Penn Medicine
Lancaster General Health

LG SELECT/LG CONSUMER
EMPLOYEE HEALTH BENEFIT PROGRAM

PLAN DOCUMENT

AND

SUMMARY PLAN DESCRIPTION

Effective Date
February 1, 2024

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SUMMARY PLAN DESCRIPTION

Name of Plan:

LG Select/LG Consumer Employee Health Benefit Program (***Plan***)

Name, Address and Phone Number of Employer/Plan Sponsor:

Lancaster General Health
555 North Duke Street
P.O. Box 3555
Lancaster, PA 17604-3555
717-544-5511

Employer Identification Number:

23-2250941

Plan Number:

501

Group Number:

71-5942S

Type of Plan:

Welfare Benefit Plan: medical, behavioral health and prescription drug benefits

Type of Administration:

Contract administration: The processing of claims for benefits under the terms of the ***Plan*** is provided through one or more companies contracted by the ***employer*** and shall hereinafter be referred to as the ***Claims Processor***.

Name, Address and Phone Number of Plan Administrator, Fiduciary, and Agent for Service of Legal Process:

Chief Human Resources Officer
Lancaster General Health
555 North Duke Street
P.O. Box 3555
Lancaster, PA 17604-3555
717-544-5511

Legal process may be served upon the ***Plan Administrator***.

Eligibility Requirements:

For detailed information regarding a person's eligibility to participate in the ***Plan***, refer to the following section:
Eligibility, Enrollment and Effective Date

For detailed information regarding a person being ineligible for benefits through reaching ***maximum benefit*** levels, termination of coverage or ***Plan*** exclusions, refer to the following sections:
Schedule of Benefits

Termination of Coverage
Plan Exclusions

Source of Plan Contributions:

Contributions for ***Plan*** expenses are obtained from the ***employer*** and from enrolled ***employees***. The ***employer*** evaluates the costs of the ***Plan*** based on projected ***Plan*** expenses and determines the amount to be contributed by the ***employer*** and the amount to be contributed by the enrolled ***employees***. Contributions by the enrolled ***employees*** are deducted from their pay on a pre-tax basis as authorized (unless otherwise directed) by the ***employee*** on the enrollment form (whether paper or electronic) or other applicable forms.

Funding Method:

The ***employer*** pays ***Plan*** benefits and administration expenses directly from general assets. Contributions received from ***enrolled individuals*** are used to cover ***Plan*** costs and are expended immediately.

Procedures for Filing Claims:

For detailed information on how to submit a claim for benefits, or how to file an appeal on a processed claim, refer to the section entitled, *Health Benefit Claim Filing Procedure*.

The designated ***Claims Processor*** for health benefit (excluding behavioral health) claims is:

Capital Blue Cross
P.O. Box 772531
Harrisburg, PA 17177

The designated ***Claims Processor*** for behavioral health claims is:

Quest
P.O. Box 565
Arnold, MD 21012

Except as otherwise provided herein, the designated ***Claims Processor*** for claims and benefits under the *Prescription Drug Program* is:

Liviniti
411 Bienville St
Natchitoches, LA 71457

Statement of ERISA Rights:

Participants in the ***Plan*** are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA). ERISA provides that all participants shall be entitled to:

1. Examine, without charge, at the ***Plan Administrator's*** office and at other specified locations, such as worksites and union halls, all documents governing the ***Plan***, including insurance contracts and collective bargaining agreements and a copy of the latest annual report (Form 5500 Series) filed by the ***Plan*** with the U.S. Department of Labor, if applicable.

2. Obtain, upon written request to the ***Plan Administrator***, copies of documents governing the operation of the ***Plan***, including insurance contracts and collective bargaining agreements and copies of the latest annual report (Form 5500 Series) and updated summary plan description, if applicable. The ***Plan Administrator*** may make a reasonable charge for the copies.

3. Receive a summary of the ***Plan's*** annual financial report. The ***Plan Administrator*** is required by law to furnish each participant with a copy of this summary annual report, if applicable.

4. Continue health care coverage for the participant, the participant's spouse or ***dependents*** if there is a loss of coverage under the ***Plan*** as the result of a qualifying event. The participant or ***dependent*** may have to pay for such coverage. Review this summary plan description and the documents governing the ***Plan*** on the rules governing COBRA continuation coverage rights.

In addition to creating rights for ***covered person***s, ERISA imposes obligations upon the people who are responsible for the operation of the ***Plan***. The people who operate the ***Plan***, called "fiduciaries" of the ***Plan***, have a duty to do so prudently and in the interest of all ***covered person***s.

No one, including the ***employer*** or any other person, may fire an ***employee*** or discriminate against an ***employee*** to prevent the ***employee*** from obtaining any benefit under the ***Plan*** or exercising their rights under ERISA.

If claims for benefits under the ***Plan*** are denied, in whole or in part, the participant must receive a written explanation of the reason for the denial. The participant has the right to have the ***Plan*** review and reconsider the claim.

Under ERISA, there are steps participants can take to enforce their rights. For instance, if material is requested from the ***Plan*** and the material is not received within thirty (30) days, the participant may file suit in a federal court. In such case, the court may require the ***Plan Administrator*** to provide the materials and pay the participant up to $110 a day until the materials are received, unless the materials were not provided for reasons beyond the control of the ***Plan Administrator***. If a claim for benefits is denied or ignored in whole or in part and after exhaustion of all administrative remedies, the participant may file suit in a state or federal court.

If it should happen that ***Plan*** fiduciaries misuse the ***Plan's*** money, or if participants are discriminated against for asserting their rights, participants may seek assistance from the U.S. Department of Labor, or may file suit in a federal court. The court will decide who will pay the costs and legal fees. If the participant is successful, the court may order the person who is sued to pay these costs and fees. If the participant loses, the court may order the participant to pay the costs and fees; for example, if it finds the participant's claim frivolous.

Participants should contact the ***Plan Administrator*** for questions about the ***Plan***. For questions about this statement or about rights under ERISA, participants should contact the nearest office of the Employee Benefits Security Administration, U.S. Department of Labor listed in their telephone directory or the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue, N.W., Washington, D.C. 20210.

SCHEDULE OF BENEFITS

The following *Schedule of Benefits* is designed as a quick reference. For complete provisions of the ***Plan's*** benefits, refer to the following sections: *Health Benefit Claim Filing Procedure, Health Benefits, Medical Exclusions, Prescription Drug Program, Plan Exclusions* and *Preferred Provider or Nonpreferred Provider*.

LG Select Plan Health Benefits	
Maximum Benefit Per Enrolled Individual While Enrolled In This Plan For:	
Fertility Services – Medical and Prescription Drug Combined	$30,000
Maximum Benefit Per Enrolled Individual Per Plan Year For:	
Extended Care Facility	180 Days
Maximum Benefit Per Enrolled Individual Every Five (5) Years For:	
Non-Medically Necessary Foot Orthotics (Employees Only)	1 Pair
Maximum Benefit Per Transplant:	
Donor Screening Tests	$10,000
Travel Expenses	$10,000
Maximum Benefit Every Three Plan Years:	
Hearing Aids (maximum applies to left and right combined, excludes exam)	$2,500

	Tier 1	***Tier 2***	***Nonpreferred Provider***
Deductible Per Plan Year:			
Individual	$250	$750	$900
Family Member	$250	$750	$900
Family Cumulative (Embedded)	$500	$1,500	$1,800
Medical/Prescription Drug Out-of-Pocket Expense Limit Per Plan Year: Individual	$1,500	$3,750	$6,400
Family Member	$1,500	$3,750	$6,400
Family Cumulative (Embedded)	$3,000	$7,500	$12,800

Refer to *Health Benefits, Out-of-Pocket Expense Limit* for a listing of charges not applicable to the out-of-pocket expense limit. Amounts applied toward satisfaction of any deductible or out-of-pocket expense limit may also be applied toward satisfaction of all other deductibles and out-of-pocket expense limits.

Coinsurance:

The ***Plan*** pays the percentage listed on the following pages for ***covered expenses incurred*** by an ***enrolled individual*** during a plan year after the individual or family deductible has been satisfied and until the individual or family out-of-pocket expense limit has been reached. Thereafter, the ***Plan*** pays one hundred percent (100%) of ***covered expenses*** for the remainder of the plan year or until the ***maximum benefit*** has been reached. Refer to *Health Benefits, Out-of-Pocket Expense Limit,* for a listing of charges not applicable to the one hundred percent (100%) ***coinsurance***.

BENEFIT DESCRIPTION	***Tier 1*** (% of ***negotiated rate***, if applicable)	***Tier 2*** (% of ***negotiated rate***, if applicable)	***Nonpreferred Provider*** (% of the ***allowable amount***)
Inpatient Hospital (Facility Expense Only) Copay waived if admitted through emergency room. Tier 1 copay waived for re-admission within 90 days. Pre-certification required.	100% (after $200 copay per admission)	*80% (after $5,000 copay per admission for certain stays)	*60%
Preadmission Testing (Facility Expense Only)	100%	*80%	*60%
Outpatient Surgery/Ambulatory Surgical Facility	100%	*80%	*60%
Emergency Room Services			
Emergency Care	*80%	*80%	*80%
Non-Emergency Care	*80%	*80%	*80%
Urgent Care Center	100% (after $30 copay)	100% (after $50 copay)	100% (after $50 copay)
Retail Health Clinic Visit	100% (after $15 copay)	100% (after $40 copay)	*60%
e-Visit	100% (after $20 copay)	100% (after $20 copay)	*60%
Telemedicine Benefit through Penn Medicine OnDemand For Employees and Dependents age 14+ Contact Penn Medicine OnDemand for certain approved conditions/symptoms at 215-615-2222.	100%	N/A	N/A
Ambulance Services	*90%	*90%	*90%
Physician Services			
Office Visit/Virtual Visit			
Personal Family Physician	100% (after $15 copay)	100% (after $40 copay)	*60%
Specialist Physician	100% (after $30 copay)	100% (after $50 copay)	*60%
Inpatient Visit / Outpatient Visit	*90%	*80%	*60%
Surgery			
Inpatient	*90%	*80%	*60%
Ambulatory or Surgical Center	*90%	*80%	*60%
In Physician's Office	*90%	*80%	*60%
Allergy Injections	*90%	*80%	*60%
Pathology			
Inpatient	100%	*80%	*60%
Outpatient	100%	*80%	*60%
Pre-certification may be required. Expenses incurred by an out-of-network pathologist rendering services at a Tier 1 or Tier 2 facility will be considered as if participating with that Tier's network but provider may balance bill.			

*** After Deductible**

BENEFIT DESCRIPTION	***Tier 1*** (% of ***negotiated rate***, if applicable)	***Tier 2*** (% of ***negotiated rate***, if applicable)	***Nonpreferred Provider*** (% of the ***allowable amount***)
Physician Services (continued)			
Anesthesiology			
Inpatient	*100%	*80%	*60%
Outpatient	*90%	*80%	*60%
Nurse Anesthetist	100%	*N/A*	*N/A*
Expenses incurred by an out-of-network anesthesiologist rendering services at a Tier 1 or Tier 2 facility will be considered as if participating with that Tier's network but may be balance billed by provider.			
Radiology (Pre-certification may be required)			
Inpatient and Outpatient			
Expenses incurred by an out-of-network radiologist rendering services at a Tier 1 or Tier 2 facility will be considered as if participating with that Tier's network but provider may balance bill.	100%	*80%	*60%
Diagnostic Services and Supplies			
Inpatient	100%	*80%	*60%
Outpatient Tier 2 and Non-Preferred Provider - Pre-authorization may apply to advanced imaging services.	100%	100% (lab and x-rays) 90% (advanced imaging)	*60%
Independent Lab	Not Available	*80%	*60%
Second Surgical Opinion	100% (after $30 copay)	100% (after $50 copay)	*60%
Vaccinations (Non-Travel, Non-Employment Related) Includes flu, COVID-19, pneumonia, and shingles shots. Non-Preferred Provider – COVID-19 and flu shots/mist covered 100%.	100%	100%	*60%
Well Child Care Limitation: one (1) visit per ***plan*** year through age 18.	100%	100%	*60%
Routine Preventive Care Limitation: one (1) visit per ***plan*** year age 19 and over.	100%	100%	*60%
Women's Preventive Services Limitation: one (1) pap test per ***plan*** year.	100%	100%	*60%
Routine Mammograms Limitation: through age 39 - one (1) mammogram ***maximum benefit*** while enrolled in this ***Plan;*** age 40 and over - one (1) mammogram ***maximum benefit*** per plan year.	100%	100%	*60%

*** After Deductible**

BENEFIT DESCRIPTION	***Tier 1*** (% of ***negotiated rate***, if applicable)	***Tier 2*** (% of ***negotiated rate***, if applicable)	***Nonpreferred Provider*** (% of the ***allowable amount***)
Routine Prostate Examination Limitation: one (1) per ***plan*** year.	100%	100%	*60%
Routine Sigmoidoscopy Limitation: one (1) exam ***maximum benefit*** every 5 years age 50 and over.	100%	100%	*60%
Routine Colonoscopy Limitation: one (1) exam ***maximum benefit*** every 10 years age 45 and over.	100%	100%	*60%
Extended Care Facility Limitation: 180 days ***maximum benefit*** per ***plan*** year Pre-certification required.	*90%	*80%	*60%
Home Health Care Pre-certification required.	*90%	*80%	*60%
Hospice Care Pre-certification required.	*90%	*80%	*60%
Durable Medical Equipment Durable medical equipment rental and any purchase or repair in excess of $500 is subject to pre-certification. Failure to pre-certify results in $100 penalty.	*90%	*80%	*60%
Corrective Appliance Pre-certification required.	*90%	*80%	*60%
Hearing Aid Up to $2,500 for left and right combined every three years, excludes exam.	100%	100%	100%
Non-Medically Necessary Foot Orthotics Limitation: one (1) pair ***maximum benefit*** every 5 years for employees only.	100%	100%	100%
Human Organ Transplant Limitation per transplant: $10,000 ***maximum benefit*** for donor screening tests. $10,000 ***maximum benefit*** for travel expenses. Pre-certification required.	*90%	*80%	Not Covered
Outpatient Therapy Services			
Physical, Occupational and Speech Therapies	90%	*80%	*60%
Respiratory Therapy	90%	*80%	*60%
Radiation Therapy and Chemotherapy Initial notification requested	100%	*80%	*60%
Cardiac/Pulmonary Rehabilitation Therapy	*90%	*80%	*60%
Dialysis	*90%	*80%	Not Covered
Acupuncture Limitation: 20 visits per plan year	80%	*80%	*60%
Massage Therapy	80%	*80%	*60%
KneeKG	90%	*N/A*	*N/A*

***After Deductible**

BENEFIT DESCRIPTION	***Tier 1*** (% of ***negotiated rate***, if applicable)	***Tier 2*** (% of ***negotiated rate***, if applicable)	***Nonpreferred Provider*** (% of the ***allowable amount***)
Proton & Car-T Cellular Therapies (Pre-certification required)			
Office Visit	100% (after $20 copay)	100% (after $50 copay)	Not Covered
Inpatient and Outpatient[1]	100%	*80% (after $500 copay)	Not Covered
All Other Eligible Outpatient Therapies	*90%	*80%	*60%
Birthing Center	100%	*80%	*60%
Wigs	100%	100%	100%
Podiatry Office Visit	100% (after $30 copay)	100% (after $50 copay)	*60%
Hyperalimentation or Total Parenteral Nutrition (TPN)	*90%	*80%	*60%
Outpatient Lactation Counseling	100%	100%	*60%
Nutritional Counseling	100%	100%	*60%
Personal Family Physician	(after $15 copay)	(after $40 copay)	
Specialist Physician	100% (after $30 copay)	100% (after $50 copay)	*60%
Dietitian and Nutritionist	100%	100%	*60%
HealthWorks Clinic Wellness visits and primary care, same day appointments, medications, and virtual visits.	100%	*N/A*	*N/A*
Bariatric Surgery Pre-certification required.	100%	*80% (after $2,500 copay)	*N/A*
WW Reimbursement Limitation: New Onsite Member up to $100 reimbursement per plan year. Returning Onsite Member up to $75 reimbursement per plan year. Offsite Member up to $140 per plan year.	*Annual Registration Fee*	*N/A*	*N/A*
Diabetic Care	*90%	*80%	*60%
Diabetes Outpatient Self-Management Training and Education			
Personal Family Physician	100% (after $15 copay)	100% (after $40 copay)	*60%
Specialist Physician	100% (after $30 copay)	100% (after $50 copay)	*60%
Dietitians and Nutritionists	100%	100%	*60%
Pediatric Medical Foods	*90%	*80%	*60%
Group Health Education Courses Limitation: For information on the classes offered at Lancaster General Health visit www.LGHealth.org and click on Classes & Events.	100%^	*N/A*	*N/A*

*** After Deductible**

^ Applicable only to approved Group Health Education Courses

[1] Tier 2 coverage must be rendered at a Center of Excellence. There is no coverage for other Tier 2 providers.

BENEFIT DESCRIPTION	***Tier 1*** (% of ***negotiated rate***, if applicable)	***Tier 2*** (% of ***negotiated rate***, if applicable)	***Nonpreferred Provider*** (% of the ***allowable amount***)
Private Duty Nursing Pre-certification required.	*90%	*80%	*60%
Fertility Services Limitation: $30,000 ***maximum benefit*** while covered by the ***Plan*** *(Tier 1 benefits based on service provider; benefit determined by place of service).*	*90%	Not Covered	Not Covered
Specialty Drugs Administered as Inpatient, in a Physician's Office or Outpatient Facility	100%	*60%	Not Covered
Medication Management Certain specialty medications prescribed by LGH primary care or specialty practices may be eligible for medication management and education.	100%	Not Covered	Not Covered
All Other Covered Expenses	*90%	*80%	*60%

*** After Deductible**

Prescription Drug Program					
Select Plan					
	LGH Convenience Pharmacy	Other Pharmacy	LGH Convenience Mail Order	Postal Prescription Services Mail Order	Important Information
	Up to 30-day supply		Up to 31-90 day supply		
Generic Drugs	$5 copay	$15 copay	$10 copay	$30 copay	Contact Liviniti for prescription plan details Retail drugs – one copay per prescription for a 30-day supply Mail order drugs – one copay for a 31-90 day supply per prescription Copays do not apply to preventive medications (e.g., generic contraceptives, prescribed aspirin and fluoride) These copay amounts do not apply to drugs eligible for the Variable Copay Program
Generic Hypertension Drugs	$0 copay	$15 copay	$0 copay		
Generic Hyperlipidemia Drugs	$0 copay	$15 copay	$0 copay		
Preferred Brand Name Drugs	$15 copay	$45 copay	$30 copay	$90 copay	
Non-Preferred Brand Name Drugs	$30 copay	$75 copay	$60 copay	$150 copay	
Specialty Drugs	$0 copay	N/A			

Refer to *Prescription Drug Program* for complete details.

