paid, are subject to the Plan's equitable lien thereon and are deemed to be held in constructive trust for the benefit of the Plan until such funds are delivered to the Plan or its attorneys. The Plan does not pay for, nor is responsible for the participant's attorney's fees.

2. The Plan's rights of subrogation and/or reimbursement shall have priority against and shall constitute a first lien against any and all payments, settlements, judgments or awards made by or received from:
 - a) the responsible party, its insurer, or any other source on behalf of that party
 - b) any insurance company under an uninsured, underinsured or medical payment provision on behalf of the covered person and
 - c) any other source (such as crime victim restitution funds and Workers' Compensation) whose payment is designed or intended to compensate or reimburse the covered person for the injury or damages sustained.

3. It is the covered person's obligation to:
 - a) cooperate with the Plan or its agents in defining, verifying and protecting its rights of subrogation and reimbursement
 - b) provide the Plan with pertinent information regarding the injury or sickness, including various forms of documentation, accident reports, settlement reports and any other requested additional information.
 - c) do nothing to prejudice the Plan's rights of subrogation and reimbursement
 - d) promptly reimburse the Plan when a recovery through settlement, judgment, award or other payment is received and
 - e) to not settle, without the prior consent of the Plan, any claim that the covered person may have against any legally responsible party or insurance carrier.

Failure to comply with any of these requirements may result in the withholding of payment by the Plan of further medical, dental or disability benefits and/or shall render the covered person responsible for the attorneys' fees and costs incurred by the Plan in protecting its rights.

4. This provision shall not limit any other remedies of the Plan provided by law. These rights of subrogation and reimbursement shall apply without regard to the location of the event that led to or caused the applicable sickness, injury, disease or disability.

These rights of subrogation and reimbursement shall apply without regard to whether any separate written acknowledgment of these rights is required by the Plan or its administrator and signed by the Covered person.

RIGHTS OF RECOVERY - Whenever payments have been made by the Claims Administrator with respect to allowable expenses in excess of the maximum amount of payment necessary to satisfy the intent of this Plan, the Claims Administrator shall have the right to recover such excess payments. If a covered Employee is paid a benefit greater than that allowed by the Plan, the

covered Employee will be requested to refund the overpayment. If the refund is not received from the covered Employee, the amount of overpayment will be deducted from future benefits. Similarly, if payment is made on the behalf of a covered Employee to a hospital, Physician, or other provider of health care, and that payment is found to be an overpayment, the Plan will request a refund of the overpayment from the provider.

NO VERBAL MODIFICATIONS - The Participant shall not rely on any oral statement from an Employee of NCAS including, but not limited to, a customer service representative to:

- a. Modify or otherwise affect the benefits, General Limitations And Exclusions, or other provisions of this Plan;
- b. Increase, reduce, waive or void any coverages or benefits under this Plan.

In addition, such oral statement shall not be used in the prosecution or defense of a claim under this Plan. Any written or oral verification received from NCAS is based upon eligibility information and Plan benefits, which are subject to change. Therefore, any verification should not be interpreted as a guarantee of coverage or payment for any services rendered or otherwise provided to a Participant.

PLAN MODIFICATION AND AMENDMENT - Amendment/modification of the Plan shall be in writing and signed by an officer of the Plan Sponsor pursuant to authorization by the Plan Sponsor's Board of Directors. The Plan Sponsor may modify or amend the Plan from time to time at its sole discretion. The amendments or modifications which affect the Plan Participants will be communicated to them. The foregoing shall not be deemed to modify the provisions of any collective bargaining agreements which may have been made by the Plan Sponsor with the bargaining representatives of any Employees. Participants will be notified of material reductions in services or benefits within 60 days of adoption of the change.

PLAN TERMINATION - The Plan Sponsor may terminate the Plan which shall be accomplished in writing and signed by an officer of the Plan Sponsor pursuant to authorization of the Plan Sponsor's Board of Directors. Upon termination, the rights of Participants to benefits are limited to claims incurred and due up to the date of termination. Any termination of the Plan will be communicated to Participants. In the event of Plan termination, all claims incurred by a Participant must be received by the Claims Administrator within 90 days after the date of termination.

WORKERS' COMPENSATION - If a participant is injured while at his/her place of employment or requires medical care as a result of employment, the participant should obtain care for such injuries through the arrangements provided by his/her Employer under Workers' Compensation laws. This Plan does not provide benefits for expenses which can be reimbursed under Workers' Compensation laws. However, benefits will be provided for expenses not covered by Workers' Compensation.

