

**MILLSAPS COLLEGE  
High Deductible PPO Plan**

**Plan Type C598**

## CUSTOMER SERVICE

Blue Cross & Blue Shield of Mississippi, A Mutual Insurance Company, a member of the Blue Cross and Blue Shield Association, an Association of Independent Blue Cross and Blue Shield Plans, has Customer Service Representatives available to assist you. If you have a question or need additional information, contact our Customer Service Department by using the numbers listed below Monday through Friday between the hours of 8:00 a.m. and 4:30 p.m.

Customer Service Center Jackson, MS	(601) 932-3747 or 1-800-325-4836
Membership and Billing	(601) 932-3704
Prescription Drug Service Center	(601) 932-9788 or 1-800-551-5258
General Information	(601) 932-3704 or 1-800-222-8046

Also, you may visit our Customer Service Center Monday through Friday between the hours of 8:00 a.m. and 4:30 p.m.

The center is located at:

3545 Lakeland Drive  
Jackson, Mississippi

## INTRODUCTION

This is your Employee Booklet. This booklet describes the Benefits you have under your Employee Health Protection Plan. In the event of a conflict between the booklet and the Plan, the terms of the Plan will prevail.

To use your booklet, first read the Important Information section that follows and then familiarize yourself with the Schedule of Benefits and Definitions section. You can then refer to the following specific sections for further information and explanation:

**Schedule of Eligibility:** This section explains who is covered under the Plan, when your coverage starts and how and when to change your coverage.

**Benefits Provided:** This section contains information about Covered Services and Pre-Certification and Certification requirements.

**Limitations and Exclusions:** This section lists Benefit limitations and services that are not covered under the Plan.

**General Provisions:** This section includes information about Coordination of Benefit, Termination of Coverage, Continuation Coverage, Conversion Rights and Payment of Benefits.

If you ever have any questions about the information in your Membership Certificate Booklet, please contact our Membership Service or Customer Service Department. These service departments are available Monday through Friday between the hours of 8:00 a.m. and 4:30 p.m.

## **IMPORTANT INFORMATION**

### **Your Identification Card**

Your Identification Card is the card which identifies you as a member of the Plan. It contains information such as your name and your identification number. You should always carry your Identification Card with you and present it when you visit a Hospital, Physician or health care provider.

Should you lose your ID card, please contact us as soon as possible so you can be issued a replacement card.

### **Certification of Hospital Admissions**

The Plan requires that all non-Emergency Hospital Admissions be pre-certified and all Emergency Admissions be certified within one working day of the Emergency Admission. It is your responsibility to ensure that your Physician or Hospital contacts the Claims Administrator if you are being admitted to the Hospital.

Please refer to the Benefits Provided section of this booklet for more information about Certification of Admissions, Continued Stay Review and other Benefit Certification requirements.

### **Provider Network Directory**

You may request a copy of the Network Provider Directory by visiting Claims Administrator's web site at [www.bcbsms.com](http://www.bcbsms.com) or by contacting Claims Administrator's Customer Service Department. This Directory includes Physicians, Hospitals and Allied Providers that have a business agreement with the Claims Administrator (Blue Cross & Blue Shield of Mississippi).

You do not have to use the Providers listed in the Directory to receive Benefits under the Plan. However, using these Providers may save on your personal out-of-pocket expense. Also, these Providers will file claims for you.

Your Directory will give more information about the advantages of these participating programs.

### **How to File Claims**

Participating Providers will file your claim for you. You should not file a claim for services of a Participating Provider even if you have paid for the charges in full. Keep your receipt for your personal records.

Providers that do not have a participating agreement may file your medical claims if you ask them to do so. If they do not file claims, then it is your responsibility.

### **Medical Claims**

When filing a claim for medical services you should use the Blue Cross and Blue Shield Medical Claim Form. Always read and follow the instructions on the back of the form. A claim should be filed no later than one year from the date of service.

Completed claim forms should be mailed to the following address:

Blue Cross & Blue Shield of Mississippi,  
A Mutual Insurance Company  
Post Office Box 1043  
Jackson, Mississippi 39215-1043

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## INTRODUCTION

**PLEASE READ THIS PLAN DOCUMENT CAREFULLY.** We suggest that you start with a review of the terms listed in the DEFINITIONS section (at the back of the Plan Document). The meaning of those terms will help you understand the provisions of this Plan.

Millsaps College has established this benefit plan to provide financial help for you when a covered loss occurs. This Plan is funded through the EIIA Group Life, Accident and Health Insurance Trust ("Trust").

Certain of the benefits provided by the Plan may be provided through one or more insurance policies purchased by the Trust. To the extent that benefits under the Plan are not provided through insurance, responsibility for funding for the payment of benefits is assumed by Millsaps College. The benefits provided by this Plan are limited to those provided through the Trust, or the insurance policies purchased by the Trust in the case of an insured benefit. Only the Trust has discretion to construe or interpret the provisions of this Plan and to determine eligibility for uninsured benefits under this Plan. To the extent permitted by law, each insurance company that has issued an insurance policy to the Trust has the discretion to construe or interpret the provisions of its policy, including eligibility for benefits thereunder.

The Trust has delegated claims administration and certain other duties to the Blue Cross/Blue Shield of Mississippi (BC/BS). While one of the functions of BC/BS is to process claims according to Plan provisions, all claims under the Plan are paid by the Trust. The final decision on any disputed claim may involve review of these files by the Trustees of the Trust. Benefits under this Plan will be paid only if the Trustees of the Trust (or the applicable insurance company in the case of an insured benefit) decide in their discretion that the applicant is entitled to them.

As a covered Member of the Plan, your rights and benefits are determined by the provisions of this Plan Document. This Plan Document also outlines what you must do to be covered and explains how to file claims.

**FUTURE OF PLAN.** It is expected that this Plan will be continued indefinitely. However, Millsaps College has reserved the right to change or terminate the Plan at any time.

The Plan shall be construed and administered to comply in all respects with applicable federal law.

Administered by:

Blue Cross Blue Shield of Mississippi  
3545 Lakeland Drive  
Flowood, MS 39232

## SCHEDULE OF BENEFITS

LIFETIME MAXIMUM BENEFITS \$5,000,000 (Limited to a  
\$1,000,000 per Calendar Year)

### DEDUCTIBLE AMOUNTS

#### Network

Individual Deductible (Per Member Per Calendar Year)	\$2,000
Family Maximum (No more than 3 times the Individual Deductible)	\$6,000

#### Non-Network

Individual Deductible (Per Member Per Calendar Year)	\$2,000
Family Maximum (No more than 3 times the Individual Deductible)	\$6,000

The Network and Non-Network Deductible Amounts are combined. The Deductible does not apply where there is a Co-payment amount. The Co-payment amount does not accrue toward the Deductible Amount.

### OUT-OF-POCKET MAXIMUM

#### Network

Individual (Per Member Per Calendar Year)	\$4,000
Family (No more than 3 times the Individual Out-of-pocket)	\$12,000

#### Non-Network

Individual (Per Member Per Calendar Year)	\$7,000
Family (No more than 3 times the Individual Out-of-pocket)	\$21,000

The Network and Non-Network Out-of-pocket amounts are combined.

When a Participant's or Dependent's Out-of-pocket expenses for Coinsurance for Covered Services rendered by Network Providers reaches the Network Out-of-pocket amount during a Calendar Year, charges for Covered Services will be paid at 100% (where applicable) for the rest of the Calendar Year.

When a Participant's or Dependent's Out-of-pocket expenses for Coinsurance for Covered Services rendered by Non-Network Providers reaches the Non-Network Out-of-pocket amount during a Calendar Year, charges for Covered Services will be paid at 100% (where applicable) for the rest of the Calendar Year.

The terms "pay," "paid," "payment," "payable," as well as similar terms, are found throughout this Plan. When the aforementioned terms are used with respect to the provision of Benefits, the terms are referencing the Benefits provided by Plan, rather than an actual amount paid by Plan.

Coinsurance for Covered Services incurred for the treatment of Temporomandibular/Craniomandibular Joint Disorder cannot be used toward satisfying the Network or Non-Network Out-of-pocket of this Plan. Once the Network or Non-Network Out-of-pocket amount has been satisfied, Plan will not pay 100% of the Allowable Charges for services incurred for treatment and care of Temporomandibular/Craniomandibular Joint Disorder. Co-payment amounts do not accrue toward the Out-of-pocket amount. Co-payment amounts are still applicable after the Out-of-pocket amount is satisfied.

Plan will provide Benefits for Covered Services as specified below. Benefits are based on the Allowable Charge minus: (1) any applicable Deductible Amount, (2) any applicable Coinsurance, and/or (3) any applicable Co-payment.

<u>COVERED SERVICES</u>	<u>BENEFIT</u>	
	<u>Network Provider</u>	<u>Non-Network Provider</u>
<u>Hospital Services</u>		
Bed, Board and General Nursing Services (Private, Semiprivate or Special Care Unit)	80% to OOP, then 100% (Deductible Applies)	60% to OOP, then 100% (Deductible Applies)
Other Services	80% to OOP, then 100% (Deductible Applies)	60% to OOP, then 100% (Deductible Applies)
Inpatient Rehabilitation Services (Limited to 30 Inpatient days per Calendar Year)(Covered Services must be rendered by a Network Provider and subject to Case Management)	80% to OOP, then 100% (Deductible Applies)	Not Covered
Newborn Well Baby (Nursery)	80% to OOP, then 100% (Deductible Applies)	60% to OOP, then 100% (Deductible Applies)

	<u>Network Provider</u>	<u>Non-Network Provider</u>
Outpatient Hospital Services		
Surgery	80% (Deductible Waived)	60% to OOP, then 100% (Deductible Applies)
Emergency Room Services (Professional Services are excluded)	80% to OOP, then 100% (Deductible Applies)	60% to OOP, then 100% (Deductible Applies)
Other Outpatient Services	80% to OOP, then 100% (Deductible Applies)	60% to OOP, then 100% (Deductible Applies)
X-Ray and Lab	80% to OOP, then 100% (Deductible Applies)	60% to OOP, then 100% (Deductible Applies)

Emergency Room Services - When Emergency Room Services (excluding Emergency Room Physician Services) of a Non-Network Provider (Hospital) are used in the case of an accident or emergency, the Network coinsurance will be provided subject to the Member satisfying the Benefit Period Deductible Amount and the Non-Network Hospital Emergency Room Deductible.

<u>Ambulatory Surgical Facility Services (ASF)</u>	80% (Deductible Waived)	60% to OOP, then 100% (Deductible Applies)
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<u>Physician Services</u> (M.D. and D.O. only)	<u>Network Provider</u>		<u>Non-Network Provider</u>
	<u>Primary Care</u>	<u>Specialist</u>	
Office Visits (Note: The Co-pay does not apply to any other Services rendered in the Physician's Office)(Benefits do not apply to Preventive Wellness Services)	100% after \$20 Co-pay (Family Practice, General, Internal Medicine, Pedia- tricians, OB/GYN)	100% after \$20 Co-pay	60% to OOP, then 100% (Deductible Applies)

	<u>Network Provider</u>	<u>Non-Network Provider</u>
Other Services Rendered in the Physician's Office (Deductible does not apply to Services rendered in a Network Physician's Office)	100% (Deductible Waived)	60% to OOP then 100% (Deductible Applies)
Newborn Well Baby Care (Subsequent Visits, Circumcision and Discharge of Baby)	80% to OOP, then 100% Deductible Applies)	60% to OOP, then 100% (Deductible Applies)
Surgery (Hospital/ASF)	80% to OOP, then 100% (Deductible Applies)	60% to OOP, then 100% (Deductible Applies)
Outpatient Anesthesia and Surgery	80% (Deductible Waived)	60% to OOP, then 100% (Deductible Applies)
Outpatient (All Other Services)	80% to OOP, then 100% (Deductible Applies)	60% to OOP, then 100% (Deductible Applies)
Diagnostic Services	100% (Deductible Waived)	60% to OOP, then 100% (Deductible Applies)
Therapy Services (Includes Drug Therapy for chronic disease or condition)	80% to OOP, then 100% (Deductible Applies)	60% to OOP, then 100% (Deductible Applies)
Allergy Injections/Testing	100% (Deductible Waived)	60% to OOP, then 100% (Deductible Applies)

NOTE: When there is not a Network Physician designated in a specialty for a certain Network Service Area, Benefits will be the same as for a Network Physician subject to Claims Administrator's approval.

<u>Other Covered Services, Supplies or Equipment Provided by an Allied Provider (Facility, Professional)</u>	<u>Network Provider</u>	<u>Non-Network Provider</u>
Ambulance Services	80% to OOP, then 100% (Deductible Applies)	60% to OOP, then 100% (Deductible Applies)
Durable Medical Equipment (Medical Necessity Certificate Required)	80% to OOP, then 100% (Deductible Applies)	60% to OOP, then 100% (Deductible Applies)
Home Infusion Therapy (Pre-certification Required)	80% to OOP, then 100% (Deductible Applies)	60% to OOP, then 100% (Deductible Applies)
Orthotic Devices (Medical Necessity Certificate Required)	80% to OOP, then 100% (Deductible Applies)	60% to OOP, then 100% (Deductible Applies)
Prosthetic Appliances (Medical Necessity Certificate Required)	80% to OOP, then 100% (Deductible Applies)	60% to OOP, then 100% (Deductible Applies)
Free-standing Diagnostic Facility	80% to OOP, then 100% (Deductible Applies)	60% to OOP, then 100% (Deductible Applies)
Therapy Services (Chemo, Radiation, Dialysis, Respiratory, Inhalation, Infusion and Drug Therapy)	80% to OOP, then 100% (Deductible Applies)	60% to OOP, then 100% (Deductible Applies)
Outpatient Cardiac Rehabilitation (Covered Services must be rendered by a Network Provider that is a Certified Facility)(Visit limits are based on the severity of patient's condition, not to exceed 36 visits). (Subject to Case Management)	80% to OOP, then 100% (Deductible Applies)	Not Covered

	<u>Network Provider</u>	<u>Non-Network Provider</u>
Sleep Studies (Services must be rendered by a facility accredited by AASM)	80% to OOP, then 100% (Deductible Applies)	60% to OOP, then 100% (Deductible Applies)
Speech Therapy (Restorative)	80% to OOP, then 100% (Deductible Applies)	60% to OOP, then 100% (Deductible Applies)
Home Health (Limited to 100 visits per Calendar Year)	100% (Deductible Waived)	100% (Deductible Waived)
Hospice (Subject to Case Management)	100% (Deductible Waived)	100% (Deductible Waived)
Skilled Nursing Facility (Limited to 120 days per Calendar Year)	80% to OOP, then 100% (Deductible Applies)	80% to OOP, then 100% (Deductible Applies)
	<u>Network Provider</u>	<u>Non-Network Provider</u>
<u>Allied Primary Care Health Professional</u> (Nurse Practitioner, Physician Assistant and Nurse Mid-wife)		
Office Services (Co-pay does not apply to any other services rendered in the Physician's Office)	100% after \$20 Co-pay	60% to OOP, then 100% (Deductible Applies)
Other Covered Services rendered in the Office (Deductible does not apply to services rendered by a Network Provider)	100% (Deductible Waived)	60% to OOP, then 100% (Deductible Applies)

<u>Allied Specialist</u>	<u>Network Provider</u>	<u>Non-Network Provider</u>
Office Services (Co-pay does not apply to any other services rendered in the Office)	100% after \$20 Co-pay	60% to OOP, then 100% (Deductible Applies)
Other Covered Services rendered in the Office	100% (Deductible Waived)	60% to OOP, then 100% (Deductible Applies)

Note: Chiropractic Care limited to 26 visits per Calendar Year.

<u>Prescription Drugs</u>	<u>Community * PLUS Pharmacy (Deductible Waived)</u>	<u>Non-Community PLUS Pharmacy (Deductible Waived)</u>
<u>Retail Prescription Drugs</u> (Limited to a 30 day supply)		
Generic	100% after \$10 Co-pay	100% after \$20 Co-pay
Preferred Brand	100% after \$25 Co-pay	100% after \$50 Co-pay
Non-Preferred Brand (Includes all Compound Prescription Drugs)	100% after \$40 Co-pay	100% after \$80 Co-pay

IF A HIGH QUALITY GENERIC ALTERNATIVE IS AVAILABLE, BUT THE MEMBER PURCHASES THE BRAND NAME, THE MEMBER WILL PAY THE APPLICABLE CO-PAY PLUS THE COST DIFFERENCE BETWEEN THE BRAND NAME DRUG AND THE GENERIC DRUG PRICES.

\* A Community PLUS Pharmacy is a Participating Provider (where applicable) a Preferred Provider (where applicable) or a Network Provider (where applicable). A pharmacy that is not designated as a Community PLUS Pharmacy is a Non-Participating Provider (where applicable), Non-Preferred Provider (where applicable) or a Non-Network Provider (where applicable).

<u>Prescription Drugs (cont.)</u>	<u>Designated Mail Order Pharmacy (Deductible Waived)</u>	<u>Non-Designated Mail Order Pharmacy</u>
<u>Maintenance Drugs</u> (Limited to a 90 day supply)		
Generic	100% after \$20 Co-pay	Not Covered
Preferred Brand	100% after \$50 Co-pay	Not Covered
Non-Preferred Brand (Includes all Compound Prescription Drugs)	100% after \$80 Co-pay	Not Covered

	<u>Network Provider</u>	<u>Non-Network Provider</u>
<u>Nervous/Mental Care and Substance Abuse</u> (Services rendered by Psychologists, Psychiatrists, Licensed Social Workers, Licensed Counselors and Family Therapists)		
Inpatient Care (Not to exceed 90 days Lifetime Maximum – Combined with Partial Hospitalization)	80% to OOP, then 100% (Deductible Applies)	60% to OOP, then 100% (Deductible, Applies)
Partial Hospitalization (Not to exceed 90 days Lifetime Maximum – Combined with Inpatient Hospitalization)	80% to OOP, then 100% (Deductible Applies)	60% to OOP, then 100% (Deductible, Applies)
Outpatient Hospital Visits (Not to exceed 60 visits per Calendar Year - Combined with Outpatient Physician Services)	60% to OOP, then 100% (Deductible Applies)	50% to OOP, then 100% (Deductible Applies)
Other Outpatient Physician Services	60% to OOP, then 100% (Deductible Applies)	50% to OOP, then 100% (Deductible Applies)

Nervous/ Mental Care and  
Substance Abuse (cont.)

Network  
Provider

Non-Network  
Provider

	<u>Primary</u>	<u>Specialist</u>	
Physician Office Visits (Not to exceed 60 visits per Calendar Year - Combined with Outpatient Hospital Visits and Outpatient Physician Services) (Note: Co-pay does not apply to any other services rendered in the Physician's Office)	100% after \$20 Co-pay (Family Practice, General, Internal Medicine, Pedia- tricians, OB-GYN)	100% after \$20 Co-pay	60% to OOP, then 100% (Deductible Applies)
Other Services rendered in the Physician's office (Deductible does not apply to services rendered in a Network Physician's Office)	60% to OOP, then 100% (Deductible Waived)		60% to OOP, then 100% (Deductible Applies)

Transplant Benefits\*\*

Renal Transplants  
limited to the Annual and Lifetime Maximum

Other Solid Organ Transplants  
(Liver, Heart, Lung) limited to the  
Annual and Lifetime Maximum

Tissue Transplants  
(Bone Marrow Transplants)  
limited to the Annual and Lifetime Maximum

Donor Benefits  
(Limited to the Annual and Lifetime Maximum  
includes expenses for organ/tissue search, travel for  
the organ and/ or donor, removal hospitalization)  
(Benefit will be provided at 100% of the Allowable  
Charge for Network Services with the Deductible Waived)

NOTE: PRIOR APPROVAL AND CASE MANAGEMENT ARE REQUIRED. NO BENEFITS WILL BE PROVIDED FOR ORGAN TRANSPLANT SERVICES RECEIVED FROM A NON-NETWORK PROVIDER UNLESS APPROVED BY THE CLAIMS ADMINISTRATOR'S CASE MANAGER.

\*\* Claims Administrator will pay the percentage (subject to the applicable Co-payment or Deductible Amount) as previously outlined (Network or Non-Network) based on the type Covered Services rendered.

TEMPOROMANDIBULAR/CRANIOMANDIBULAR \*\*\*  
JOINT DISORDER (TMJ)

Surgery

Diagnostic

Diagnostic Services  
 and Removable Oral  
 Appliances limited to \$500  
 per Calendar Year.)

\*\*\* Claims Administrator will pay the percentage (subject to the applicable Co-payment or Deductible Amount) as previously outlined (Network or Non-Network) based on the type Covered Services rendered.