SCHEDULE OF BENEFITS

The following *Schedule of Benefits* is designed as a quick reference. For complete provisions of the ***Plan's*** benefits, refer to the following sections: *Health Benefit Claim Filing Procedure, Health Benefits, Medical Exclusions, Prescription Drug Program, Plan Exclusions* and *Preferred Provider or Nonpreferred Provider*.

LG Consumer Plan Health Benefits	
Maximum Benefit Per Enrolled Individual While Enrolled In This Plan For:	
Fertility Services – Medical and Prescription Drug Combined	$30,000
Maximum Benefit Per Enrolled Individual Per Plan Year For:	
Extended Care Facility	180 Days
Maximum Benefit Per Enrolled Individual Every Five (5) Years For:	
Non-Medically Necessary Foot Orthotics (Employees Only)	1 Pair
Maximum Benefit Per Transplant:	
Donor Screening Tests	$10,000
Travel Expenses	$10,000
Maximum Benefit Every Three Plan Years:	
Hearing Aids (maximum applies to left and right combined, excludes exam)	$2,500

	Tier 1	***Tier 2***	***Nonpreferred Provider***
Deductible Per Plan Year:			
Individual	$2,000		
Family Member	$3,000		
Family Cumulative (Embedded)	$4,000		
Medical/Prescription Drug Out-of-Pocket Expense Limit Per Plan Year:			
Individual	$4,000		$6,000
Family Member	$4,000		$6,000
Family Cumulative (Embedded)	$8,000		$12,000

Refer to *Health Benefits, Out-of-Pocket Expense Limit* for a listing of charges not applicable to the out-of-pocket expense limit. Amounts applied toward satisfaction of any deductible or out-of-pocket expense limit may also be applied toward satisfaction of all other deductibles and out-of-pocket expense limits.

Coinsurance:

The ***Plan*** pays the percentage listed on the following pages for ***covered expenses incurred*** by an ***enrolled individual*** during a plan year after the individual or family deductible has been satisfied and until the individual or family out-of-pocket expense limit has been reached. Thereafter, the ***Plan*** pays one hundred percent (100%) of ***covered expenses*** for the remainder of the plan year or until the ***maximum benefit*** has been reached. Refer to *Health Benefits, Out-of-Pocket Expense Limit*, for a listing of charges not applicable to the one hundred percent (100%) ***coinsurance***.

BENEFIT DESCRIPTION	*Tier 1* (% of ***negotiated rate***, if applicable)	*Tier 2* (% of ***negotiated rate***, if applicable))	*Nonpreferred Provider* (% of the ***allowable amount***)
Inpatient Hospital (Facility Expense Only) Tier 2 copay waived if admitted through emergency room. Pre-certification required.	*90%	*90% (after $5,000 copay per admission for certain stays)	*60%
Preadmission Testing (Facility Expense Only)	*100%	*100%	*60%
Outpatient Surgery/Ambulatory Surgical Facility	*100%	*100%	*60%
Emergency Room Services			
Emergency Care	*80%	*80%	*80%
Non-Emergency Care	*80%	*80%	*80%
Urgent Care Center	*90%	*90%	*90%
Retail Health Clinic Visit	*90%	*90%	*90%
e-Visit	*100% (after $20 copay)	*100% (after $20 copay)	*60%
Telemedicine Benefit through Penn Medicine OnDemand For Employees and Dependents age 14+ Contact Penn Medicine OnDemand for certain approved conditions/symptoms at 215-615-2222.	$49 copay until deductible is met; *$20 copay after deductible is met	N/A	N/A
Ambulance Services	*90%	*90%	*90%
Physician Services Office Visit/Virtual Visit			
Personal Family Physician	*100% (after $20 copay)	*100% (after $20 copay)	*60%
Specialist Physician	*100% (after $35 copay)	*100% (after $35 copay)	*60%
Inpatient Visit / Outpatient Visit	*90%	*90%	*60%
Surgery			
Inpatient	*90%	*90%	*60%
Ambulatory or Surgical Center	*100%	*100%	*60%
In Physician's Office	*90%	*90%	*60%
Allergy Injections	*90%	*90%	*60%
Pathology			
Inpatient	*90%	*90%	*60%
Outpatient	*100%	*90%	*60%
Pre-certification may be required. Expenses incurred by an out-of-network pathologist rendering services at a Tier 1 or Tier 2 facility will be considered as if participating with that Tier's network but provider may balance bill.			

*** After Deductible**

BENEFIT DESCRIPTION	***Tier 1*** (% of ***negotiated rate***, if applicable)	***Tier 2*** (% of ***negotiated rate***, if applicable)	***Nonpreferred Provider*** (% of the ***allowable amount***)
Physician Services (continued)			
Anesthesiology			
Inpatient	*90%	*90%	*60%
Outpatient	*100%	*100%	*60%
Nurse Anesthetist	*100%	N/A	N/A
Expenses incurred by an out-of-network anesthesiologist rendering services at a Tier 1 or Tier 2 facility will be considered as if participating with that Tier's network but may be balance billed by provider.			
Radiology (Pre-certification may be required)			
Inpatient	*100%	*90%	*60%
Outpatient	*100%	*90%	*60%
Expenses incurred by an out-of-network radiologist rendering services at a Tier 1 or Tier 2 facility will be considered as if participating with that Tier's network but provider may balance bill.			
Diagnostic Services and Supplies			
Inpatient	*90%	*90%	*60%
Outpatient Tier 2 and Non-Preferred Provider - Pre-authorization may apply to advanced imaging services.	*100%	*100% (lab and x-rays) *90% (advanced imaging)	*60%
Independent Lab	Not Available	*90%	*60%
Second Surgical Opinion	*100% (after $35 copay)	*100% (after $35 copay)	*60%
Vaccinations (Non-Travel, Non-Employment Related) Includes flu, COVID-19, pneumonia, and shingles shots. Non-Preferred Provider–COVID-19 and flu shots/mist covered 100%.	100%	100%	*60%
Well Child Care Limitation: one (1) visit per ***plan*** year through age 18.	100%	100%	*60%
Routine Preventive Care Limitation: one (1) visit per ***plan*** year age 19 and over.	100%	100%	*60%
Women's Preventive Services Limitation: one (1) pap test per ***plan*** year.	100%	100%	*60%
Routine Mammograms Limitation: through age 39 - one (1) mammogram ***maximum benefit*** while enrolled in this ***Plan;*** age 40 and over - one (1) mammogram ***maximum benefit*** per ***plan*** year.	100%	100%	*60%

* **After Deductible**

BENEFIT DESCRIPTION	***Tier 1*** (% of ***negotiated rate***, if applicable)	***Tier 2*** (% of ***negotiated rate***, if applicable)	***Nonpreferred Provider*** (% of the ***allowable amount***)
Routine Prostate Examination Limitation: one (1) per ***plan*** year.	100%	100%	*60%
Routine Sigmoidoscopy Limitation: one (1) exam ***maximum benefit*** every 5 years age 50 and over.	100%	100%	*60%
Routine Colonoscopy Limitation: one (1) exam ***maximum benefit*** every 10 years age 45 and over.	100%	100%	*60%
Extended Care Facility Limitation: 180 days ***maximum benefit*** per plan year. Pre-certification required.	*90%	*90%	*60%
Home Health Care Pre-certification required.	*90%	*90%	*60%
Hospice Care Pre-certification required.	*90%	*90%	*60%
Durable Medical Equipment Durable medical equipment rental and any purchase or repair in excess of $500 is subject to pre-certification. Failure to pre-certify results in $100 penalty.	*90%	*90%	*60%
Corrective Appliance Pre-certification required.	*90%	*90%	*60%
Hearing Aid Up to $2,500 for left and right combined every three years, excludes exam.	*100%	*100%	*100%
Non-Medically Necessary Foot Orthotics Limitation: one (1) pair ***maximum benefit*** every 5 years for employees only.	*100%	*100%	*100%
Human Organ Transplant Limitation per transplant: $10,000 ***maximum benefit*** for donor screening tests. $10,000 ***maximum benefit*** for travel expenses. Pre-certification required.	*90%	*90%	Not Covered
Outpatient Therapy Services			
Physical, Occupational and Speech Therapies	*90%	*90%	*60%
Respiratory Therapy	*90%	*90%	*60%
Radiation Therapy and Chemotherapy Initial notification requested.	*90%	*90%	*60%
Cardiac/Pulmonary Rehabilitation Therapy	*90%	*90%	*60%
Dialysis	*90%	*90%	Not Covered
Acupuncture Limitation: 20 visits per ***plan*** year.	*80%	*80%	*60%
Massage Therapy	*80%	*80%	*60%
KneeKG	*90%	Not Covered	Not Covered

*** After deductible**

BENEFIT DESCRIPTION	***Tier 1*** (% of ***negotiated rate***, if applicable)	***Tier 2*** (% of ***negotiated rate***, if applicable)	***Nonpreferred Provider*** (% of the ***allowable amount***)
Proton & Car-T Cellular Therapies (Pre-certification required)			
Office Visit	*100% (after $20 copay)	*100% (after $50 copay)	Not Covered
Inpatient and Outpatient[1]	*100%	*80% (after $500 copay)	Not Covered
All Other Eligible Outpatient Therapies	*90%	*90%	*60%
Birthing Center	*90%	*90%	*60%
Wigs	*100%	*100%	*100%
Podiatry Office Visit	*100% (after $35 copay)	*100% (after $35 copay)	*60%
Hyperalimentation or Total Parenteral Nutrition (TPN)	*90%	*90%	*60%
Outpatient Lactation Counseling	100%	100%	*60%
Nutritional Counseling			
Personal Family Physician	*100% (after $20 copay)	*100% (after $20 copay)	*60%
Specialist Physician	*100% (after $35 copay)	*100% (after $35 copay)	*60%
Dietitian and Nutritionist	*90%	*90%	*60%
HealthWorks Clinic Wellness visits and primary care, same day appointments, medications, and virtual visits.	$99 copay until deductible is met, then 100%	*N/A*	*N/A*
Bariatric Surgery Pre-certification required.	*100%	*90% after $2,500 copay	*N/A*
WW Reimbursement Limitation: New Onsite Member up to $100 reimbursement per plan year. Returning Onsite Member up to $75 reimbursement per plan year. Offsite Member up to $140 per plan year.	*Annual Registration Fee*	*N/A*	*N/A*
Diabetic Care	*90%	*90%	*60%
Diabetes Outpatient Self-Management Training and Education			
Personal Family Physician	*100% (after $20 copay)	*100% (after $20 copay)	*60%
Specialist Physician	*100% (after $35 copay)	*100% (after $35 copay)	*60%
Dietitians and Nutritionists	*100%	*100%	*60%
Pediatric Medical Foods	*90%	*90%	*60%
Group Health Education Courses Limitation: For information on the classes offered at Lancaster General Health visit www.LGHealth.org and click on Classes & Events.	*100%^	*N/A*	*N/A*

***** **After Deductible**

^ **Applicable only to approved Group Health Education Courses**

1 **Tier 2 coverage must be rendered at a Center of Excellence. There is no coverage for other Tier 2 providers.**

BENEFIT DESCRIPTION	***Tier 1*** (% of ***negotiated rate***, if applicable)	***Tier 2*** (% of ***negotiated rate***, if applicable)	***Nonpreferred Provider*** (% of the ***allowable amount***)
Private Duty Nursing Pre-certification required	*90%	*90%	*60%
Fertility Services Limitation: $30,000 ***maximum benefit*** while covered by the ***Plan*** *(Tier 1 benefits based on service provider; benefit determined by place of service).*	*90%	Not Covered	Not Covered
Specialty Drugs Administered as Inpatient, in a Physician's Office or Outpatient Facility	*60%	*60%	Not Covered
Medication Management Certain specialty medications prescribed by LGH primary care or specialty practices may be eligible for medication management and education.	*100%	Not Covered	Not Covered
All Other Covered Expenses	*90%	*90%	*60%

***** **After Deductible**

Prescription Drug Program

Consumer Plan					
	LGH Convenience Pharmacy	Other Pharmacy	LGH Convenience Mail Order	Postal Prescription Services Mail Order	Important Information
	Up to 30-day supply		Up to 31-90 day supply		
Generic Drugs	*$5 copay	*$15 copay	*$10 copay	*$30 copay	Contact Liviniti for prescription plan details Retail drugs – one copay per prescription for a 30-day supply after annual deductible Mail order drugs – one copay for a 31-90 day supply per prescription after annual deductible Copays and deductible do not apply to preventive medications (e.g., generic contraceptives, prescribed aspirin and fluoride) These copay amounts do not apply to drugs eligible for the Variable Copay Program
Generic Hypertension Drugs	*$0 copay	*$15 copay	*$0 copay		
Generic Hyperlipidemia Drugs	*$0 copay	*$15 copay	*$0 copay		
Preferred Brand Name Drugs	*$15 copay	*$45 copay	*$30 copay	*$90 copay	
Non-Preferred Brand Name Drugs	*$30 copay	*$75 copay	*$60 copay	*$150 copay	
Specialty Drugs	*$0 copay	N/A			

*** After deductible**

Refer to *Prescription Drug Program* for complete details.

PREFERRED PROVIDER OR NONPREFERRED PROVIDER

Covered persons have the choice of using either a ***preferred provider*** or a ***nonpreferred provider***. The ***preferred provider organization*** has a variety of relationships with other Blue Cross and/or Blue Shield Licensees referred to generally as "Inter-Plan Arrangements."

Covered persons have the choice of using an LG Health provider, a PHC, Capital Blue Cross, or Quest ***preferred provider*** or a ***nonpreferred provider***.

PREFERRED PROVIDER (Tier 1)

A ***preferred provider*** is a ***physician***, ***hospital*** or ancillary service provider which has an agreement in effect with the ***Preferred Provider Organization*** (PPO) to accept a ***negotiated rate*** for services rendered to ***covered persons***. In turn, the PPO has an agreement with the ***plan administrator*** or ***claims processor*** to allow access to ***negotiated rates*** for services rendered to ***covered persons***. The PPO's name and/or logo is shown on the front of the ***covered person's*** ID card. The ***preferred provider*** cannot bill the ***covered person*** for any amount in excess of the ***negotiated rate*** for ***covered expenses*** when this plan pays primary (refer to Coordination of Benefits section for additional information). ***Covered persons*** should contact the ***employer's*** Human Resources Department, contact the ***claims processor's*** customer service department, or review the PPO's website noted on the ID card for a current listing of ***preferred providers***. ***Covered persons*** should contact Quest for a listing of preferred behavioral health providers.

NETWORK PROVIDERS (Tier 2)

The ***Plan*** has contracted with ***physicians, hospitals*** and ancillary service providers that will be considered at the Tier 2 coverage level. A current listing is located on the website noted on the ID card.

IMPORTANT: The providers listed below are considered Tier 2 providers that may result in a $5,000 copay as noted on the *Schedule of Benefits*.

UPMC Lititz
Penn State Health (The Milton S Hershey Medical Center)
Penn State Health Lancaster Medical Center
York Hospital (WellSpan York Hospital)
Ephrata Community Hospital (WellSpan Ephrata Community Hospital)
Reading Hospital – Tower Health
St. Joseph Medical Center
UPMC Pinnacle - Harrisburg
Lebanon VA Medical Center
Alfred Dupont Hospital for Children (Nemours Children's Hospital)
WellSpan Good Samaritan Hospital – Lebanon

NONPREFERRED PROVIDER (Tier 3)

A ***nonpreferred provider*** does not have an agreement in effect with the ***Preferred Provider Organization***. When a ***covered person*** receives care outside of the ***Capital Blue Cross Service Area*** and that care is not subject to the Inter-Plan Arrangements, the amount allowed for such care will be based on the ***allowable amount***. This may result in greater out of pocket expenses to the ***covered person***.

Covered expenses for ***emergency services*** by a ***nonpreferred provider*** shall be paid at the greatest of the following amounts: the amount negotiated with ***preferred providers*** for such ***covered expenses***, the amount determined as the ***allowable amount*** usually determined for ***nonpreferred providers*** or the amount that would be paid under ***Medicare*** for such ***emergency services***.

REFERRALS

Referrals to a ***nonpreferred provider*** are covered as ***nonpreferred provider*** services, supplies and treatments. It is the responsibility of the ***covered person*** to assure services to be rendered are performed by ***preferred providers*** in order to receive the ***preferred provider*** level of benefits.

NO SURPRISE BILLS

Emergency care or treatment by an out-of-network provider at an in-network hospital or ambulatory surgical center will not be balance billed. Charges must be no more than the plan's Tier 2 copayments, coinsurance and/or deductible.

Emergency services
When a ***covered person*** has an emergency medical condition and gets emergency services from a non-preferred provider or facility, the most that can be billed is the plan's Tier 2 cost-sharing amount (such as copayments, coinsurance, and deductibles). Balance billing is prohibited for these emergency services. This includes services provided after the ***covered person*** is in a stable condition, unless the ***covered person*** gives written consent and gives up his/her protections not to be balanced billed for post-stabilization services.

Certain services at an in-network hospital or ambulatory surgical center
Services at an in-network hospital or ambulatory surgical center may be provided by certain non-preferred providers. In these cases, the most those providers can bill is the plan's Tier 2 in-network cost-sharing amount. This applies to emergency medicine, anesthesia, pathology, radiology, laboratory, neonatology, assistant surgeon, hospitalist, or intensivist services. These providers can't balance bill the ***covered person*** and may not ask the ***covered person*** to give up his/her protections not to be balance billed.

If other types of services are provided at these in-network facilities, out-of-network providers can't balance bill you, unless you give written consent and give up your protections.

Covered persons are never required to give up their protections from balance billing. Covered persons also are not required to get out-of-network care. They can choose a provider or facility in the plan's network.

When balance billing isn't allowed, these protections apply:

- ***Covered persons*** are only responsible for paying their share of the Tier 2 costs (like the copayments, coinsurance, and deductible that would apply if the provider or facility was in-network). The health plan will pay any additional costs to out-of-network providers and facilities directly.

- Generally, the health plan must:
    - Cover emergency services without requiring ***covered person***s to get approval for services in advance (also known as "prior authorization").
    - Cover emergency services by out-of-network providers.
    - Base what is owed to the provider or facility (cost-sharing) on what it would pay a Tier 2 in-network provider or facility and show that amount in the corresponding explanation of benefits.
    - Count any amount the ***covered person*** pays for emergency services or out-of-network services toward their Tier 2 in-network deductible and out-of-pocket limit.