NO GUARANTEE OF EMPLOYMENT - Neither the Plan nor any provisions contained in the Plan shall be construed to be a contract between the Employer and the Employee, or consideration for, or an inducement of, the employment of any Employee by the Employer. Nothing contained in the Plan shall grant any Employee the right to be retained in the service of the Employer nor shall it limit in any way the right of the Employer to discharge or to terminate the service of any Employee at any time, without regard to the effect such discharge or termination may have on any rights under the Plan.

CONFORMITY WITH THE LAW – This Plan of benefits shall be provided in compliance with COBRA, HIPAA, FMLA, USERRA, and other group health plan laws to the extent required by such laws. If any provision of this plan is contrary to any applicable law to which it is subject, the

provision is hereby automatically changed to meet the law's minimum requirements.

INTERPRETATION OF THE PLAN – The Plan Administrator has the sole and absolute discretion to construe and interpret the provisions and terms of the plan, to resolve any disputes which may arise under the plan and otherwise determine the operation and administration of the plan. In making such interpretations and determinations, the Plan Administrator shall take into account the interpretation of the provisions and terms of the plan by the plan's reinsurance carrier and any other relevant information.

Any and all such decisions and determinations made by the Plan shall be final and binding upon all parties.

CLAIM PROVISIONS

PROOF OF LOSS – Proof of Loss is the information necessary to process a claim. Required information consists of an itemized bill on the provider's letterhead which includes: patient's name, employee's name, patient's identification number, provider's tax ID#, description of service, procedure code, diagnosis code, date of service and charge for each service. Proof of Loss related to a Covered Service incurred by a Participant must be received by the Claims Administrator or PPO no later than one year from the date the service was rendered or otherwise provided.

The Plan reserves the right at its discretion to accept or to require verification of any alleged fact or assertion pertaining to any claim.

In the event of Plan termination, all claims incurred by a Participant must be received by the Claims Administrator within 90 days of the date of termination of the Plan.

NOTE: If a Participant or a Participant's spouse, dependent or beneficiary (hereinafter referred to as a "Claimant") is denied any benefit under this Plan, the Claimant may request review of the claims with the Claims Administrator. This request for review must be submitted as specified under "Claims Appeal Procedures" within one year from the date the service was rendered.

ASSIGNMENT – Payment for services rendered by PPO providers are automatically sent directly to the provider. It is recommended that payment for services rendered by Non-PPO providers be assigned and paid directly to the provider. If you submit Proof of Loss for services rendered by a Non-PPO provider, please state in writing that you want payment sent directly to the provider. NCAS will make payment to the provider, provided the Proof of Loss contains all required claims information and is accompanied by a signed Assignment of Benefits from the Participant. NCAS may override the Assignment of Benefits if the provider was issued a Form W-9 and B-Notice letter of instruction requesting IRS reporting information and the provider did not respond within the time frame noted on the letter.

RIGHT TO RECEIVE AND RELEASE NECESSARY INFORMATION - For the purpose of determining the applicability of and implementing the terms of this provision of this Plan or any provision of similar purpose of any other plan, the Claims Administrator may, without the consent of or notice to any person, release to or obtain from any insurance company or other organization or person any information, with respect to any person, which the Claims Administrator deems to be necessary for such purposes. Any person claiming benefits under this Plan shall furnish to the Claims Administrator such information as may be necessary to implement this provision.

EXAMINATION - The Plan, at its own expense, shall have the right and opportunity to have the Participant examined whose injury or sickness is the basis of a claim when and so often as it may reasonably require during the processing of the claim. The Claims Administrator shall also have the right and opportunity to have an autopsy performed where it is not forbidden by law.

FACILITY OF PAYMENT - If a Participant is a minor, or physically or mentally incapable of giving a valid release for payment, the Claims Administrator, at its option, may make payment to a party who has assumed responsibility for the care of such person. Such payments will be made until claim is made by a guardian. If a Participant dies while benefits remain unpaid, benefits will be paid, at the Claims Administrator's option to:

- a. the provider of services;
- b. a surviving relative (Spouse, parent or child).

Such payment will release the Plan of all further liability to the extent of payment.

GENDER AND NUMBER - The masculine gender shall be deemed to include the feminine and the singular shall include the plural unless otherwise clearly required by the context.

CLAIM APPEAL PROCEDURES – Claims for benefits under the Plan must be filed in the manner and within the time limits stated under “Proof of Loss” above. If a Participant or a Participant’s spouse, dependent or beneficiary (hereinafter referred to as a “Claimant”) is denied any Benefit under this Plan, the Claimant may request review of the claims with the Claims Administrator. Request for review must be made within one year from the date of service. The claims procedures do not preclude an authorized representative of a Claimant from acting on behalf of such Claimant in pursuing a benefit claim or appeal of an adverse benefit determination. The Claims Administrator shall review the claim itself or appoint an individual or an entity to review the claim.