	<u>Network Provider</u>	<u>Non-Network Provider</u>
<u>DIABETES TREATMENT</u> (Must have diagnosis of Diabetes)		
Equipment, Supplies for the monitoring of blood glucose and insulin administration (Home glucose monitors limited to 1 monitor every 2 years.)	80% to OOP, then 100% (Deductible Applies)	60% to OOP, then 100% (Deductible Applies)
Self-Management Training/ Education and Medical Nutrition Therapy (Limited to \$250 per Calendar Year maximum)	80% to OOP, then 100% (Deductible Applies)	60% to OOP, then 100% (Deductible Applies)
Dilated Eye Exam (Limited to one exam per Calendar Year)	80% to OOP, then 100% (Deductible Applies)	60% to OOP, then 100% (Deductible Applies)
Preventive Foot Care (Limited to one visit per Calendar Year)	80% to OOP, then 100% (Deductible Applies)	60% to OOP, then 100% (Deductible Applies)

	<u>Network Provider</u>		<u>Non-Network Provider</u>
<u>OUTPATIENT PREVENTIVE/ WELLNESS BENEFIT</u>			
Physician Office Visits must must be rendered by a Primary Care Physician, Specialist, Nurse Practitioner, or Physician Assistant	<u>Primary Care</u> 100% after, \$20 Co-pay	<u>Specialist</u> 100% after, \$20 Co-pay	60% to OOP, then 100% (Deductible Waived)
All Other Services	100% (Deductible Waived)		60% to OOP, then 100% (Deductible Waived)

### PRE-CERTIFICATION/CERTIFICATION

Pre-Certification of Elective Inpatient Admissions	Required
Certification of Emergency Inpatient Admissions	Required
Continued Stay Review	Required
Pre-Certification of Home Infusion Therapy	Required
Pre-Certification of Solid Organ Transplant	Required
Pre-Certification of Tissue Transplant (i.e. Bone Marrow Transplant)	Required

Network Provider - It is the responsibility of the Network Hospital and/or Physician to certify Elective and Emergency Admissions to a Network Hospital and pre-certify/certify all other services as required. The Member will not be held responsible for charges by a Network Provider that are not documented Medically Necessary. Additionally, the Member is not responsible for Covered Services that are not pre-certified or certified.

Non-Network Provider - It is the sole responsibility of the Member to ensure that a Non-Network Hospital and/or Physician pre-certify/certify all Elective Admissions and Emergency Admissions and all other services as required. The Member will be responsible for all charges not specifically listed as Covered Services and for up to \$300 of the Covered Services if Elective or Emergency Admissions are not pre-certified or certified as well as services not documented Medically Necessary.

Inpatient Transfers - The Network Provider should notify Claims Administrator of all Inpatient transfers.

### Non-Network Providers (in-state or out-of-state)

The higher Benefit level will not be paid to a Non-Network Provider unless the services meet one of the following criteria:

- A. In unique situations when the Member requires the special services of a Non-Network Provider due to the fact that special services are not available by a Network Provider. The Member and his Network Provider must:
  - (1) obtain the Claims Administrator's pre-approval for a referral to a Non-Network Provider, and
  - (2) provide documentation supporting the fact that the Admission to such Hospital or referral to such Provider is Medically Necessary.
  - (3) In instances of further referrals (a third or more referral), the higher Benefit level will be paid as long as the Network Provider is involved in the referral and the referral is pre-approved by the Claims Administrator.
- B. Member is admitted as an Inpatient to a Hospital as a result of an accident or an Emergency.
- C. Member receives Outpatient Services as a result of an accident or an Emergency.
- D. Any time the higher Benefit level is paid in the cases listed in Section A, Section B or Section C above, Coinsurance will accrue toward the Network Out-of-pocket amount. Once the Network Out-of-pocket amount is met, Benefits will be paid at 100% (where applicable).

Hospital Savings - Claims Administrator has entered into payment agreements with participating hospitals to provide services to persons entitled to participating hospital benefits under plans administered by Claims Administrator, including Members under this Plan. Under these payment agreements, this Plan does not always pay an amount to the hospital which corresponds to the Benefit amount. The payment made by Plan together with the Member's Deductible, Coinsurance, and/or Co-payment may be greater than or less than Covered Charges. Any savings as a result of these payment agreements are utilized in the financing of this Plan. A Member's Coinsurance is based on the lesser of Covered Charges or the amount established by Claims Administrator as the maximum amount for Provider services covered under the terms of this Plan.

Medical Policy – Claims Administrator develops formal written guidelines regarding new and existing medical and surgical procedures, products, drugs, technology and tests. These guidelines are determined by review of currently available peer reviewed scientific literature as well as input from practicing professionals. Claims Administrator relies on medical policy for reaching decisions on matters of: 1) Medical Necessity, 2) Covered

Services under this Plan, 3) appropriate adjudication of claims, 4) Utilization Management, and 5) quality assessment programs. The specific guidelines found in the Medical Policy are not set out in their entirety in this Plan.

Managed Care Drug Formulary - Blue Cross & Blue Shield of Mississippi has developed a Managed Care Drug Formulary (hereinafter Formulary). The Formulary provides clinical and cost comparative information to physicians servicing Blue Cross & Blue Shield of Mississippi's Members. In addition to being an information source on drugs, the use of the Formulary may generate savings from drug manufacturers. These savings are generated from prescription drug claims. Any savings as a result of the Formulary are utilized in the financing of this Plan. A Member's Coinsurance/Co-payment for the prescription drug is based on the cost of the drug before Blue Cross & Blue Shield of Mississippi receives the savings from the Managed Care Drug Formulary.

Network Providers: When a Member utilizes a Network Provider (Hospital, Physician or Allied Provider), the Provider is responsible for: (1) following the Claims Administrator's Utilization Management requirements, (2) complying with all the Claims Administrator's Medical Policy, (3) filing the Member's claim with the Claims Administrator and (4) complying with the Claims Administrator's Participating Provider Agreements by not billing the Member for any charges that are determined not to be Medically Necessary or above the Allowable Charge except for any non-covered expenses, any Deductible Amount, Coinsurance and/or Co-payment Amount required by the Plan.

Non-Network Provider: When a Member utilizes a Non-Network Provider (Hospital, Physician, or Allied Provider), the Member is solely responsible for (1) ensuring that the Non-Network Provider complies with the Utilization Management requirements set out in this Plan, (2) ensuring the Non-Network Provider complies with all the Claims Administrator's Medical Policy and (3) filing his or her claim with the Claims Administrator. The Non-Network Provider's failure to comply with the Utilization Management requirements or to follow Medical Policy can result in a Pre-Certification penalty to the Member as well as a determination by Claims Administrator that the services are non-covered or not Medically Necessary. Additionally, no Benefits are provided for certain Covered Services when the Member receives the services from a Non-Network Provider

Special Note - Claims Administrator does not insure against any condition, disease, ailment or injury (including pregnancy and conditions arising from it), but only provides Benefits for Covered Services which are furnished by a Provider to the Member during his or her effective dates of coverage under the Plan.

MEMBERSHIP CERTIFICATE BOOKLETS - THE MEMBERSHIP CERTIFICATE BOOKLET DESCRIBES THE BENEFITS PROVIDED UNDER THE GROUP PLAN. MEMBERS ARE RESPONSIBLE FOR READING, UNDERSTANDING AND BEING AWARE OF THE CONTENT OF HIS OR HER MEMBERSHIP CERTIFICATE BOOKLET.

## Article I DEFINITIONS

Note: Many of the definitions contained in Article I describe different types of services or supplies which may or may not be Covered Services under this Plan. For full details of Covered Services and Non-covered Services, please refer to the Benefit sections and the Limitation and Exclusion section.

Accidental Injury - A condition occurring as a direct result of a traumatic bodily injury sustained solely through accidental means from an external force. With respect to injuries to teeth, the act of chewing does not constitute an injury caused by external force.

Acute Care - Inpatient care provided for an illness, injury or condition, which is Medically Necessary to reach a point of stability that would allow a patient to: (1) receive care on an outpatient basis, (2) receive home care, or (3) transfer to a long-term care facility for further treatment including any Rehabilitative Care facility.

Administrator – Trustees of the Trust identified on the introduction page of your booklet.

Admission - The period from entry (Admission) into a Hospital for Inpatient care, until discharge. In counting days of care, the date of entry and the date of discharge are together counted as one day.

Adopting Institution – Your employer, the Sponsor, identified on the Introduction page of your booklet.

Allied Health Facility - An institution, other than a Hospital, licensed by the appropriate state agency where required, and/or approved by the Claims Administrator to render Covered Services.

Allied Health Professional – A person other than a medical doctor, or doctor of Osteopathy who is licensed by the appropriate state agency, where required and/or approved by Claims Administrator to render Covered Services. An Allied Health Professional includes dentists, psychologists, certified nurse practitioners, optometrists, chiropractors, podiatrists and any other health professional which is mandated by state law for specified services. For purposes of this Plan, Allied Health Professionals are divided into two types:

- A. Allied Primary Care Health Professionals – A person who is licensed by the appropriate state agency and approved by Claims Administrator to render Covered Services, which are within the lawful scope of his or her license to Members. For purposes of this Plan, Nurse Practitioners and Physician Assistants will be designated as Allied Primary Care Health Professionals.

- B. Allied Specialist – An Allied Health Professional, other than a Nurse Practitioner, who is licensed by the appropriate state agency and approved by Claims Administrator to render Covered Services, which are within the lawful scope of his or her license to Members. For the purposes of this Plan, Allied Health Professionals, other than Nurse Practitioners, will be designated as Allied Specialist.

Allied Provider - Any Allied Health Facility or Allied Health Professional.

Allowable Charge - The lesser of the: (1) Covered Charges or (2) the amount established by Claims Administrator as the maximum amount for Provider services covered under the terms of the Plan. NOTE: For the purposes of the BlueCard Program, the Allowable Charge may be determined by the out-of-state Blue Cross & Blue Shield Plan (See Article XVI, for the BlueCard Program).

Alternative Benefits - Benefits for services not routinely covered under the Plan but which may be provided by agreement through Individual Case Management.

Ambulance Service - Medically Necessary transportation by means of a specially designed and equipped vehicle used only for transporting the sick and injured.

Ambulatory Surgical Facility - An institution licensed as such by the appropriate state agency, certified by Medicare, and approved by the Claims Administrator whose primary purpose is performing elective surgical procedures on an Outpatient basis.

Annual Maximum – The maximum amount the Claims Administrator will pay on behalf of the Member for covered services.

Bed, Board and General Nursing Service - Room accommodations, meals and all general services and activities provided by a Hospital employee for the care of a patient including all nursing care and nursing instructional services provided as a part of the Hospital's bed and board charge whether the patient is in a private room, a room with two or more beds, or a Special Care Unit, but exclusive of incremental nursing services by a Hospital employee.

Benefit - The amount provided under the Plan for Covered Services. Benefits are based on the Allowable Charge minus any applicable Deductible Amount, Coinsurance or Co-payment.

Benefit Period - A period of one calendar year commencing each January 1 through December 31. Any Covered Services incurred during the Calendar months of October, November, and December which will be applied toward the Deductible Amount, may be applied to the Deductible Amount for the next succeeding Calendar Year.

Billed Charges - The total charges submitted by a Provider for all Covered Services and Non-covered Services provided to a Member.

Case Management - A component of the Claims Administrator's Utilization Management programs. Case Management is the development of a comprehensive plan of action for Members with complex health care needs. Case managers collaborate with Members, their families, doctors, hospital social workers/case managers and other health care providers to minimize unnecessary medical and service complications, promote care in the least restrictive setting, and facilitate efficient, appropriate and cost effective care. The goal of Case Management process is to provide effective, appropriate and quality controlled management of high cost and/or catastrophic cases.

Certified Diabetes Educator - A Diabetes Educator who currently holds a certification from the National Certification Board for Diabetes Educators.

Claims Administrator - Blue Cross & Blue Shield of Mississippi, A Mutual Insurance Company.

Coinsurance - That portion of the Allowable Charge expressed as a percentage for which the Member is financially responsible under the Plan in addition to any applicable Deductible Amount.

Community PLUS Pharmacy - A pharmacy which has entered into an agreement with Claims Administrator (and has met the criteria for the Community PLUS Network) wherein the Community PLUS Pharmacy as a Participating Provider (where applicable), a Preferred Provider (where applicable) or a Network Provider (where applicable) agrees to render pharmaceutical services to Members of the Plan.

Concurrent Care - Hospital Inpatient medical and surgical care by a Physician, other than the attending Physician; (1) for a condition not related to the primary diagnosis or, (2) because the medical complexity of the patient's condition requires additional medical care.  
Consultation - Another Physician's opinion or advice as to the evaluation or treatment of a Member which is furnished upon the request of the attending Physician. These services are not intended to include those Consultations required by Hospital rules and regulations, anesthesia Consultations, routine Consultations for clearance for Surgery, or Consultations between colleagues who exchange medical opinions as a matter of courtesy and normally without charge.

Continued Stay Review - A review to determine the Medical Necessity of continued hospitalization beyond the initial approved length of stay and level of care.

Co-payment - That portion of the Allowable Charge expressed as an amount for which the Member is financially responsible under the Plan in addition to the Deductible Amount where applicable.

Cosmetic Surgery - Any operative procedure or any portion of an operative procedure intended solely to improve physical appearance. Exceptions to the above procedures are those procedures which restore bodily function or correct deformity resulting from disease, trauma or complications of previous Surgery.

Covered Charges - Provider Charges for Covered Services. Covered Charges are Billed

Charges minus Non-covered Charges.

Covered Service - A service or supply specified in the Plan for which Benefits are available when rendered by a Provider. A charge for a Covered Service is considered to have been incurred on the date the service or supply was provided to the Member.

#### Deductible Amounts

##### A. Benefit Period Deductible Amount

1. "Benefit Period Deductible Amount" - The dollar amount, as shown in the Schedule of Benefits, of Covered Services first hereunder incurred in connection with a Member's injury or illness within a Benefit Period.

Dental Care and Treatment - All procedures, treatment, and Surgery considered to be within the scope of the practice of dentistry, which is defined as follows:

The diagnosis or profession to diagnose, or the examination or contracting for the treatment of, or treating or professing to treat, or holding oneself out as treating any of the diseases or disorders or lesions of the oral cavity, teeth, gingivae, or maxillary bones, the extraction of teeth, repair or filling of cavities in human teeth, the correction of malposition or irregularities of the teeth or jaws, the practice of Surgery of the head or neck incident to the practice of Oral Surgery, or the construction, repair or mending of artificial teeth, crowns, or bridges. The administration of anesthetics or the use of X-rays in connection with any of the above-referenced acts is defined as the practice of dentistry as is any other practice which is included in the curricula of dental schools accredited by the Council on Dental Education or the American Dental Association.

Dental Implants – Devices specially designed to be placed surgically within the mandibular or maxillary bone as a means of providing for dental replacement.

Dependent - A person, other than the Participant, who has been accepted for coverage as specified in and determined by the Schedule of Eligibility.

Developmental Disability - A Dependant child's substantial handicap, which results from mental retardation, cerebral palsy, epilepsy, or other neurological disorder; and is diagnosed by a Physician as a permanent or long term continuing condition.

Diabetes - Diabetes mellitus is a disorder of carbohydrate metabolism, characterized by hyperglycemia and glycosuria and resulting from inadequate production or utilization of insulin.

Diagnostic Service - Radiology, laboratory, and pathology services and other tests or procedures recognized by Claims Administrator as accepted medical practice, rendered because of specific symptoms, and which are directed toward detection or monitoring of a

definite condition, illness or injury. A Diagnostic Service must be ordered by a Provider.

Disease Management - Systematic approach to medical care which incorporates development and implementation of clinical practice guidelines, patient education, and provider education to improve the quality of care for selective disease states. Through the Claims Administrator's Utilization Management program, the Claims Administrator seeks to identify Members who would qualify for Disease Management. The Claims Administrator will work with the Member, their Physician and family, to assess treatment alternatives and available benefits through Case Management.

Disease Specific Drugs – Drugs or medications for the prevention or treatment of a chronic complex disease state which include, but are not limited to: (a) Multiple Sclerosis; (b) RSV Prevention; (c) Rheumatoid Arthritis; (d) Crohn's Disease; and (e) Metabolic Disorders.

Disease Specific Pharmacy – a provider that has an area of expertise in disease states as well as the drugs and medications used to treat disease states. In order to be considered a Disease Specific Pharmacy under this Plan, Claims Administrator must have a Disease Specific Pharmacy Arrangement with the Provider.

Domestic Partner – Two individuals of the same sex who live together in a mutually exclusive and enduring relationship, consider themselves life partners, share joint responsibility for their common welfare and are financially interdependent.

Drug Utilization Management - A program which is part of Utilization Management. Through this program, the Claims Administrator will determine the Medical Necessity of Prescription Drugs. The Claims Administrator's determination of Medical Necessity will be based upon established pharmaceutical policy.

Durable Medical Equipment - - Items which are used to serve a medical purpose, can withstand repeated use, are generally not useful to a person in the absence of illness, injury, or disease, and are appropriate for use in the patient's home. Construction costs to the Member's residence to accompany the equipment is not considered Durable Medical Equipment.

Effective Date - The date when the Member's coverage begins under the Plan as determined by the Schedule of Eligibility.

Elective Admission - Any Inpatient Hospital Admission, whether it be for surgical or medical care, for which a reasonable delay will not unfavorably affect the outcome of the treatment.

Eligible Person - A person entitled to apply to be a Participant as specified in the Schedule of Eligibility.

Emergency - See "Medical Emergency."

Emergency Admission - "Emergency Admission" may be an "Emergency Medical Admission" or "Emergency Psychiatric Admission."

- A. "Emergency Medical Admission" means an Inpatient Admission to a Hospital resulting from the sudden onset of a medical condition manifesting itself by acute symptoms of sufficient severity that the absence of immediate Inpatient Hospital care could reasonably result in:
1. Permanently placing the patient's health in jeopardy;
  2. Serious impairment to bodily functions; or
  3. Serious and permanent dysfunction of any bodily organ or part, or other serious medical consequences.
- B. "Emergency Psychiatric Admission" means an Inpatient Admission to a Hospital resulting from a mental illness or substance abuse with presenting symptoms of such severity, that in the absence of immediate intervention, could reasonably result in:
1. Permanently placing the patient's mental health in jeopardy;
  2. A serious threat to the physical welfare of the patient and/or others; or
  3. Serious or permanent mental dysfunctions or other medical or psychiatric consequences. The acute symptoms must be of such severity as to cause a person to seek medical or psychiatric assistance regardless of the hour of the day or night.

Group – Millsaps College.

Home Health Care - Health services rendered in the individual's place of residence by an organization licensed as a home health Provider by the appropriate state agency and/or approved by the Claims Administrator. These organizations are primarily engaged in providing to individuals, at the written direction of a licensed Physician, in the individual's place of residence, skilled nursing services by or under the supervision of a Registered Nurse licensed to practice in the state.

Home Infusion Therapy - Services and Supplies required for the administration of a Home Infusion Therapy regimen. These services and supplies must be (1) Medically Necessary for the treatment of the disease; (2) ordered by a Physician; (3) as determined by the Claims Administrator, capable of safe administration in the home; (4) provided by a Home Infusion Therapy Provider approved by the Claims Administrator when Pre-Certification has been obtained from the Claims Administrator; (5) ordinarily in lieu of Inpatient Hospital Therapy; and (6) more cost effective than Inpatient Therapy.

Hospice Care - Provision of an integrated set of services and supplies designed to provide

palliative and supportive care to meet the special needs of Members and their families during the final stages of terminal illness, normally six months or less. Full scope health services are centrally coordinated through an interdisciplinary team directed by a Physician and provided by or through a Hospice Care agency licensed by the state and approved by the Claims Administrator.

Hospital - a short-term, acute-care, general hospital which:

- A. is a licensed institution;
- B. provides inpatient services and is compensated by or on behalf of its patients;
- C. provides surgical and medical facilities primarily to diagnose, treat, and care for the injured and sick; except that a psychiatric hospital will not be required to have surgical facilities;
- D. has a staff of physicians licensed to practice medicine; and
- E. provides 24-hour nursing care by registered nurses.

A Facility which serves, other than incidentally, as a nursing home, custodial care home, rest home, rehabilitative facility or place for the aged is not considered a Hospital.

Inpatient - A Member who is a registered bed patient for whom a Bed, Board and General Nursing Service charge is made.

Inpatient Rehabilitation Services – rehabilitation services that can not be adequately performed in an Outpatient setting. These services must have Case Management approval as well as comply with the Claims Administrator’s criteria for Inpatient Rehabilitation Care.

Investigative - The use of any treatment procedure, facility, equipment, drug, device, or supply not yet recognized by certifying boards and/or approving or licensing agencies or published peer review criteria as standard, effective medical practice for the treatment of the condition being treated.

Lifetime Maximum - The maximum amount the Claims Administrator will pay on behalf of the Member for Covered Services.