Contact www.cms.gov/nosurprises/consumers with question or concerns. The phone number for information and complaints is: 1-800-985-3059

EXCEPTIONS

The following lists additional situations when ***covered expenses*** rendered by a ***nonpreferred provider*** shall be payable at the Tier 2 level of benefits unless otherwise specified:

1. ***Nonpreferred*** anesthesiologist when the operating surgeon is a ***preferred provider*** and/or the ***facility*** where such services are rendered is a ***preferred provider***.

2. ***Nonpreferred*** assistant surgeon if the operating surgeon is a ***preferred provider***.

3. Radiologist or pathologist services for interpretation of x-rays and diagnostic laboratory and surgical pathology tests rendered by a ***nonpreferred provider*** when the ***facility*** where such services are rendered is a ***preferred provider*** *shall be payable dependent upon the facility's being a Tier 1 or Tier2* ***provider***. For non-emergency services, the provider may balance bill.

4. While the ***enrolled individual*** is confined to a ***preferred provider hospital***, the ***preferred provider physician*** requests a consultation from a ***nonpreferred provider***, or a newborn visit is performed by a ***nonpreferred provider***.

5. ***Medically necessary*** specialty services, supplies or treatments which are not available from a provider within the ***Preferred Provider Organization***.

6. Treatment rendered at a ***facility*** of the uniformed services.

7. Transportation by a ***nonpreferred provider*** ambulance for a condition that meets the definition of ***emergency***.

8. Lactation counseling providers.

HEALTH BENEFITS

This section describes the ***covered expenses*** of the ***Plan***. All ***covered expenses*** are subject to applicable ***Plan*** provisions including, but not limited to: deductible, ***copay***, ***coinsurance*** and ***maximum benefit*** provisions as shown on the *Schedule of Benefits*, unless otherwise indicated. Any portion of an expense ***incurred*** by the ***enrolled individual*** for services, supplies or treatment that is greater than the ***allowable amount*** for ***nonpreferred providers*** or ***negotiated rate*** for ***preferred providers*** will not be considered a ***covered expense*** by this ***Plan***. Specified preventive care expenses will be considered to be ***covered expenses***.

COPAY

The ***copay*** is the amount payable by the ***enrolled individual*** for certain services, supplies or treatment rendered by a ***professional provider***. The service and applicable ***copay*** are shown on the *Schedule of Benefits*. The ***copay*** must be paid each time a treatment or service is rendered.

Copays will not be applied toward the plan year deductible, however they do accumulate toward the out-of-pocket maximum.

DEDUCTIBLES

Individual Deductible

The individual deductible is the dollar amount of ***covered expense*** which each ***enrolled individual*** must have ***incurred*** during each plan year before the ***Plan*** pays applicable benefits. The individual deductible amount is shown on the *Schedule of Benefits.*

Family Deductible (Embedded)

With an embedded family deductible, the plan begins to make payments for a family member as soon as that family member has reached his/her per family member deductible or the family deductible is met with combined expenses from all family members. One family member cannot contribute more than the individual deductible to the overall family deductible.

COINSURANCE

The ***Plan*** pays a specified percentage of ***covered expenses*** at the ***allowable amount*** for ***nonpreferred providers***, or the percentage of the ***negotiated rate*** for ***preferred providers***. That percentage is specified on the *Schedule of Benefits*. For ***nonpreferred providers***, the ***enrolled individual*** is responsible for the difference between the percentage the ***Plan*** paid and one hundred percent (100%) of the billed amount. The ***enrolled individual's*** portion of the ***coinsurance*** represents the out-of-pocket expense limit.

OUT-OF-POCKET EXPENSE LIMIT

After the ***enrolled individual*** has incurred an amount equal to the out-of-pocket expense limit listed on the *Schedule of Benefits* for ***covered expenses*** (after satisfaction of any applicable deductibles), the ***Plan*** will begin to pay one hundred percent (100%) of ***covered expenses*** for the remainder of the plan year.

After an enrolled family has incurred a combined amount equal to the family out-of-pocket expense limit shown on the *Schedule of Benefits*, the ***Plan*** will pay one hundred percent (100%) of ***covered expenses*** for all enrolled family members for the remainder of the plan year.

Out-of-Pocket Expense Limit Exclusions
The following items do not apply toward satisfaction of the plan year out-of-pocket expense limit and will not be payable at one hundred percent (100%), even if the out-of-pocket expense limit has been satisfied:

1. Expenses for services, supplies and treatments not covered by this ***Plan***, to include charges in excess of the ***allowable amount*** or ***negotiated rate***, as applicable.

2. Expenses ***incurred*** as a result of failure to obtain pre-certification.

MAXIMUM BENEFIT

The *Schedule of Benefits* may contain separate ***maximum benefit*** limitations for specified conditions and/or services.

ACUPUNCTURE

Acupuncture performed to induce surgical anesthesia or for therapeutic purposes shall be a ***covered expense*** as specified on the *Schedule of Benefits*.

AMBULANCE SERVICES

Covered expenses shall include:

1. Ambulance services for air or ground transportation for the ***enrolled individual*** from the place of ***injury*** or serious medical incident to the nearest ***hospital*** where treatment can be given.

2. Ambulance service is covered in a non-emergency situation only to transport the ***enrolled individual*** to or from a ***hospital*** or between ***hospitals*** for required treatment when such transportation is certified by the attending ***physician*** as ***medically necessary***. Such transportation is covered only from the initial ***hospital*** to the nearest ***hospital*** qualified to render the special treatment.

3. ***Emergency*** services actually provided by an advance life support unit, even though the unit does not provide transportation.

If the ***enrolled individual*** is admitted to a ***nonpreferred hospital*** after ***emergency*** treatment, ambulance service is covered to transport the ***enrolled individual*** from the ***nonpreferred hospital*** to a ***preferred hospital*** after the patient's condition has been stabilized, provided such transport is certified by the attending ***physician*** as ***medically necessary***.

BIRTHING CENTER

Covered expenses shall include services, supplies and treatments rendered at a ***birthing center*** provided the ***physician*** in charge is acting within the scope of his license and the ***birthing center*** meets all legal requirements. Services of a midwife acting within the scope of his license or registration are a ***covered expense*** provided that the state in which such service is performed has legally recognized midwife delivery.

CORRECTIVE APPLIANCES

Pre-certification required for:

- all rentals;
- appliance costs in excess of $500

Failure to pre-certify will result in denial of benefit.

Cranial Orthoses

Cranial helmets or molding helmets shall be a ***covered expense*** when ***medically necessary*** and prescribed by the pediatrician for a covered diagnosis.

Prosthetic Appliances

The initial purchase of a prosthetic appliance (other than dental) shall be a ***covered expense***. A charge for the purchase of a prosthesis is considered ***incurred*** on the date the prosthesis is received/delivered. A prosthesis that is received/delivered after the termination date of an ***enrolled individual's*** coverage under this ***Plan*** is not covered.

Routine cleaning and polishing of prosthetic eyes will be considered a ***covered expense***.

Wigs when prescribed by a covered health care provider for the treatment of cancer, alopecia, burns, or cranial surgery are a ***covered expense***.

Orthotic Appliances

Orthotic appliances, including initial purchase, fitting and repair shall be a ***covered expense***. Replacement will be covered only after two (2) years from the date of original placement, unless a physiological change in the patient's condition necessitates earlier replacement. ***Covered expenses*** for non-medically necessary foot orthotics for ***employees*** only will be limited to the ***maximum benefit*** as specified on the *Schedule of Benefits*.

COSMETIC/RECONSTRUCTIVE SURGERY

Pre-certification is required or penalty may apply.

Cosmetic surgery or ***reconstructive surgery*** shall be a ***covered expense*** provided:

1. An ***enrolled individual*** receives an ***injury*** as a result of an ***accident*** and as a result requires surgery. ***Cosmetic*** or ***reconstructive surgery*** and treatment must be for the purpose of restoring the ***enrolled individual*** to his normal function immediately prior to the ***accident***.

2. It is required to correct a congenital anomaly, for example, a birth defect, for a child.

DENTAL SERVICES

Pre-certification may apply.

Covered expenses shall include repair of sound natural teeth or surrounding tissue provided it is the result of an ***injury***. Treatment must be completed within twelve (12) months of the ***injury***. Damage to the teeth as a result of chewing or biting shall not be considered an ***injury*** under this benefit.

Covered expenses shall include charges for oral surgery for partially or completely bone impacted third molars, closed or open reduction of fractures or dislocations of the jaw, and other incision or excision procedures for cysts and tumors of the mouth.

Facility charges for oral surgery or dental treatment that ordinarily could be performed in the provider's office will be covered only if the ***enrolled individual*** has a concurrent hazardous medical condition that prohibits performing the treatment safely in an office setting.

DIABETIC CARE

Covered expenses shall include the following when required in connection with the treatment of diabetes:

1. Blood glucose monitors.

2. Orthotics and shoes related to the treatment of diabetes.

3. Monitoring supplies.

4. Insulin and insulin infusion devices.

5. Syringes and injection aids.

6. Pharmacological agents for controlling blood sugar.

NOTE: Refer to the *Prescription Drug* section for Omnipod glucose management coverage.

DIABETES OUTPATIENT SELF-MANAGEMENT TRAINING AND EDUCATION

Diabetes outpatient self-management training and education, including medical nutrition therapy for treating insulin treated, non-insulin-treated and gestational diabetes will be considered ***covered expenses***. Benefits are limited to visits:

1. upon diagnosis of diabetes;

2. to treat a significant change in the ***enrolled individual's*** symptoms/conditions that requires changes in the ***enrolled individual's*** self-management; or

3. for a new medication or therapeutic process to treat/manage the ***enrolled individual's*** diabetes.

DIAGNOSTIC SERVICES AND SUPPLIES

Covered expenses shall include services and supplies for diagnostic laboratory tests, electronic tests, pathology, ultrasound, nuclear medicine, magnetic imaging and x-rays. **Pre-certification** for Tier 2 and ***non-preferred providers*** is required for advanced imaging services.

DURABLE MEDICAL EQUIPMENT

Pre-certification required for all rentals and expenses in excess of $500 for purchase and repair. Pre-certification required; failure to pre-certify results in $100 penalty.

Rental or purchase, whichever is less costly, except as noted below, for ***medically necessary durable medical equipment*** which is prescribed by a ***physician*** and required for therapeutic use by the ***enrolled individual*** shall be a ***covered expense***. A charge for the purchase or rental of ***durable medical equipment*** is considered ***incurred*** on the date the equipment is received/delivered. ***Durable medical equipment*** that is received/delivered after the termination date of an ***enrolled individual's*** coverage under this ***Plan*** is not covered.

Equipment containing features of an aesthetic nature or features of a medical nature which are not required by the ***enrolled individual's*** condition, or where there exists a reasonably feasible and medically appropriate alternative piece of equipment which is less costly than the equipment furnished, will be covered based on the usual charge for the equipment which meets the ***enrolled individual's*** medical needs.

Replacement of existing durable medical equipment may be considered by the plan provided the following conditions are met:

- The warranty date is more than two years old; and
- There are specific malfunctions that prevent the item from functioning in a normal manner; and
- A Letter of Medical Necessity or statement is signed by the ordering provider indicating warranty information and specific malfunctions; or
- The ordering provider submits documentation that indicates a specific malfunction warranty. Precertification history will count toward the warranty or clinical documentation that supports the member's diagnosis, treatment, and date the member began using the requested DME.

E-VISIT

E-visits are available for ***employees***, and ***dependents*** over age eighteen (18). To be eligible, patients must have been seen in person at a LG Health Physicians Family Medicine Practice within the past two (2) years.

Six (6) non-urgent common symptoms will be able to be treated by e-visits through MyLGHealth.org:

1. Cough
2. Sinus/cold symptoms
3. Red-Eye
4. Urinary symptoms
5. Diarrhea
6. Heart Burn

Participants will answer a series of questions regarding their symptoms and a provider will respond within five hours, during normal business hours.

Copays are applicable, as indicated in the *Schedule of Benefits*.

EMERGENCY ROOM SERVICES

Emergency Care

Coverage for emergency room treatment shall be paid in accordance with the *Schedule of Benefits*. Emergency services shall also include emergency transportation and related emergency services provided by a licensed ambulance service.

Non-Emergency Care

Emergency room treatment for conditions that do not meet the definition of ***emergency*** will be considered non-***emergency*** use of the emergency room.

EXTENDED CARE FACILITY

Extended care facility confinement **is subject to pre-certification. Failure to obtain pre-certification may result in a reduction of benefits as specified in the *Health Benefit Claim Filing Procedure* section of this document.**

Extended care facility services, supplies and treatments shall be a ***covered expense*** provided the ***enrolled individual*** is under a ***physician's*** continuous care and the ***physician*** certifies that the ***enrolled individual*** must have twenty-four (24) hours-per-day nursing care.

Covered expenses shall include:

1. ***Room and board*** (including regular daily services, supplies and treatments furnished by the ***extended care facility***) limited to the ***facility's*** average ***semiprivate*** room rate; and

2. Other services, supplies and treatment ordered by a ***physician*** and furnished by the ***extended care facility*** for ***inpatient*** medical care.

Extended care facility benefits are subject to the ***maximum benefit*** specified on the *Schedule of Benefits*.

FACILITY PROVIDERS

Services provided by a ***facility*** provider are covered if such services would have been covered if performed in a ***hospital*** or ***ambulatory surgical facility***.

FERTILITY SERVICES

Covered expenses shall include expenses for ***fertility*** testing, ***fertility*** counseling which may also include a telehealth consultation(s) via Nurse Talk, treatment and follow-up, artificial insemination and embryo storage. ***Covered expenses*** for ***fertility*** services are limited to the amount indicated on the *Schedule of Benefits*.

GENETIC COUNSELING, TESTING AND SCREENING

Covered expenses shall include expenses for genetic counseling, testing and screening that are needed for diagnosis or treatment of genetic abnormalities.

GENDER TRANSITION

Gender Transition Surgery will require precertification. If the surgery is not pre-certified, the surgery may not be covered.

Covered expenses when ordered by a ***professional provider*** and conforming to the World Professional Association for Transgender Health's standard shall include the following:

a. Psychotherapy
b. Pre and Post-surgical hormone treatment.
c. Sex reassignment surgery/surgeries. Surgery must be performed by a qualified provider.

GROUP HEALTH EDUCATION COURSES

Covered expenses shall include charges for Lancaster General Health-approved group health education courses for the following programs:

1. Pre-Natal and Post-Natal Education
   a. Childbirth class; 80% attendance – Reimbursement $70
   b. Baby Care Basics; 80% attendance – Reimbursement $25
   c. Fathers' Boot Camp – Reimbursement $20
   d. Breastfeeding class; 80% attendance – Reimbursement $25
   e. Breastfeeding and returning to work class; 80% attendance – Reimbursement $15

2. Pre-Diabetes; Group classes only – Reimbursement $32

Reimbursement

Reimbursement request should be submitted to Capital Blue Cross (the Health Education Reimbursement Form is available at www.LGHealthbenefits.com). To be reimbursed by Capital Blue Cross, participants must provide signed reimbursement request form and proof of payment.

HEALTHWORKS CLINC

HealthWorks is a wellness and primary care clinic that offers same-day appointments, free commonly-prescribed medications, and virtual visits. A HealthWorks location may also be chosen as a ***primary care provider***.

LOCATIONS

Rock Lititz Campus	Queen Street
Pod 2 Suite 14	100 North Queen St.
201 Rock Lititz Blvd.	Suite 200
Lititz, PA 17534	Lancaster, PA 17603
Phone: 717-544-ROCK (7625)	Phone: 717-544-7500

HEARING AIDS

A ***covered expense*** when prescribed by a covered health care provider up to $2,500 for both left and right hearing aids every three plan years.

HOME HEALTH CARE

Home health care **and services rendered during** ***home health care*** **are subject to pre-certification or penalty may apply.**

Home health care enables the ***enrolled individual*** to receive treatment in his home for an ***illness*** or ***injury*** instead of being confined in a ***hospital*** or ***extended care facility***. ***Covered expenses*** shall include the following services and supplies provided by a ***home health care agency***:

1. Part-time or intermittent nursing care by a ***nurse***;

2. Physical, respiratory, occupational or speech therapy;

3. Part-time or intermittent ***home health aide services*** (under the supervision of a registered nurse) for an ***enrolled individual*** who is receiving covered nursing or therapy services.

Covered expenses shall be subject to the ***maximum benefit*** specified on the *Schedule of Benefits*.

A visit by a member of a ***home health care*** team and four (4) hours of ***home health aide service*** will each be considered one (1) ***home health care*** visit.

No ***home health care*** benefits will be provided for dietitian services (except as may be specifically provided herein), homemaker services, maintenance therapy, food or home delivered meals, rental or purchase of ***durable medical equipment*** or prescription or non-prescription drugs or biologicals.

HOSPICE CARE

Hospice **care is subject to pre-certification. Failure to obtain pre-certification may result in a reduction of benefits as specified in the** ***Health Benefit Claim Filing Procedure*** **section of this document.**

Hospice care is a health care program providing a coordinated set of services rendered at home, in ***outpatient*** settings, or in ***facility*** settings for an ***enrolled individual*** suffering from a condition that has a terminal prognosis.

Hospice care will be covered only if the ***enrolled individual's*** attending ***physician*** certifies that:

1. The ***enrolled individual*** is terminally ill, and
2. The ***enrolled individual*** has a life expectancy of six (6) months or less.

Covered expenses shall include:

1. ***Confinement*** in a ***hospice*** to include ancillary charges and ***room and board***.

2. Services, supplies and treatment provided by a ***hospice*** to an ***enrolled individual*** in a home setting.

3. ***Physician*** services and/or nursing care by a ***nurse***.

4. Counseling services provided through the ***hospice***.

5. Bereavement counseling as a supportive service to ***enrolled individuals*** in the terminally ill ***enrolled individual's*** immediate family. Benefits will be payable for services within three (3) months after the terminally ill person's death.

Charges ***incurred*** during periods of remission are not eligible under this provision of the ***Plan***. Any ***covered expense*** paid under ***hospice*** benefits will not be considered a ***covered expense*** under any other provision of this ***Plan***.