I. INITIAL BENEFIT DETERMINATION

Health Benefit Claims – Urgent Care Claims

If the Claimant’s claim is for urgent care health benefits, the Claims Administrator shall notify the Claimant of the Plan’s benefit determination (whether adverse or not) as soon as possible, taking into account the medical exigencies, but not later than 72 hours after receipt of the claim by the Plan, unless the Claimant fails to provide sufficient information to determine whether, or to what extent, benefits are covered or payable under the Plan. In the case of such a failure, the Claims Administrator shall notify the Claimant as soon as possible, but not later than 24 hours after receipt of the claim by the Plan, of the specific information necessary to complete the claim. The notification may be oral unless written notification is requested by the Claimant.

The Claimant shall be afforded a reasonable amount of time, taking into account the circumstances, but not less than 48 hours, to provide the specified information. The Claims Administrator shall notify the Claimant of the Plan’s determination as soon as possible, but in no case later than 48 hours after the earlier of (1) the Plan’s receipt of the specified additional information or (2) the end of the period afforded the Claimant to provide the specified additional information.

A health benefits claim is considered an urgent care claim if the application of the time periods for making non-urgent care determinations could seriously jeopardize the life or health of the Claimant or the ability of the Claimant to regain maximum function or, in the opinion of a physician with knowledge of the Claimant’s medical condition, would subject the Claimant to severe pain that could not be adequately managed without the care or treatment which is the subject of the claim.

Health Benefit Claims – Concurrent Care Claims

If the Plan has previously approved an ongoing course of health care treatment to be provided over a period of time or number of treatments, any reduction or termination by the Plan of the previously approved course of treatment (other than by Plan amendment or termination) before the approved time period or number of treatments shall constitute an adverse initial benefit determination. These determinations shall be known as concurrent care decisions. In such a case, the Claims Administrator shall notify the Claimant of the adverse concurrent care decision at a time sufficiently in advance of the reduction or termination to allow the Claimant to appeal and obtain a determination on review of that adverse benefit determination before reduction or termination of the benefit.

Any request by a Claimant to extend a course of urgent care treatment beyond the approved period of time or number of treatments shall be decided as soon as possible, taking into account the

medical exigencies, and the Claims Administrator shall notify the Claimant of the benefit determination, whether adverse or not, within 24 hours after receipt of the claim by the Plan, provided that any such claim is made to the Plan at least 24 hours prior to the expiration of the prescribed period of time or number of treatments.

Other Health Benefit Claims – Pre-Service Claims

In the case of a pre-service health benefit claim, the Claims Administrator shall notify the Claimant of the Plan's benefit determination (whether adverse or not) within a reasonable period of time appropriate to the medical circumstances, but not later than 15 days after receipt of the claim by the Plan. This period may be extended one time by the plan for up to 15 days, provided that the Claims Administrator both determines that such an extension is necessary due to matters beyond the control of the plan and notifies the Claimant, prior to the expiration of the initial 15-day period, of the circumstances requiring the extension of time and the date by which the plan expects to render a decision. If such an extension is necessary due to a failure of the Claimant to submit the information necessary to decide the claim, the notice of extension must specifically describe the required information, and the Claimant shall be afforded at least 45 days from receipt of the notice within which to provide the specified information.

A health benefit claim is considered a pre-service claim if the claim requires approval, in part or in whole, in advance of obtaining the health care in question.

Other Health Benefit Claims – Post-Service Claims

In the case of a post-service health benefit claim, the Claims Administrator shall notify the Claimant of the Plan's adverse benefit determination within a reasonable period of time, but not later than 30 days after receipt of the claim. This period may be extended one time by the plan for up to 15 days, provided that the Claims Administrator both determines that such an extension is necessary due to matters beyond the control of the plan and notifies the Claimant, prior to the expiration of the 30-day period, of the circumstances requiring the extension of time and the date by which the plan expects to render a decision. If such an extension is necessary due to the failure of the Claimant to submit the information necessary to decide the claim, the notice of extension shall specifically describe the required information, and the Claimant shall be afforded at least 45 days from receipt of the notice within which to provide the specified information.

A health benefit claim is considered a post-service claim if it is a request for payment for services which the Claimant has already received.

Calculation of Time Period

For purposes of the time periods specified, the period of time during which a benefit determination is required to be made begins at the time a claim is filed in accordance with the Plan procedures without regard to whether all the information necessary to make a benefit determination accompanies the claim. If a period of time is extended due to a Claimant's failure to submit all information necessary, the period for making the determination shall be tolled from the date the notification of the extension is sent to the Claimant until the date the Claimant responds to the request for additional information.