Low Dose Mammography - The x-ray examination of the breast using equipment dedicated specifically for mammography, including the x-ray tube, filter, compression device, screens, films and cassettes with a radiation exposure (radiation exposure must be in keeping with the recommended “Average Patient Exposure Guides As Published By The Conference Of Radiation Control Program Directors, Inc.”).

Medical Emergency - The sudden onset of a medical condition manifesting itself by acute symptoms of sufficient severity that the absence of immediate medical care could reasonably result in: (1) permanently placing the patient's health in jeopardy; (2) serious impairment of bodily functions; or (3) serious and permanent dysfunction of any bodily organ or part, or other serious medical consequences. Some examples of Medical

Emergency are severe chest pain, convulsions, excessive bleeding and a decreased level of consciousness. Conditions that would not warrant emergency care include, but are not limited to, the following conditions: colds, sore throat or flu, arthritis that is recurrent, chronic less severe pain such as earache, headache, sore "pulled muscles" or indigestion, small bruises or scrapes of the skin.

Medically Necessary (or "Medical Necessity") - means those services, treatments, procedures, equipment, drugs, devices, items or supplies furnished by a covered Provider that are required to identify or treat a Member's illness or injury, and which Claims Administrator determines are covered under the Plan based on the criteria as follows in A through D;

- A. consistent with the symptoms or diagnosis and treatment of the Member's condition, illness, or injury; and
- B. appropriate with regard to standards of good medical practice; and
- C. not solely for the convenience of the Member, his or her Provider; and
- D. the most appropriate supply or level of care which can safely be provided to Member. When applied to the care of an Inpatient, it further means that services for the Member's medical symptoms or conditions require that the services cannot be safely provided to the Member as an Outpatient.

The Claims Administrator makes no payment for services, treatments, procedures, equipment, drugs, devices, items or supplies which are not documented to be Medically Necessary. The fact that a Physician or other Provider has prescribed, ordered, recommended, or approved a service or supply does not in itself, make it Medically Necessary.

Medical Nutrition Therapy - The assessment of the nutrition status of a patient with a condition, illness, or injury that appropriately requires Medical Nutrition Therapy as part of the treatment, followed by appropriate therapy. The assessment includes review and analysis of medical and diet history, blood chemistry lab values, and anthropometric measurements to determine nutritional status and treatment modalities. Therapy can range from diet modifications and counseling to the administration of specialized therapies such as intravenous or tube feedings.

Member - A Participant or an enrolled Dependent.

Nervous/Mental Conditions - Conditions which are manifested in a disturbance of intellectual and emotional functions to a degree of severity where; (1) the presence of anxiety and/or depression is significantly beyond minor behavior aberrations, or (2) the patient's mental state is such that there has been a break with reality.

Non-covered Charges - Provider charges for Non-covered Services.

Non-covered Services - Health care or other services and supplies provided to a Member for which benefits are not available under the Plan.

Non-Preferred Brand – a Prescription Drug or medication which is not included in the Preferred Drug Formulary. The Member will be responsible for a higher co-payment amount when purchasing a Non-Preferred Brand.

Orthotic Device - A rigid or semi-rigid supportive device which restricts or eliminates motion of a weak or diseased body part.

Out-of-pocket - Unreimbursable expenses incurred by a Member for Covered Services in one Benefit Period. This amount does not include: (a) any charges in excess of the Allowable Charge; (b) any penalty for failure to pre-certify/certify any Emergency, elective or non-Emergency Inpatient Hospital Admission; (c) any charges incurred by Member for non-approved days in a Hospital as a bed patient; or (d) Covered Services as specified in the Plan or (e) Co-payments.

Outpatient - A Member who receives services or supplies while not an Inpatient.

Outpatient Cardiac Rehabilitation - The process by which a person with Cardiovascular Disease is restored to their optimal function states, including their physiological, psychological, social, vocational, and emotional states. Cardiac Rehabilitation services include formal exercise sessions, risk factor education, and behavior modification counseling.

Partial Hospitalization - Inpatient treatment, other than full twenty-four-hour programs in a treatment facility licensed as required by state law and approved by Claims Administrator. Partial hospitalization also includes day, night and weekend treatment programs.

Participant - An Eligible Person who has satisfied the specifications of the Plan's Schedule of Eligibility and has enrolled for coverage; also, the person whose name appears on the identification card and to whom the Claims Administrator, at the request of the Group, has issued a certificate summarizing coverage available under the Plan.

Physical Medicine - The modalities, therapeutic procedures, tests and measurements performed by a licensed Physician, licensed Chiropractor, licensed Physical Therapist, licensed Occupational Therapist or other Allied Health Professional (while acting within the scope of his or her license) used to evaluate and treat acute neuromusculoskeletal conditions.

Physician - A Doctor of Medicine or a Doctor of Osteopathy, legally qualified and licensed to practice medicine and practicing within the scope of his or her license at the time and place service is rendered.

Plan - Employee Health Protection Plan for Millsaps College.

Pre-Certification/Certification - A determination by the Claims Administrator that an Admission or health care service is Medically Necessary as well as meets the Utilization Management requirements of the Plan.

Pre-existing Condition - A Pre-existing Condition means any injury, illness or congenital defect, or condition related to injury, illness, or congenital defect for which a person received medical care, treatment, consultation, or prescribed drugs during the 6-month period immediately preceding:

- A. an individual's Effective Date of coverage under the Plan, or
- B. if the individual is subject to a probationary period, the first day of the individual's probationary period.

Preferred Brand – A Prescription Drug or medication which has been identified by a committee of Network physicians and Network pharmacists as a high quality and effective product. Claims Administrator has included this Prescription drug or medication in the Preferred Drug Formulary.

Preferred Drug Formulary – A list of Prescription Drugs or medications which have been identified by a committee of Network physicians and Network pharmacists as a high quality and effective product.

Prescription Drugs - Medications that under Federal law may be dispensed only upon a written prescription and which are approved for general use by the Food and Drug Administration. Benefits for Prescription Drugs will be based on the Allowable Charge established by the Claims Administrator.

Preventive/Wellness Services - Services designed to effectively prevent or screen for a disease for which there is an effective treatment when discovered in an early stage.

Prior Authorization – A determination by Claims Administrator that: (1) the service, procedure, supply, equipment or Prescription Drug or medication is Medically Necessary; and (2) the medical setting is appropriate for the procedure, service, supply or equipment, or Prescription Drug or medication.

Private Duty Nursing Services - Services of an actively practicing Registered Nurse (R.N.) or Licensed Practical Nurse (L.P.N.) who is unrelated to the patient by blood or marriage. These services must be ordered by the attending Physician and require the technical skills of an R.N. or L.P.N. in shifts of at least 8 continuous hours.

Prosthetic Appliance - Appliances which replace all or part of a body organ, or replace all or part of the function of a permanently inoperative, absent, or malfunctioning body part.

Provider - A Hospital, Allied Health Facility, Physician, or Allied Health Professional, licensed where required, performing within the scope of license, and approved by the Claims Administrator.

- A. Participating Provider - A Provider that has an agreement with the Claims Administrator pertaining to payment for Covered Services rendered to a Member.
- B. Nonparticipating Provider - A Provider that does not have an agreement with the Claims Administrator pertaining to payment for Covered Services rendered to a Member.

- C. Network Provider - Physician who has a Participating Provider Agreement with Claims Administrator pertaining to Covered Services rendered to a Member. A Network Provider will file claims for Member and will not bill the Member for any charges above the Allowable Charge except for any non-covered expenses, any Deductible Amount and Coinsurance/Co-payment amount required by the Plan.
- D. Non-Network Provider - A Physician, Hospital or Allied Provider (Allied Health Professionals are designated as either Allied Primary Care Health Professional or Allied Specialists) who does not have a Participating Provider Agreement with Claims Administrator (Payment for Covered Services and supplies as provided in this Plan are limited when provided by a Non-Network Provider as stated in the Schedule of Benefits section of this Plan).

Note: A pharmacy with a Community Pharmacy Agreement that meets Claims Administrator's criteria for participating in the Community PLUS Network is a Network Provider (where applicable). A pharmacy that is not designated as a Community PLUS Pharmacy is a Non-Network Provider (where applicable).

Recertification - A determination by the Claims Administrator that an extension of stay or a health care service is Medically Necessary as well as meets the Utilization Management requirements of the Plan.

Registered Dietitian - A Registered Dietitian who currently holds a registration from the Commission on Dietetic Registration of The American Dietetic Association.

Rehabilitative Care - The coordinated use of medical, social, educational or vocational services, beyond the Acute Care stage of disease or injury, for the purpose of upgrading the physical functional ability of a patient disabled by disease or injury so that the patient may independently carry out ordinary daily activities.

Residential Treatment Facility – A non-hospital treatment facility which provides a twenty-four (24) hour program of care by qualified therapists, including but not limited to, fully licensed mental health professionals, psychiatrist, psychologists and licensed certified social workers for individuals referred to such facility. Facility services include, however are not limited to, anger management, psychotherapy, neuropsychiatry, hypnotherapy, yoga, equine therapy, acupressure, harmonic resonance therapy, nutritional counseling and biofeedback. These facilities typically do not have 24 hour nursing care on the premises and individuals do not receive services from a Physician on daily basis. Although a facility's state license may designate the facility as a hospital (Example: Psychiatric Hospital), the services that the facility provides will determine whether it is a Residential Treatment Facility for the purpose of this Plan (See the exclusion for services and supplies provided by a Residential Treatment Facilities).

Respite Care - Short-term care at a level comparable to that provided by "caregiver" and approved by the Claims Administrator, which is provided to relieve a person ("caregiver")

who is caring for a terminally ill Member at home free of charge.

Self-Management Training/Education - Diabetes Self-Management Training is the teaching and the learning of the body of knowledge, attitudes, and self-management skills related to the control of Diabetes. The ultimate goal of training is to promote the behavior changes necessary for optimal health outcomes, psychosocial adaptation, and quality of life. The content of the educational experience should include, but not be limited to the following topics: pathophysiology of Diabetes mellitus, nutrition management and diet, pharmacologic interventions, exercise and activity, self-monitoring for glycemic control, prevention and management of acute and chronic complications, psychosocial adjustment, problem-solving skills, stress management, and use of the health care delivery system.

Special Care Unit - A designated Hospital unit which is approved by the Claims Administrator and which has concentrated all facilities, equipment, and supportive services for the provision of an intensive level of care for critically ill patients.

Speech Therapy - Treatment of a speech impairment resulting from disease or injury. Learning disabilities and developmental problems do not qualify for treatment. This treatment must be provided by a licensed speech therapist and prescribed by a Physician.

Sponsor - The employer, the Adopting Institution, identified of the Introduction page of your booklet.

Spouse – The person recognized as the covered Employee's husband or wife under the laws of the state in which the Employee resides.

### Surgery

- A. The performance of generally accepted operative and cutting procedures including specialized instrumentations, endoscopic examinations, incisional and excisional biopsies and other invasive procedures,
- B. The correction of fractures and dislocations,
- C. Maternity Care to include vaginal deliveries and caesarean sections.
- D. Usual and related pre-operative and post-operative care,
- E. Other procedures as defined and approved by the Claims Administrator.

Temporomandibular/Craniomandibular Joint Disorder - Disorders resulting in pain and dysfunction of the temporomandibular/craniomandibular joint which arise out of rheumatic disease, dental occlusive disorders, and internal and external joint stress.

Therapy Service - The following services or supplies ordered by a Physician and used for the treatment of a condition, illness or injury to promote the recovery of the patient.

- A. Radiation Therapy - The treatment of disease by X-ray, radium, or radioactive isotopes.
- B. Chemotherapy - The treatment of malignant disease by chemical or biological antineoplastic agents.
- C. Dialysis Treatment - The treatment of an acute renal failure or chronic irreversible renal insufficiency for removal of waste materials from the body ordinarily removed by the kidneys, to include hemoperfusion, hemodialysis or peritoneal dialysis.
- D. Respiratory Therapy - Therapy utilizing many medically approved modalities to clear the lungs of secretions as well as improve lung function.
- E. Drug Therapy - The treatment of a chronic disease or condition by medication administered under the supervision of a physician in his or her office or administered by the patient (or family member) in the Members home.
- F. Infusion Therapy - Services and supplies required for the administration of an Infusion Therapy regimen. Services include Cancer Intravenous Chemotherapy, Intravenous Antibiotic Therapy, Total Parenteral Nutrition, Intravenous Pain Management for the terminally ill or major trauma patients, and treatment for Acquired Immunodeficiency Syndrome.

NOTE: See Physical Medicine for Physical Therapy and Occupational Therapy. See separate definition for Speech Therapy.

Utilization Management - Evaluation of necessity, appropriateness and efficiency of the use of health care services, procedures and facilities.

Article II  
SCHEDULE OF ELIGIBILITY

A. Eligible Person

Eligible Person is defined as an employee who is:

1. Any full-time or part-time person who:
  - a. is employed by the Adopting Institution on other than a temporary basis; and
  - b. is regularly scheduled to work for the Adopting Institution for at least 1,000 hours per year; and
  - c. meets the guidelines defined by the Adopting Institution on file with and approved by the Administrator; and
  - d. elects to contribute to the cost of coverage, if applicable.
2. Any person who is retired from the Adopting Institution provided such person:
  - a. is age 55 but less than age 65 and has 25 or more years of continuous service; or
  - b. has any combination of age (56-64) and years of service totaling 80 or greater; and
  - c. meets the guidelines defined by the Adopting Institution on file with and approved by the administrator; and
  - d. elects to contribute to the cost of coverage, if applicable.
3. An employee, who is absent from work due to a health condition, is still considered an Eligible Person. An Eligible Person becomes a Participant when enrolled for coverage under this Plan.

B. Eligible Dependent

Eligible Dependent is defined as follows:

1. The Participant's legal Spouse or Domestic Partner.
2. The Participant's unmarried Dependent children, including: (a) newborn children, (b) step-children, (c) children for whom the Participant has been appointed legal guardian by a court of competent jurisdiction, (d) adopted children or children who

have been placed by a court of competent jurisdiction in the custody of the Participant for the purposes of adoption, (e) children designated by a court of competent jurisdiction under the terms of a "Qualified Medical Child Support Order (QMCSO)" as defined by Section 609(a)(2)(A) of ERISA; (f) children who have been placed in the custody of the Participant by a court of competent jurisdiction.

3. A Dependent child must meet all of the following criteria in order to be covered under the Plan:
  - a. he or she must be under the age of 19; and,
  - b. unmarried; and,
  - c. not eligible for, or covered by, another group health plan.

Note: A Dependent Child is covered to age 19, if they are a full time student they may be covered to age 28. Students who receive a degree will be covered up to 3 months after receipt of a degree provided that he or she is less than age 28. A Dependent Child of a Subscriber, who is not currently enrolled under the Plan and who meets the above criteria must wait until the Plan's Open Enrollment Period or a HIPAA qualifying event to obtain coverage under the Plan.

4. Mentally or Physically Handicapped Dependents - A mentally or physically handicapped child must be unmarried, incapable of self sustaining employment, living with the Participant in a parent/child relationship and dependent on the Participant for more than one half of his or her support. The following guidelines apply to the enrollment of a handicapped child:
  - a. A handicapped child may be covered as any other unmarried child under this Plan to age 19 (See Section B, Paragraph 3 above). Once the handicapped Dependent reaches the limiting age of 19, a "Request For Coverage For a Mentally or Physically Handicapped Dependent" form must be submitted to extend coverage beyond age 19. This form must be received by Claims Administrator and approved by the Underwriting Department of Claims Administrator.
  - b. A Participant may not apply for coverage for a handicapped child who is over the limiting age of 19 (as described in subparagraphs a and b above). Handicapped children other than those meeting the above criteria are not considered eligible Dependents for the purposes of this Plan.

## C. Kinds of Coverage

1. Participant-Only Coverage means coverage for Participant only.
2. Family Coverage means coverage for Participant and two or more Dependents.
3. Participant and one Dependent Coverage (where available) means coverage for Participant and one Dependent.

## D. Enrollment Requirements

When an application has been submitted and any fees for coverage have been paid in advance as required by the Plan, coverage will commence on the following applicable Effective Date.

### 1. Enrollment of New Participant

- a. If a person becomes an Eligible Person after the Group's Plan Date, and applies for coverage for himself/herself or himself/herself and any eligible Dependent(s) within 31 days of his or her date of hire, the Effective Date will be the 1st day of the calendar month following the date of hire (FOR COVERAGE TO BE EFFECTIVE AS SPECIFIED ABOVE, CLAIMS ADMINISTRATOR MUST RECEIVE THE APPLICATION WITHIN 31 DAYS OF THE PERSON BEING FIRST ELIGIBLE). If the Eligible Person fails to apply within 31 days of being first eligible, he or she will not be able to enroll in the plan.

### 2. Special Enrollment Periods

- a. Special Enrollment Periods due to loss of coverage.

An Eligible Person and/or an Eligible Dependent who loses coverage under another group health plan or health insurance coverage may be eligible to enroll under the Plan during a Special Enrollment Period subject to the following conditions:

- (1) The Eligible Person must have declined coverage for himself/herself and/or his/her Eligible Dependent(s) (a Participant must have declined coverage for his/her Eligible Dependents) under the Plan when initially eligible. The reason for declining coverage must be due to the fact the Eligible Person or Eligible Dependent(s) was covered under another group health plan or other health insurance coverage.
- (2) The loss of coverage must be due to one of the following conditions:
  - (a) The Eligible Person or Eligible Dependent must become ineligible for coverage under another group health plan or other health insurance coverage. For the purposes of the Plan, loss of eligibility includes loss of coverage as a result of divorce, death, termination of employment or reduction in the number of hours of employment.

- (b) The employer contribution for the other group health plan was terminated.
  - (c) When the Eligible Person declines coverage for himself/herself and/or his/her Eligible Dependent(s) (or the Participant declines coverage for his/her eligible Dependent(s)), the Eligible Person or Dependent(s) had COBRA Continuation Coverage under another group health plan and the COBRA Continuation Coverage has been exhausted.
  - (d) An Eligible Dependent reaches the age at which dependent coverage is no longer provided under another group health plan or other health insurance coverage.
  - (e) An individual loses Health Maintenance Organization coverage due to the fact that he or she moves outside of the Health Maintenance Organization area.
  - (f) An Eligible Person or Eligible Dependent exhausts the maximum lifetime benefit amount under another group health plan or other health insurance coverage and is no longer eligible for Benefits.
  - (g) An Eligible Person or Eligible Dependent loses coverage under a benefit option offered by a group. He or she would need to be permitted to enroll in the group's other benefit option (if applicable).
- (3) The Eligible Person (or where applicable the Participant) must submit and Claims Administrator must receive an Enrollment Form, requesting the appropriate coverage, within 31 days of the loss in coverage as described above. The Eligible Person (or where applicable the Participant) will be required to provide written confirmation of his/her coverage and/or his/her Eligible Dependent(s) coverage under another plan to Claims Administrator. If the Eligible Person (or where applicable the Participant) fails to apply within the allowed 31 day period, he or she will not be eligible to enroll in the plan.
- (4) The Effective Date of the Eligible Person and/or Dependent(s) coverage will be the first day of the first calendar month beginning after the date Claims Administrator received the applicable form (Enrollment Form or Request For Change Form).
- b. Special Enrollment Period for Newly Eligible Dependents
- (1) If a Participant acquires an Eligible Dependent through birth, marriage adoption, placement in anticipation of adoption, Legal Guardianship or a Qualified Medical Child Support Order (hereinafter Qualifying Event), the Participant may apply for coverage for the Eligible Dependent and other

Eligible Dependent(s). The Participant must submit and Claims Administrator must receive a Request for Change Form, applying for the appropriate coverage, within 31 days from the date of the Qualifying Event. The Effective Date of coverage for the Eligible Dependent(s) will be the date of the Qualifying Event.

(2) If the Participant does not submit and Claims Administrator does not receive the Request for Change Form within 31 days of the date of the Qualifying Event as outlined in the paragraph above, he or she will not be able to enroll the dependant in the plan.

c. Special Enrollment Period for Non-Covered Eligible Person Acquiring a Newly Eligible Dependent

(1) If a non-covered Eligible Person acquires an Eligible Dependent through birth, marriage, adoption, placement in anticipation of adoption, Legal Guardianship or a Qualifying Medical Child Support Order (hereinafter Qualifying Event), the non-covered Eligible Person may apply for coverage for himself, herself, the Eligible Dependent and other Eligible Dependent(s). The non-covered Eligible Person must submit and Claims Administrator must receive an Enrollment Form, applying for the appropriate coverage, within 31 days of the Qualifying Event. The Effective Date of Coverage for the non-covered Eligible Person and the Eligible Dependent will be the date of the Qualifying Event. Note: In order to qualify for this special Enrollment Period, the non-covered Eligible Person must apply for coverage for himself or herself and his or her newly Eligible Dependent.