HOSPITAL/AMBULATORY SURGICAL FACILITY

Inpatient hospital **admissions are subject to pre-certification. Failure to obtain pre-certification may result in a reduction of benefits as specified in the *Health Benefit Claim Filing Procedure* section of this document.**

Covered expenses shall include:

1. ***Room and board*** for treatment in a ***hospital***, including ***intensive care units***, cardiac care units and similar ***medically necessary*** accommodations. ***Covered expenses*** for ***room and board*** shall be limited to the ***hospital's semiprivate*** rate. ***Covered expenses*** for ***intensive care*** or cardiac care units shall be the ***allowable amount*** for ***nonpreferred providers*** and the percentage of the ***negotiated rate*** for ***preferred providers***. A full private room rate is covered if the private room is necessary for isolation purposes and is not for the convenience of the ***enrolled individual***.

2. Miscellaneous ***hospital*** services, supplies, and treatments including, but not limited to:
   a. Admission fees, and other fees assessed by the ***hospital*** for rendering services, supplies and treatments;
   b. Use of operating, treatment or delivery rooms;
   c. Anesthesia, anesthesia supplies and its administration by an employee of the ***hospital***;
   d. Medical and surgical dressings and supplies, casts and splints;
   e. Blood transfusions, including the cost of whole blood, the administration of blood, blood processing and blood derivatives (to the extent blood or blood derivatives are not donated or otherwise replaced);
   f. Drugs and medicines (except drugs not used or consumed in the ***hospital***);
   g. X-ray and diagnostic laboratory procedures and services;
   h. Oxygen and other gas therapy and the administration thereof;
   i. Therapy services.

3. Services, supplies and treatments described above furnished by an ***ambulatory surgical facility***, including follow-up care provided within seventy-two (72) hours of a procedure.

4. Charges for pre-admission testing (x-rays and lab tests) which are related to the condition which is necessitating the ***confinement***.

HYPERALIMENTATION OR TOTAL PARENTERAL NUTRITION (TPN)

Covered expenses shall include charges for Hyperalimentation or Total Parenteral Nutrition (TPN) for ***covered persons*** recovering from or preparing for surgery or if ***medically necessary*** for sustaining life.

MASSAGE THERAPY

Covered expenses shall include charges for prescribed Massage Therapy as outlined in the ***Schedule of Benefits.***

MASTECTOMY (WOMEN'S HEALTH AND CANCER RIGHTS ACT OF 1998)

This ***Plan*** intends to comply with the provisions of the federal law known as the Women's Health and Cancer Rights Act of 1998.

Covered expenses will include eligible charges related to ***medically necessary*** mastectomy.
For an ***enrolled individual*** who elects breast reconstruction in connection with such mastectomy, ***covered expenses*** will include:

1. reconstruction of a surgically removed breast; and

2. surgery and reconstruction of the other breast to produce a symmetrical appearance.

Prostheses (and ***medically necessary*** replacements) and physical complications from all stages of mastectomy, including lymphedemas will also be considered ***covered expenses*** following all ***medically necessary*** mastectomies.

MEDICAL FOODS (PEDIATRIC)

Medical food is formulated to be consumed by mouth or administered by tube under supervision of a ***physician*** and which is intended for the specific dietary management of a disease or condition for which distinctive nutritional requirements are established by medical evaluation. Proof of ***medical necessity*** required.

MORBID OBESITY AND PEDIATRIC OBESITY

You are encouraged to contact Capital Blue Cross prior to receiving the following services. Pre-certification may apply.

Adult ***morbid obesity*** is defined as a BMI greater than 40 kilos per meter squared, or as a BMI greater than 35 kilos per meter squared and when two (2) or more co-morbidities exist.

Pediatric obesity is defined as children under age 18 with a BMI above the 95th percentile.

Covered expenses for ***morbid obesity*** and pediatric obesity shall include office visits and/or consultations, lab studies that are ordered for the purpose of diagnosis and/or on-going management of adult ***morbid obesity*** or pediatric obesity and associated co-morbid conditions, surgical treatment of morbid obesity for ***enrolled individuals*** with health problems that are aggravated by or related to morbid obesity, including, but not limited to Gastric Bypass, Sleeve Gastrectomy, and Adjustable Banding.

The patient is required to successfully complete a twelve-week pre-operative program that includes monitoring by a dietician, exercise physiologist, psychologist, and the bariatric surgeon who will be performing the surgical treatment. The successful completion of this program is demonstrated through a patient's behavior modification, indicative of post-operative change.

Pre-certification is required for adult surgical treatment of *morbid obesity*. Bariatric surgical treatment of pediatric patients will require pre-certification with peer review to determine *medical necessity*.

NUTRITIONAL COUNSELING

Nutritional counseling shall be considered a ***covered expense*** when (1) provided by a registered dietician or nutritionist, and (2) in connection with morbid obesity, diabetes, coronary artery disease and hyperlipidemia.

OUTPATIENT CARDIAC/PULMONARY REHABILITATION PROGRAMS

Covered expenses shall include charges for qualified ***medically necessary outpatient*** cardiac/pulmonary rehabilitation programs, limited to the ***maximum benefit*** as specified on the *Schedule of Benefits*.

OUTPATIENT LACTATION COUNSELING

Outpatient lactation counseling shall be considered a ***covered expense***, regardless of medical necessity.

OUTPATIENT THERAPY SERVICES

Therapy services must be ordered by a ***physician*** to aid restoration of normal function lost due to ***illness*** or ***injury*** and significant improvement is expected to be achieved through short-term therapy or for congenital anomaly.

Covered expenses shall include:

1. Services of a ***professional provider*** for physical therapy, occupational therapy or ***speech therapy***.
2. Respiratory therapy.
3. Radiation therapy. (Initial notification is required.)
4. C***hemotherapy***. (Initial notification is requested.)
5. Dialysis therapy or treatment**.**
6. KneeKG.
7. Home administered infusion therapy, **subject to pre-certification**.

PHYSICIAN SERVICES AND PROFESSIONAL PROVIDER SERVICES

You are encouraged to contact Capital Blue Cross prior to receiving any of the following services.

Covered expenses shall include the following services when performed by a ***physician*** or a ***professional provider***:

1. Medical treatment, services and supplies including, but not limited to: office visits/virtual visits, ***inpatient*** visits, home visits.

2. Surgical treatment. Separate payment will not be made for ***inpatient*** pre-operative or post-operative care normally provided by a surgeon as part of the surgical procedure.

   For related operations or procedures performed through the same incision or in the same operative field, ***covered expenses*** shall include the surgical allowance for the highest paying procedure and a percentage of the surgical allowance for each additional procedure.

3. Surgical assistance provided by a ***physician*** or ***professional provider*** if it is determined that the condition of the ***enrolled individual*** or the type of surgical procedure requires such assistance. ***Covered expenses*** for the services of an assistant surgeon are limited to a percentage of the surgical allowance.

4. Furnishing or administering anesthetics, other than local infiltration anesthesia, by other than the surgeon or his assistant. However, benefits will be provided for anesthesia services administered by oral and maxillofacial surgeons when such services are rendered in the surgeon's office.

5. Consultations requested by the attending ***physician*** during a ***hospital confinement***. Consultations do not include staff consultations that are required by a ***hospital's*** rules and regulations.

6. Radiologist or pathologist services for interpretation of x-rays and laboratory tests necessary for diagnosis and treatment.

7. Radiologist or pathologist services for diagnosis or treatment, including radiation therapy and chemotherapy (initial notification requested).
8. Allergy testing consisting of percutaneous, intracutaneous and patch tests and allergy injections.

PODIATRY SERVICES

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

PREGNANCY

Statement of Health Equity

LG Health offers LGBTQ+ inclusive family formation benefits regardless of sex, sexual orientation, gender identity and marital status that are equivalent to the family formation benefits offered to non-LGBTQ+ employees and that remove barriers that limit LGBTQ+ individuals from accessing these benefits.

Covered expenses shall include services, supplies and treatment related to ***pregnancy*** or complications for an enrolled female ***employee***, an enrolled female spouse of an enrolled ***employee***, and ***dependent*** female children.

If the mother chooses early discharge from a ***hospital*** or ***birthing center*** following delivery, postpartum home health care visits will be covered at 100%.

The ***Plan*** shall cover services, supplies and treatments for ***medically necessary*** abortions when the life of the mother would be endangered by continuation of the ***pregnancy*** or when the ***pregnancy*** is a result of rape or incest. Effective August 1, 2022, elective termination of pregnancy and related services and treatments are a ***covered expense.***

Complications from an abortion shall be a ***covered expense***.

PRIVATE DUTY NURSING

Private duty nursing services are subject to pre-certification. ***Medically necessary*** services of a private duty ***nurse*** shall be a ***covered expense***.

PROTON & CAR-T CELLULAR THERAPIES

Proton therapy includes non-invasive treatment for localized, solid tumors near critical organs and non-invasive treatment for recurring tumors in locations where conventional radiation has previously been used.
Car-T cellular therapy includes cancer immunotherapy services that uses genetically altered T-cells to destroy cancer cells.

RETAIL HEALTH CLINIC

Covered expenses shall include ***professional provider*** services rendered in a ***retail health clinic***, including but not limited to basic, non-emergent medical care for acute ***illnesses*** and minor ***injuries***, such as sore throat, cold, flu, rashes, coughs, fever, bronchitis, earaches, pink eye, headaches, poison ivy, sunburn, nausea and vomiting, diarrhea, etc.

ROUTINE COLONOSCOPY

Covered expenses shall include routine colonoscopy, subject to the ***maximum benefit*** as specified on the *Schedule of Benefits*.

ROUTINE MAMMOGRAMS

Covered expenses shall include routine mammograms, subject to the ***maximum benefit*** as specified on the *Schedule of Benefits*.

ROUTINE PATIENT COSTS FOR APPROVED CLINICAL TRIALS

Covered expenses shall include charges for "routine patient costs" incurred by a "qualified individual" participating in an ***approved clinical trial,*** **subject to pre-certification.** "Routine patient costs" do not include:

1. An investigational item, device or service;

2. An item or service provided solely to satisfy data collection and analysis needs, which are not used in the direct clinical management of the patient; or,

3. A service that is clearly inconsistent with widely accepted and established standards of care for a particular diagnosis.

"Life-threatening disease or condition" means any disease or condition from which the likelihood of death is probable unless the course of the disease or condition is interrupted.

"Qualified Individual" means a ***covered person*** who is eligible to participate in an ***approved clinical trial*** according to the trial protocol with respect to the treatment of cancer or another "life-threatening disease or condition" and either;

1. The referring health care professional has concluded that the ***covered person's*** participation in such trial would be appropriate; or,

2. The ***covered person*** provides medical and scientific information establishing that the ***covered person's*** participation in such trial would be appropriate.

"Routine patient costs" include all items and services consistent with the coverage provide by the ***Plan*** that is typically covered for a ***covered person*** who is not enrolled in a clinical trial.

ROUTINE PREVENTIVE CARE

Covered expenses shall include the following routine services and supplies which are not required due to ***illness*** or ***injury***: physical check-up; immunizations and inoculations as required by state law (except when required for employment or school); hearing tests; laboratory and other tests given in connection with routine examinations.

Covered expenses shall also include evidence-based supplies or services that have in effect a rating of A or B in the current recommendations of the United States Preventive Services Task Force (USPSTF).

ROUTINE PROSTATE EXAMINATION

Covered expenses shall include routine prostate examinations and prostate specific antigen (PSA) tests, subject to the ***maximum benefit*** as specified on the *Schedule of Benefits*.

ROUTINE SIGMOIDOSCOPY

Covered expenses shall include routine sigmoidoscopy, subject to the ***maximum benefit*** as specified on the *Schedule of Benefits*.

SECOND SURGICAL OPINION

Benefits for a second surgical opinion will be payable according to the *Schedule of Benefits* if an elective surgical procedure (non-emergency surgery) is recommended by the ***physician***.

The ***physician*** rendering the second opinion regarding the ***medical necessity*** of such surgery must be a board certified specialist in the treatment of the ***enrolled individual's illness*** or ***injury*** and must not be affiliated in any way with the ***physician*** who will be performing the actual surgery.

In the event of conflicting opinions, a third opinion may be obtained. The ***Plan*** will consider payment for a third opinion, the same as a second surgical opinion.

SPECIAL EQUIPMENT AND SUPPLIES

Covered expenses shall include ***medically necessary*** special equipment and supplies including, but not limited to: casts; splints; braces; trusses; surgical and orthopedic appliances; colostomy and ileostomy bags and supplies required for their use; catheters; allergy serums; crutches; electronic pacemakers; oxygen and the administration thereof; the initial pair of eyeglasses or contact lenses due to cataract surgery; soft lenses or sclera shells intended for use in the treatment of ***illness*** or ***injury*** of the eye; anti-embolic stockings with a pressure gradient of 20 MM

HG or more; a wig or hairpiece when required due to chemotherapy, surgery or burns; surgical dressings and other medical supplies ordered by a ***professional provider*** in connection with medical treatment, but not common first aid supplies.

SURCHARGES

Any surcharge or assessment (by whatever name called) on ***covered expenses***, required by state or federal law to be paid by the ***Plan*** for services, supplies and/or treatments rendered by a health care provider shall be a ***covered expense*** subject to the ***covered person's*** obligations under the ***Plan***.

TELEMEDICINE BENEFIT – FOR EMPLOYEES AND DEPENDENTS AGE 14+

For ***Employees*** **and** ***Dependents*** age 14+, ***covered expenses*** shall include charges for telemedicine services provided by Penn Medicine OnDemand. Contact Penn Medicine OnDemand at 215-615-2222.

TEMPOROMANDIBULAR JOINT DYSFUNCTION

You are encouraged to contact Capital Blue Cross prior to receiving the following services. Pre-certification may apply.

Covered expenses shall include surgical (including orthognathic surgery) and nonsurgical treatment of temporomandibular joint dysfunction (TMJ) or myofascial pain syndrome when caused by acute traumatic, dislocation, fractures, neoplasms, rheumatic arthritis, ankylosing spondylitis or disseminated lupus erythematosus, but shall not include orthodontia or prosthetic devices prescribed by a ***physician*** or ***dentist***.

TRANSPLANT

Transplant procedures are subject to pre-certification. Failure to obtain pre-certification will result in a denial of benefits for the ***hospital confinement*** as specified in the *Health Benefit Claim Filing Procedure* section of this document.

Services, supplies and treatments in connection with human-to-human organ and tissue transplant procedures will be considered ***covered expenses*** subject to the following conditions:

1. When the recipient is enrolled under this ***Plan***, the ***Plan*** will pay the recipient's ***covered expenses*** related to the transplant.

2. When the donor is enrolled under this ***Plan***, the ***Plan*** will pay the donor's ***covered expenses*** related to the transplant, provided the recipient is also covered under this ***Plan***. ***Covered expenses incurred*** by each person will be considered separately for each person.

3. Expenses ***incurred*** by the donor who is not ordinarily enrolled under this ***Plan*** according to eligibility requirements will be ***covered expenses*** to the extent that such expenses are not payable by any other form of health coverage, including any government plan or individual policy of health coverage, and provided the recipient is enrolled under this ***Plan***. The donor's expense shall be applied to the recipient's ***maximum benefit***. In no event will benefits be payable in excess of the ***maximum benefit*** still available to the recipient.

4. Surgical, storage and transportation costs directly related to procurement of an organ or tissue used in a transplant procedure will be covered for each procedure completed. If an organ or tissue is sold rather than donated, the purchase price of such organ or tissue shall not be considered a ***covered expense*** under this ***Plan***.

5. Travel expenses for the enrolled recipient and one (1) other person (two (2) other persons if the recipient is an eligible ***dependent*** child) to accompany the recipient or donor to and from a ***facility*** and for lodging and meals at or near the ***facility*** where the recipient or donor is confined, subject to the ***maximum benefit*** as specified on the *Schedule of Benefits*.

If an ***enrolled individual's*** transplant procedure is not performed as scheduled due to the intended recipient's medical condition or death, benefits will be paid for organ or tissue procurement as described above.

Institutes of Excellence Program

In addition to the above transplant benefits, the ***enrolled individual*** may be eligible to participate in an Institutes of Excellence Program. An Institute of Excellence is a ***facility*** within an Institutes of Excellence Network that has been chosen for its proficiency in performing one or more transplant procedures. Usually located throughout the United States, the Institutes of Excellence ***facilities*** have greater transplant volumes and surgical team experience than other similar ***facilities***.

Donor screening tests will be considered ***covered expenses*** when performed at an *Institute of Excellence*, subject to the ***maximum benefit*** as specified on the *Schedule of Benefits*.

Transplant procedures are subject to pre-certification. Failure to obtain pre-certification will result in a reduction of benefits for the ***hospital confinement*** as specified in the *Health Benefit Claim Filing Procedure* section of this document.

URGENT CARE CENTER

Covered expenses shall include charges for treatment in an ***Urgent Care Center***, payable as specified on the *Schedule of Benefits*.

VACCINATIONS

Covered expenses shall include non-travel or non-employment related flu, COVID-19, pneumonia, and shingles shots as specified on the *Schedule of Benefits*.

WEIGHT WATCHERS

Covered expenses will allow for a portion of the annual registration fee when a covered member is enrolled in a certified Weight Watchers program.

WELL CHILD CARE

Covered expenses for well child care shall include charges for the following services provided to enrolled ***dependent*** children, through age 18: routine pediatric examinations for a reason other than to diagnose an ***injury*** or ***illness***; developmental assessments; immunizations (childhood immunizations only, including immunizing agents as required by state law except when required for employment or school); hearing tests (limited as specified on the *Schedule of Benefits*); vision screening; laboratory and other tests given in connection with pediatric examinations.

WELL NEWBORN CARE

The ***Plan*** shall cover well newborn care. ***Covered expenses*** for services, supplies or treatment of the newborn child shall be considered charges of the child and as such, subject to a separate deductible and ***coinsurance*** from the mother.

Such care shall include, but is not limited to:

1. ***Physician*** services

2. ***Hospital*** services

3. Circumcision

WOMEN'S PREVENTIVE SERVICES

Covered expenses shall include the following preventive services as recommended in guidelines issued by the U.S. Department of Health and Human Services' Health Resources and Services Administration:

1. Annual well-woman office visits to obtain preventive care;

2. Screening for gestational diabetes in a pregnant woman:
   a. Between twenty-four (24) and twenty-eight (28) weeks of gestation; and
   b. At the first prenatal visit for a pregnant woman identified to be at high risk for diabetes.

3. Human papillomavirus DNA testing no more frequently than every three (3) years for a woman age thirty (30) and above;

4. Annual counseling for sexually transmitted infections for a sexually active woman;

5. Annual counseling and screening for human immune-deficiency virus for a sexually active woman;

6. FDA approved contraceptive methods (unless covered under the *Prescription Drug Program*), sterilization procedures and patient education and counseling for a woman with reproductive capacity (reversal of surgical sterilization is not a ***covered expense***);

7. Breastfeeding support, supplies and counseling in conjunction with each birth, including the cost of renting breastfeeding equipment; and

8. Annual screening and counseling for interpersonal and domestic violence.

The ***Plan*** will apply reasonable medical management techniques to determine the appropriate frequency, method, treatment, or setting for a preventive item or service to the extent that such techniques are not specified in the recommendations or guidelines.