Manner and Content of Denial of Initial Claims

If the Claims Administrator denies a claim, it must provide to the Claimant, in writing or by electronic communication:

- (a) The specific reasons for the adverse determination;
- (b) A reference to the specific plan provisions on which the determination is based;
- (c) A description of any additional information or material necessary for the Claimant to perfect the claim and an explanation of why such material or information is necessary;
- (d) A description of the plan's review procedures and the time limits applicable to such procedures;
- (e) In the case of an adverse benefit determination by a group health plan or a plan providing disability benefits, the following must be provided:
 - (i) A copy of any internal rule, guideline, protocol, or other similar criterion relied upon in making the adverse determination or a statement that the same will be provided upon request by the Claimant and without charge; or
 - (ii) If the adverse benefit determination is based on the Plan's medical necessity, experimental treatment or similar exclusion or limit, either an explanation of the scientific or clinical judgment applying the exclusion or limit to the Claimant's medical circumstances or a statement that the same will be provided upon request by the Claimant and without charge.

In the case of an adverse benefit determination concerning a health claim involving urgent care, the information described in this section may be provided to the Claimant orally within the permitted time frame, provided that a written or electronic notification in accordance with this Section is furnished not later than 3 days after the oral notification.

II. REVIEW PROCEDURES

Health Benefit Claims

In addition to having the right to review documents and submit comments as described above, a Claimant for health benefits, has a right to a review which meets the following requirements:

- (a) The Plan provides two levels of appeal for all health benefit claims. A claimant has the right to file an appeal to the Plan within 180 days from the date of the initial notice and within 30 days of the date of a second adverse benefit determination notice. The claimant's appeal request should include the patient's name, identification number, and any additional documentation to be reviewed.
- (b) The Plan provides for a review that does not afford deference to the initial adverse benefit determination and that is conducted by an appropriate named fiduciary of the Plan who is neither the individual who made the adverse benefit determination that is the subject of the appeal, nor the subordinate of any such individual;
- (c) The Plan provides that, in deciding an appeal of any adverse benefit determination that is based in whole or in part on a medical judgment, including determinations with regard to whether a particular treatment, drug or other item is experimental, investigational or not medically necessary or appropriate, the appropriate named fiduciary of the Plan will consult with a health care professional who has appropriate training and experience in the field of medicine involved in the medical judgment;

- (d) The Plan provides for the identification of medical or vocational experts whose advice was obtained on behalf of the Plan in connection with a Claimant's adverse benefit determination, without regard to whether the advice was relied upon in making the benefit review determination;
- (e) The Plan provides that the health care professional engaged for purposes of consultation be an individual who is neither an individual who was consulted in connection with the adverse benefit determination that is the subject of the appeal, nor the subordinate of any such individual; and
- (f) The Plan provides in the case of a claim involving urgent care, for an expedited review process pursuant to which:
 - (i) A request for an expedited appeal of an adverse benefit determination may be submitted orally or in writing by the claimant; and
 - (ii) All necessary information, including the plan's benefit determination on review, shall be transmitted between the plan and the claimant by telephone, facsimile, or other available similarly expeditious method.

III. DEADLINE FOR REVIEW DECISIONS

Urgent Health Benefit Claims

This Plan will have two levels of appeal. In case of urgent care health claims, the Claims Administrator shall notify the Claimant of the Plan's determination on review as soon as possible, taking into account the medical exigencies, but not later than 72 hours after receipt of the Claimant's request for review of an adverse benefit determination by the Plan.

Pre-Service Health Benefit Claims

This Plan will have two levels of appeal. In the case of a pre-service health claim, the Claims Administrator shall notify the Claimant of the Plan's benefit determination on review with respect to any one of such two appeals, not later than 15 days after receipt of the Claimant's request for review of the adverse determination.

Post-Service Health Benefit Claims

This Plan will have two levels of appeal. In the case of a post-service health claim, the Claims Administrator shall notify the Claimant of the Plan's benefit determination on review with respect to any one of such two appeals, not later than 30 days after receipt of the Claimant's request for review of the adverse determination.

Calculation of Time Periods

For purposes of the time periods specified in this Section, the period of time during which a benefit determination is required to be made begins at the time a claim is filed in accordance with the Plan procedures without regard to whether all the information necessary to make a benefit determination on review accompanies the filing. If a period of time is extended due to a Claimant's failure to submit all information necessary, the period for making the benefit determination on review shall be tolled from the date the notification requesting the additional information is sent to the Claimant until the date the Claimant responds.