(2) If the non-covered Eligible Person does not submit and Claims Administrator does not receive the Enrollment Form within 31 days of the date of the Qualifying Event as outlined in the paragraph above, he or she (nor the dependant) will be eligible to enroll in the plan.

Article III  
BENEFITS PROVIDED

A. Payments

1. Subject to the maximum limitations as well as the terms and provisions of the Plan, Claims Administrator will provide Benefits for Covered Services provided that the Covered Services are furnished or rendered prior to the cancellation or termination date of the Member's coverage. Benefits are based on the Allowable Charge minus (a) any applicable Deductible Amount, (b) any applicable Coinsurance and/or any applicable Co-payment.
2. When a Participant's or Dependent's Out-of-pocket expenses for Coinsurance reach the Network Out-of-pocket amount shown in the Schedule of Benefits, Claims Administrator will pay one hundred percent (100%) of the Allowable Charges for Covered Services rendered by a Network Provider during the remainder of the Benefit Period.
3. When a Participant's or Dependent's Out-of-pocket expenses for Coinsurance reach the Non-Network Out-of-pocket amount shown in the Schedule of Benefits, Claims Administrator will pay one hundred percent (100%) of the Allowable Charges for Covered Services rendered by a Non-Network Provider during the remainder of the Benefit Period.
4. Any penalty for failure to pre-certify any elective or non-emergency inpatient hospital admission will not apply toward the Out-of-pocket amount.
5. Any charges incurred by Member for non-approved days in a Hospital as a bed patient will not apply toward the Out-of-pocket amount.

B. Lifetime Maximum Benefits

The Lifetime Maximum Benefits available hereunder to the Participant and each Dependent, if any, will be \$5,000,000.

Article IV  
HOSPITAL BENEFITS

Benefits as specified in the Schedule of Benefits and this Section will be available for the following Covered Services furnished to the patient by a Hospital:

A. Inpatient Bed, Board and General Nursing Service

1. In a private room or room with two or more beds.
2. In a Special Care Unit for a critically ill Member requiring an intensive level of care.

B. Other Hospital Services (Inpatient and Outpatient)

1. Use of operating, delivery, recovery and treatment rooms and equipment.
2. Drugs and medicines including take-home Prescription Drugs.
3. Blood transfusions, including the cost of whole blood, blood plasma and expanders, processing charges, administrative charges, equipment and supplies.
4. Anesthesia, anesthesia supplies and anesthesia services rendered by a Hospital employee.
5. Medical and surgical supplies, casts, and splints.
6. Diagnostic Services rendered by a Hospital employee.
7. Therapy Services rendered by a Hospital employee.
8. Psychological testing and Psychotherapy when ordered by the attending Physician and performed by an employee of the Hospital.

C. Inpatient Rehabilitation Services

Benefits as specified in the Schedule of Benefits and this section will be available for Inpatient Rehabilitation Services.

1. Benefits for Inpatient Rehabilitation Services will only be provided when Covered Services are determined to be Medically Necessary by Claims Administrator.
2. Covered Services must be recommended by the Member's treating Physician.
3. A treatment plan outlining the goals of the Inpatient Rehabilitation Services must

be submitted to Claims Administrator by the Network Provider before the initiation of the service.

4. The Covered Services must have Case Management approval.
5. Benefits are limited to 30 Inpatient days per Member per Calendar Year.
6. The facility providing the Inpatient Rehabilitation Services must be accredited by the Joint Commission on Accreditation of Healthcare Organizations (JCAHO) and the Commission on Accreditation of Rehabilitation Facilities (CARF).
7. The facility providing the Inpatient Rehabilitation Services must be a Network Provider. No Benefits will be provided when a Member receives services from a Non-Network Provider.

All Hospital Admissions (to include Emergency, Nervous/Mental, and alcohol/drug abuse Admissions) must be pre-certified as outlined in Article XIII, Section A.

In addition, at regular intervals during the Inpatient stay, the Claims Administrator will perform a Continued Stay Review to determine the appropriateness of continued hospitalization.

#### Article V AMBULATORY SURGICAL FACILITY BENEFITS

Benefits as specified in the Schedule of Benefits and this Section will be available for the following Covered Services furnished to the patient by an Ambulatory Surgical Facility:

- A. Services consisting of routine pre-operative laboratory procedures directly related to the surgical procedure.
- B. Pre-operative preparation.
- C. Use of Facility (operating rooms, recovery rooms, and all surgical equipment).
- D. Anesthesia, drugs and surgical supplies.
- E. Implants, prostheses and nourishments.

Article VI  
SURGICAL AND MEDICAL BENEFITS

Benefits as specified in the Schedule of Benefits and this Section will be available for the following surgical and medical services furnished to a Member by a Physician or Allied Health Professional.

A. Surgical Services

1. Surgery

- a. The Allowable Charge for Inpatient Surgery includes all pre- and post-operative medical visits.

The pre- and post-operative period is defined and determined by the Claims Administrator and is that period of time which is appropriate as routine care for the particular surgical procedure.

- b. For Surgery performed in a Physician's office, Benefits are allowed for the surgical procedure and surgical tray. No Benefits are allowed for the office facility charge unless the (1) Claims Administrator has an agreement with the office facility; and (2) the office facility has been approved by Claims Administrator.

When performed in the Physician's office, the Allowable Charge for the Surgery includes the office visit. No additional Benefits are allowed toward charges for office visits on the same day as the Surgery.

2. Multiple Surgical Services - When Medically Necessary multiple procedures (concurrent, successive, or other multiple surgical services) are performed at the same surgical setting, the Allowable Charge will be as follows:

- a. Primary Procedure.

(1) The primary, or major procedure, will be the procedure with the greatest value based on the Allowable Charge.

(2) Benefits for the primary procedure will be based on the Allowable Charge.

- b. Secondary Procedure(s).

(1) The secondary procedure(s) is a procedure(s) performed in addition to the primary procedure which adds significant time, risk, or complexity to the Surgery.

(2) The secondary procedure(s) is paid at 50% of the Allowable Charge for the procedure.

c. Incidental Procedure.

(1) The incidental procedure is one which is a routine part of a primary or secondary procedure or one for which the Medical Necessity for performing such procedure is not documented.

(2) No Benefits are provided for incidental procedures.

3. Assistant at Surgery

a. The assistant surgeon is a Physician/surgeon who assists the primary surgeon in the performance of a covered surgical procedure. Benefits for an assistant surgeon will be provided only if the Claims Administrator determines that the Medical Necessity for an assistant surgeon is documented.

b. The Physician Assistant, Nurse Practitioner, or Certified Registered First Assistant must be an employee of the primary surgeon's clinic.

c. When the need for an assistant surgeon is documented to be Medically Necessary, Benefits will be based on 20% of the Allowable Charge for the primary surgical procedure.

4. Anesthesia

a. Benefits will be provided for general anesthesia service when requested by the attending Physician and performed by a nurse anesthetist or Physician, other than the operating Physician or the assistant, for covered surgical services. Benefits will also be provided for other forms of anesthesia services as defined and approved by the Claims Administrator.

b. Benefits for administration of anesthesia will be based on the Allowable Charge for anesthesia administration as determined by the primary surgical procedure performed.

c. Supervision of anesthesia administration includes pre-operative, operative, and post-operative supervision of anesthesia care. Benefits for supervision of anesthesia administration will be less than those provided for administration of anesthesia. These Benefits will be based on the Allowable Charge for anesthesia supervision as determined by the primary surgical procedure performed.

B. Inpatient Medical Services - Subject to provisions as specified in the sections

pertaining to Surgery and maternity in the Plan.

1. Inpatient Medical Care Visits
2. Concurrent Care
3. Consultation

C. Outpatient Medical Services

1. Home, Office, and Other Outpatient visits for examination, diagnosis, and treatment of an illness or injury. These Benefits do not include routine pre- and post-operative medical visits for Surgery or maternity.
2. Consultation

D. Diagnostic Services

E. Therapy Services

1. Benefits for Radiation Therapy, Chemotherapy, Dialysis Treatment, Infusion Therapy (in a setting other than the home) and Drug Therapy (in a setting other than the home), are subject to the following provisions:
  - (a) Therapy Services will only be provided when Covered Services are Medically Necessary.
  - (b) Claims Administrator may require a treatment plan, outlining the goals of therapy, mode of therapy, and duration of therapy, to be submitted by the Provider prior to the initiation of treatment.

F. Surgery for Mastectomy and Reconstruction of the Breast

When the Claims Administrator determines the Medical Necessity of medical and surgical benefits with respect to a Member's mastectomy, Benefits will be provided for breast reconstruction when such Covered Service is elected by the Member. In accordance with the terms and provisions of the Plan, including but not limited to Benefit Period Deductible Amount, Out-of-Pocket Amount and applicable benefit and coinsurance amounts, the following benefits will be provided:

1. Reconstruction of the breast on which the mastectomy has been performed;
2. Surgery and reconstruction of the other breast to produce a symmetrical appearance; and

3. Prostheses and physical complications all stages of mastectomy, including lymphedemas.

G. Outpatient Preventive/Wellness Services

Benefits for Outpatient Preventive/Wellness Care as specified in the Schedule of Benefits shall be available for services designed to effectively screen for a disease for which there is a treatment or a cure when discovered in an early stage.

1. Outpatient Preventive/Wellness Covered Services may include:
  - a. Physical examinations (including well child care).
  - b. Immunizations (flu shot, well child vaccinations).
  - c. Diagnostic Services.
2. Outpatient Preventive/Wellness Services do not include:
  - a. Vision (exams or eyeglasses).
  - b. Hearing (exams or hearing aids).
  - c. Dental.
  - d. Inpatient nursery care.

Article VII  
MATERNITY BENEFITS

Benefits as specified in the Schedule of Benefits and this Section will be available for maternity care furnished by a Hospital, Physician, Allied Health Professional, and Allied Health Facility.

- A. For a patient who is covered as a Participant, Dependent wife of a Participant, or Dependent child of a Participant and, whose coverage remains in effect at the time services are furnished in connection with her pregnancy:
  1. Surgical and Medical Services.
    - a. Initial office visit.
    - b. Diagnostic Services.
    - c. Delivery, including necessary pre-natal and post-natal care.
    - d. Interruptions of Pregnancy.

- (1) Miscarriage.
  - (2) Medically Necessary abortion required:
    - (i) to preserve the life or physical health of the mother;
    - (ii) as the result of rape or incest;
    - (iii) when the fetus has a known condition which is incompatible with life.
  - 2. Hospital Services required in connection with Pregnancy and Interruptions of Pregnancy as described above.
- B. For a newborn who is covered at birth as a Dependent:
- 1. Surgical and Medical Services.
    - a. Treatment of illness, prematurity, postmaturity, or congenital condition for an ill newborn.
    - b. Circumcision.
  - 2. Hospital Services.
    - a. Circumcision during the newborn's post-delivery stay.
    - b. Treatment of illness, prematurity, postmaturity, or congenital condition of an ill newborn.
- C. Newborn Well Baby Care
- 1. Physician's initial examinations of a well newborn or, when delivery is by cesarean section, one Consultation for standby resuscitation and infant care in the operating room by a Physician other than the operating surgeon. Benefits will also be provided for subsequent visits by the Physician while the well newborn is in the hospital with the mother. These Benefits will not extend beyond the mother's stay.
  - 2. Routine Hospital nursery care of a well newborn for the mother's authorized routine length of stay for an uncomplicated vaginal delivery or caesarian section..

Article VIII  
OTHER COVERED SERVICES, SUPPLIES OR EQUIPMENT

Benefits as specified in the Schedule of Benefits and this Section will be available for the following surgical and medical services furnished by an Allied Provider.

A. Ambulance Service Benefits

Benefits as specified in the Schedule of Benefits will be available for the following covered Ambulance Services when Medically Necessary:

1. Medically Necessary transportation by means of a specially designed and equipped vehicle used only for transporting the sick and injured;
  - a. from the place where the Member is injured by accident or stricken by illness to the nearest Hospital where treatment is to be given;
  - b. from a Hospital where a Member is an Inpatient to another Hospital or free-standing facility to receive specialized diagnostic or therapeutic services not available at the Hospital of origin and back to the Hospital of origin after such services have been rendered;
  - c. from a Hospital to another Hospital when the discharging Hospital has inadequate treatment facilities and the receiving Hospital has appropriate treatment facilities;
  - d. to a Hospital, a Physician's office or Ambulatory Surgical Facility for Outpatient care of an Accidental Injury or a Medical Emergency.
2. Ambulance Service also includes transportation by air ambulance when, as determined by the Claims Administrator, Member's condition or urgency of needed medical care precludes travel by surface transportation. Air ambulance service is helicopter transportation to the nearest institution with appropriate facilities for treatment of the Member's injury or illness. Fixed wing air transportation is for long distance travel only and is not ordinarily considered to be an air ambulance service.
3. Ambulance Service Benefits will not be provided for a Member's comfort or convenience.

#### B. Durable Medical Equipment

1. Benefits for Durable Medical Equipment will only be provided when:
  - a. The equipment is prescribed by a Physician.
  - b. The equipment does not serve as a comfort or convenience item.
  - c. The equipment has been certified by the Claims Administrator.
2. Determination of Benefits for Durable Medical Equipment will be based on the following:
  - a. The equipment must meet all Durable Medical Equipment requirements of the Claims Administrator and must meet the following criteria:
    - (1) can withstand repeated use,

- (2) is primarily and customarily used to serve a medical purpose,
  - (3) is generally not useful to a person in the absence of illness or injury,
  - (4) is appropriate for use in the patient's home.
- b. The equipment must meet all Medical Necessity requirements. Therefore, the equipment must be:
- (1) appropriate for the symptoms and diagnosis or treatment of the Member's condition, illness, disease or injury.
  - (2) provided for the diagnosis, or the direct care and treatment of the Member's condition, illness, disease or injury.
  - (3) in accordance with accepted standards of medical practice.
  - (4) the most appropriate supply or level of service that can safely be provided to the Member.
3. Benefits for rental or purchase of Durable Medical Equipment.
- a. Benefits for the rental of Durable Medical Equipment will be based on the Claims Administrator's rental Allowable Charge (but not to exceed the purchase Allowable Charge).
  - b. At the option of the Claims Administrator, Benefits will be provided for the purchase of Durable Medical Equipment, appropriate supplies, and oxygen required for therapeutic use.
  - c. Benefits based on the Allowable Charge for standard equipment will be provided toward any deluxe equipment when selected by the Member solely for the Member's comfort or convenience.
  - d. Benefits for deluxe equipment based on the Allowable Charge for deluxe equipment will only be provided when documented to be Medically Necessary.
  - e. Accessories and medical supplies necessary for the effective functioning of covered Durable Medical Equipment are considered an integral part of the rental or purchase allowance.
  - f. Benefits will be provided for the repair, adjustment or replacement of purchased Durable Medical Equipment or components only within a reasonable time period of purchase subject to the lifetime expectancy of the equipment.

4. Limitations in connection with Durable Medical Equipment.
  - a. No Benefits will be provided during rental for repair, adjustment, or replacement of components and accessories necessary for the effective functioning and maintenance of covered equipment as this is the responsibility of the Durable Medical Equipment supplier.
  - b. Benefits will not be provided for Durable Medical Equipment used in Home Infusion Therapy except as provided in Article VIII, Section C.
  - c. Benefits will not be provided for equipment where a commonly available supply or appliance can substitute to effectively serve the same purpose.
  - d. Benefits will not be provided for construction costs to the Member's residence to accompany the Durable Medical Equipment.
  - e. Benefits will not be provided for hot tubs, swimming pools, whirlpools, lift chairs, and air purifiers.

C. Home Infusion Therapy/Drug Therapy

1. Benefits as specified in the Schedule of Benefits and this section will be available for Medically Necessary Infusion Therapy and Drug Therapy in the Member's home.
2. Covered Services are limited to drugs, intravenous solutions, Durable Medical Equipment, pharmacy compounding and dispensing services, fees associated with drawing blood for the purpose of monitoring response to therapy, therapist services, ancillary medical supplies, and nursing visits, including initiation of Home Infusion Therapy, intravenous restarts and Emergency care when Medically Necessary to provide Home Infusion Therapy.
3. Limitations in connection with Infusion Therapy and Drug Therapy
  - a. No Benefits are payable under any other section of the Plan for services, drugs, equipment or supplies used in Infusion Therapy or Drug Therapy, except as provided for in this section.
  - b. No Benefits are payable for the supervision of self-administered medications or family-administered medications.
  - c. No Benefits are payable for any charges for nursing visits, care, services or supplies associated with Infusion Therapy other than as stipulated in the per day Allowable Charge.
  - d. No Benefits are payable for other services required to administer Infusion Therapy or Drug Therapy in the home setting but which do not involve direct

patient contact, including but not limited to delivery charges and record keeping.

#### D. Orthotic Devices

Benefits in this section and as specified in the Schedule of Benefits will be available for the purchase of Orthotic Devices as approved by Claims Administrator. These Benefits will be subject to the following:

1. No Benefits will be available for fitting or adjustments as this is included in the Allowable Charge for the Orthotic Device.
2. Benefits will be provided for repair or replacement of the Orthotic Device only within a reasonable time period of purchase subject to the lifetime expectancy of the equipment.
3. Benefits based on the Allowable Charge for standard equipment will be provided toward any deluxe equipment when selected by the Member solely for the Member's comfort or convenience.
4. Benefits for deluxe equipment based on the Allowable Charge for deluxe equipment will only be provided when documented to be Medically Necessary.
5. No Benefits are available for supportive devices for the foot.
6. Benefits will not be provided for deluxe or customized devices if Claims Administrator has already provided Benefits for standard devices.
7. No Benefits will be provided for Orthotic Devices which are required by the Member for the specific purpose of participating in recreational or sporting activities.

#### E. Prescription Drug Benefits

Based on the Allowable Charge established by Claims Administrator, Benefits as specified in the Schedule of Benefits will be available for drugs that under Federal law may be dispensed only by written prescription and which are approved for general use by the Food and Drug Administration. The drugs must be dispensed on or after the Member's Effective Date by a licensed pharmacist upon the prescription of a Physician. These Benefits will be subject to the following:

1. Only those Prescription Drugs which are determined by Claims Administrator to be Medically Necessary for the treatment of illness or injury will be covered.
2. Benefits for Retail Prescription Drugs will be limited to increments of a 30-day supply per dispensing.

3. Benefits for Maintenance Prescription Drugs will be limited to a 90 day supply. The mail order Prescription Drug program is offered by PharmaCare when there is an ongoing need for prescribed medications which are covered by this Plan. The Prescription Drugs must be available through the mail services Prescription Drug program; however, certain Prescription Drugs cannot be supplied by mail easily (i.e. drugs requiring refrigeration) and are not available through the mail order program.
4. Benefits will be provided for injectable insulin necessary syringes.
5. Benefits paid for covered Prescription Drugs are applied to the Lifetime Maximum.
6. Member will not receive Benefits for refills of Outpatient Prescription Drugs until 75% of the last dispensed 30 day supply is exhausted by the Member.
7. Prescription Drug benefits are not subject to the Pre-existing Condition limitations of this Policy; however, the condition for which the prescription drug is prescribed remains subject to any Pre-existing condition limitation.
8. Due to the nature and use of certain Prescription Drugs, Claims Administrator classifies these drugs as Drug Therapy or Infusion Therapy. The aforementioned drugs are not considered retail prescription drugs.
9. Drugs or medication for the prevention or treatment of a chronic complex disease state must be prescribed by a Physician and dispensed by a Disease Specific Pharmacy approved by Claims Administrator. These drugs or medications will not be considered retail Prescription Drugs.
10. As specified in the Schedule of Benefits in the Prescription Drug section, Prescription Drug Benefits will be provided for diabetic supplies (e.g. blood testing supplies, urine testing supplies and lancets) approved by the Claims Administrator.
11. Compound Prescription Drugs may be subject to Prior Authorization. If any active ingredient in the Compound Drug is not covered under the Plan, then no Benefits will be provided for the Compound Drug.

#### F. Prosthetic Appliances

Benefits as specified in the Schedule of Benefits and this Section will be available for the purchase of Prosthetic Appliances as approved by Claims Administrator. These Benefits will be subject to the following:

1. No Benefits will be provided for fitting or adjustments as this is included in the Allowable Charge for the Prosthetic Appliance.
2. Benefits will be provided for the repair or replacement of the Prosthetic Appliance after a reasonable length of time. This time period will be determined by Claims

Administrator.

3. Benefits based on the Allowable Charge for standard equipment will be provided toward any deluxe equipment when selected by the Member solely for the Member's comfort or convenience.
4. Benefits for deluxe equipment based on the Allowable Charge for deluxe equipment will only be provided when documented to be Medically Necessary.
5. No Benefits will be provided for Prosthetic Appliances which are required by the Member for the specific purpose of participating in recreational or sporting activities.