HEALTH BENEFITS EXCLUSIONS

In addition to *Plan Exclusions,* no benefit will be provided under this ***Plan*** for medical expenses for the following:

1. Charges for services, supplies or treatment for the reversal of surgical sterilization procedures.

2. Unless otherwise specified, charges for services, supplies or treatment related to fetal reduction surgery and artificial reproductive procedures, including, but not limited to: surrogate mother, embryo implantation, or gamete intrafallopian transfer (GIFT).

3. Charges for treatment or surgery for sexual dysfunction or inadequacies unless related to ***injury*** or organic ***illness***.

4. Charges for services, supplies or treatment for pervasive developmental disorder, learning disabilities, mental retardation, or senile deterioration. However, the initial examination, office visit/virtual visit and diagnostic testing to determine the ***illness*** shall be a ***covered expense***.

5. Charges for services, supplies or treatments which are primarily educational in nature, except as specified herein; charges for services for educational or vocational testing or training and work hardening programs regardless of diagnosis or symptoms; charges for self-help training or other forms of non-medical self-care.

6. Charges for marriage or relationship counseling.

7. Except as specifically stated in *Health Benefits, Dental Services*, charges for or in connection with: treatment of ***injury*** or disease of the teeth; oral surgery related to the treatment of the teeth; treatment of gums or structures directly supporting or attached to the teeth; or dental implants. (NOTE: ***Medically necessary*** coverage is provided under the medical plan for services to treat and restore damage done to sound, natural, unrestored teeth as a result of an accidental injury.)

8. Charges for vision exercises and therapy (orthoptics); eyeglasses or contact lenses, and/or dispensing optician's services, except as specified herein.

9. Charges for any eye surgery solely for the purpose of correcting refractive defects of the eye, such as nearsightedness (myopia) and astigmatism including radial keratotomy by whatever name called; contact lenses and eyeglasses required as a result of such surgery.

10. Except as ***medically necessary*** for the treatment of metabolic or peripheral-vascular ***illness***, charges for routine, palliative or cosmetic foot care, including, but not limited to: treatment of weak, unstable, flat, strained or unbalanced feet; subluxations of the foot; treatment of corns or calluses; non-surgical care of toenails.

11. Charges for services, supplies or treatment which constitute personal comfort or beautification items, whether or not recommended by a ***physician***, such as: television, telephone, air conditioners, air purifiers, humidifiers, electric heating units, orthopedic mattresses, blood pressure instruments, scales, elastic bandages, nonhospital adjustable beds, exercise equipment.

12. Charges for nonprescription drugs, such as vitamins, cosmetic dietary aids, and nutritional supplements. (Refer to Prescription section.)

13. Charges for ***outpatient*** prescription drugs. (Refer to Prescription section.)

14. Unless otherwise specified, charges for clothing or non-prosthetic shoes of any type, including but not limited to orthopedic shoes, children's corrective shoes, shoes used in conjunction with leg braces and shoe inserts except for inserts and shoes for enrolled individuals with diabetes or peripheral vascular disease.

15. Expenses for a ***cosmetic surgery*** or procedure and all related services, except as specifically stated in *Health Benefits, Cosmetic/Reconstructive Surgery*.

16. Charges ***incurred*** as a result of, or in connection with, any procedure or treatment excluded by this ***Plan*** which has resulted in medical complications either directly or indirectly as specified herein.

17. Prior to August 1, 2022, charges for services provided to an ***enrolled individual*** for an elective abortion (See *Health Benefits, Pregnancy* for specifics regarding the coverage of abortions). However, complications from termination of pregnancy shall be a ***covered expense***.

18. Charges for services, supplies or treatment primarily for weight reduction or treatment of obesity, including, but not limited to: exercise programs or use of exercise equipment; special diets or diet supplements; appetite suppressants; Nutri/System, or similar programs; and ***hospital confinements*** for weight reduction programs, except as part of USPSTF recommendations.

19. Charges for surgical weight reduction procedures and all related charges, except as specified herein.

20. Charges for services, supplies and treatment for smoking cessation programs, or related to the treatment of nicotine addiction, including smoking deterrent patches, except as part of USPSTF recommendations.

21. Charges for a cochlear implant.

22. Charges for chiropractic treatment and expenses related to manipulative therapies, including charges for diagnostic X-ray, laboratory and pathology, performed in a chiropractor's office.

23. Charges for examinations for employment, school, camp, sports, licensing, insurance, adoption, marriage, driver's license, foreign travel, passports or those ordered by a third party.

24. Except as specifically stated in *Health Benefits, Temporomandibular Joint Dysfunction*, charges for treatment of temporomandibular joint dysfunction and myofascial pain syndrome including, but not limited to: charges for treatment to alter vertical dimension or to restore abraded dentition, orthodontia and intra-oral prosthetic devices.

25. Charges for oral surgery that encompasses orthognathic, prosthodontics or prognathic surgical procedures. Note: Orthognathic surgery related to Temporomandibular Joint Dysfunction is a covered service.

26. Charges for ***custodial care***, residential care, domiciliary care or rest cures.

27. Charges for travel or accommodations, whether or not recommended by a ***physician***, unless related to covered transplant services (travel expenses not to exceed $10,000 per occurrence).

28. Charges for hair analysis, wigs, artificial hairpieces, artificial hair transplants, or any drug - prescription or otherwise - used to eliminate baldness or stimulate hair growth, except as specified herein.

29. Charges for expenses related to hypnosis.

30. Charges for the expenses of the donor of an organ or tissue for transplant to a recipient who is not an ***enrolled individual*** under this ***Plan.*** Example: The expenses incurred by a plan member of PennMedicine LG health plan when donating an organ will only be eligible for coverage if the patient receiving the organ is also enrolled on the PennMedicine LG health plan.

31. Charges for chelation therapy, except as treatment of heavy metal poisoning.

32. Charges for sex therapy, diversional therapy or recreational therapy.

33. Charges for holistic medicines or providers of naturopathy.

34. Charges for or related to the following types of treatment unless prescribed and covered under massage therapy services:
    a. primal therapy;
    b. rolfing;
    c. psychodrama;
    d. megavitamin therapy;
    e. visual perceptual training.

35. Charges for structural changes to a house or vehicle.

36. Charges for exercise programs for treatment of any condition, except as specified herein.

37. Charges for immunizations required for travel or employment.

38. Charges for ***corrective appliances*** that do not require prescription specifications and/or are used primarily for recreational sports; sports medicine treatment plans, surgery, ***corrective appliances*** or artificial aids primarily intended to enhance athletic functions.

39. Charges for ***corrective appliances*** used primarily for cosmetic purposes, unless otherwise specified.

40. Charges for speech therapy for developmental delay, school-related problems, apraxic disorders (unless caused by an accident or episodic illness), stuttering, speech delay, articulation disorder, functional dysphonia, or speech problems resulting from psychoneurotic or personality disorders.

41. Charges for newborn home deliveries.

42. Charges for surgery performed solely to address psychological or emotional factors. (See Behavioral Health summary plan description.)

43. Charges for genetic counseling and genetic studies that are not required for diagnosis or treatment of genetic abnormalities.

44. Charges for services rendered at Cancer Treatment Centers of America.

45. Charges for any services, supplies or treatment not specifically provided herein.

46. Charges related to ***injuries*** incurred while intoxicated or under the influence of a narcotic not prescribed by a ***physician***.

PRESCRIPTION DRUG PROGRAM

PRESCRIPTION DRUG PROGRAM

Participating pharmacies have contracted with the ***Plan*** to charge ***enrolled individuals*** reduced fees for covered prescription drugs.

PHARMACIES

The pharmacy provides medications at discounted prices and chooses to pass those savings onto our ***enrolled individuals***. When you fill your prescriptions at the Convenience Pharmacy, both ***enrolled individuals*** and LG Health save considerable dollars. The copays for medications dispensed by the LG Health Convenience/SOP LifeCare Pharmacies are generally much less when compared to those of the other retail and mail-order pharmacy options. You may also purchase eligible 90-day prescriptions at the Convenience Pharmacy for much lower ***copays*** than those offered at retail pharmacies.

The LG Health Convenience Pharmacy (CP) is located in the Lancaster General Health building and provides daily and weekly delivery service to LG Health ***enrolled individuals*** employed at off-site facilities and can provide mail-order prescriptions shipped to the home.

CONVENIENCE PHARMACY (CP) LOCATIONS

Lancaster General Health Convenience Pharmacy– Duke Street
1st Floor
555 North Duke Street
Lancaster, PA 17602
717.544.5929

LG Health Convenience Pharmacy - Suburban Outpatient Pavilion
3rd Floor
Suburban Building 2108
Lancaster, PA 17601
717.544.3154

LG Health Convenience Pharmacy - Kissel Hill
51 Peters Road
Lititz, PA 17543
717.627.7689

LG Health Convenience Pharmacy – Columbia
304 North 7th Street
Columbia, PA 17512
717.684.1450

RETAIL PHARMACY OPTION COPAY

The ***copay*** is applied to each covered pharmacy drug card charge and is shown on the *Schedule of Benefits*. The ***copay*** amount is not a ***covered expense*** under the *Health Benefits*. Any one prescription is limited to a thirty (30) day supply. Preferred Plus medications are available at the Convenience Pharmacy for lower ***copay*** amounts than those same prescriptions purchased at a retail pharmacy.

Drugs purchased from a ***nonparticipating pharmacy*** are covered only for a quantity sufficient to treat the acute phase of the illness or injury. The ***enrolled individual*** must pay the entire cost of the prescription and then submit the receipt to the prescription program claims processor for reimbursement within ninety (90) days of purchase.

MAIL ORDER PROGRAM

The mail order drug benefit option is available for maintenance medications (those that are taken for long periods of time, such as drugs which may be prescribed for heart disease, high blood pressure, asthma, etc.).

MAIL ORDER OPTION COPAY

The ***copay*** is applied to each covered mail order prescription charge and is shown on the *Schedule of Benefits*. The ***copay*** is not a ***covered expense*** under the *Health Benefits*. Any one prescription is limited to a ninety (90) day supply. Preferred Plus medications are available at the Convenience Pharmacy, as a 90-day supply, for lower ***copay*** amounts than those same prescriptions purchased from the Mail Order Option.

SPECIALTY MEDICATIONS OPTION

Specialty medications help patients with complex conditions like multiple sclerosis, cancer, rheumatoid arthritis or hemophilia. These drugs can be injected or taken orally. These medications typically require special handling and can be purchased at the Convenience Pharmacy.

VARIABLE COPAY PROGRAM

The Plan has adopted the Liviniti Variable Copay™ Program to help ***enrolled individuals*** who utilize manufacturer copay programs save money on prescription drugs. Under the Variable Copay™ Program, your out-of-pocket cost for prescription drugs may be reduced or eliminated by a drug manufacturer's copay subsidy. If you are eligible to receive a manufacturer copay subsidy for a drug, your copay obligation for that drug will be the maximum manufacturer copay subsidy for that drug. **Note: Any manufacturer copay subsidy obtained under the Variable Copay™ Program will not accumulate toward your deductible or out of pocket costs.** If you are not eligible to receive a manufacturer copay subsidy, your copay obligation will be the copay amount listed for the drug in the standard formulary under the Plan. **Note: If you are eligible for a manufacturer copay subsidy for a drug but fail to obtain the subsidy, your copay obligation—and the out-of-pocket cost you may be required to pay—will be the maximum manufacturer copay subsidy for that drug.**

Manufacturer eligibility requirements are subject to change without notice. As a result, **in certain instances, drugs may no longer be available under the Variable Copay Program ("Excepted Drug").** The Plan has a drug-specific cost-sharing obligation with respect to each Excepted Drug. This cost-sharing obligation is solely your responsibility and is fixed regardless of whether you are eligible for or receive third party cost-sharing assistance. While the Excepted Drug is no longer eligible under the Plan's Variable Copay program, cost-sharing assistance may be available to you from a third party (such as a drug manufacturer). Please note that any cost-sharing assistance you receive with respect to an Excepted Drug will accumulate against your deductible or maximum-out-of-pocket limit, subject to you having satisfied your statutory minimum deductible for purposes of the federal tax rules governing Health Savings Account (HSA) eligibility if you are enrolled in the LG Consumer Health Plan option. For information on the Excepted Drugs subject to a drug-specific cost-sharing obligation under the Plan, and for more information on the specific cost-sharing that applies each Excepted Drug, please visit variablecopay.com or you may call (833) 439-9617.

BENEFIT LIMITATIONS

This benefit applies only when an ***enrolled individual*** incurs a covered prescription drug charge. The covered drug charge for any one prescription will be limited to:

1. Refills only up to the number of times specified by a ***physician***.

2. Refills up to one year from the date of order by a ***physician***.

AFFORDABLE CARE ACT MEDICATIONS

The following over-the-counter drugs are covered in accordance with the Affordable Care Act:

1. Aspirin for cardiovascular protection.
2. Folic acid for women considering getting pregnant.
3. Fluoride.
4. Iron supplements to prevent anemia.

PLAN EXCLUSIONS

The ***Plan*** will not provide benefits for any of the items listed in this section, regardless of ***medical necessity*** or recommendation of a ***physician*** or ***professional provider***.

1. Charges for services, supplies or treatment from any ***hospital*** owned or operated by the United States government or any agency thereof or any government outside the United States, or charges for services, treatment or supplies furnished by the United States government or any agency thereof or any government outside the United States, unless payment is legally required.

2. Charges for an ***injury*** sustained or ***illness*** contracted while on active duty in military service, unless payment is legally required.

3. Charges for services, treatment or supplies for treatment of ***illness*** or ***injury*** which is caused by or attributed to by war or any act of war, participation in a riot, civil disobedience or insurrection. "War" means declared or undeclared war, whether civil or international, or any substantial armed conflict between organized forces of a military nature.

4. Any condition for which benefits of any nature are payable or are found to be eligible, either by adjudication or settlement, under any Workers' Compensation law, Employer's liability law, or occupational disease law, even though the ***covered person*** fails to claim rights to such benefits or fails to enroll or purchase such coverage. This does not include a ***covered person*** that is a sole proprietor, partner or executive officer that is not required by law to have workers' compensation or similar coverage and does not have such coverage.

5. Charges in connection with any ***illness*** or ***injury*** arising out of or in the course of any employment intended for wage or profit, including self-employment.

6. Charges made for services, supplies and treatment which are not ***medically necessary*** for the treatment of ***illness*** or ***injury***, or which are not recommended and approved by the attending ***physician***, except as specifically stated herein, or to the extent that the charges exceed ***allowable amount*** or exceed the ***negotiated rate***, as applicable.

7. Charges in connection with any ***illness*** or ***injury*** of the ***enrolled individual*** resulting from or occurring during commission or attempted commission of a criminal battery or felony by the ***enrolled individual***, or engagement in an illegal occupation.

8. To the extent that payment under this ***Plan*** is prohibited by any law of any jurisdiction in which the ***enrolled individual*** resides at the time the expense is ***incurred***.

9. Charges for services rendered and/or supplies received prior to the ***effective date*** or after the termination date of a person's coverage.

10. Any services, supplies or treatment for which the ***enrolled individual*** is not legally required to pay; or for which no charge would usually be made; or for which such charge, if made, would not usually be collected if no coverage existed; or to the extent the charge for the care exceeds the charge that would have been made and collected if no coverage existed.

11. Charges for services, supplies or treatment that are considered ***experimental/investigational***.

12. Charges ***incurred*** outside the United States if the ***enrolled individual*** traveled to such a location for the sole purpose of obtaining services, supplies or treatment.

13. Charges for services, supplies or treatment rendered by any individual who is a ***close relative*** of the ***enrolled individual*** or who resides in the same household as the ***enrolled individual***.

14. Charges for services, supplies or treatment rendered by ***physicians*** or ***professional providers*** beyond the scope of their license; for any treatment, ***confinement*** or service which is not recommended by or performed by an appropriate ***professional provider***.

15. Charges for ***illnesses*** or ***injuries*** suffered by an ***enrolled individual*** due to the action or inaction of any party if the ***enrolled individual*** fails to provide information as specified in the section, *Subrogation/Reimbursement*.

16. Claims not submitted within the ***Plan's*** filing limit deadlines as specified in the section, *Health Benefit Claim Filing Procedure*.

17. Charges for telephone or e-mail consultations (except as specified herein), completion of claim forms, charges associated with missed appointments.

18. Charges assessed by another plan, due to non-compliance with that plan's rules and regulations.

19. For expenses in connection with an ***injury*** arising out of or relating to an accident involving the maintenance or use of a motor vehicle (other than a recreational vehicle not intended for highway use, motorcycle, motor driven cycle, motorized pedal cycle or like type vehicle). This exclusion shall apply to those expenses up to the minimum amount required by law in the state of residence for any ***injury*** arising out of an accident of the type for which benefits are or would be payable under automobile insurance, regardless of whether or not automobile insurance is in force and regardless of any benefit limits under such insurance. However, this exclusion does not apply to an ***enrolled individual*** who is a non-driver when involved in an uninsured motor vehicle accident.

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

20. Court-ordered services, or services that are a condition of probation or parole, to the extent permitted by law.

21. Charges for ***injuries*** sustained while an active participant in a professional sporting event (engaged in on an individual or group basis for wage or profit) or professional hazardous avocations.

ELIGIBILITY, ENROLLMENT AND EFFECTIVE DATE

This section identifies the ***Plan's*** requirements for a person to participate in the ***Plan***.

EMPLOYEE ELIGIBILITY

An employee's eligibility for coverage and effective date will vary depending upon whether he or she is regularly employed for twenty (20) hours or more of service per week. In the event an employee's weekly work schedule will vary and the ***employer*** cannot reasonably predict his or her eligibility status at the time of hire, he or she will be deemed a "variable hour employee." The ***employer*** shall determine the eligibility status of newly hired variable hour employees using a "lookback method" and a twelve (12) month initial measurement period ("IMP"). Coverage shall be offered for the corresponding twelve (12) month initial stability period ("ISP") to newly hired variable hour employees who are deemed eligible based on average weekly "hours of service" during their IMP. The IMP shall commence on the first pay period of the first full month following the date of hire. For purposes of this provision, hours of service include any hours for which an employee is entitled to compensation (including PTO) as well as unpaid FMLA leave, military leave under USERRA and jury duty leave.