Manner and Content of Notice of Decision on Review

Upon completion of its review of an adverse initial claim determination, the Claims Administrator will provide the Claimant with written or electronic notification of a plan's benefit determination on review. In the case of an adverse benefit determination, the notification shall contain:

- (a) The specific reason or reasons for the adverse determination;
- (b) Reference to the specific Plan provisions on which the benefit determination is based;
- (c) A statement that the Claimant is entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records and other information in the Plan's files which is relevant to the Claimant's claim for benefits;
- (d) If an internal rule, guideline, protocol or other similar criterion was relied upon in making the adverse determination, either the specific rule, guideline, protocol or other similar criterion; or a statement that such rule, guideline, protocol, or other similar criterion was relied upon in making the adverse determination and that a copy of the rule, guideline, protocol, or other similar criterion will be provided without charge to the Claimant upon request;
- (e) If the adverse benefit determination is based on a medical necessity or experimental treatment or similar exclusion or limit, either an explanation of the scientific or clinical judgment on which the determination was based, applying the terms of the Plan to the Claimant's medical circumstances, or a statement that such an explanation will be provided without charge upon request.

IV. MISCELLANEOUS

Failure of Plan to Follow Procedures

If the Plan fails to follow the claims procedures required by this Article, a Claimant shall be deemed to have exhausted the administrative remedies available under the Plan and shall be entitled to pursue any available remedy under applicable law on the basis that the Plan has failed to provide a reasonable claims procedure that would yield a decision on the merits of the claim.

Preemption of State Law

With respect to any insured benefit under this Plan, nothing in this Section shall be construed to supercede any provision of any applicable State law that regulates insurance, except to the extent that such law prevents application of this Section.

Statute of Limitations

Notwithstanding any otherwise applicable statutory statute of limitations, no legal action may be commenced or maintained to recover benefits under this Plan more than 12 months after the final review decision by the Claims Administrator has been rendered (or deemed rendered).

PRIVACY OF PROTECTED HEALTH INFORMATION

1. Plan Sponsor's Certification of Compliance.

Neither the Plan nor any health insurance issuer or business associate servicing the Plan will disclose Plan Participants' Protected Health Information to the Employer (Plan Sponsor) unless the Employer (Plan Sponsor) certifies that the Plan Documents have been amended to incorporate this section and agrees to abide by this section.

2. Purpose of Disclosure to Employer (Plan Sponsor).

- (a) Except to the extent permitted under paragraphs 3 and 4 of this section, the Plan will disclose Plan Participants' Protected Health Information to the Employer (Plan Sponsor) only to permit the Employer (Plan Sponsor) to carry out plan administration functions for the Plan only if the disclosure is consistent with the requirements of the Health Insurance Portability and Accountability Act of 1996 and its implementing regulations (45 C.F.R. Parts 160-64). Any disclosure to and use by the Employer (Plan Sponsor) of Plan Participants' Protected Health Information will be subject to and consistent with the provisions of paragraphs 5 and 6 of this section.
- (b) Neither the Plan nor any health insurance issuer or business associate servicing the Plan will disclose Plan Participants' Protected Health Information to the Employer (Plan Sponsor) except to the extent that the disclosures are permitted under the Notice of Privacy Practices distributed to the Plan Participants.
- (c) Neither the Plan nor any health insurance issuer or business associate servicing the Plan will disclose Plan Participants' Protected Health Information to the Employer (Plan Sponsor) for the purpose of employment-related actions or decisions or in connection with any other benefit or employee benefit plan of the Employer (Plan Sponsor).

3. Summary Health Information.

The Plan or any health insurance issuer or business associate servicing the Plan, may disclose Protected Health Information that is summary health information (as defined in 45 C.F.R. 164.504(a)) to the Employer if the Employer requests the summary health information for the purpose of:

- (a) Obtaining premium bids from insurance issuers for providing health insurance coverage under the Plan; or
- (b) Modifying, amending or terminating the Plan. The Plan may disclose Protected Health Information to the Employer and may permit the disclosure of Protected Health Information to the Employer by a health insurance issuer or HMO with respect to the Plan.

4. Enrollment Information.

The Plan or any health insurance issuer or business associate servicing the Plan, may disclose to the Employer information on whether an individual is participating in the Plan, or is enrolled in or has disenrolled from a health option or HMO offered by the Plan.

5. Restrictions on Plan Sponsor's Use and Disclosure of Protected Health Information.

- (a) The Employer (Plan Sponsor) will not use or disclose Participants' Protected Health Information, except as permitted or required by the Plan Documents, as amended, or

required by law.