#### G. Speech Therapy

1. Benefits as specified in the Schedule of Benefits and this section will be available for Speech Therapy. These Benefits are subject to the following provisions:
  - a. Speech Therapy will only be provided when Covered Services are Medically Necessary.
  - b. A treatment plan outlining goals of therapy, mode of therapy and duration of therapy must be submitted to Claims Administrator by the Provider prior to the initiation of treatment.
  - c. Speech Therapy as limited in the Schedule of Benefits and this section is covered up to the Benefit maximum or when maintenance level of therapy is attained (whichever the Member reaches first). A maintenance program consists of activities that preserve the Member's present level of function and prevent regression of that function. Maintenance begins when the therapeutic goals of a treatment plan have been achieved, or when no additional functional progress is apparent or expected to occur.

#### H. Diabetes Treatment

Benefits as specified in the Schedule of Benefits and this section will be available for Diabetes Treatment. These Benefits will be subject to the following provisions:

1. Benefits will be provided for equipment and supplies used in connection with the monitoring of blood glucose and insulin administration. Benefits for home glucose monitors will be limited to one (1) monitor every two Calendar Years.
2. Subject to Pre-certification, Benefits will be provided for training/education and Medical Nutrition Therapy in an outpatient, inpatient or home health setting up to \$250 per Calendar Year.
  - a. Training/education must be provided by a Certified Diabetes Educator (CDE),

who is appropriately certified, licensed or registered to practice in the State of Mississippi.

- b. Medical nutrition therapy must be provided by a Registered Dietitian (RD) appropriately licensed or registered to practice in the State of Mississippi.
  - c. All Covered Services provided by a Certified Diabetes Educator or Registered Dietitian must be based on nationally recognized standards, including, but not limited to, the American Diabetes Association guidelines.
3. Benefits will be provided for a dilated eye exam for Members with a diagnosis of Diabetes. Dilated eye exams are limited to one (1) exam per Calendar Year.
  4. Benefits will be provided for preventive or routine foot care rendered to a Member by a Provider practicing within the scope of his/her license and who is approved by the Claims Administrator. The Member must have a diagnosis of Diabetes. Preventive or routine foot care is limited to one (1) visit per Calendar Year.
  5. Benefits will be provided for care of corns, bunions, calluses, or debridement of nails rendered to a Member by a Provider practicing within the scope of his/her license and who is approved by the Claims Administrator. The Member must have diagnosis of Diabetes with complications of neuropathy or peripheral vascular disease making such care Medically Necessary.

#### I. Outpatient Cardiac Rehabilitation

Benefits as specified in the Schedule of Benefits and this section will be provided for Outpatient Cardiac Rehabilitation (Phase II).

1. No Benefits will be provided unless the Member receives Case Management approval for Covered Services from Claims Administrator.
2. Covered Services must be rendered by a facility that is a Network Provider and holds a current certification from the American Association of Cardiovascular and Pulmonary Rehabilitation (AACVPR). No Benefits will be provided when a Member receives services from a Non-Network Provider.
3. Benefits must be recommended by the Member's treating Physician.
4. A treatment plan outlining the goals of the Outpatient Cardiac Rehabilitation must be submitted to Claims Administrator by the Network Provider before the initiation of the services.
5. Outpatient Cardiac Rehabilitation Services must be initiated within 3 months after the Member's discharge from the Hospital.
6. The number of visits for Outpatient Cardiac Rehabilitation Services are based on

the severity of the Member's condition; however, Covered Services can not exceed 36 visits per Member per Calendar Year.

7. No Benefits will be provided for Pulmonary Rehabilitation.

#### J. Home Health Care

Benefits as specified in the Schedule of Benefits and this Section will be available for the purchase of Home Health Care as approved by Claims Administrator. These Benefits will be subject to the following provisions:

1. The Member's Physician must submit a written treatment plan to Claims Administrator. The Claims Administrator must give prior approval for the written treatment plan.
2. The Member must be confined to home and unable to carry out the basic activities of basic living.
3. Home Health Care includes the following services:
  - a. Part-time or intermittent nursing care, by a registered nurse or licensed practical nurse;
  - b. Physical therapy, by a Physical Therapist;
  - c. Occupational therapy, by an occupational therapist;
  - d. Speech Therapy, by a speech therapist;
  - e. Home health aide services;
  - f. Medical social services.
4. The following Home Health Care services and supplies are Non-Covered Services under this Plan:
  - a. Homemaker services;
  - b. Domestic maid services;
  - c. Sitter services;
  - d. Companion services; and
  - e. Services and supplies rendered by an employee or operator of an adult congregate living facility, an adult foster home, an adult day care center, or a

nursing home facility.

#### K. Hospice Care

Benefits as specified in the Schedule of Benefits and this Section will be available for Hospice Care as approved by Claims Administrator. These Benefits are subject to the following provisions:

1. The Member's Network Physician must: (a) submit a life expectancy certification to certify that the Member is not expected to live more than 6 months; and (b) submit a written Hospice Care plan or program. All Covered Services for Hospice Care must be approved in writing by Claims Administrator.
2. Members who elect Hospice Care under this Plan are not entitled to other Benefits under this Plan for the terminal illness while the hospice election is in effect.
3. Covered Services do not include bereavement counseling, pastoral counseling, financial or legal counseling or custodial care.
4. The Hospice treatment program must:
  - a. Meet the standards outlined by the National Hospice Association,
  - b. Be recognized as an approved Hospice program by Claims Administrator,
  - c. Be licensed, certified and registered as required by state law, and
  - d. Be directed a Network Physician and coordinated by a Registered Nurse, with a treatment plan that provides an organized system of hospice facility care; uses a hospice team; and has round-the-clock care available.

### Article IX NERVOUS/MENTAL AND SUBSTANCE ABUSE

Benefits for treatment of Nervous/Mental Conditions as shown in the Schedule of Benefits are limited to Benefits for conditions which are manifested in a disturbance of intellectual and emotional functions to a degree of severity where; (1) the presence of anxiety and/or depression is significantly beyond minor behavior aberrations, or (2) the patient's mental state is such that there has been a break with reality. When there are structural or space occupying lesions of the brain causing intellectual or emotional disturbances, Benefits will be provided as medical Benefits. Substance Abuse Benefits as shown in the Schedule of Benefits are limited to Benefits for treatment of the uncontrollable or excessive abuse of alcohol, drugs or other chemicals and the resultant physiological and/or psychological dependency which develops with continued use.

- A. Subject to Pre-Certification, as defined in this Plan, as well as this Plan deductible, benefits for Nervous/Mental Care and Substance Abuse will be provided at a percentage of the Allowable Charge, as specified in this Plan. Benefits previously

provided for Nervous/Mental Care and Substance Abuse under this Plan will be applied toward the lifetime maximum.

B. Inpatient Care Benefits

As specified in the Schedule of Benefits, Claims Administrator will pay regular Benefits based on the Allowable Charge for Covered Services provided to a Member for Inpatient services and Partial Hospitalization. Treatment under this section shall be limited to a combined 90 day lifetime maximum for Nervous/Mental Care and Substance Abuse.

C. Outpatient Care Benefits

As specified in the Schedule of Benefits, Claims Administrator will provide Benefits based on the Allowable Charge for Covered Services provided to a Member for Outpatient services. Outpatient services are those services which are received in a Hospital, an Outpatient treatment facility or other appropriate setting licensed by the State of Mississippi and approved by Claims Administrator. Treatment under this section shall be covered for sixty (60) Outpatient visits per year.

D. Benefits for treatment of Nervous and Mental Conditions do not include counseling services such as career counseling, marriage counseling, divorce counseling, parental counseling, and job counseling, treatment or testing related to autistic disease of childhood, learning disabilities, mental retardation, or for hospitalization for environmental change.

## Article X

### TEMPOROMANDIBULAR/CRANIOMANDIBULAR JOINT DISORDER

Benefits as specified in the Schedule of Benefits and this Section will be available for Surgery and Diagnostic Services of the temporomandibular/craniomandibular joint as approved by Claims Administrator. These Benefits will be subject to the following:

- A. Benefits for diagnostic services and removable oral appliances limited to \$500 per Calendar Year. This Lifetime Maximum will apply regardless of whether the Temporomandibular/ Craniomandibular Joint Disorder was caused by an Accidental Injury or was congenital in nature.
- B. Medical Necessity documentation and a treatment plan, including charges for each service, must be submitted to and approved by the Claims Administrator prior to the commencement of treatment.
- C. Benefits will not be provided for appliances (Exception: Splints inserted after surgery may be considered appropriate by Claims Administrator).

Article XI  
DENTAL CARE AND TREATMENT/DENTAL SURGERY

Benefits will be provided only for the following services or procedures:

- A. Excision of tumors or cysts (excluding dentigerous cysts) of the jaws, gums, cheeks, lips, tongue, roof and floor of mouth.
- B. Dental Care and Treatment including Surgery and dental appliances required to correct Accidental Injuries of the jaws, cheeks, lips, tongue, roof or floor of mouth, and of sound natural teeth (For the purposes of this section, sound natural teeth are those which are capped, crowned or attached by way of a crown or cap to a bridge. Sound natural teeth may have fillings or a root canal Accident means any injury caused by external force. The act of chewing does not constitute an injury caused by external force.
- C. Excision of exostoses or tori of the jaws and hard palate.
- D. Incision and drainage of abscess and treatment of cellulitis.
- E. Incision of accessory sinuses, salivary glands, and salivary ducts.
- F. Surgical procedures related to micrognathism and macrognathism provided prior approval is obtained and Medical Necessity is documented by appropriate x-rays and photographs.
- G. When a Member has a nondental organic disease or condition which makes an alternative treatment setting (hospital or ambulatory surgical facility) necessary to safeguard health while undergoing treatment for non-covered Dental Care and Treatment, Benefits will be provided for room, board, and other necessary services if Claims Administrator determines that: (1) the alternative treatment setting is Medically Necessary and (2) the Covered Services required to treat the non-dental organic disease or condition are Medically Necessary. No Benefits will be provided for the alternative setting or the Covered Services needed to treat the nondental organic disease unless the Member's dentist pre-certifies with Claims Administrator the Medical Necessity of the alternative setting and the Covered Services needed to treat the non-dental organic disease.
- H. Removal of impacted teeth.

Article XII  
TRANSPLANT BENEFITS

Subject to the provisions of the Schedule of Benefits and this section, Benefits will be provided for treatment and care related to or required as a result of the transplant procedures outlined below:

- A. This Plan covers the following organ transplant procedures: (1) Renal, (2) Heart, (3) Heart/Lung, (4) Liver, (5) Bone Marrow, and (6) other organ transplant procedures which Claims Administrator determines to be effective procedures through Medical Policy (which includes but is not limited to the review of peer review literature, second opinions and administrative policy in existence at the time of the request for the procedure). Procedures of this type will be considered on an individual basis. The aforementioned transplant procedures are subject to the following provisions:
1. No benefits will be provided for a covered transplant procedure or a transplant evaluation unless the Member receives prior written approval from Claims Administrator. Additionally, the Member must receive Covered Services from a facility (i.e. hospital which is considered a center of excellence for transplant procedures) approved by Claims Administrator.
  2. Benefits for services related to or required as a result of a covered transplant procedure will be limited to the lifetime. Once the lifetime maximum is exhausted, no further Benefits will be provided for the specific transplant type.
  3. Benefits for surgical, storage and transportation expenses incurred and directly related to the donation of an organ or tissue used in a covered organ or tissue transplant procedure are limited to the lifetime maximum.
- B. Benefits as specified in this Section B. will be provided for solid organ and tissue transplant living donor coverage. If a covered solid organ or tissue transplant is provided from a living donor to a human transplant recipient:
1. Donor coverage includes expenses for:
    - a. A search for matching tissue, bone marrow or organ.
    - b. Donor's transportation.
    - c. Charges for removal, withdrawal and preservation.
    - d. Donor's hospitalization.
  2. When only the recipient is a Member, the donor is entitled to the Benefits of this Plan which are not available to the donor from any other source. This includes, but is not limited to, other insurance coverage, or other Blue Cross or Blue Shield coverage or any governmental program.
  3. When the donor is a Member, the donor is entitled to the Benefits of this Plan. No Benefits will be provided to the Non-Member transplant recipient.
  4. If any organ or tissue is sold rather than donated to the Member recipient, no

Benefits will be payable for the purchase price of such organ or tissue; however, other costs related to evaluation and procurement are covered up to the Member recipient's Plan limit.

Article XIII  
UTILIZATION MANAGEMENT

- A. Utilization Management is a Claims Administrator program designed to review and determine whether services provided, or to be provided, are Medically Necessary and are Covered Services under the Plan. Utilization Management includes, but is not limited to, the following: (1) Pre-Certification (2) Disease and Case Management; and (3) Drug Utilization Management.
  
- B. SPECIAL NOTE: NOTWITHSTANDING THE UTILIZATION MANAGEMENT PROGRAM DESCRIBED HEREIN, CLAIMS ADMINISTRATOR RESERVES THE RIGHT TO DENY CLAIMS FOR SERVICES AT ANY TIME DURING THE CLAIMS REVIEW PROCESS. ANY CLAIMS ADMINISTRATOR DETERMINATION THAT AN ADMISSION IS PRE-CERTIFIED DOES NOT MEAN THAT SERVICES RENDERED DURING THE ADMISSION ARE COVERED SERVICES PAYABLE UNDER THE PLAN, BUT MERELY MEANS THAT THE HOSPITAL SETTING IS APPROPRIATE FOR RENDERING THOSE SERVICES. CLAIMS ADMINISTRATOR MAKES ALL CLAIMS PAYMENT DECISION RETROSPECTIVELY DURING THE CLAIMS REVIEW PROCESS.
  
- C. Pre-Certification of Admissions and Outpatient Procedures
  - 1. Pre-Certification of Elective Admissions
    - a. When a Member uses a Non-Participating (or Non-Network) Provider, it is the sole responsibility of the Member to ensure that his/her Non-Participating Physician (or Non-Network) or Hospital, or a representative thereof, notifies Claims Administrator of any elective or non-emergency Inpatient Hospital Admission. Claims Administrator must be notified prior to the Admission regarding the nature and purpose of any Elective Admission or non-Emergency Admission to a Hospital's Inpatient department. The most appropriate setting for the elective service and the appropriate length of stay will be agreed upon when the Hospital Inpatient setting is documented to be Medically Necessary (In addition to any Deductible Amount, Coinsurance amount or Co-payment amount required in the Plan, the Member will be responsible for all charges not specifically listed as Covered Services and for up to \$300 of the Covered Services if such Elective Admission is not pre-certified.). Additionally, all days not pre-certified will be reviewed for Medical Necessity.
  
    - b. When a Member uses a Participating (or Network) Provider, it is the

responsibility of the Physician or Hospital, or a representative thereof, to notify Claims Administrator of any elective, Emergency or non-Emergency Inpatient Hospital Admission in the Hospital. It is also the responsibility of the Physician or Hospital, or a representative thereof, to contact Claims Administrator in the event additional days of Inpatient care are needed beyond the amount originally certified. When a Participating (or Network) Provider fails to notify the Claims Administrator of any elective emergency or non-emergency Inpatient Hospital Admission, the payment amount to the Participating (or Network) Hospital will be reduced by a \$300 penalty. The Participating (or Network) Hospital will hold the Member harmless for the \$300 penalty.

- c. Federal law prohibits Plan from restricting Benefits or requiring Pre-certification or Certification of a maternity admission for which the maternity admission is not in excess of forty-eight (48) hours for a normal vaginal delivery or ninety-six (96) for a caesarian section. In the event the attending Physician, after consultation with the mother, decides to discharge the mother and her newborn child prior to the expiration of the forty-eight (48) or ninety-six (96) hour stay, Plan will only provide benefits for the applicable period of the stay. If a Physician believes that it is Medically Necessary for hospitalization in connection with childbirth to extend beyond the length of time of forty-eight (48) hours following a normal vaginal delivery or ninety-six (96) hours following a caesarian section, the Physician must request the additional days. Claims Administrator will determine the Medical Necessity of the additional days.

## 2. Certification of Emergency Admissions

- a. When a Member uses a Non-Participating (or Non-Network) Provider, it is the sole responsibility of the Member to ensure that his/her Physician or Hospital, or a representative thereof, notifies Claims Administrator of all Emergency Inpatient Hospital Admissions. Within one (1) working day of the Emergency Admission, Claims Administrator must be notified regarding the nature and purpose of the Emergency Admission. In the event that the end of the notification period falls on a holiday or weekend Claims Administrator must be notified on its next working day. The appropriate length of stay for the Emergency Admission will be agreed upon when the Hospital Inpatient setting is documented to be Medically Necessary (In addition to any Deductible Amount, Coinsurance amount or Co-payment amount required in the Plan, the Member will be responsible for all charges not specifically listed as Covered Services and for up to \$300 of the Covered Services if such Emergency Admission is not certified within the time frame as specified above.). Additionally, all days not certified will be reviewed for Medical Necessity.
- b. Network Provider (See Section 1.b. above).

### 3. Durable Medical Equipment

- a. All Durable Medical Equipment submitted for Benefits requires a Medical Necessity Certification Form completed by the prescribing Physician that documents:
  - (1) prescribed equipment,
  - (2) Medical Necessity of the equipment, and
  - (3) required time period for use.
- b. Certain Durable Medical Equipment will require periodic re-certification during use to evaluate significant therapeutic improvement in the Member's condition in order to determine the continued Medical Necessity for the equipment.
- c. Requests for deluxe items require documentation of Medical Necessity for deluxe features (including mechanical or electrical features). Benefits for deluxe equipment will only be provided when Medically Necessary.

### 4. Home Infusion Therapy/Drug Therapy

The Member's attending Physician or the approved Home Infusion Therapy Provider is required to pre-certify all Home Infusion Therapy Services and supplies or all Drug Therapy services and supplies prior to the initiation of any Home Infusion Therapy services or Drug Therapy services. Only those services furnished after Pre-Certification has been approved will be considered for Benefits. Benefits will not be allowed for services furnished prior to Pre-Certification.

### 5. Solid Organ and Tissue Transplant

No Benefits will be provided hereunder unless a written Pre-Certification is obtained from the Claims Administrator and services are rendered by a Hospital which has been approved by Claims Administrator. The Claims Administrator will be advised of the proposed transplant Surgery prior to Admission and a written request for Pre-Certification will be filed with the Claims Administrator. The Claims Administrator will be provided with adequate information so that it might verify coverage, determine that Medical Necessity is documented, and approve of the Hospital at which the transplant Surgery will occur. The Claims Administrator will forward written Pre-Certification to Member and Providers.

### 6. Outpatient Procedures

When a Member utilizes a Network or Non-Network Provider, it is the Providers responsibility to ensure compliance with all Medical Policy related to outpatient

diagnostic and surgical procedures. It is within Claims Administrator's discretion to require the Provider or the Member to pre-certify certain outpatient diagnostic and surgical procedures.

#### 7. Disease Specific Drugs or Medications

- a. When a Member uses a Non-Network Provider who prescribes a disease specific drug or medication, it is the sole responsibility of the Member to ensure that the Non-Network Provider receives Prior Authorization from Claims Administrator for the disease specific medication. No Benefits will be provided for a disease specific drug or medication unless the Member receives Prior Authorization from Claims Administrator and the drug or medication is issued by a Disease Specific Pharmacy.
- b. When a Member uses a Network Provider who prescribes a disease specific drug or medication, it is the responsibility of the Network Provider to obtain Prior Authorization from Claims Administrator for the disease specific drug or medication. No Benefits will be provided for the disease specific drugs or medications unless the Network Provider receives Prior Authorization from Claims Administrator and the drug or medication is issued by a Disease Specific Pharmacy.

#### 8. Prior Authorization of Prescription Drugs

- a. As a part of Utilization Management, Claims Administrator has identified certain Prescription Drugs and medications which require Prior Authorization due to the fact that (1) the drug or medication may not be the most appropriate product for the Member's specific illness, injury, or disease state, or; (2) the drug or medication is being prescribed by a Provider for a Non-covered Service.
- b. When a Member uses a Non-Network Provider who prescribes one of the identified Prescription Drugs or medications, it is the sole responsibility of the Member to ensure that the Non-Network Provider obtains Prior Authorization from Claims Administrator. No Benefits will be provided for the drug or medication unless Member receives Prior Authorization from the Claims Administrator.
- c. When a Member uses a Network Provider who prescribes one of the identified Prescription Drugs or medications, it is the sole responsibility of the Network Provider to obtain Prior Authorization from Claims Administrator. No Benefits will be provided for the drug or medication unless the Network Provider receives Prior Authorization from the Claims Administrator.