Employees hired full time on a temporary long-term assignment also may be eligible for the Penn Medicine Lancaster General Health Employee Benefits Plan based on the business needs of the organization.

For ongoing variable hour employees, continued eligibility for coverage shall be determined using a lookback method and a twelve (12) month "standard measurement period" ("SMP") which commences on the first pay period in October each year. An "ongoing" employee is any variable hour employee who has completed at least one full SMP. Ongoing variable hour employees who are deemed eligible for coverage based on average weekly hours of service during a SMP, shall be offered coverage for the corresponding twelve (12) month stability period, provided they are not rendered ineligible for other reasons (e.g. break in service).

The ***employer*** shall utilize an "administrative period" of thirty (30) days in duration at the end of every measurement period to determine the eligibility status of variable hour employees. Employees who transfer into or out of variable hour positions or who experience a break in service shall have their eligibility for coverage determined in accordance with IRS regulations. The preceding eligibility provisions shall also apply to employees whose employment is limited to no more than six months per year (i.e. seasonal employees).

These provisions shall be interpreted and applied in accordance with IRS regulations.

EMPLOYEE ENROLLMENT

An ***employee*** must complete an enrollment submission (electronic) with the ***employer*** for coverage hereunder for himself within one (1) month of becoming eligible for coverage. The ***employee*** shall have the responsibility for timely completion of the electronic enrollment process.

EMPLOYEE(S) EFFECTIVE DATE

For the following Management Levels, eligible ***employees***, as described in the *Employee Eligibility* section, are enrolled under the ***Plan*** immediately upon the date of hire, provided the ***employee*** has enrolled for coverage as described in *Employee Enrollment*.

Chair	Executive Vice President	Staff Physician
Chief	Managing Physician	Staff Resident
Vice President	Director/Physician	Supervising Physician
Senior Vice President	Vice President Physician	Director AIP
Senior Director	Director	

For Management Levels not noted above, eligible ***employees***, as described in the *Employee Eligibility* section, are enrolled under the ***Plan*** upon completion of thirty (30) days of active service, provided ***employee*** has enrolled for coverage as described in *Employee Enrollment*.

For Full and Part-time employees transferring to or between UPHS entities, past service credit will count towards waiting period for benefit programs, contingent upon eligibility outlined in Plan Documents and waiting period specified by receiving entity.

DEPENDENT(S) ELIGIBILITY

The following describes ***dependent*** eligibility requirements. The ***employer*** will require proof of ***dependent*** status.

1. The term "spouse" means the spouse of the ***employee*** under a legally valid existing marriage, as defined by the state in which the ***employee*** was legally married, unless court ordered separation exists.

2. The term "child" means the ***employee's*** natural child, stepchild, legally adopted child and a child for whom the ***employee*** or enrolled spouse has been appointed legal guardian, provided the child is less than twenty-six (26) years of age.

3. An eligible child shall also include any other child of an ***employee*** or their spouse who is recognized in a Qualified Medical Child Support Order (QMCSO) or National Medical Support Notice (NMSN) which has been issued by any court judgment, decree, or order as being entitled to enrollment for coverage under this ***Plan***, even if the child is not residing in the ***employee's*** household. Such child shall be referred to as an ***alternate recipient***. ***Alternate recipients*** are eligible for coverage only if the ***employee*** is also enrolled under this ***Plan***. An application for enrollment must be submitted to the ***employer*** for coverage under this ***Plan***. The ***employer/Plan Administrator*** shall establish procedures for administering the provision of benefits under the ***Plan*** pursuant to a valid QMCSO or NMSN. Within a reasonable period after receipt of a medical child support order, the ***employer/Plan Administrator*** shall determine whether such order is a QMCSO, as defined in Section 609 of ERISA, or a NMSN, as defined in Section 401 of the Child Support Performance and Incentive Act of 1998.

   The ***employer/Plan Administrator*** reserves the right, waivable at its discretion, to seek clarification with respect to the order from the court or administrative agency which issued the order, up to and including the right to seek a hearing before the court or agency.

4. A ***dependent*** child who lives with the ***employee***, is unmarried, incapable of self-sustaining employment and dependent upon the ***employee*** for support due to a mental and/or physical disability, will be eligible for coverage under the ***Plan*** beyond the date that ***dependent*** child would otherwise be ineligible for coverage. Proof of incapacitation must be provided within one (1) month of the child's loss of eligibility and thereafter as requested by the ***employer*** or ***Claims Processor***, but not more than once every year. Eligibility may not be continued beyond the earliest of the following:

   a. Cessation of the mental and/or physical disability;
   b. Failure to furnish any required proof of mental and/or physical disability or to submit to any required examination.

Every eligible ***employee*** may enroll eligible ***dependents***. However, if both the husband and wife are ***employees***, each individual may be enrolled as an ***employee*** and as a ***dependent*** of the other spouse. Eligible children may be enrolled as ***dependents*** of one or both spouses.

DEPENDENT ENROLLMENT

An ***employee*** must complete an enrollment submission (electronic) with the ***employer*** for coverage hereunder for his eligible ***dependents*** within one (1) month of becoming eligible for coverage; and within one (1) month of marriage or the acquiring of children or birth of a child. The ***employee*** shall have the responsibility for timely completion of the electronic enrollment process.

DEPENDENT(S) EFFECTIVE DATE

Eligible ***dependent(s)***, as described in *Dependent(s) Eligibility*, will become enrolled under the ***Plan*** on the later of the dates listed below, provided the ***employee*** has enrolled them in the ***Plan*** within one (1) month of meeting the ***Plan's*** eligibility requirements and any required contributions are made.

1. The date the ***employee's*** coverage becomes effective.

2. The date the ***dependent*** is acquired, provided the ***employee*** has applied for ***dependent*** coverage within one (1) month of the date acquired.

3. Newborn children born shall be enrolled from birth, provided the ***employee*** has applied for ***dependent*** coverage within one (1) month of birth.

4. Coverage for a newly adopted or to be adopted child shall be effective on the date the child is ***placed for adoption***, provided the ***employee*** has applied for ***dependent*** coverage within one (1) month of the date the child is ***placed for adoption***.

SPECIAL ENROLLMENT PERIOD (OTHER COVERAGE)

An ***employee*** or ***dependent*** who did not enroll for coverage under this ***Plan*** because he was covered under other group coverage or had health insurance coverage at the time he was initially eligible for coverage under this ***Plan***, may request a special enrollment period if he is no longer eligible for the other coverage. Special enrollment periods will be granted if the individual's loss of eligibility is due to:

1. Termination of the other coverage (including exhaustion of COBRA benefits).

2. Cessation of employer contributions toward the other coverage.

3. Divorce.

4. Termination of other employment or reduction in number of hours of other employment.

5. Death of ***dependent*** or spouse.

6. Cessation of other coverage because ***employee*** or ***dependent*** no longer resides or works in the service area and no other benefit package is available to the individual.

7. Cessation of ***dependent*** status under other coverage and ***dependent*** is otherwise eligible under ***employee's Plan***.

8. An incurred claim that would exceed the other coverage's maximum benefit limit. The maximum benefit limit is all-inclusive and means that no further benefits are payable under the other coverage because the

specific total benefit pay out maximum has been reached under the other coverage. The right for special enrollment continues for thirty (30) days after the date the claim is denied under the other coverage.

Notwithstanding any provision of this ***Plan*** to the contrary, all benefits received by an individual under any benefit option, package or coverage under the ***Plan*** shall be applied toward the ***maximum benefit*** paid by this ***Plan*** for any one ***enrolled individual*** for such option, package or coverage under the ***Plan***, and also toward the ***maximum benefit*** under any other options, packages or coverages under the ***Plan*** in which the individual may participate in the future.

The end of any extended benefits period, which has been provided due to any of the above, will also be considered a loss of eligibility.

However, loss of eligibility does not include a loss due to failure of the individual to pay premiums or contributions on a timely basis or termination of coverage for cause (such as making a fraudulent claim or an intentional misrepresentation of a material fact in connection with the other coverage).

The ***employee*** or ***dependent*** must request the special enrollment and enroll no later than one (1) month from the date of loss of other coverage.

SPECIAL ENROLLMENT PERIOD (NEW DEPENDENT)

An ***employee*** who is currently enrolled or not enrolled under the ***Plan***, but who acquires a new ***dependent*** may request a special enrollment period for himself, if applicable; and/or his newly acquired ***dependent*** and his spouse, if not already enrolled under this ***Plan*** and otherwise eligible for coverage.

For the purposes of this provision, the acquisition of a new ***dependent*** includes:

- marriage
- birth of a ***dependent*** child
- adoption or ***placement for adoption*** of a ***dependent*** child

The ***employee*** must request the special enrollment within one (1) month of the acquisition of the ***dependent***.

The ***effective date*** of coverage as the result of a special enrollment shall be:

1. in the case of marriage, the date of such marriage;

2. in the case of a ***dependent's*** birth, the date of such birth;

3. in the case of adoption or ***placement for adoption***, the date of such adoption or ***placement for adoption***.

SPECIAL ENROLLMENT PERIOD (CHILDREN'S HEALTH INSURANCE PROGRAM (CHIP) REAUTHORIZATION ACT OF 2009)

This ***Plan*** intends to comply with the Children's Health Insurance Program Reauthorization Act of 2009.

An ***employee*** who is currently enrolled or not enrolled under the ***Plan*** may request a special enrollment period for himself, if applicable, and his ***dependent***. Special enrollment periods will be granted if:

1. the individual's loss of eligibility is due to termination of coverage under a state children's health insurance program or Medicaid; or,
2. the individual is eligible for any applicable premium assistance under a state children's health insurance program or Medicaid.

The ***employee*** or ***dependent*** must request the special enrollment and enroll no later than sixty (60) days from the date of loss of other coverage or from the date the individual becomes eligible for any applicable premium assistance.

ANNUAL BENEFIT ENROLLMENT

Annual benefit enrollment is the period designated by the ***employer*** during which the ***employee*** may change benefit plans or enroll in the ***Plan*** if he did not do so when first eligible or does not qualify for a special enrollment period. An annual benefit enrollment will be permitted once in each plan year during the month of May.

During this annual benefit enrollment period, an ***employee*** and his ***dependents*** who are enrolled under this ***Plan*** or enrolled under any ***employer*** sponsored health plan may elect coverage or change coverage under this ***Plan*** for himself and his eligible ***dependents***. An ***employee*** must complete an electronic enrollment submission as provided by the ***employer***, during the annual benefit enrollment period to change benefit plans.

The ***effective date*** of coverage as the result of an annual benefit enrollment period will be the following July 1st. Except for a status change listed below, the annual benefit enrollment period is the only time an ***employee*** may change benefit options or modify enrollment. Status changes include:

1. Change in family status. A change in family status shall include only:

    a. Change in ***employee's*** legal marital status;
    b. Change in number of ***dependents***;
    c. Termination or commencement of employment by the ***employee***, spouse or ***dependent***;
    d. Change in work schedule;
    e. ***Dependent*** satisfies (or ceases to satisfy) ***dependent*** eligibility requirements;
    f. Change in residence or worksite of ***employee***, spouse or ***dependent***.

2. Change in the cost of coverage under the ***employer's*** group health benefits program.

3. Cessation of required employee contributions.
4. Taking or returning from a ***leave of absence*** under the Family and Medical Leave Act of 1993 (FMLA).

5. Significant change in the health coverage of the ***employee*** or spouse attributable to the spouse's employment.

6. A Special Enrollment Period as mandated by the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

7. A court order, judgment or decree.

8. Entitlement to ***Medicare*** or Medicaid, or enrollment in a state child health insurance program (CHIP).

9. A COBRA qualifying event.

TERMINATION OF COVERAGE

Except as provided in the ***Plan's*** *Continuation of Coverage* (COBRA) provision, coverage will terminate on the earliest of the following dates:

TERMINATION OF EMPLOYEE COVERAGE

1. The date the ***employer*** terminates the ***Plan*** and offers no other group health benefits program.

2. The date the ***employee*** is no longer eligible for benefits.

3. The last day worked by the ***employee***.

4. Twenty-four (24) months following the date the ***employee*** becomes a full-time, active member of the armed forces of any country.

5. The date the ***employee*** ceases to make any required contributions.

TERMINATION OF DEPENDENT(S) COVERAGE

1. The date the ***employer*** terminates the ***Plan*** and offers no other group health benefits program.

2. The date the ***employee*** is no longer eligible for benefits.

3. The last day worked by the ***employee***.

4. The date such person ceases to meet the eligibility requirements of the ***Plan***, except that for a ***dependent*** child who reaches age 26, termination shall be the last day of the month in which the ***dependent*** child reaches age 26.

5. The date the ***employee*** ceases to make any required contributions on the ***dependent's*** behalf.

6. The date the ***employee's*** spouse becomes a full-time, active member of the armed forces of any country.

7. The date the ***Plan*** discontinues ***dependent*** coverage for any and all ***dependents***.

LEAVE OF ABSENCE

Coverage may be continued for a limited time, contingent upon payment of any required contributions for ***employees*** and/or ***dependents***, when the ***employee*** is on an authorized ***leave of absence*** from the ***employer***.

FAMILY AND MEDICAL LEAVE ACT (FMLA)

Eligible Leave

An ***employee*** who is eligible for unpaid leave and benefits under the terms of the Family and Medical Leave Act of 1993, as amended, has the right to continue coverage under this ***Plan*** for up to twelve (12) weeks, except as noted, during any twelve (12) month period because of any of the following:

1. Birth of a child of the ***employee*** and in order to care for such child;

2. Placement of a child with the ***employee*** for adoption or foster care;

3. To care for the spouse, child, or parent of the ***employee***, if such spouse, child, or parent has a serious health condition;

4. Because of a serious health condition that makes the ***employee*** unable to perform the functions of the position of such ***employee***;

5. Because of any qualifying exigency (as determined by regulation) arising out of the fact that the spouse, child, or parent of the ***employee*** is on active duty (or has been notified of an impending call or order to active duty) in the Armed Forces in support of a contingency operation; or

6. To care for a service member who is the spouse, child, parent or next of kin to the ***employee*** for up to twenty-six (26) weeks during any twelve (12) month period. An enrolled service member means –

    - A current member of the Armed Forces, including a member of the National Guard or Reserves, who is undergoing medical treatment, recuperation or therapy, is otherwise in an outpatient status, or is otherwise on the temporary disability retired list, for a serious injury or illness*:
    - A veteran who was discharged or released under conditions other than dishonorable, at any time during the five-year period prior to the first date the eligible employee takes FMLA leave, to care for the covered veteran, and who is undergoing medical treatment, recuperation, or therapy for a serious injury or illness*.

    *The FMLA definitions of 'serious injury or illness' for current service members and veterans are distinct from the FMLA definition of 'serious health condition'.

As identified in this FMLA section, the terms "Outpatient Status" and "Serious Injury or Illness" shall have the following meanings:

Outpatient Status

With respect to an enrolled service member, outpatient status means the status of a member of the Armed Forces assigned to (a) a military medical treatment facility as an outpatient; or (b) a unit established for the purpose of providing command and control of members of the Armed Forces receiving medical care as outpatients.

Serious Injury or Illness

A serious injury or illness, in the case of a member of the Armed Forces, including a member of the National Guard or Reserves, means an injury or illness incurred by the service member in the line of duty on active duty in the Armed Forces that may render the service member medically unfit to perform the duties of the service member's office, grade, rank, or rating.

Contributions

During this leave, the ***employer*** will continue to pay the same portion of the ***employee's*** contribution for the ***Plan***. The ***employee's*** portion of the contribution will go to arrears. Upon return to work, the amount in arrears will be collected through insurance deductions on their paycheck. Employees will notice a 25% increase in their deductions until up to date. Example: If an employee misses one (1) paycheck with insurance deductions, the arrears will be made up over four (4) pay periods. If the employee misses two (2) paychecks, the arrears will be made up over eight (8) pay periods.

Reinstatement

If coverage under the ***Plan*** was terminated during an approved FMLA leave, and the ***employee*** returns to active employment immediately upon completion of that leave, ***Plan*** coverage will be reinstated on the date the ***employee*** returns to active employment as if coverage had not terminated, provided the ***employee*** makes any necessary contributions and enrolls for coverage within one (1) month of his return to active employment.

Repayment Requirement

The ***employer*** may require ***employees*** who fail to return from a leave under FMLA to repay any contributions paid by the ***employer*** on the ***employee's*** behalf during an unpaid leave. This repayment will be required only if the ***employee's*** failure to return from such leave is not related to a "serious health condition," as defined in FMLA, or events beyond the ***employee's*** control.

EMPLOYEE REINSTATEMENT

Employees and eligible ***dependents*** who lost coverage due to an approved ***leave of absence*** or termination of employment with the ***employer*** are eligible for reinstatement of coverage as follows:

1. Reinstatement of coverage is available to ***employees*** and ***dependents*** who were previously enrolled under the ***Plan***.

2. Rehire or return to active service must occur within six months of the last pay date.

3. The ***employee*** must submit the completed application for enrollment to the ***employer*** within one (1) month of rehire or return to work.

4. Coverage shall be effective from the date of rehire or return to work. Prior benefits and limitations, such as deductible and/or ***maximum benefit***, shall be applied with no break in coverage.

If the provisions of (1) through (3) above are not met, the ***Plan's*** provisions for eligibility and application for enrollment shall apply.

Unless otherwise required by law, an ***employee*** who returns to work more than six months after the termination date, following an approved ***leave of absence*** or termination of employment will be considered a new ***employee*** for purposes of eligibility and will be subject to all eligibility requirements, including all requirements relating to the ***effective date*** of coverage.

CONTINUATION OF COVERAGE

In order to comply with federal regulations, this ***Plan*** includes a continuation of coverage option for certain individuals whose coverage would otherwise terminate. The following is intended to comply with the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA), as amended. This continuation of coverage may be commonly referred to as "COBRA coverage" or "continuation coverage."

The coverage which may be continued under this provision consists of health benefits coverage. It does not include life insurance benefits, accidental death and dismemberment benefits, or income replacement benefits. Health coverage includes medical and prescription drug benefits as provided under the ***Plan***.

QUALIFYING EVENTS

Qualifying events are any one of the following events that would cause an ***enrolled individual*** to lose coverage under this ***Plan*** or cause an increase in required contributions, even if such loss of coverage or increase in required contributions does not take effect immediately, and allow such person to continue coverage beyond the date described in *Termination of Coverage*:

1. Death of the ***employee***.

2. The ***employee's*** termination of employment (other than termination for gross misconduct), or reduction in work hours to less than the minimum required for coverage under the ***Plan***. This event is referred to below as an "18-Month Qualifying Event."