- (b) The Employer (Plan Sponsor) will ensure that any agent, including any subcontractor, to whom it provides Plan Participants' Protected Health Information agrees to the restrictions and conditions of the Plan Documents, including this section, with respect to Plan Participants' Protected Health Information.
- (c) The Employer (Plan Sponsor) will not use or disclose Plan Participants' Protected Health Information for employment-related actions or decisions or in connection with any other benefit or employee benefit plan of the Employer (Plan Sponsor).
- (d) The Employer (Plan Sponsor) will report to the Plan any use or disclosure of Plan Participants' Protected Health Information that is inconsistent with the uses and disclosures allowed under this [section/article] promptly upon learning of such inconsistent use or disclosure.
- (e) The Employer (Plan Sponsor) will make Protected Health Information available to the Plan Participant who is the subject of the information in accordance with 45 Code of Federal Regulations § 164.524.
- (f) The Employer (Plan Sponsor) will make Plan Participants' Protected Health Information available for amendment, will consider any requested amendment and will incorporate any accepted amendment of Plan Participants' Protected Health Information, in accordance with 45 Code of Federal Regulations § 164.526.
- (g) The Employer (Plan Sponsor) will track certain disclosures it may make of Plan Participants' Protected Health Information so that it can make available the information required for the Plan to provide an accounting of disclosures in accordance with 45 Code of Federal Regulations § 164.528.
- (h) The Employer (Plan Sponsor) will make its internal practices, books, and records, relating to its use and disclosure of Plan Participants' Protected Health Information available to the Plan and to the U.S. Department of Health and Human Services to determine compliance with 45 Code of Federal Regulations Parts 160-64.
- (i) The Employer (Plan Sponsor) will, if feasible, return or destroy all Plan Participant Protected Health Information, in whatever form or medium (including in any electronic medium under the Employer's (Plan Sponsor's) custody or control), received from the Plan, including all copies of and any data or compilations derived from and allowing identification of any Participant who is the subject of the Protected Health Information, when the Plan Participants' Protected Health Information is no longer needed for the plan administration functions for which the disclosure was made. If it is not feasible to return or destroy all Plan Participant Protected Health Information, the Employer (Plan Sponsor) will limit the use or disclosure of any Plan Participant Protected Health Information it cannot feasibly return or destroy to those purposes that make the return or destruction of the information infeasible.

6. Adequate Separation Between the Employer (Plan Sponsor) and the Plan.

(a) The following employees or classes of employees or other workforce members under the control of the Employer (Plan Sponsor) may be given access to Plan Participants' Protected Health Information received from the Plan or a health insurance issuer or business associate servicing the Plan:

Employee Benefits Specialist, HR

Executive Director, HR

Administrative Assistant, HR

This list includes every employee or class of employees or other workforce members under the control of the Employer (Plan Sponsor) who may receive Plan Participants' Protected Health Information relating to payment under, health care operations of, or other matters pertaining to the Plan in the ordinary course of business.

- (b) The employees, classes of employees or other workforce members identified in paragraph 6(a) of this section will have access to Plan Participants' Protected Health Information only to perform the plan administration functions that the Employer (Plan Sponsor) provides for the Plan.
- (c) The employees, classes of employees or other workforce members identified in paragraph 6(a) of this section will be subject to disciplinary action and sanctions, including termination of employment or affiliation with the Employer (Plan Sponsor), for any use or disclosure of Plan Participants' Protected Health Information in breach or violation of or noncompliance with the provisions of this section to the Plan Documents. Employer (Plan Sponsor) will promptly report such breach, violation or noncompliance to the Plan, as required by paragraph 5(d) of this section, and will cooperate with the Plan to correct the breach, violation or noncompliance, to impose appropriate disciplinary action or sanctions on each employee or other workforce member causing the breach, violation or noncompliance, and to mitigate any deleterious effect of the breach, violation or noncompliance on any Participant, the privacy of whose Protected Health Information may have been compromised by the breach, violation or noncompliance.

HIPAA SECURITY STANDARDS

Plan Sponsor Obligations - Where Electronic Protected Health Information will be created, received, maintained, or transmitted to or by the Plan Sponsor on behalf of the Plan, the Plan Sponsor shall reasonably safeguard the Electronic Protected Health Information as follows:

- a. Plan Sponsor shall implement administrative, physical, and technical safeguards that reasonably and appropriately protect the confidentiality, integrity, and availability of the Electronic Protected Health Information that Plan Sponsor creates, receives, maintains, or transmits on behalf of the Plan;
- b. Plan Sponsor shall ensure that the adequate separation that is required by 45 C.F.R. § 164.504(f)(2)(iii) of the HIPAA Privacy Rule is supported by reasonable and appropriate security measures;
- c. Plan Sponsor shall ensure that any agent, including a subcontractor, to whom it provides Electronic Protected Health Information agrees to implement reasonable and appropriate security measures to protect such Information; and
- d. Plan Sponsor shall report to the Plan any Security Incidents of which it becomes aware as described below:
 1. Plan Sponsor shall report to the Plan within a reasonable time after Plan Sponsor becomes aware, any Security Incident that results in unauthorized access, use, disclosure, modification, or destruction of the Plan's Electronic Protected Health Information; and
 2. Plan Sponsor shall report to the Plan any other Security Incident on an aggregate basis every quarter or more frequently upon the Plan's request.