Article XIV  
DISEASE MANAGEMENT OR CASE MANAGEMENT

- A. Members are referred to the Disease Management or Case Management program based on various criteria including diagnosis, severity and length of illness, and proposed or rendered treatment. Through the Claims Administrator's Utilization Management program, the Claims Administrator seeks to identify Members who would qualify for Disease Management or Case Management.
- B. In administering Disease Management or Case Management, the Claims Administrator will utilize the Benefits specified in the Plan. In some instances, the Claims Administrator may determine that alternative benefits should be provided to cover a specific service not otherwise covered under the Plan. In those instances, the following provisions will apply:
1. Alternative benefits will be recommended by the Case Management staff in conjunction with the Member's treating Physician. Alternative Benefits will be implemented only when a written agreement, indicating that the alternative benefits are a medically appropriate alternative for the Member's continuing care, has been signed by the Member (or Member's representative), the treating Physician, other Physicians as appropriate, the Group and the Claims Administrator.
  2. Alternative benefits will only be provided when the Member receives care, treatment services or supplies from designated Providers as set forth in the written alternative benefits plan.
  3. Claims Administrator's determination that a particular Member's medical condition renders the Member a suitable candidate for alternative benefits will not obligate Claims Administrator to make the same or similar determination for any other Member; nor will the provision of alternative benefits entitle any other Member to such benefits or be construed as a waiver of Claims Administrator's right to administer and enforce the Plan in accordance with its express terms.
  4. Claims Administrator's determination that a particular Member's medical condition renders the Member a suitable candidate for referral to a particular provider will not obligate the Claims Administrator to make the same referral for any other Member; nor will the provision of benefits to a particular provider to whom the Member was referred, entitle any other Member to such Benefits or be construed as a waiver of Claims Administrator's right to enforce the Plan in accordance with its expressed terms.
  5. Except as otherwise expressly provided in the alternative benefits Plan or notification of referral, all terms and conditions of the Plan -- including, but not limited to, maximum Benefit limitations and all other limitations and exclusions will be and remain in full force and effect with respect to a Member who is under the

Disease Management or Case Management program.

6. Claims Administrator will terminate a Member's alternative benefits or benefits for services rendered by provider to whom Member was referred, when the Member exhausts his or her maximum Benefit under the Plan, when the Member is non-compliant with the alternative benefit agreement provided by Claims Administrator; the Member ceases to be eligible to receive Benefits under the terms of the Plan; the Plan is amended or terminates so as to eliminate the Member's eligibility to receive Benefits and/or coverage under the terms of the Plan; or any other event occurs under the terms of the Plan that results in the Member's ineligibility to receive Benefits and/or loss of coverage under the Plan.

Article XV  
LIMITATIONS AND EXCLUSIONS

- A. Benefits will not be provided for the following:
1. Incremental nursing charges which are in addition to the Hospital's standard charge for Bed, Board and General Nursing Service.
  2. The amount of charges for luxury accommodations or any accommodations in any Hospital or Allied Health Facility provided primarily for the patient's convenience which exceeds the Allowable Charge for a standard Hospital room.
  3. Bed and Board in any other room at the same time Benefits are provided for use of a Special Care Unit.
  4. Prescription Drugs that are determined by the Claims Administrator not to be Medically Necessary for the treatment of illness or injury. These drugs include but are not limited to the following:
    - a. Drugs used for cosmetic purposes or weight reduction.
    - b. Any medication not proven effective in general medical practice including any drug used for smoking cessation.
    - c. Investigative drugs and drugs used other than for the FDA approved diagnosis.
    - d. Fertility drugs.
    - e. Minerals and vitamins (exception: pre-natal vitamins).
    - f. Nutritional supplements.
    - g. Immunizations for prevention of infectious diseases (measles, polio, etc.).
    - h. Drugs that do not require a prescription.
    - i. Contraceptive devices (Exception: prescription contraceptives including Birth Control Pills, Norplant, Depro Provera, Intrauterine Devices (IUD) and Diaphragms.)
    - j. Prescription Drugs if an equivalent product is available over the counter.

- k. Refills in excess of the number specified by the Physician or any refills dispensed more than one year after the date of Physician's original prescription.
- 5. Outpatient Occupational Therapy, except as provided in the Plan.
- 6. For treatment related to sex transformations, sexual function, sexual dysfunctions or inadequacies regardless of Medical Necessity.
- 7. Elective abortions including, however not limited to, the Member's request for payment of prescription abortifacients (Exception: Upon proper documentation from the Member's Provider, Claims Administrator may determine that the elective abortion procedure was Medically Necessary in order to preserve the life or physical health of the mother).
- 8. Services and supplies related to infertility, artificial insemination, intrauterine insemination and in vitro fertilization regardless of any claim of Medical Necessity.
- 9. Provider services or supplies rendered or furnished prior to the Member's Effective Date or subsequent to Member's termination date.
- 10. Charges for services paid or payable under Medicare Parts A or B when the Member has Medicare coverage.
- 11. Provider services, supplies, or charges to the extent payment has been made or is available under any other contract issued by this or any other Blue Cross or Blue Shield Claims Administrator, or to the extent provided for under any other group Plan.
- 12. Acupuncture, anesthesia by hypnosis, hypnosis of any kind, or charges for anesthesia for non-Covered Services.
- 13. Cosmetic Surgery and any complications of Cosmetic Surgery.
- 14. Services or expenses for which the Member has no legal obligation to pay, or for which no charge would be made if the Member had no health coverage.
- 15. Services or supplies which are not prescribed by or performed by or upon the direction of a Physician or Allied Health Professional.
- 16. Services or supplies rendered by Providers other than those specifically covered by the Plan.
- 17. Services or items which are Investigative in nature.

18. Any injury, illness or condition for which a claim has been or will be pursued under any worker's compensation laws. If no claim has been or will be pursued or where there is ultimately no recovery of any type under the applicable worker's compensation laws, Benefits of the Plan will be available (see Article XVI, Section P).
19. Any injury growing out of an act or omission of another party for which a claim or recovery is or will be pursued. If no claim or recovery is or will be pursued, Benefits otherwise will be available under the terms of the Plan (see Article XVI, Section Q).
20. By any governmental Hospital such as a charity Hospital, mental institution or sanatorium, except in those cases where enforcement of this exclusion would be prohibited by Federal law or the laws of the State of Mississippi.
21. Diseases contracted or injuries sustained as a result of war, declared or undeclared, or any act of war.
22. Care received from a dental or medical department maintained by or on behalf of an employer, a mutual Benefit association, labor union, trust, or similar person or group.
23. Care rendered by a Provider who is related to the Member by blood or marriage or who regularly resides in the Member's household.
24. Personal comfort, personal hygiene and convenience items such as, but not limited to, air conditioners, humidifiers, or personal fitness equipment.
25. Charges for telephone Consultations, failure to keep a scheduled visit, completion of a claim form, or to obtain medical records or information required to adjudicate a claim(s).
26. For palliative or cosmetic foot care including flat foot conditions, supportive devices for the foot, care of corns, bunions (except capsular or bone Surgery), calluses, toenails, fallen arches, weak feet, chronic foot strain, and symptomatic complaints of the feet, except for preventive or routine foot care rendered to a Member with a diagnosis of Diabetes. Preventive or routine foot care is limited to the Covered Services specified in Article VI.
27. Medical exams and/or diagnostic tests for routine or periodic physical examinations and screening examinations and for immunizations (except as provided in the optional Outpatient Preventive/Wellness Services).
28. Any surgical procedure that is performed in order to correct a visual acuity defect

that can be corrected by contact lens or glasses is not eligible for coverage.

29. Travel, whether or not recommended by a Physician, except as specified under Ambulance Services Benefits and Organ Transplant Benefits.
30. Weight reduction programs or treatment for obesity including any Surgery for morbid obesity or for removal of excess fat or skin following weight loss, regardless of Medical Necessity, or Services at a health spa or similar facility.
31. Treatment of any Member confined in a prison, jail, or other penal institution.
32. Dental Care and Treatment, Dental Surgery, and dental appliances except as specified in the Plan.
33. Charges for eyeglasses, contact lenses, eye exercises, orthoptic therapy, hearing aids or for examination or fitting regardless of Medical Necessity (Benefits will be provided for dilated eye exams rendered to Members with a diagnosis of Diabetes. Dilated eye exams are limited as specified in Article VI.).
36. Nursing home care or custodial home care regardless of the level of care required or provided, except as provided in this plan
37. Respite Care.
38. Industrial testing or self help programs (including, but not limited to, smoking cessation programs, stress management programs).
39. Work hardening programs.
40. Any care or service not specified as a Covered Service.
41. Supplies or equipment used or related to Home Infusion Therapy except as provided in Article VIII, Section C.
42. Care of a newborn not covered at birth as a Dependent.
43. Provider services or supplies which are not documented to be Medically Necessary as determined by the Claims Administrator.
44. Inpatient Hospital services and supplies for Rehabilitative Care and treatment except as provided in this Plan (See Hospital Benefits)
45. No Benefits will be provided under the Plan for any Pre-existing Condition until the Plan has been in effect as to the Member for whom such Benefits are sought for a

period of twelve consecutive months. After the twelve consecutive months have elapsed, Benefits of the Plan will be provided for Covered Services for such Pre-existing Condition. Note: This exclusion is subject to the following provisions:

- a. If the individual is subject to a probationary period for coverage under the Plan, the twelve consecutive months is calculated from the first day of the probationary period.
- b. The Pre-existing Condition exclusion does not apply to a newborn child who is covered under the Plan within 31 days of the date of birth. If the newborn child is not covered within 31 days of the date of birth, the Pre-existing Condition exclusion applies to the newborn child.
- c. The Pre-existing Condition exclusion does not apply to a child who is adopted or placed for adoption prior to attaining 18 years of age and who is covered under the Plan within 31 days of the date of the adoption or placement for adoption. If the child is not covered within 31 days from the date of adoption or the date of placement for adoption, the Pre-existing Condition applies to the child.
- d. The Pre-existing Condition exclusion does not apply to pregnancy.
- e. The twelve consecutive months of the Pre-existing Condition exclusion period will be reduced by the number of days of prior creditable coverage the Member has as of his or her effective date (or the first day the probationary period) Note: See the "Counting Creditable Coverage" section in the GENERAL PROVISIONS section of the Plan.
- f. The twelve consecutive months of the Pre-existing Condition exclusion period will be reduced by the number of days of prior creditable coverage the Member has as of his or her effective date (or the first day of the probationary period) Note: See the "Certification of Coverage" section in the GENERAL PROVISIONS section of the Plan.
- g. If a newborn child, an adopted child or a child placed for adoption, who was previously covered under another group benefit plan, becomes covered under this Plan within 31 days of the date of being first eligible due to initial enrollment or a Special Enrollment Period, the Pre-existing Condition exclusion will not be applied to such child solely on the basis that the child does not have prior creditable coverage to eliminate the 12 month Pre-existing Condition Exclusion period. In the event the child has experienced a significant break in coverage before becoming covered under this Plan, the Pre-existing Condition Exclusion period will apply to the child. A significant break in coverage is 63 consecutive days or more in which the individual does not have creditable

coverage.

46. For reversal of a voluntary sterilization procedure.
47. Benefits for treatment of Nervous/Mental Conditions do not include counseling services.
48. No Benefits will be provided for bone marrow transplants (autologous and allogeneic) except as provided in Article XII, Section B.
49. For any loss which is due to or results from the Member's commission of or attempt to commit an assault, felony or other illegal act.
50. For any loss which is due to or results from the Member engaging in any illegal occupation.
51. Services, care, treatment or supplies which are furnished or rendered after the cancellation or termination date of the Member's coverage (whether or not such services, care, treatment or supplies are for or related to a condition, disease, ailment or injury which commenced before or existed on the termination date of the Member's coverage).
52. Speech Therapy for learning disabilities and development problems.
53. Pre-Admission Testing.
54. Private Duty Nursing.
55. Drugs and medications that are prescribed by a Provider in order to enhance the Member's performance in certain activities (example: blood enhancing drugs).
56. Services and supplies provided by a Residential Treatment Facility.
57. Dental Implants.
58. Hot tubs, swimming pools, whirlpools, lift chairs, and air purifiers, regardless of the Provider's recommendation.
59. Drugs to improve sexual performance, except Benefits for Viagra, Cialis, and Levitra. Benefits are limited to 5 tabs per month.
60. Human Growth Hormones regardless of statement of medical necessity.

Article XVI  
GENERAL PROVISIONS

A. The Plan

1. Neither the Group nor the Claims Administrator will be liable for or on account of any fault, act, omission, negligence, misfeasance, malfeasance or malpractice on the part of any Hospital or other institution, or any agent or employee thereof, or on the part of any Physician, Allied Provider, nurse, technician or other person participating in or having to do with the care or treatment of Member.

B. Plan Changes

The Group reserves the right to modify terms of this Plan.

C. Certificates or Booklets and Identification Cards

Claims Administrator will issue to the Group, for delivery to Covered Participants, certificates or booklets which describe this Plan's Benefits, the procedures for obtaining Benefits, and identification cards. In the event of a conflict between this Plan and the certificates or booklets, the terms of this Plan will prevail.

D. Benefits to Which Members are Entitled

1. The liability of Group is limited to the Benefits specified in this Plan.
2. Subject to the terms and provisions of this Plan, Benefits will be provided for Covered Services rendered or furnished by a Provider to a Member while he or she is covered under this Plan.

E. Termination of a Member's Coverage

1. Member's coverage may be terminated for fraud or material misrepresentations in connection with application for coverage or claim for Benefits.
2. In the event a Participant ceases to be in the employ of the Group, or in the event the Group notifies Claims Administrator that coverage of a Participant is terminated pursuant to Section F herein, the coverage of such Participant and all of his/her Dependents automatically, and without notice, terminates at the end of the period for which payment of fees has been made by the Group.
3. The coverage of the Participant's Spouse/Domestic Partner will automatically terminate without notice at the end of the period for which fees have been paid at the time of the entry of a final decree of divorce or other legal termination of marriage.

4. The coverage of a child as a Member will terminate automatically without notice at the end of the month the child ceases to be an Eligible Dependent if fees have been paid through that month. Divorce of a Participant's child does not restore eligibility.
5. Upon the death of a Participant, the coverage of all of his/her surviving Dependents will terminate automatically and without notice at the end of the month that death occurred if fees have been paid through that month.
6. In the event the Group cancels this Plan such cancellation or termination alone will operate to terminate all rights of the Member to Benefits under the terms of this Plan as of the Effective Date of such cancellation or termination whether or not the Member is an Inpatient or Totally Disabled.
7. Unless as otherwise specified in this Plan, no Benefits are available for services, care, treatment or supplies furnished or rendered to a Member after the date of cancellation or termination of the Member's coverage.

F. Continuation Of Coverage

**NOTE: This Plan is not subject to COBRA because it is a "Church Plan." However, other continuation provisions, not legally required, are outlined below.**

**Period of Continued Coverage**

Member who qualifies may be eligible to continue benefits if active employment ends because they are completing their term as at least a nine but less than 12 month employee. The period of continuation will be the lesser of:

- the date the Member resumes active employment as scheduled; or
- three months.

Members who continue coverage under this provision are not subject to a Waiting Period when active employment resumes immediately following this period.

**CONTINUATION OF COVERAGE – Applicable only to Members covered under the Plan for less than six months:**

Coverage may also continue for the following periods:

Resignation, Dismissal, or Layoff	Last day of the month in which resignation, dismissal, or layoff occurs.
Reduction of Hours	Last day of the month in which reduction of hours occurs.

**Continuation Of Coverage - Applicable only to Members covered under the Plan**

**for six months or more:**

1. Benefits Available

If you and/or your Dependents become Qualified Individuals at any time during which continuation applies to your Plan, medical benefits described in your booklet may be continued beyond normal termination dates.

a. Qualified Persons/Qualifying Events

Continuation of group health coverage will be offered to the following persons if they would otherwise lose that coverage as a result of the following events:

- (1) A Member (and any covered Dependents) following the Member's:
  - (a) termination of employment for a reason other than gross misconduct; or
  - (b) a reduction in work hours.

(Note Taking a family or medical leave under the Federal Family & Medical Leave Act (FMLA) is not a qualifying event. A Member qualifies when the Member does not return to work after end of FMLA); and
- (2) A Member's former Spouse/Domestic Partner (and any Dependent children) following a divorce or legal separation from the Member; and
- (3) A Member's surviving Spouse/Domestic Partner (and any Dependent children), following the Member's death; and
- (4) A Member's Dependent child following loss of status as a Dependent under the terms of the Plan Document (e.g., attaining the maximum age, marriage, joining the armed forces, etc.); and
- (5) A Member's Spouse/Domestic Partner (and any Dependent children) following the Member's entitlement to Medicare; and
- (6) A Member's Dependent child who is born to or placed for adoption with the Member who is on continuation due to termination of employment or reduction in work hours; and
- (7) If the Plan Document covers retired Members, a retired Member and his/her Dependents (or surviving Dependents) when retiree health benefits are "substantially eliminated" or terminated within one year

before or after the employer files Chapter 11 (United States Code) bankruptcy proceedings.

b. Maximum Continuation Period

Following a qualifying event, health coverage can continue up to the maximum continuation period. The maximum continuation period for a Member (and any Dependents) following a termination of employment or reduction in work hours is 18 months. The maximum continuation period for a Member's Dependent child that is born to or placed for adoption with the Member while on continuation will extend to the end of the Member's maximum continuation period.

Following a termination of employment or reduction in work hours, a qualified person may request an 11-month extension of continuation. The maximum continuation will be 29 months (see Disabled Extension, Section D).

When a Member becomes entitled to Medicare before employment terminates or work hours are reduced, the maximum continuation period for the Dependents will be the longer of:

- (1) 36 months dating back to the Member's enrollment under Medicare; or
- (2) 18 months from the date of the qualifying event (termination of employment or reduction in work hours).

The maximum continuation period for qualified Dependents following a qualifying event described in a(2) through a(5) is 36 months.

If the Plan Document covers retired Members and the qualifying event is the employer's bankruptcy filing, the following rules apply:

- (1) If the retired Member is alive on the date of the qualifying event, the retired Member and his or her Spouse/Domestic Partner and Dependent children may continue coverage for the life of the retired Member. In addition, if the retired Member dies while covered, the Spouse/Domestic Partner or Dependent children may continue coverage for an additional 36 months.
- (2) If the retired Member is not alive on the date of the qualifying event, his or her Spouse/Domestic partner may continue coverage to the date of his or her death.

c. Second Qualifying Events

If during an 18-month continuation period (or, 29 months for qualified persons on the disabled extension), a second qualifying event described in a(2) through a(5) occurs, the maximum continuation period may be extended for

the qualified Dependents up to 36 months. That is, following a second qualifying event, qualified Dependents may continue for up to a maximum of 36 months dating from the Member's termination of employment or reduction in work hours. The extension is only available if the second qualifying event described in a(2) through a(5), absent the first qualifying event, results in a loss of coverage for Dependents under the Plan. A Member's Dependent child who is born to or placed for adoption with the Member who is on continuation may also be eligible for a second qualifying event that occurred prior to birth or placement for adoption.

d. Disabled Extension

Following a termination of employment or reduction in work hours, a qualified person (Member or Dependent) who has been determined disabled by the Social Security Administration either before or within 60 days after the qualifying event may request an extension of the continued coverage from 18 months to 29 months. A Member's Dependent child who is born or placed for adoption with the Member who is on continuation must be determined disabled by the Social Security Administration within 60 days after the date of birth or placement for adoption. The disabled extension also applies to each qualified person (the disabled person and any family members) who is not disabled and who is on continuation as a result of termination of employment or reduction in work hours.

The 11-month extension for all qualified persons will end the earlier of (a) 30 days following the date the disabled person is no longer determined by Social Security to be disabled; or (b) the date continuation would normally end as outlined in Section (e) below.

e. Termination of Continued Coverage

Continued coverage ends the earliest of the following:

- (1) The date the maximum continuation period ends; or
- (2) The date the qualified person enrolls in Medicare. However, this does not apply to a person who is already enrolled in Medicare on the date he or she elects continuation or to a person who is on continuation due to the employer's bankruptcy filing as described in a(7); or
- (3) The end of the last coverage period for which payment was made if payment is not made prior to the expiration of the grace period. (See Grace Period, Section I.); or
- (4) The date the Adopting Institution's group health coverage is terminated (and not replaced by another group health plan); or

- (5) The date the qualified person becomes covered by and has satisfied the preexisting exclusion provision of another group health plan, however, this does not apply to a person who is already covered by the other group health plan on the date he or she elects continuation.