3. Divorce or legal separation from the ***employee***.

4. The ***employee's*** entitlement to ***Medicare*** benefits under Title XVIII of the Social Security Act, if it results in the loss of coverage under this ***Plan***.

5. A ***dependent*** child no longer meets the eligibility requirements of the ***Plan***.

6. The last day of leave under the Family and Medical Leave Act of 1993, or an earlier date on which the ***employee*** informs the ***employer*** that he or she will not be returning to work.

7. The call-up of an ***employee*** reservist to active duty.

NOTIFICATION REQUIREMENTS

1. When eligibility for continuation of coverage results from a spouse being divorced or legally separated from an enrolled ***employee***, or a child's loss of ***dependent*** status, the ***employee*** or ***dependent*** must submit a completed Qualifying Event Notification form to the ***Plan Administrator*** (or its designee) within sixty (60) days of the latest of:

    a. The date of the event;
    b. The date on which coverage under this ***Plan*** is or would be lost as a result of that event; or
    c. The date on which the ***employee*** or ***dependent*** is furnished with a copy of this Plan Document and Summary Plan Description.

A copy of the Qualifying Event Notification form is available from the ***Plan Administrator*** (or its designee). In addition, the ***employee*** or ***dependent*** may be required to promptly provide any supporting documentation as may be reasonably requested for purposes of verification. Failure to provide such notice and any requested supporting documentation will result in the person forfeiting their rights to continuation of coverage under this provision.

Within fourteen (14) days of the receipt of a properly completed Qualifying Event Notification, the ***Plan Administrator*** (or its designee) will notify the ***employee*** or ***dependent*** of his rights to continuation of coverage, and what process is required to elect continuation of coverage. This notice is referred to below as "Election Notice."

2. When eligibility for continuation of coverage results from any qualifying event under this ***Plan*** other than the ones described in Paragraph 1 above, the ***employer*** must notify the ***Plan Administrator*** (or its designee) not later than thirty (30) days after the date on which the ***employee*** or ***dependent*** loses coverage under the ***Plan*** due to the qualifying event. Within fourteen (14) days of the receipt of the notice of the qualifying event, the ***Plan Administrator*** (or its designee) will furnish the Election Notice to the ***employee*** or ***dependent***.

3. In the event it is determined that an individual seeking continuation of coverage (or extension of continuation coverage) is not entitled to such coverage, the ***Plan Administrator*** (or its designee) will provide to such individual an explanation as to why the individual is not entitled to continuation coverage. This notice is referred to here as the "Non-Eligibility Notice." The Non-Eligibility Notice will be furnished in accordance with the same time frame, as applicable to the furnishing of the Election Notice.

4. In the event an Election Notice is furnished, the eligible ***employee*** or ***dependent*** has sixty (60) days to decide whether to elect continued coverage. Each person who is described in the Election Notice and was enrolled under the ***Plan***, on the day before the qualifying event, has the right to elect continuation of coverage on an individual basis, regardless of family enrollment. If the ***employee*** or ***dependent*** chooses to have continuation coverage, he must advise the ***Plan Administrator*** (or its designee) of this choice by returning to the ***Plan Administrator*** (or its designee) a properly completed Election Notice not later than the last day of the sixty (60) day period. If the Election Notice is mailed to the ***Plan Administrator*** (or its designee), it must be postmarked on or before the last day of the sixty (60) day period. This sixty (60) day period begins on the later of the following:

   a. The date coverage under the ***Plan*** would otherwise end; or
   b. The date the person receives the Election Notice from the ***Plan Administrator*** (or its designee).

5. Within forty-five (45) days after the date the person notifies the ***Plan Administrator*** (or its designee) that he has chosen to continue coverage, the person must make the initial payment. The initial payment will be the amount needed to provide coverage from the date continued benefits begin, through the last day of the month in which the initial payment is made. Thereafter, payments for the continuation coverage are to be made monthly, and are due in advance, on the first day each month.

COST OF COVERAGE

1. The ***Plan*** requires that ***enrolled individuals*** pay the entire costs of their continuation coverage, plus a two percent (2%) administrative fee. Except for the initial payment (see above), payments must be remitted to the ***Plan Administrator*** (or its designee) by, or before the first day of each month, during the continuation period. The payment must be remitted on a timely basis in order to maintain the coverage in force.

2. For a person originally enrolled as an ***employee*** or as a spouse, the cost of coverage is the amount applicable to an ***employee*** if coverage is continued for himself alone. For a person originally enrolled as a child and continuing coverage independent of the family unit, the cost of coverage is the amount applicable to an ***employee***.

WHEN CONTINUATION COVERAGE BEGINS

When continuation coverage is elected and the initial payment is made within the time period required, coverage is reinstated back to the date of the loss of coverage, so that no break in coverage occurs. Coverage for ***dependents*** acquired and properly enrolled during the continuation period begins in accordance with the enrollment provisions of the ***Plan***.

FAMILY MEMBERS ACQUIRED DURING CONTINUATION

A spouse or ***dependent*** child newly acquired during continuation coverage is eligible to be enrolled as a ***dependent***. The standard enrollment provision of the ***Plan*** applies to enrollees during continuation coverage. A ***dependent*** acquired and enrolled after the original qualifying event, other than a child born to or ***placed for adoption*** with an enrolled ***employee*** during a period of COBRA continuation coverage, is not eligible for a separate continuation if a subsequent event results in the person's loss of coverage.

EXTENSION OF CONTINUATION COVERAGE

1. In the event any of the following events occur during the period of continuation coverage resulting from an 18-Month Qualifying Event, it is possible for a ***dependent's*** continuation coverage to be extended:

    a. Death of the ***employee***.
    b. Divorce or legal separation from the ***employee***.
    c. The child's loss of ***dependent*** status.

    Written notice of such event must be provided by submitting a completed Additional Extension Event Notification form to the ***Plan Administrator*** (or its designee) within sixty (60) days of the latest of:

    (i.) The date of that event;
    (ii.) The date on which coverage under this ***Plan*** would be lost as a result of that event, if the first qualifying event had not occurred; or
    (iii.) The date on which the ***employee*** or ***dependent*** is furnished with a copy of this Plan Document and Summary Plan Description.

    A copy of the Additional Extension Event Notification form is available from the ***Plan Administrator*** (or its designee). In addition, the ***dependent*** may be required to promptly provide any supporting documentation as may be reasonably required for purposes of verification. Failure to properly provide the Additional Extension Event Notification and any requested supporting documentation will result in the person forfeiting their rights to extend continuation coverage under this provision. In no event will any extension of continuation coverage extend beyond thirty-six (36) months from the later of the date of the first qualifying event or the date as of which continuation coverage began.

    Only an individual enrolled prior to the original qualifying event or a child born to, or ***placed for adoption*** with, an enrolled ***employee*** during a period of COBRA coverage may be eligible to continue coverage through an extension of continuation coverage as described above. Any other ***dependent*** acquired during continuation coverage is not eligible to extend continuation coverage as described above.

2. A person who loses coverage on account of an 18-Month Qualifying Event may extend the maximum period of continuation coverage from eighteen (18) months to up to twenty-nine (29) months in the event both of the following occur:

a. That person (or another person who is entitled to continuation coverage on account of the same 18-month Qualifying Event) is determined by the Social Security Administration, under Title II or Title XVI of the Social Security Act, to have been disabled before the sixtieth (60^{th}) day of continuation coverage; and
b. The disability status, as determined by the Social Security Administration, lasts at least until the end of the initial eighteen (18) month period of continuation coverage.

The disabled person (or his representative) must submit written proof of the Social Security Administration's disability determination to the ***Plan Administrator*** (or its designee) within the initial eighteen (18) month period of continuation coverage and no later than sixty (60) days after the latest of:

(i.) The date of the disability determination by the Social Security Administration;
(ii.) The date of the 18-Month Qualifying Event;
(iii.) The date on which the person loses (or would lose) coverage under this ***Plan*** as a result of the 18-month Qualifying Event; or
(iv.) The date on which the person is furnished with a copy of this Plan Document and Summary Plan Description.

Should the disabled person fail to notify the ***Plan Administrator*** (or its designee) in writing within the time frame described above, the disabled person (and others entitled to disability extension on account of that person) will then be entitled to whatever period of continuation he or they would otherwise be entitled to, if any. The ***Plan*** may require that the individual pay one hundred and fifty percent (150%) of the cost of continuation coverage during the additional eleven (11) months of continuation coverage. In the event the Social Security Administration makes a final determination that the individual is no longer disabled, the individual must provide notice of that final determination no later than thirty (30) days after the later of:
(A.) The date of the final determination by the Social Security Administration; or
(B.) The date on which the individual is furnished with a copy of this Plan Document and Summary Plan Description.

END OF CONTINUATION

Continuation of coverage under this provision will end on the earliest of the following dates:

1. Eighteen (18) months (or twenty-nine (29) months if continuation coverage is extended, due to certain disability status as described above) from the date continuation began because of an 18-Month Qualifying Event or the last day of leave under the Family and Medical Leave Act of 1993.

2. Twenty-four (24) months from the date continuation began because of the call-up to military duty.

3. Thirty-six (36) months from the date continuation began for ***dependents*** whose coverage ended because of the death of the ***employee***, divorce or legal separation from the ***employee***, or the child's loss of ***dependent*** status.

4. The end of the period for which contributions are paid if the ***enrolled individual*** fails to make a payment by the date specified by the ***Plan Administrator*** (or its designee). In the event continuation coverage is terminated for this reason, the individual will receive a notice describing the reason for the termination of coverage, the effective date of termination, and any rights the individual may have under this ***Plan*** or under applicable law to elect an alternative group or individual coverage, such as a conversion right. This notice is referred to below as an "Early Termination Notice."

5. The date coverage under this ***Plan*** ends and the ***employer*** offers no other group health benefit plan. In the event continuation coverage is terminated for this reason, the individual will receive an Early Termination Notice.

6. The date the ***enrolled individual*** first becomes entitled, after the date of the ***enrolled individual's*** original election of continuation coverage, to ***Medicare*** benefits under Title XVIII of the Social Security Act. In the event continuation coverage is terminated for this reason, the individual will receive an Early Termination Notice.

7. The date the ***enrolled individual*** first becomes enrolled under any other employer's group health plan after the original date of the ***enrolled individual's*** election of continuation coverage, but only if such group health plan does not have any exclusion or limitation that affects coverage of the ***enrolled individual's*** pre-existing condition. In the event continuation coverage is terminated for this reason, the individual will receive an Early Termination Notice.

8. For the spouse or ***dependent*** child of an enrolled ***employee*** who becomes entitled to ***Medicare*** prior to the spouse's or ***dependent's*** election for continuation coverage, thirty-six (36) months from the date the enrolled ***employee*** becomes entitled to ***Medicare***.

SPECIAL RULES REGARDING NOTICES

1. Any notice required in connection with continuation coverage under this ***Plan*** must, at minimum, contain sufficient information so that the ***Plan Administrator*** (or its designee) is able to determine from such notice the ***employee*** and ***dependent(s)*** (if any), the qualifying event or disability, and the date on which the qualifying event occurred.
2. In connection with continuation coverage under this ***Plan***, any notice required to be provided by any individual who is either the ***employee*** or a ***dependent*** with respect to the qualifying event may be provided by a representative acting on behalf of the ***employee*** or the ***dependent***, and the provision of the notice by one individual shall satisfy any responsibility to provide notice on behalf of all related eligible individuals with respect to the qualifying event.
3. As to an Election Notice, Non-Eligibility Notice or Early Termination Notice:
    a) A single notice addressed to both the ***employee*** and the spouse will be sufficient as to both individuals if, on the basis of the most recent information available to the ***Plan***, the spouse resides at the same location as the ***employee***; and
    b) A single notice addressed to the ***employee*** or the spouse will be sufficient as to each ***dependent*** child of the ***employee*** if, on the basis of the most recent information available to the ***Plan***, the ***dependent*** child resides at the same location as the individual to whom such notice is provided.

PRE-EXISTING CONDITIONS

In the event that an ***enrolled individual*** becomes eligible for coverage under another employer-sponsored group health plan, and that group health plan has an applicable exclusion or limitation regarding coverage of the ***enrolled individual's*** pre-existing condition, the ***enrolled individual's*** continuation coverage under the ***Plan*** will not be affected by enrollment under that other group health plan. This ***Plan*** shall be primary payer for the ***covered expenses*** that are excluded or limited under the other employer sponsored group health plan and secondary payer for all other expenses.

MILITARY MOBILIZATION

If an ***employee*** is called for active duty by the United States Armed Services (including the Coast Guard, the National Guard or the Public Health Service), the ***employee*** and the ***employee's dependent*** may continue their health coverage, pursuant to the Uniformed Services Employment and Reemployment Rights Act (USERRA).

When the leave is less than thirty-one (31) days, the ***employee*** and the ***employee's dependent*** may not be required to pay more than the ***employee's*** share, if any, applicable to that coverage. If the leave is thirty-one (31) days or longer, then the ***Plan Administrator*** (or its designee) may require the ***employee*** and the ***employee's dependent*** to pay no more than one hundred and two percent (102%) of the full contribution.

The maximum length of the continuation coverage required under the Uniformed Services Employment and Reemployment Rights Act (USERRA) is the lesser of:

1. Twenty-four (24) months beginning on the day that the leave commences, or
2. A period beginning on the day that the leave began and ending on the day after the ***employee*** fails to return to employment within the time allowed.

The period of continuation coverage under USERRA will be counted toward any continuation coverage period concurrently available under COBRA. Upon return from active duty, the ***employee*** and the ***employee's dependent*** will be reinstated without a waiting period, regardless of their election of COBRA continuation coverage.

PLAN CONTACT INFORMATION

Questions concerning this ***Plan***, including any available continuation coverage, can be directed to the ***Plan Administrator*** (or its designee).

ADDRESS CHANGES

In order to help ensure the appropriate protection of rights and benefits under this ***Plan***, ***enrolled individuals persons*** should keep the ***Plan Administrator*** (or its designee) informed of any changes to their current addresses.

HEALTH BENEFIT CLAIM FILING PROCEDURE

A "pre-service claim" is a claim for a ***Plan*** benefit that is subject to the prior certification rules, as described in the section, *Pre-Service Claim Procedure*. All other claims for ***Plan*** benefits are "post-service claims" and are subject to the rules described in the section, *Post-Service Claim Procedure*.

POST-SERVICE CLAIM PROCEDURE

FILING A CLAIM

1. Claims should be submitted to the address shown on the ID card.

   The date of receipt will be the date the claim is received by the ***Claims Processor***.

2. All claims submitted for benefits must contain all of the following:

   a. Name of patient.
   b. Patient's date of birth.
   c. Name of ***employee***.
   d. Address of ***employee***.
   e. Name of ***employer*** and group number.
   f. Name, address and tax identification number of provider.
   g. ***Employee*** Capital Blue Cross Member Identification Number.
   h. Date of service.
   i. Diagnosis.
   j. Description of service and procedure number.
   k. Charge for service.
   l. The nature of the ***accident***, ***injury*** or ***illness*** being treated.

   Cash register receipts, credit card copies, labels from containers and cancelled checks are not acceptable.

3. All claims not submitted within 365 days from the date the services were rendered will not be a ***covered expense*** and will be denied.

The ***enrolled individual*** may ask the health care provider to submit the claim directly to the ***Claims Processor***, or the ***enrolled individual*** may submit the bill. However, it is ultimately the ***enrolled individual's*** responsibility to make sure the claim for benefits has been filed.

NOTICE OF AUTHORIZED REPRESENTATIVE

The ***enrolled individual*** may provide the ***Plan Administrator*** (or its designee) with a written authorization for an authorized representative to represent and act on behalf of an ***enrolled individual*** and consent to the release of information related to the ***enrolled individual*** to the authorized representative with respect to a claim for benefits or an appeal. Authorization forms may be obtained from the Human Resource Department.

NOTICE OF CLAIM

A claim for benefits should be submitted to the ***Claims Processor*** within ninety (90) calendar days after the occurrence or commencement of any services by the ***Plan***, or as soon thereafter as reasonably possible.

Failure to file a claim within the time provided shall not invalidate or reduce a claim for benefits if: (1) it was not reasonably possible to file a claim within that time; and (2) that such claim was furnished as soon as possible, but no later than 365 days after the loss occurs or commences, unless the claimant is legally incapacitated.
Notice given by or on behalf of an ***enrolled individual*** or his beneficiary, if any, to the ***Plan Administrator*** or to any authorized agent of the ***Plan***, with information sufficient to identify the ***enrolled individual***, shall be deemed notice of claim.

TIME FRAME FOR BENEFIT DETERMINATION

After a completed claim has been submitted to the ***Claims Processor***, and no additional information is required, the ***Claims Processor*** will generally complete its determination of the claim within thirty (30) calendar days of receipt of the completed claim unless an extension is necessary due to circumstances beyond the ***Plan's*** control.

After a completed claim has been submitted to the ***Claims Processor***, and if additional information is needed for determination of the claim, the ***Claims Processor*** will provide the ***enrolled individual*** (or authorized representative) with a notice detailing information needed. The notice will be provided within thirty (30) calendar days of receipt of the completed claim and will state the date as of which the ***Plan*** expects to make a decision. The ***enrolled individual*** will have forty-five (45) calendar days to provide the information requested, and the ***Plan*** will complete its determination of the claim within fifteen (15) calendar days of receipt by the ***Claims Processor*** of the requested information. Failure to respond in a timely and complete manner will result in the denial of benefit payment.

NOTICE OF BENEFIT DENIAL

If the claim for benefits is denied, the ***Plan Administrator*** (or its designee) shall provide the ***covered person*** (or authorized representative) with a written Notice of Benefit Denial within the time frames described immediately above.

The Notice of Benefit Denial shall include an explanation of the denial, including:

1. Information sufficient to identify the claim involved.
2. The specific reasons for the denial, to include:
    a. The denial code and its specific meaning, and
    b. A description of the Plan's standards, if any, used when denying the claim.
3. Reference to the ***Plan*** provisions on which the denial is based.
4. A description of any additional material or information needed and an explanation of why such material or information is necessary.
5. A description of the ***Plan's*** claim appeal procedure and applicable time limits.
6. A statement that if the ***covered person's*** appeal (Refer to *Appealing a Denied Post-Service Claim* below) is denied, the ***covered person*** has the right to bring a civil action under section 502 (a) of the Employee Retirement Income Security Act of 1974.
7. If an internal rule, guideline, protocol or other similar criterion was relied upon, the Notice of Benefit Denial will contain either:
    a. A copy of that criterion, or
    b. A statement that such criterion was relied upon and will be supplied free of charge, upon request.
8. If denial was based on ***medical necessity***, ***experimental/investigational*** treatment or similar exclusion or limit, the plan administrator (or its designee) will supply either:
    a. An explanation of the scientific or clinical judgment, applying the terms of the ***Plan*** to the ***covered person's*** medical circumstances, or
    b. A statement that such explanation will be supplied free of charge, upon request.