PLAN INFORMATION

Name and Type of Administration of the Plan:

College of Southern Maryland Group Benefits Plan. This Plan is a form of employee welfare benefit plan called a "cafeteria plan" because it allows you to choose the benefits you will receive from the Plan. You are given the opportunity to direct the Employer to reduce your salary by a specified amount. You then can use the amount of the salary reduction to purchase benefits under the Plan.

Because your salary is reduced before federal taxes (and, in most states, state taxes) are imposed, you pay less in taxes if you participate in the Plan. The medical portion of the plan is provided through contract administration by a third party administrator referred to as the Claims Administrator.

Plan Sponsor:

College of Southern Maryland
8730 Mitchell Road (P.O. Box 910)
LaPlata, Maryland 20646-0910

Plan Sponsor's Federal Employer Identification Number: 52-0848273

Plan Number: 502

Plan Administrator:

College of Southern Maryland
8730 Mitchell Road (P.O. Box 910)
LaPlata, Maryland 20646-0910
(301) 934-2251

Claims Administrator:

NCAS
P. O. Box 10136
Fairfax, Virginia 22038-8022
(866) 219-9292

Plan Year: January 1st – December 31st

Source of Financing of the Plan:

Please note that participant benefit accounts under the Plan merely are bookkeeping entries, that no assets or funds are ever paid to, held in, or invested in any separate trust or account and no interest is paid on or credited to any benefit account. Benefits are paid from the Employer's general assets.

Service of process may be made upon the Plan Administrator.

Summary of Available Benefits:

In addition to the Medical and Prescription Drug benefits described in this Summary Plan Description, the following benefits are also available under the Plan. Any salary reduction contributions you will be

required to make to obtain any elected benefit will be determined by the Employer, and will be communicated to you from time to time. Please note that all elections and benefits under the Plan are subject to a number of legal rules. If any of these rules affect or require an alteration of your elections or benefits, you will be notified.

(a) Life Insurance Coverage. If you are eligible to participate in the Plan, you will receive at the Employer's sole expense life insurance coverage and you may purchase additional life insurance coverage. A description explaining additional details of this coverage appears in the additional materials regarding your benefits delivered to you with this Summary. Any salary reduction contributions you will be required to make to obtain the benefits will be determined by the Employer, and will be communicated to you from time to time.

(b) Long-Term Disability Coverage. If you are eligible to participate in the Plan, you will receive at the Employer's sole expense long-term disability coverage and you may purchase additional long-term disability coverage. A description explaining additional details of this coverage appears in the additional materials regarding your benefits delivered to you with this Summary. Any salary reduction contributions you will be required to make to obtain the benefits will be determined by the Employer, and will be communicated to you from time to time.

(c) Dependent Care Flexible Spending Account. If you are eligible to participate in the Plan, you may elect to have salary reduction contributions, in an aggregate amount not to exceed \$5,000 per plan year or, in the case of married participants filing separately, \$2,500 per plan year, credited to your Dependent Care Flexible Spending Account. You can receive amounts from this Account, in cash, as reimbursement for Employment Related Expenses (as defined in the Plan) incurred during the calendar year. However, the amount of any reimbursement for Employment Related Expenses may not exceed the amount credited to your Account at the time of your reimbursement request. Generally, Employment Related Expenses are expenses for household services and expenses related to the care of a dependent who is under the age of 13, or a spouse or dependent who is mentally or physically incapacitated, which are incurred to enable you to work.

Please be aware that the amount of reimbursements that you may receive from your Dependent Care Flexible Spending Account on a tax-free basis in a calendar year cannot exceed the lesser of your Earned Income (as defined in the Plan) or your spouse's Earned Income. Any amount that you receive in excess of that amount will be taxable to you. Thus, for example, if you have \$5,000 in your Dependent Care Flexible Spending Account and you and your spouse have Earned Income of \$20,000 and \$4,000, respectively, you can receive \$4,000 worth of reimbursement from the Account on a tax-free basis, and you will be taxed on \$1,000 worth of the reimbursement you receive.

Also, please be aware that amounts held in your Dependent Care Flexible Spending Account for which a request for reimbursement has not been received by the 90th day following the close of the plan year will be forfeited. If you have amounts credited to your Dependent Care Flexible Spending Account and you separate from service with the Employer, you may continue to receive reimbursements from the Account for eligible expenses incurred during the plan year, but you may not continue to contribute to the Account.

If you wish to have reimbursement from your Dependent Care Flexible Spending Account, you must submit to the Plan Administrator a request for reimbursement on a form provided by the Plan Administrator. You also must provide evidence of the amount, nature and payment of the underlying expense for which reimbursement is sought, as required by the Plan Administrator. You must submit such requests by the 90th day following the close of the plan year (or by a later date if a later date is designated by the Plan Administrator).