NOTE: Persons who, after the date of continuation election, become entitled to Medicare or become covered under another group health plan and have satisfied the preexisting exclusion provision, are not eligible for continued coverage. However, if the Plan covers retired Members, continued coverage for retired persons and their Dependents (or surviving Dependents) due to qualifying event a(7) above may not be terminated due to Medicare coverage.

f. Employer/Plan Administrator Notification Requirement

When a Member or Dependent becomes ineligible and loses group health coverage due to termination of employment, reduction in work hours, death of the Member, the Member entitlement to Medicare, or if the Plan covers retired Members, the commencement of the employer's Chapter 11 (United States Code) bankruptcy proceedings, the employer must notify the plan administrator of the qualifying event. The plan administrator must notify the qualified person of the right to continuation within 14 days after receiving notice of a qualifying event from the employer.

g. Qualified Person Notice and Election Requirements

Qualified persons must notify the plan administrator within 60 days after (a) the date of a qualifying event (i.e., divorce, legal separation, or a child ceases to be a Dependent child under the terms of the Plan) (b) the date the qualified person would otherwise lose coverage as a result of a qualifying event; or (c) the date the qualified person is first informed of this notice obligation; otherwise the right to continuation ends. This 60-day notice period applies to initial and second qualifying events.

Qualified persons who request an extension of continuation due to disability must submit a written request to the plan administrator before the 18-month continuation period ends and within 60 days after the latest of the following dates: (a) the date of disability determination by the Social Security Administration; (b) the date of the qualifying event; (c) the date the qualified person would otherwise lose coverage as a result of a qualifying event; or (d) the date the qualified person is first informed of this notice obligation; otherwise the right to the disabled extension ends. Qualified persons must also notify the plan administrator within 30 days after the date the Social Security Administration determines the qualified person is no longer disabled.

Notification of a qualifying event to the plan administrator must include the following information: (a) name and identification number of the Member and each qualified beneficiary; (b) type and date of initial or second qualifying event; (c) if the notice is for an extension due to disability, a copy of any letters from the Social Security Administration and the Notice of Determination; and (d) the name, address and daytime phone number of the qualified person (or legal representative) that the plan administrator may contact if additional information is needed to determine continuation rights.

Within 14 days after receiving notice of a qualified event from the qualified person, the plan administrator must provide the qualified person with an election notice.

Qualified persons must make written election within 60 days after the later of: (a) the date group health coverage would normally end; or (b) the date of the plan administrator's election notice. The election notice must be returned to the plan administrator within this 60-day period; otherwise the right to elect continuation ends.

Each qualified person has an independent right to elect continuation. A covered Member may elect continuation on behalf of his/her covered Spouse/Domestic Partner. A covered Member, parent, or legal guardian may elect continuation on behalf of his/her covered Dependent children.

To protect continuation rights, the plan administrator must be informed of any address changes for covered Members and Dependents. Retain copies of any notices sent to the plan administrator.

h. Monthly Cost

Persons electing continued coverage can be required to pay 102% of the cost for the applicable coverage. Persons who qualify for the disabled extension and are not part of the family unit that includes the disabled person can be required to continue to pay 102% of the cost for the applicable coverage during the disability extension. Persons who qualify for the disabled extension and are part of the family unit that includes the disabled person can be required to continue to pay 148% of the cost for the applicable coverage (plus a 2% billing fee) for the 19th through the 29th month of coverage (or through the 36<sup>th</sup> month if a second qualifying event occurs during the disabled extension).

i. Grace Period

Qualified persons have 45 days after the initial election to remit the first contribution. The first contribution must include all contributions due when sent. All other contributions (except for the first contribution) will be timely if

made within the Grace Period. "Grace Period" means the first 30-day period following a contribution due date. Except for the first contribution, a Grace Period of 30 days will be allowed for payment of contributions. Continued coverage will remain in effect during the Grace Period provided payment is made prior to the expiration of the Grace Period. If payment is not made prior to the expiration of the Grace Period, continued coverage will terminate at the end of the last coverage period for which payment was made.

j. Plan Changes

Continued coverage will be subject to the same benefits and changes as the group Plan.

k. Newly Acquired Dependents

A qualified person may elect coverage for a Dependent acquired during continuation. All enrollment and notification requirements that apply to Dependents of active Members apply to Dependents acquired by qualified persons during continuation.

Coverage for a newly acquired Dependent will end on the same dates as described for qualified persons in Section B above. Exception: Coverage for newly acquired Dependents, other than the Member's Dependent child who is born to or placed for adoption with the Member, will not be extended as a result of a second qualifying event.

l. Individual Purchase Privilege

When a qualified person is no longer eligible for continued coverage, he/she may apply for Individual Purchase. Persons who are eligible for similar benefits which would result in over-coverage may not purchase conversion coverage. An application for Individual Purchase will be provided 180 days prior to the end of the maximum continuation period. Application for Individual Purchase, and payment of the required premium, must be made within 31 days after the continued coverage ends. Dental, Vision Care, and Prescription Drug coverages are not included with the Individual Purchase Option (however, benefits for prescription drugs are included in the Individual Purchase coverage).

m. Contact Information

To notify the plan administrator of an initial or second qualifying event, request a disabled extension, request termination of continuation, change of address, or request additional information concerning the Plan Document or continuation, contact the following:

For initial events, notify:  
Millsaps College  
Attn Benefits Department

1702 N State Street  
Jackson MS 39210  
601-974-1443

G. Claim Filing and Request for services

1. Neither Claims Administrator or Group will be liable under this Plan unless, within one year from the date the Covered Service is rendered, a claim is filed with the Claims Administrator in a form and manner that effectively provides notice to the Claims Administrator that the Covered Service has been rendered. A claim will be considered incurred on the date the service or supply is actually rendered or provided to the Member.
2. A claim for a Covered Service that has been provided by a Participating or Network Provider must be filed directly with the Claims Administrator by such Provider within one year from the date the service is rendered.
3. Nonparticipating and Non-Network Providers may file the claim for a Covered Service if the Member asks them to do so. If they do not file the claim, it is the Member's responsibility to submit the claim to the Claims Administrator on a standard claim form that is appropriate for the services rendered. It is the responsibility of the Member to assure that any claim for a Covered Service that has been provided by Nonparticipating or Non-Network Provider is filed with the Claims Administrator within one year from the date the service is rendered.
4. Claims Administrator will not be liable for issuing claims and appeals decisions as set forth herein where Group payments for administrative fees and/or claims funding is delinquent or where an agreement between the Claims Administrator and the Group for administration of claims has not been finalized. Once any delinquent fees or claims funding is brought current and/or any outstanding agreement between Claims Administrator and Group is finalized, the provisions related to claims and appeals decisions will apply to Members under this Plan.

H. Individual Benefit Determination and Appeal Procedure

1. DEFINED TERMS (APPLICABLE ONLY TO SECTION H)
  - a. Designation of Authorized Representative: A Member may designate an Authorized Representative to act on the Member's behalf. A designated Authorized Representative may be any individual who is not otherwise included under the same coverage as the Member. A natural parent of a minor dependent Member and a provider of services for a Member may act on behalf of the Member without obtaining a formal designation. Any designation of an Authorized Representative must be submitted to the Claims Administrator on a

form that will be provided by the Claims Administrator upon request of the Member. This Designation of Authorized Representative form must be signed by the Member whose claim is involved and submitted to CLAIMS REVIEW at the address specified on the form. Once an Authorized Representative has been formally designated by a Member, all communications pertaining to the claim at issue will be directed to the Authorized Representative. Anyone acting as an Authorized Representative for a Member must adhere to all procedures and requirements contained herein which are otherwise the responsibility and obligation of the Member.

- b. Post-Service Claim: A claim that is submitted for medical services that have already been rendered to the Member. The Member will receive an Explanation of Benefit form reflecting the initial Benefit determination for claims that have been processed.

## 2. INITIAL BENEFIT DETERMINATION PROCEDURES

- a. Following the procedures outlined in the Utilization Management section of the Plan, the Member's Provider or the Member (when utilizing a Non-Network or Non-Participating Provider) will certify an Emergency Admission, request for Pre-Certification, Prior Authorization or Prior Approval of services where required.
- b. Once a claim or request for a Covered Service is received by the Claims Administrator, the Member or the Provider may be advised if additional information is needed to finalize the claim processing. Claims Administrator has the right to deny any claim where additional information (i.e. medical records, etc.) is not received within the timeframes provided for making an initial Benefit determination.

NOTE: If the Member disagrees with any pharmacy service and the Claims Administrator does not provide an Explanation of Benefits for the transaction, the Member must submit written notice of an initial claim to the Pharmacy Benefit Management Department.

- c. Time Lines for initial Benefit determinations

- (1) Certification of Emergency Admissions

- (a) When the Member's Provider or the Member (only when utilizing a Non-network or Nonparticipating Provider) requests Certification of an Emergency Admission in accordance with the Utilization Management section of the Plan, Claims Administrator will advise the Member's Provider of a decision as soon as possible taking into account the medical urgency, and in no case later than 72 hours after the request for Certification. Claims Administrator will provide oral notice of approval to the

Provider. If the request is denied, the Claims Administrator will provide the Member written notification of the decision within three days.

(2) Notice of Initial Benefit Decision for Pre-Certification, Prior Authorization or Prior Approval of Services

(a) Only when the Member or the Member's Provider submits a request for services not yet rendered and the terms of the Utilization Management or Transplant sections of the Plan require Pre-Certification, Prior Authorization or Prior Approval, a notification of a determination will be made within a reasonable period of time appropriate to the medical circumstances, but no later than 15 days from receipt of the request for services. The Claims Administrator has discretion (but is under no obligation) to extend the 15 day time period for reasons beyond the control of the Claims Administrator.

(b) If the request for Pre-Certification, Prior Authorization or Prior Approval of medical services is approved, Claims Administrator will advise the Member's Provider of the approval. If the request for Prior Authorization of pharmacy services is approved, Claims Administrator will advise the Member or the Provider of this decision. If the request for Pre-Certification, Prior Authorization or Prior Approval of either medical or pharmacy services is denied, Claims Administrator will provide the Member with written notification.

(3) Notice of Initial Benefit Decision for Claims

(a) When a claim is submitted for services that already have been rendered, a notification of a determination will be sent within a reasonable time period but not longer than 30 days from receipt of the claim. Claims Administrator has the discretion (but is under no obligation) to extend the 30 day time period for reasons beyond the control of the Claims Administrator.

d. Appeal Procedures

(1) The Member or the Member's properly designated Authorized Representative will be entitled to request an appeal of an

adverse Benefit determination. An appeal must be filed within 180 days from the receipt of the notice of an initial Benefit determination.

- (2) A request for an appeal must be submitted in writing to CLAIMS REVIEW at the address specified in the initial Benefit determination notification or the Explanation of Benefit form.
- (3) The Member's request for an appeal should state why the decision is incorrect. The Member will have the opportunity to submit written comments, documents, or other information in support of the appeal. Once a request for an appeal is received by Claims Administrator, the Member or the Provider may be advised if additional information is needed to finalize the decision. Claims Administrator has the right to deny any appeal where additional information (medical records, etc.) is not received within the timeframes provided for making a decision on an appeal.
- (4) Upon request and free of charge, the Member will have access to and be provided copies of relevant documents. The review of the initial Benefit determination will take into account all new information, whether or not presented or available at the initial determination. No deference will be afforded to the initial determination.
- (5) The appeal will be conducted by a representative of the Claims Administrator who is neither the individual who made the initial Benefit determination nor the subordinate of such individual. If the appeal involves a medical judgment question, the Claims Administrator will consult with an appropriately qualified health care practitioner with training and experience in the field of medicine involved in the medical judgment.
- (6) A final decision on an appeal will be made within the time periods specified below:
  - (a) Appeal of an Emergency Admission

In the event the request for Certification of the Emergency Admission is denied, the Member's Provider may request an expedited review of the Certification. This request should be made by telephone, facsimile, or similarly rapid communication method. Utilizing the same communication method, Claims Administrator will notify the Member's Provider as soon as possible, but in no less than 72 hours after the receipt of the expedited

review of the Claims Administrator's approval or continued denial of the services. The Member will be notified of the continued denial of services.

(b) Appeal of Pre-Certification, Prior Authorization or Prior Approval of Services

When a Member requests an appeal of the Pre-Certification, Prior Authorization or Prior Approval of services, the Member will be notified of the determination within a reasonable period of time taking into account the medical circumstances, but no later than 30 days from the date the request is received.

(c) Appeal of Claims

When the Member requests an appeal of a claim denial, the Member will be notified of the determination or status within a reasonable period of time but no later than 60 days from the date the request is received.

e. Contents of notification for adverse decisions for Pre-Certification, Prior Authorization, Prior Approval of services, claims and appeals.

(1) The notice of initial Benefit determination for adverse decisions for Pre-Certification, Prior Authorizations or Prior Approvals, claims and appeals will contain the following information:

(a) the specific reason or reasons for the adverse determination;

(b) a reference to the Claims Administrator's claims review procedures and a statement of the Member's rights pursuant to Section 502(a) of ERISA, if the Member's Plan is subject to ERISA;

(c) state whether the denial is based on a medical necessity exclusion or limitation and advise that the Member will be provided with an explanation of the determination free of charge upon request.

(2) In addition, the notification of an adverse decision for Pre-Certification, Prior Authorization, Prior Approval of services and appeals will disclose whether any internal rule, guideline or protocol was relied on in making the adverse determination and provide that a copy of such information will be made available free of charge upon request. It will reference the

specific plan provision on which the Benefit determination is based.

- (3) Notifications for Pre-Certification, Prior Authorization or Prior Approvals will also indicate whether additional material or information is needed to perfect the request for services. Notifications for appeals will provide that the Member is entitled to receive upon request and free of charge reasonable access to and copies of all documents, records and other information relevant to the claim for Benefits.
- (4) The notice of initial Benefit determination for adverse claims will also indicate whether additional material or information is needed to perfect the claim.

#### I. Legal Action

The Member may not bring a lawsuit to recover Benefits under this Plan until the Member has exhausted the administrative process described in Section H. No action may be brought at all unless brought no later than 3 years following a final decision on the claim for Benefits by Claims Administrator. The 3-year statute of limitations on suits for all Benefits shall apply in any forum where the Member may initiate such suit.

#### J. Release of Information

1. Each Member receiving care under this Plan authorizes and directs any Provider to furnish to Claims Administrator, at any time upon its request, all information, records, copies of records or testimony relating to attendance, diagnosis, examination, or treatment. Such authorization and compliance therewith by each Provider affected will be a condition precedent to rights to Benefits to each Member hereunder, and no Benefits will be provided in any case where such authorization is not given full effect. Claims Administrator will utilize the information described in this paragraph for internal administration of this Plan, medical analysis, coordination of benefit provisions with other plans, subrogation of claims, or in the reviewing of a disputed claim. Additionally, Claims Administrator will hold such information, records, or copies of records, as confidential except where in its discretion the same should be disclosed.
2. Claims Administrator, as part of Utilization Management activities may disclose health information or information about a Member's Utilization to a treating physician or a dispensing pharmacy.

#### K. Payment of Benefits

## Nonparticipating Benefits and Direct Payment to Member

1. All Benefits payable under this Plan and any amendment hereto are personal to the Member and are not assignable in whole or in part by the Member, but the Plan, through the Claims Administrator, has the right to make payment to a Hospital, Physician, or other Provider (instead of to the Member) for Covered Services which they provide while there is in effect between the Claims Administrator and any such Hospital, Physician, or other Provider an agreement calling for the Claims Administrator to make payment directly to them. In the absence of such an agreement for direct payment, the Plan, through the Claims Administrator will pay to the Member and only the Member those Benefits called for herein and Claims Administrator will not recognize a Member's attempted assignment to, or direction to pay, another.
2. Hospitals, Physicians, and other Providers which have agreed with the Claims Administrator or another Blue Cross and Blue Shield Plan for such direct payment are, by reason of such agreements, "Participating Hospitals," "Participating Physicians," or "Participating other Providers," respectively, and are referred to collectively as "Participating Providers." Those Hospitals, Physicians, and other Providers which do not have such agreements for direct payment are "Nonparticipating Hospitals," "Nonparticipating Physicians," and "Nonparticipating other Providers," respectively, and are referred to collectively as "Nonparticipating Providers."
3. If the Claims Administrator has offered a Hospital, Physician or other Provider an agreement for direct payment by the Claims Administrator, but there is no such agreement in effect when Covered Services are rendered to a Member by such Hospital, Physician or other Provider, the Claims Administrator will not recognize a Member's attempted assignment to, or direction to pay, such Hospital, Physician or other Provider, but the Plan, through the Claims Administrator will pay to the Member and only the Member those Benefits called for in this Plan and any amendment thereto.
4. If a Hospital, Physician or other Provider meets the Claims Administrator criteria for participating status but has not yet been offered an agreement for direct payment by the Claims Administrator at the time Covered Services are rendered to a Member, the Claims Administrator will recognize a Member's direction to pay such Hospital, Physician or other Provider.
5. The Claims Administrator reserves the right to select the Hospitals, Physicians, and other Providers with which it will make agreements for direct payment by the Plan, through the Claims Administrator, for Covered Services they render Members, based on criteria which include the Claims Administrator's need in the locality, Utilization Management practices of the Hospital, Physician, or other Provider, quality of services, and the like.

6. The Deductible Amount and Lifetime Maximum Benefit will remain the same as specified herein and will not be increased or reduced by this provision.

L. Member/Provider Relationship

1. Claims Administrator does not render Covered Services but only makes payment for Covered Services received by Members. Neither Claims Administrator nor Plan is liable for any act or omission of any Provider. Claims Administrator has no responsibility for a Provider's failure or refusal to render Covered Services to a Member.
2. The use or non-use of an adjective such as Network or Non-Network in referring to any Provider is not a statement as to the ability of the Provider.

M. Applicable Law

This Plan will be governed and construed in accordance with the laws and regulations of the State of Mississippi except when preempted by federal law.

N. Coordination of Benefits (Group and Individual Coverage)

1. Applicability:
  - a. This Coordination of Benefits ("COB") section applies to This Plan when the Employee or the Employee's covered Dependent has health care coverage under more than one plan. "Plan" and "This Plan" are defined below.
  - b. If this COB section applies, the Order of Benefit Determination Rules should be looked at first. Those rules determine whether the Benefits of This Plan are determined before or after those of another plan. The Benefits of This Plan:
    - (1) will not be reduced when, under the Order of Benefit Determination Rules, This Plan determines its Benefits before another plan.
    - (2) may be reduced when under the Order of Benefit Determination Rules, another Plan determines its Benefits first. That reduction is described in part 4 of this COB section.
2. Definitions: (Applicable only to Section N)
  - a. "Plan" means any health plan which provides services, supplies, or equipment for Hospital, surgical, medical, or Dental Care or Treatment, including but not limited to, coverage under group or

individual insurance policies, non-profit health service plans, health maintenance organizations, Employee contracts, self-insured group plans, pre-payment plans, automobile or homeowners medical pay-plans, and Medicare as permitted by federal law. This does not include, Medicaid, Hospital daily indemnity plans, specified diseases only policies, limited occurrence policies which provide only for intensive care or coronary care in the Hospital.

Each Plan or other arrangement for coverage is a separate plan. If an arrangement has two parts and COB rules apply only to one of the two, each of the parts is a separate Plan.

- b. "This Plan" means the part of this Group's Master Contract and any Amendatory Rider thereto that provides Benefits for health care expenses.
- c. "Primary Plan"/"Secondary Plan," The Order of Benefit Determination Rules state whether This Plan is a Primary Plan or Secondary Plan as to another Plan covering the person. When This Plan is a Primary Plan, its Benefits are determined before those of the other Plan and without considering the other Plan's Benefits.

When This Plan is a Secondary Plan, its Benefits are determined after those of the other Plan and may be reduced because of the other Plan's Benefits.

When there are more than two Plans covering the person, This Plan may be a Primary Plan as to one or more other Plans, and may be a Secondary Plan as to a different Plan or Plans.

- d. "Claim Determination Period," means the calendar year during which a person covered by This Plan is eligible to receive Benefits under the provisions of This Plan.
- e. "Group Coverage" means plans or policies which can be obtained only because of employment with or membership in a particular organization, corporation, or other business entity.
- f. "Individual Coverage" means any plan, contract, or policy (other than Group Coverage) which provides Benefits, care, or treatment for an illness or injury and which is sold directly to an individual.

The term "Individual Coverage" will also include any conversion contract or policy issued directly to a group Employee or Dependent upon termination of group eligibility.

3. Order of Benefit Determination Rules:

- a. When there is a basis for a claim under This Plan and another plan, This Plan is a Secondary Plan if the other plan contains no provision for Coordination of Benefits. If This Plan and another Plan both contain Coordination of Benefit provisions, the plan that provides group coverage will be the Primary Plan. If both plans provide group coverage, or if both provide Individual Coverage, then This Plan is a Secondary Plan which has Benefits determined after those of the other Plan, unless:
  - (1) the other Plan has rules coordinating its Benefits with those of This Plan; and,
  - (2) both those rules and This Plan's rules, in subparagraph b. below, require that This Plan's Benefits be determined before those of the other Plan.
  
- b. This Plan determines its order of Benefit payments, as follows:
  - (1) Non-dependent/Dependent: The Benefits of the plan which covers the person as an employee, member or Employee (that is, other than as a Dependent) are determined before those of the plan which covers the person as a Dependent; except that if the person is also a Medicare beneficiary, and as a result of the rule established by Title XVIII of the Social Security Act and implementing regulations, Medicare is:
    - (a) Secondary to the plan covering the person as a Dependent, and
    - (b) Primary to the plan covering the person as other than a Dependent (e.g., a retired employee).then the Benefits of the plan covering the person as a Dependent are determined before those of the plan covering that person as other than a Dependent.
  
  - (2) Dependent Child/Parents Not Separated or Divorced: Except as stated in subparagraph b.(3) below, when This Plan and another Plan cover the same child as a Dependent of different persons, called "parents."
    - (a) the Benefits of the plan of the parent whose birthday falls earlier in a year are determined before those of the plan of the parent whose birthday falls later in that year; but
    - (b) if both parents have the same birthday, the Benefits of the plan which covered the parent longer are

determined before those of the plan which covered the other parent for a shorter period of time.

- (3) Dependent Child/Separated or Divorced Parents: If two or more plans cover a person who is a dependent child of divorced or separated parents, Benefits for the child are determined in this order:
- (a) first, the plan of the parent with custody of the child;
  - (b) then, the plan of the Spouse/Domestic Partner of the parent with custody of the child; and
  - (c) finally, the plan of the parent not having custody of the child.

However, if specific terms of a court decree state that one of the parents is responsible for the health care expenses of the child, and the entity obligated to pay or provide the Benefits of the plan of that parent has actual knowledge of those terms, the Benefits of that plan are determined first. This paragraph does not apply when any Benefits are actually paid or provided before the entity has that actual knowledge.

- (4) Joint Custody: If the specific terms of a court decree state that the parents will share joint custody without stating that one of the parents is responsible for the health care expenses of the child, the plans covering the child will follow the order of Benefit determination rules outlined in Paragraph 3.b.(2).
- (5) Active/Inactive Employee: The Benefits of a plan which covers a person as an employee who is neither laid off nor retired are determined before those of a plan which covers that person as a laid off or retired employee. The same would hold true if a person is a Dependent of a person covered as a retiree and an employee. If the other plan does not have this rule, and if, as a result, the plans do not agree on the order of Benefits, this rule (5) is ignored.
- (6) Continuation coverage. If a person whose coverage is provided under a right of continuation pursuant to federal or state law also is covered under another plan, the following will be the order of Benefit determination:
- (a) First, the Benefits of a plan covering the person as an employee, member or Employee (or as that person's

Dependent);

- (b) Second, the Benefits under the continuation coverage.

If the other plan does not have the rule described above, and if, as a result, the plans do not agree on the order of Benefits, this rule is ignored.

- (7) Longer/Shorter Length of Coverage: If none of the above rules determine the order of Benefits, the Benefits of the plan which covered an employee, member or dependent longer are determined before those of the plan which covered that person for the shorter time.

4. Effect on the Benefits of This Plan:

- a. This Section 4 applies when, in accordance with Section 3, This Plan is a Secondary Plan as to one or more other plans. In that event This Plan will provide Benefits based on the difference between the amount the other Plan or Plans paid and the amount established by Blue Cross & Blue Shield of Mississippi as the maximum amount for Provider Services covered under the terms of This Plan. Additionally, in the event the amount that the Primary Plan pays exceeds the amount established by Blue Cross & Blue Shield of Mississippi as the maximum amount for Provider services covered under the terms of This Plan, This Plan will incur no secondary liability. Note: In no event will the amount This Plan provides as Secondary Plan exceed the amount it would have provided as the Primary Plan.

5. Right to Receive and Release Needed Information:

Claims Administrator has the right to deny all claims unless and until the Member provides Claims Administrator with the requested facts and any of the insurance information needed to apply the Coordination of Benefits Rules.

6. Facility of Payment:

A payment made under another Plan may include an amount which should have been paid under This Plan. Blue Cross & Blue Shield of Mississippi may pay that amount to the organization which made that payment. That amount will then be treated as though it were a Benefit paid under This Plan. Blue Cross & Blue Shield of Mississippi will not have to pay that amount again. The term "payment made" includes providing Benefits in the form of services, in which case the payment made will be deemed to be the reasonable cash value of any Benefits provided in the form of services.

7. Right of Recovery:

If the amount of the payments made by Blue Cross & Blue Shield of Mississippi is more than it should have paid under this COB provision, it may recover the excess. It may get such recovery or payment from one or more of:

- a. The persons it has paid or for whom it has paid;
- b. Insurance companies; or
- c. Other organizations.

The "amount of the payments made" includes the reasonable cash value of any Benefits provided in the form of services.

#### 8. Medical Payments Coverage

- a. Where any medical payment sums are applicable to a Member under any coverages, including but not limited to automobile and premises policies, the limits of any such applicable coverage must be applied to related claims before any Benefits will be provided under This Plan.
- b. Member will take such action, furnish such information and assistance and execute such papers as Claims Administrator may require in order to document that the applicable medical payment monies have been fully utilized.
- c. In the event that applicable medical payment monies have not been fully utilized for related claims prior to the time This Plan begins providing Benefits for related claims, Claims Administrator may determine or deem certain claims to be the responsibility of medical payments coverage and may recover directly from the provider of services any payments previously made in order to facilitate full use of the applicable medical payment monies to related claims. Where any related claims for which Benefits have been provided are determined or deemed to be the responsibility of medical payments coverage, Benefits under this Plan will be denied for these same services and shall be the financial responsibility of the Member.

#### O. Working Aged Provisions

1. For employers having 20 or more active employees, federal law and regulations require that, each active Employee, age 65 or older, and each active Employee's Spouse age 65 or older, may elect to have coverage under this Plan and/or under Medicare.
  - a. Where such Employee or such Spouse elects coverage under this Plan, this Plan will be the primary payor of Benefits with the Medicare program the secondary payor.

- b. This Plan will not provide Benefits to supplement Medicare payments for an active Employee age 65 or older or for a Spouse age 65 or older of an active Employee where such Employee or such Spouse elects to have the Medicare program as the primary payor.
2. Under federal law if an active Employee under age 65 or an active Employee's Dependent under age 65 is covered under a group Plan of an employer with 100 or more employees and also has coverage under the Medicare program by reason of social security disability, the group Plan is the primary payor and Medicare is the secondary payor.
3. For persons under age 65 who are covered under this Plan and who also have coverage under the Medicare program solely by reason of end-stage renal disease, the Medicare program will be the primary payor and this Plan the secondary payor except that during the first 21-month period that such persons are eligible for Medicare Benefits solely by reason of end-stage renal disease, this Plan will be the primary payor and Medicare the secondary payor.
4. Effective August 10, 1993, if a person is eligible for or entitled to Medicare based on end-stage renal disease, the Medicare Program will be the secondary payor and this Plan will be the primary payor during the first 21 months of end-stage renal disease-based eligibility or entitlement or the portion of that period occurring after August 9, 1993, even if the person is also entitled to Medicare based on age or disability.
5. When this Plan is the primary payor, it will provide regular Benefits toward Covered Services. When this Plan is the secondary payor, it will provide Benefits not to exceed the difference between actual charges for services and the amount paid by Medicare (or the difference between the Medicare approved charge and the amount Medicare paid if assignment is accepted by the Physician).
6. In order for Claims Administrator to identify dual coverage situations and to determine whether primary or secondary payment should be made for a Member's claim, the Group agrees to provide all necessary information requested by Claims Administrator. The Group, as well as its employees and covered Dependents, is responsible for the accuracy of the information provided to Claims Administrator. Claims Administrator will not be responsible for any inaccurate information provided by the Group or the employees and Dependents covered under this Plan.
7. Effective August 5, 1997, if a person is eligible for or entitled to Medicare based on end-stage renal disease, the Medicare Program will be the secondary payor and this Plan will be the Primary Payor during the first 30 months of end-stage renal disease based on eligibility or entitlement (Special Note: This rule applies to individuals whose coordination period began on or after to March 1, 1996. The 30 month period does not apply to individuals

who reach their 21 month point, as outlined in Paragraph 4 above, on or before July 31, 1997. The Plan will only be the Primary Payor for a 21 month period for the aforementioned individuals.

P. Subrogation-Work Related

1. In order to provide Benefits and/or where Benefits have already been provided for Covered Services under the terms of the Plan for any injury, illness or condition for which a claim has been or will be pursued under any worker's compensation laws, which would otherwise be excluded under the Plan, an Accident Questionnaire must be completed and submitted by the Member or one authorized by law to act on the Member's behalf. Payments of any Benefits with notice to the worker's compensation carrier will allow Plan to be subrogated to and succeed to the rights of the Member for recovery against the employer or carrier. Nothing contained in this Section will be deemed to change, modify or vary the terms of the Coordination of Benefits section of the Plan.
2. Pursuant to the above provision, the Member agrees to provide Claims Administrator with prior notice of and opportunity to participate in any settlement of Member's claim and further agrees that, as a part of any worker's compensation settlement, Plan will be reimbursed in accordance with applicable laws for Benefits paid under the Plan.
3. Member will take such action, furnish such information and assistance and execute such papers as Claims Administrator may require to facilitate enforcement of the Plan's rights and will take no action prejudicing the rights and interest of the Plan.
4. The Member must immediately notify the Claims Administrator or any injury, illness or condition for which a claim has been or will be pursued under any applicable worker's compensation laws.

Q. Subrogation-Third Party

1. To the extent that Covered Services are reimbursed or paid under this Plan, the Plan will be subrogated and will succeed to the right of the applicable Member for the recovery of such payment or reimbursement against any person, organization or other carrier (except when such carrier provides benefits directly to a Member who is insured in which case the Coordination of Benefits provisions will apply). The acceptance of such payment or reimbursement hereunder will automatically result in such subrogation.
2. The Member will reimburse the Plan 100% of all amounts from the first dollar recovered by suit, settlement, or otherwise from any third party or his or its insurer to the extent of the payment or reimbursement under this Plan. The Plan will be entitled to such reimbursement even if the amount recovered by the Member is for, or is described as for, a partial or undifferentiated judgment or settlement, or for his damages other than health care expenses, or if the

Member is a minor. In addition, the Plan's right to 100% reimbursement from the first dollar received or recovered by Member will not be subject to any reduction as a result of any legal fees or expenses incurred by Member.

3. The Member will take such action, furnish such information and assistance, and execute such papers as the Claims Administrator may require to facilitate enforcement of the Plans' rights under this Section and will take no action prejudicing the rights and interest of the Plan hereunder. Nothing contained in this Section will be deemed to change, modify or vary the terms of the Coordination of Benefits provisions of this Plan.
4. The Claims Administrator, in its discretion, may require, as a condition of payment of benefits hereunder, that a subrogation questionnaire be completed by the Member or one authorized by law to act on the Member's behalf. In the event the Member is a minor, the Claims Administrator may require court approval of the Plan's subrogation right as a condition of the payment of any benefits. Payment of any Benefits will allow the Plan to be subrogated to and succeed to the right of the Member for the recovery against any person, organization, or carrier for the amount paid. Failure to obtain a completed subrogation questionnaire or to obtain any such court approval shall not be construed as a waiver of the Plan's right to subrogation.
5. In the event the Member pursues a claim or recovery for injury growing out of an act or omission, the Member must notify Claims Administrator immediately of such action.

R. Right of Recovery

Whenever any payment for Covered Services has been made by the Plan in an amount that exceeds the maximum Benefits available for such services under this Plan, or whenever payment has been made in error by the Plan for non-covered services, the Plan will have the right to recover such payment from the Member or, if applicable, the Provider. As an alternative, the Plan reserves the right to deduct from any pending claim for payment under this Plan any amounts the Member or Provider owes Plan.

S. Coverage in a Veterans Administration or Military Hospital

In any case in which a veteran is furnished care or services by the Veterans Administration for a non-service connected disability, the United States will have the right to recover or collect the reasonable cost of such care or services from the Plan to the extent the veteran would be eligible for Benefits for such care or services from the Plan if the care or services has been furnished by a Provider other than the Veterans Administration. The amount that the United States may recover will be reduced by the appropriate Deductible Amount and Co-payment amount. The intent of this provision is to comply with PL 99-272, section 19013.

The United States will have the right to collect from the Plan the reasonable cost of Inpatient Hospital care incurred by the United States on behalf of a military retiree or a military Dependent through a facility of the United States military to the extent that such retiree or Dependent would be eligible to receive reimbursement or indemnification from the Plan if the retiree or Dependent were to incur such cost on his or her own behalf. The amount that the United States may recover will be reduced by the appropriate Deductible Amount and Co-payment amount. The intent of this provision is to comply with PL 99-272, section 2001.

T. Inpatient Transfers

The Network Provider should notify Claims Administrator of all Inpatient transfers. The higher Benefit level will only be paid to an out-of-state Hospital or an in-state Non-Network Provider (Hospital) if the services cannot be provided by a Network Provider and are approved by the Claims Administrator.

U. Counting Creditable Coverage

1. Claims Administrator must reduce a Member's Pre-existing Condition exclusion period under this Plan by the number of days of a Member's prior creditable coverage. For the purposes of reducing the Pre-existing Condition exclusion period, Claims Administrator will determine the amount of creditable coverage by counting all the days that the individual has under one or more types of creditable coverage (If on a particular day an individual has creditable coverage from more than one source, all the creditable coverage on that day is counted as one day). Claims Administrator will use the information on the Member's Certification of Coverage to determine the prior creditable coverage.
2. The term creditable coverage means prior aggregate continuous coverage of a Member under any of the following:
  - a. A group health plan (including governmental and church plans).
  - b. Health insurance coverage (including group, individual and short-term, limited duration coverage).
  - c. Medicare and Medicaid.
  - d. CHAMPUS.
  - e. A Medical program of the Indian Health Services or a tribal organization.
  - f. A state health benefits risk pool for uninsurable individuals.
  - g. The Federal Employees Health Benefit Program.

- h. Plans established by state or local government to provide health insurance for enrolled individuals.
  - i. Health Plans offered by the Peace Corps.
  - j. State Children's Health Insurance Program.
  - k. Public health plans established by the Federal Government.
  - l. Public health plans established by foreign governments (National health care programs).
3. The term creditable coverage does not include coverage consisting solely of "excepted benefits." This type of coverage is never credited against the Pre-existing Condition exclusion period. A list of some of these coverages is provided below:
- a. Accident Insurance.
  - b. Disability income insurance.
  - c. Automobile liability insurance.
  - d. General liability insurance.
  - e. Medical benefits that are a supplement to liability insurance.
  - f. Workers' Compensation.
  - g. Credit Insurance.
  - h. Coverage through clinics operated in workplaces by employers.
  - i. Limited scope vision and dental benefits, and long term care benefits may be "excepted benefits" if they are not an integral part of a group health plan. Benefits are not integral if:
    - (1) an individual has the right to elect not to receive coverage for the benefits, and
    - (2) the individual pays an extra premium contribution if they elect coverage under the benefits.
    - (3) Dental benefits are provided under a separate policy, contract or rider from the general medical benefits under the group health plan. Additionally, the benefits must be limited to

narrowly defined services that are generally excluded from the general medical or surgical benefits.

- (4) Long term care benefits are provided under long term care insurance that is regulated by the State or that meet the requirements of the Internal Revenue Code.
- j. Benefits that are not coordinated with health insurance. These types of policies include specified or dread disease policies, hospital indemnity policies, Medicare supplemental insurance and insurance that supplements CHAMPUS.
4. Claims Administrator does not have to count an individual's days of creditable coverage that occur before a significant break in coverage. A significant break in coverage means a period of 63 consecutive days or more in which the individual does not have any creditable coverage. A probationary period or an affiliation period is not taken into account in determining a significant break in coverage.
5. Claims Administrator will not count any days in a probationary period for a plan or policy as creditable coverage.
6. Under the Law, a second COBRA election period may be required for trade assistance act eligible individuals and their dependents. When such a second COBRA enrollment period is provided, the time between a certified trade assistance act related loss in coverage and the start of the second election period will not be counted for the purposes of determining whether the individual has had a significant break in coverage which is defined as a 63 day loss in coverage.
7. At any time, if a Member believes that he or she has creditable coverage that might reduce the Pre-existing Condition exclusion period under this Plan , he or she can submit at any time a Certification of Creditable Coverage (hereinafter Certificate) or other evidence of creditable coverage to the Plan. The Plan will review the Certificate or other evidence of prior creditable coverage and determine within a reasonable time period the number of days of prior creditable coverage as well as the time period which is reduced from the Member's Pre-existing Condition exclusion period.

#### V. Certification of Coverage

1. A Member will utilize the Certification of Coverage (hereinafter Certificate) to demonstrate prior creditable coverage for a new group health plan. Claims Administrator will issue a Certificate to a Member in accordance with the following provisions:

- (a) The Member experiences a loss of coverage under the Plan. Claims Administrator will issue a certificate within a reasonable time period after Claims Administrator has notice that the Member has had a loss of coverage.
  - (b) The Member requests a Certificate within 24 months after his or her coverage under the Plan ceases. Claims Administrator will issue the Certificate within a reasonable time period after Claims Administrator receives the request from the Member or another designated party, if authorized by the Member. The Member may request a Certificate by contacting the Group Benefits Office.
  - (c) The Member exhausts the Lifetime Maximum Benefits under this Plan.
- 2. Claims Administrator is not required to issue a Certificate that was provided by another party, the Group or another carrier.
  - 3. Claims Administrator is not required to automatically issue a Certificate when the Group replaces this Plan with the coverage of another carrier.
  - 4. Claims Administrator is not required to issue a Certificate when the Member changes plan options offered by the Group.

W. BlueCard Program

- 1. The BlueCard Program applies to Members receiving Covered Services outside of the Blue Cross & Blue Shield of Mississippi service area. Benefits for these Covered Services will be based on the lower Benefit level (Non-Network) if the Member fails to comply with the provisions of the Plan dealing with Non-Network Providers (in-state or out-of-state). These provisions are addressed in the Schedule of Benefits and the General Provision sections of the Plan.
- 2. When a Member obtains health care services through the BlueCard Program outside the Blue Cross & Blue Shield of Mississippi service area, the Member's liability for Covered Services is usually calculated on the lower of:
  - a. The actual Billed Charges for the Member's Covered Services, or
  - b. The negotiated price that the out-of-state Blue Cross and/or Blue Shield Plan passes on to Blue Cross & Blue Shield of Mississippi.
- 3. The "negotiated price" may represent either:
  - a. a simple discount, or

- b. an estimated final price that factors in expected settlements or other non-claims transactions with the Member's Provider or with a specified group of Providers, or
- c. a discount from Billed Charges for Covered Services that reflects average expected savings.

The estimated or average price may be adjusted in the future to correct for over or under estimation of past prices.

- 4. In addition, laws in a small number of states other than Mississippi require Blue Cross and/or Blue Shield Plans to use a basis for calculating the Member's liability for Covered Services that does not reflect the entire savings realized or expected to be realized on a particular claim. When a Member receives covered health care services in these other states, his or her liability for Covered Services will be calculated using their statutory methods.
- 5. Due to the benefit design of the out-of-state Blue Cross and/or Blue Shield Plan, Benefits for Covered Services may vary when the Member obtains health care services through the Blue Card Program.

#### X. Provider Network Directory

The Member may request a copy of the Network Provider Directory by visiting Claims Administrator's web site at [www.bcbsms.com](http://www.bcbsms.com) or by contacting Claims Administrator's Customer Service Department. This directory includes Physicians, Hospitals, and Allied Providers that have a business agreement with Claims Administrator. This directory will be provided at no charge to the Member.

#### Y. Qualified Medical Child Support Orders

The Omnibus Budget Reconciliation Act of 1993 (OBRA 93) mandates that group health plans provide Benefits according to Qualified Medical Child Support Order (QMCSO) requirements. QMCSO's are judgements, decrees, or court orders that create or recognize a child's right to receive benefits under a group health plan. QMCSO's must contain:

- 1. The name and last known address of the participant and each covered by the order;
- 2. Type of coverage the group will provide to each child;
- 3. The period of time that the order covers; and
- 4. Each plan (medical, dental)

The Member may request from the Group the written procedures for QMCSO. This information is available at no charge to the Member.

Z. Member's Change of Address

The Member must ensure that his or her current address is provided to Plan Administrator. In the event, the Member's address changes, he or she must immediately provide notification of the new address to Plan Administrator.

AA. Agent's Limitation of Authority

The agent has no authority to interpret, waive, alter or change the Plan or any of its provisions. If the Member has any questions, including contract terms, coverage or Benefit questions, the Member should contact Claims Administrator. The agent has no authority to bind Claims Administrator with any answer he or she may give.

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