Under the Internal Revenue Code, you also may reduce your taxes by taking a dependent care tax credit. However, any amounts which you exclude from income under the Dependent Care Flexible Spending Account will reduce, dollar for dollar, the tax credit available.

(d) Health Care Flexible Spending Account. If you are eligible to participate in the Plan, you may elect to have salary reduction contributions, in an aggregate amount not to exceed \$3,000 an annual maximum per plan year, credited to your Health Care Flexible Spending Account. You can receive amounts from this Account, in cash, as reimbursement for health-related medical expenses (as defined in the Plan) incurred during the Plan Year. Generally, health-related medical expenses are those which are not covered under any plan or employer-provided medical coverage, meet the Internal Revenue Code's definition of deductible medical expenses, and have not been taken as a deduction in any tax year.

Grace Period -The Health Care Flexible Spending Account will reimburse claims for qualified expenses incurred during the Grace Period. The Grace Period extends 75 days after the last day of the Plan Year. Services that are rendered after the 75th day will not be considered for reimbursement under the prior Plan Year.

A Participant must be enrolled on the last day of the Plan Year in order for the Grace Period to apply.

To take advantage of the Grace Period benefit, participants must indicate which plan year the expense should be charged to and submit a claim form with the appropriate documentation to FlexAmerica for reimbursement.

Please be aware, however, that amounts held in your Health Care Flexible Spending Account for which a request for reimbursement has not been received by the 90th day following the close of the plan year will be forfeited. If you separate from service with the Employer while you are a participant in the Health Care Flexible Spending Account, you may, under applicable law, be permitted to continue participating in the Account.

If you wish to have reimbursement from your Health Care Flexible Spending Account, you may submit to the Plan Administrator a request for such reimbursement on an approved form provided by the Plan Administrator. Receipts must be from a third party provider that include evidence of amount, nature and payment of the underlying medical expense for which reimbursement is sought, as required by the Plan Administrator. You must submit such requests by the 90th day following the close of the plan year for which the benefit election is effective (or by a later date if a later date is designated by the Plan Administrator)

Please note that all elections and benefits under the Plan are subject to a number of legal rules. If any of these rules affect or require an alteration of your elections or benefits, you will be notified.

Note: An annual election form is required.

CLAIMS FILING INSTRUCTIONS

(For further information, refer to the section on Claim Appeal Procedure)

In-Network Providers

Before you use a provider listed in the PPO directory, call the provider or PPO network to verify that the provider is still a member. Simply present your NCAS Identification Card at the time you receive services. The provider will file a claim with the PPO network and will be directly reimbursed for the services you receive.

Out-of-Network Providers

MEDICAL and DENTAL SERVICES - Reimbursement of medical and dental expenses provided by Out-of-Network providers is handled by National Claims Administrative Services, Inc. (NCAS). Claims for benefits offered by College of Southern Maryland's Group Benefits Plan may be filed by a Hospital, Physician's or dentist's office, or by the Participant. Payment will be made by NCAS either to the provider or the Participant.

You do not need a claim form to file your claims. You should mail your itemized bill from the provider and be sure to include the following information on the bill:

- | | |
|-------------------------------------|-----------------------------|
| a. Employee Name | f. Procedure Code |
| b. Employee's Identification Number | g. Diagnosis Code |
| c. Patient Name | h. Date of Service |
| d. Employer Name or Group Number | i. Charge for Each Service. |
| e. Provider's Tax ID Number (TIN) | |

Balance due bills are not acceptable. The bill for processing claims must include all the information described above. All claims and written inquiries should be sent to:

NCAS
P.O. Box 10136
Fairfax, Virginia 22038-8022

The Customer Service telephone number is: (866) 219-9292

NOTE ON HOSPITAL CHARGES - Claims for inpatient admissions are usually filed by the hospital. Most hospitals will verify that your health coverage is in effect and will then take care of the paperwork on behalf of the patient. If you do receive a bill for inpatient services, do not pay it until you are certain that your claim has been settled. In some instances, the Participant is responsible for balances. When you are unsure, ask the hospital or NCAS for guidance.

Remember - Authorization is required from the Managed Care Vendor prior to all non-emergency hospital admissions and the next business day following an emergency admission. Failure to call the Managed Care Vendor may reduce your benefits (Refer to Chapter V).

Nationwide Better Health: (800) 315-2031

SIGNATURE PAGE

APPROVED AND ACCEPTED

IN WITNESS, Whereof, this document is executed at:

City

State

By: _____

Name

Title

Date

ON BEHALF OF:

College of Southern Maryland Group Benefits Plan
Effective July 1, 2007

Witness

Date