APPEALING A DENIED POST-SERVICE CLAIM

The "***named fiduciary***" for purposes of an appeal of a denied Post-Service claim, as described in U. S. Department of Labor Regulations 2560.503-1 (issued November 21, 2000), is the ***Claims Processor***.

A ***covered person***, or the ***covered person's*** authorized representative, may request a review of a denied claim by making written request to the ***named fiduciary*** within one hundred eighty (180) calendar days from receipt of notification of the denial and stating the reasons the ***covered person*** feels the claim should not have been denied.

The following describes the review process and rights of the ***covered person***:

1. The ***covered person*** has the right to submit documents, information and comments and to present evidence and testimony.
2. The ***covered person*** has the right to access, free of charge, ***relevant information*** to the claim for benefits.
3. Before a final determination on appeal is rendered, the ***covered person*** will be provided, free of charge, with any new or additional rationale or evidence considered, relied upon, or generated by the ***Plan*** in connection with the claim. Such information will be provided as soon as possible and sufficiently in advance of the notice of final internal determination to give the ***covered person*** a reasonable opportunity to respond prior to that date.
4. The review takes into account all information submitted by the ***covered person***, even if it was not considered in the initial benefit determination.
5. The review by the ***named fiduciary*** will not afford deference to the original denial.
6. The ***named fiduciary*** will not be:
   a. The individual who originally denied the claim, nor
   b. Subordinate to the individual who originally denied the claim.
7. If original denial was, in whole or in part, based on medical judgment:
   a. The ***named fiduciary*** will consult with a ***professional provider*** who has appropriate training and experience in the field involving the medical judgment; and
   b. The ***professional provider*** utilized by the ***named fiduciary*** will be neither:
      (i.) An individual who was consulted in connection with the original denial of the claim, nor
      (ii.) A subordinate of any other ***professional provider*** who was consulted in connection with the original denial.
8. If requested, the ***named fiduciary*** will identify the medical or vocational expert(s) who gave advice in connection with the original denial, whether or not the advice was relied upon.

NOTICE OF BENEFIT DETERMINATION ON APPEAL

The ***Plan Administrator*** (or its designee) shall provide the ***covered person*** (or authorized representative) with a written notice of the appeal decision within sixty (60) calendar days of receipt of a written request for the appeal.

If the appeal is denied, the Notice of Appeal Decision will contain an explanation of the Decision, including:

1. The specific reasons for the denial.
2. Reference to specific ***Plan*** provisions on which the denial is based.
3. A statement that the ***covered person*** has the right to access, free of charge, ***relevant information*** to the claim for benefits.
4. A statement of the ***covered person's*** right to request an external review and a description of the process for requesting such a review.
5. A statement that if the ***covered person's*** appeal is denied, the ***covered person*** has the right to bring a civil action under section 502 (a) of the Employee Retirement Income Security Act of 1974.
6. If an internal rule, guideline, protocol or other similar criterion was relied upon, the Notice of Appeal Decision will contain either:

a. A copy of that criterion, or
b. A statement that such criterion was relied upon and will be supplied free of charge, upon request.

7. If the denial was based on ***medical necessity***, ***experimental/investigational*** treatment or similar exclusion or limit, the ***Plan Administrator*** (or its designee) will supply either:
   a. An explanation of the scientific or clinical judgment, applying the terms of the ***Plan*** to the claimant's medical circumstances, or
   b. A statement that such explanation will be supplied free of charge, upon request.

EXTERNAL APPEAL

A ***covered person***, or the ***covered person's*** authorized representative, may request a review of a denied claim by making written request to the ***named fiduciary*** within four (4) months of receipt of notification of the final internal denial of benefits. If there is no corresponding date four (4) months after the date of receipt of such a notice, then the request must be made by the first day of the fifth month following the receipt of the notice of final internal denial of benefits. {*Note: If the date of receipt of the notice is October 30, because there is no February 30, the request must be filed by March 1, or the next day if March 1st falls on a Saturday, Sunday or Federal holiday.*} The ***Plan*** may charge a filing fee to the ***covered person*** requesting an external review, subject to applicable laws and regulations.

RIGHT TO EXTERNAL APPEAL

Within five (5) business days of receipt of the request, the ***Claims Processor*** will perform a preliminary review of the request to determine if the request is eligible for external review, based on confirmation that:

1. The ***covered person*** incurring the claim is or was covered under the ***Plan*** at the time the health care item or service was requested or, in the case of a retrospective review, was covered under the ***Plan*** at the time the health care item or service was provided;
2. The final internal denial does not relate to the ***covered person's*** failure to meet ***Plan*** eligibility requirements as stated in the section, *Eligibility, Enrollment and Effective Date*;
3. The ***covered person*** has exhausted the ***Plan's*** appeal process, to the extent required by law; and
4. The ***covered person*** has provided all of the information and forms required to complete an external review.

NOTICE OF RIGHT TO EXTERNAL APPEAL

The ***Plan Administrator*** (or its designee) shall provide the ***covered person*** (or authorized representative) with a written notice of the decision as to whether the claim is eligible for external review within one (1) business day after completion of the preliminary review.

The Notice of Right to External Appeal shall include the following:

1. The reason for ineligibility and the availability of the Employee Benefits Security Administration at 866444-3272, if the request is complete but not eligible for external review.
2. If the request is incomplete, the information or materials necessary to make the request complete and the opportunity for the ***covered person*** to perfect the external review request by the later of the following:
   a. The four (4) month filing period; or
   b. Within the forty-eight (48) hour time period following the ***covered person's*** receipt of notification.

INDEPENDENT REVIEW ORGANIZATION

An Independent Review Organization (IRO) that is accredited by URAC or a similar nationally recognized accrediting organization shall be assigned to conduct the external review. The assigned IRO will timely notify the ***covered person*** in writing of the request's eligibility and acceptance for external review.

NOTICE OF EXTERNAL REVIEW DETERMINATION

The assigned IRO shall provide the ***Plan Administrator*** (or its designee) and the ***covered person*** (or authorized representative) with a written notice of the final external review decision within forty-five (45) days after receipt of the external review request.

The Notice of Final External Review Decision from the IRO is binding on the ***covered person***, the ***Plan*** and ***Claims Processor***, except to the extent that other remedies may be available under State or Federal law.

EXPEDITED EXTERNAL REVIEW

The ***Plan Administrator*** (or its designee) shall provide the ***covered person*** (or authorized representative) the right to request an expedited external review upon the ***covered person's*** receipt of either of the following:

1. A denial of benefits involving a medical condition for which the timeframe noted above for completion of an internal appeal would seriously jeopardize the health or life of the ***covered person*** or the ***covered person's*** ability to regain maximum function and the ***covered person*** has filed an internal appeal request.
2. A final internal denial of benefits involving a medical condition for which the timeframe for completion of a standard external review would seriously jeopardize the health or life of the ***covered person*** or the ***covered person's*** ability to regain maximum function or if the final determination involves any of the following:
    a. An admission,
    b. Availability of care,
    c. Continued stay, or
    d. A health care item or service for which the ***covered person*** received ***emergency services***, but has not been discharged from a ***facility***.

Immediately upon receipt of the request for *Expedited External Review*, the ***Plan*** will do all of the following:

1. Perform a preliminary review to determine whether the request meets the requirements in the subsection, *Right to External Appeal.*
2. Send notice of the ***Plan's*** decision, as described in the subsection, *Notice of Right to External Appeal.*

Upon determination that a request is eligible for external review, the ***Plan*** will do all of the following:

1. Assign an IRO as described in the subsection, *Independent Review Organization*.
2. Provide all necessary documents or information used to make the denial of benefits or final denial of benefits to the IRO either by telephone, facsimile, electronically or other expeditious method.

The assigned IRO will provide notice of final external review decision as expeditiously as the ***covered person's*** medical condition or circumstances require, but in no event more than seventy-two (72) hours after receipt of the expedited external review request. The notice shall follow the requirements in the subsection, *Notice of External Review Determination*. If the notice of the expedited external review determination was not in writing, the assigned IRO shall provide the ***Plan Administrator*** (or its designee) and the ***covered person*** (or authorized representative) written confirmation of its decision within forty-eight (48) hours after the date of providing that notice.

FOREIGN CLAIMS

In the event an ***enrolled individual*** incurs a ***covered expense*** in a foreign country, the ***enrolled individual*** shall be responsible for providing the following information to the ***Claims Processor*** before payment of any benefits due are payable:

1. The claim form, provider invoice and any documentation required to process the claim must be submitted in the English language.
2. The charges for services must be converted into U.S. dollars.
3. A current published conversion chart, validating the conversion from the foreign country's currency into U.S. dollars, must be submitted with the claim.

PRE-SERVICE CLAIM PROCEDURE

You are encouraged to contact *Care Connected* (available 24/7), if you have any questions regarding the requirements of this section at 1-833-584-1828.

HEALTH CARE MANAGEMENT

Health care management is the process of evaluating whether proposed services, supplies or treatments are ***medically necessary*** and appropriate to help ensure quality, cost-effective care.

Certification of ***medical necessity*** and appropriateness by the ***Health Care Management Organization*** does not establish eligibility under the ***Plan*** nor guarantee benefits.

FILING A PRE-CERTIFICATION CLAIM

Refer to the LGH Pre-Certification Guide for details on the services requiring pre-certification.

This pre-certification provision will be waived if the ***covered expense*** is rendered/provided outside of the continental United States of America or any U.S. Commonwealth, Territory or Possession.

Inpatient admissions, ***home health care*** (excluding supplies), ***hospice*** care, transplant procedures, durable medical equipment (DME) rental, DME costs in excess of $500, and private duty nursing are to be certified by the ***Health Care Management Organization***. In addition, PET scans, MRIs, MRAs, and CT scans are to be certified by National Imaging Associates (NIA).

For non-urgent care, the ***enrolled individual*** (or their authorized representative) must contact the ***Health Care Management Organization*** at least fifteen (15) calendar days prior to initiation of services.

If the ***Health Care Management Organization*** is not contacted at least fifteen (15) calendar days prior to initiation of services for non-urgent care, benefits may be reduced. For ***urgent care***, the ***enrolled individual*** (or their authorized representative) must contact the ***Health Care Management Organization*** within forty-eight (48) hours or the next business day, whichever is later, after the initiation of services. Please note that if the ***enrolled individual*** needs medical care that would be considered as ***urgent care***, then there is no requirement that the ***Plan*** be contacted for prior approval.

Enrolled individuals **must pre-certify by contacting:**
Pre-certification Phone Number: 888-376-6544
Pre-certification Fax Number: 803-264-0181
Online: www.myhealthtoolkitcapital.com/manage your plan /understanding insurance/

When an ***enrolled individual*** (or authorized representative) calls the ***Health Care Management Organization***, he or she should be prepared to provide all of the following information:

1. ***Employee's*** name, address, phone number and Capital Blue Cross Member Identification Number.
2. ***Employer's*** name.
3. If not the ***employee***, the patient's name, address, phone number.
4. Admitting ***physician's*** name and phone number.
5. Name of ***facility*** or ***home health care agency***.
6. Date of admission or proposed date of admission.
7. Condition for which patient is being admitted.

*Group health plans generally may not, under federal law, restrict benefits for any **hospital** length of stay in connection with childbirth for the mother or newborn child to less than forty-eight (48) hours following a normal vaginal delivery, or less than ninety-six (96) hours following a cesarean section. However, federal law generally does not prohibit the mother's or newborn's attending provider, after consulting with the mother, from discharging the mother or her newborn earlier than forty-eight (48) hours (or ninety-six (96) hours as applicable). In any case, plans may not, under federal law, require that a provider obtain authorization from the **Plan** for prescribing a length of stay not in excess of the above periods.*

However, ***hospital*** maternity stays in excess of forty-eight (48) or ninety-six (96) hours as specified above must be pre-certified.

If the ***enrolled individual*** (or authorized representative) fails to contact the ***Health Care Management Organization*** prior to the hospitalization and within the timelines detailed above, the amount of benefits payable for ***nonpreferred provider covered expenses incurred*** shall be reduced by $500. If the ***Health Care Management Organization*** declines to grant the full pre-certification requested, benefits for days not certified as ***medically necessary*** by the ***Health Care Management Organization*** shall be denied. (Refer to *Post-Service Claim Procedure* discussion above.)

If the ***enrolled individual*** (or authorized representative) fails to contact the ***Health Care Management Organization*** prior to the rental, repair, or purchase of ***durable medical equipment***, the amount of benefits payable for ***covered expenses incurred*** shall be reduced by $100.

FILING A PRE-NOTIFICATION

Refer to the LGH Pre-Certification Guide for details on the services requiring pre-notification.

Pre-notification is requested for chemotherapy and radiation. The ***enrolled individual*** (or their authorized representative) should call the ***Health Care Management Organization*** prior to initiation of services. For ***urgent care***, the ***enrolled individual*** (or their authorized representative) may call the ***Health Care Management Organization*** within forty-eight (48) hours or the next business day, whichever is later, after the initiation of services.

Enrolled individuals **must pre-notify by contacting:**
Pre-notification Phone Number: 888-376-6544
Pre-notification Fax Number: 803-264-0181
Online: www.myhealthtoolkitcapital.com/manage your plan /understanding insurance/

When an ***enrolled individual*** (or authorized representative) contacts the ***Health Care Management Organization***, he or she should be prepared to provide all of the following information:

1. ***Employee's*** name, address, phone number and ***Employee*** Capital Blue Cross Member Identification Number.
2. ***Employer's*** name.

3. If not the ***employee***, the patient's name, address, phone number.
4. Treating ***physician's*** name and phone number.
5. Name of ***facility***.
6. Proposed date of when services are to begin.

NOTICE OF AUTHORIZED REPRESENTATIVE

The ***enrolled individual*** may provide the ***Plan Administrator*** (or its designee) with a written authorization for an authorized representative to represent and act on behalf of an ***enrolled individual*** and consent to release of information related to the ***enrolled individual*** to the authorized representative with respect to a claim for benefits or an appeal. Authorization forms may be obtained from the Human Resource Department. Notwithstanding the foregoing, requests for pre-certification and other pre-service claims or requests by a person or entity other than the ***enrolled individual*** may be processed without a written authorization if the request or claim appears to the ***Plan Administrator*** (or its designee) to come from a reasonably appropriate and reliable source (*e.g.*, ***physician's*** office, individuals identifying themselves as immediate relatives, etc.).

TIME FRAME FOR PRE-SERVICE CLAIM DETERMINATION

1. In the event the ***Plan*** receives from the ***enrolled individual*** (or authorized representative) a communication that fails to follow the pre-certification procedure as described above but communicates at least the name of the ***enrolled individual***, a specific medical condition or symptom, and a specific treatment, service or product for which prior approval is requested, the ***enrolled individual on*** (or the authorized representative) will be orally notified (and in writing if requested), within five (5) calendar days of the failure of the proper procedure to be followed.

2. After a completed pre-certification request for non-urgent care has been submitted to the ***Plan***, and if no additional information is required, the ***Plan*** will generally complete its determination of the claim within a reasonable period of time, but no later than fifteen (15) calendar days from receipt of the request.

3. After a pre-certification request for non-urgent care has been submitted to the ***Plan***, and if an extension of time to make a decision is necessary due to circumstances beyond the control of the ***Plan***, the ***Plan*** will, within fifteen (15) calendar days from receipt of the request, provide the ***enrolled individual*** (or authorized representative) with a notice detailing the circumstances and the date by which the ***Plan*** expects to render a decision. If the circumstances include a failure to submit necessary information, the notice will specifically describe the needed information. The ***enrolled individual*** will have forty-five (45) calendar days to provide the information requested, and the ***Plan*** will complete its determination of the claim no later than fifteen (15) calendar days after receipt by the ***Plan*** of the requested information. Failure to respond in a timely and complete manner will result in a denial.

CONCURRENT CARE CLAIMS

If an extension beyond the original certification is required, the ***enrolled individual*** (or authorized representative) shall call the ***Health Care Management Organization*** for continuation of certification.

1. If an ***enrolled individual*** (or authorized representative) requests to extend a previously approved hospitalization or an ongoing course of treatment, and;
    a. The request involves non-urgent care, then the extension request must be processed within fifteen (15) calendar days after the request was received.
    b. The ***inpatient*** admission or ongoing course of treatment involves ***urgent care***, and
        (i.) The request is received at least twenty-four (24) hours before the scheduled end of a hospitalization or course of treatment, then the request must be ruled upon and the ***enrolled individual*** (or authorized representative) notified as soon as possible taking into consideration medical exigencies but no later than twenty-four (24) hours after the request was received; or

(ii.) The request is received less than twenty-four (24) hours before the scheduled end of the hospitalization or course of treatment, then the request must be ruled upon and the ***enrolled individual*** (or authorized representative) notified as soon as possible but no later than seventy-two (72) hours after the request was received; or

(iii.) The request is received less than twenty-four (24) hours before the scheduled end of the hospitalization or course of treatment and additional information is required, the ***enrolled individual*** (or authorized representative) will be notified within twenty-four (24) hours of the additional information required. The ***enrolled individual*** (or authorized representative) has forty-eight (48) hours to provide such information (may be oral unless written is requested). Upon timely response, the ***enrolled individual*** (or authorized representative) will be notified as soon as possible but no later than forty-eight (48) hours after receipt of additional information. Failure to submit requested information timely will result in a denial of such request.

If the ***Health Care Management Organization*** determines that the ***hospital*** stay or course of treatment should be shortened or terminated before the end of the fixed number of days and/or treatments, or the fixed time period that was previously approved, then the ***Health Care Management Organization*** shall:

1. Notify the ***enrolled individual*** of the proposed change, and

2. Allow the ***enrolled individual*** to file an appeal and obtain a decision, before the end of the fixed number of days and/or treatments, or the fixed time period that was previously approved.

If, at the end of a previously approved hospitalization or course of treatment, the ***Health Care Management Organization*** determines that continued ***confinement*** is no longer ***medically necessary***, additional days will not be certified. (Refer to *Appealing a Denied Pre-Service Claim* discussion below.)

NOTICE OF PRE-SERVICE CLAIM DENIAL

If a pre-certification request is denied in whole or in part, the ***Plan Administrator*** (or its designee) shall provide the ***covered person*** (or authorized representative) with a written Notice of Pre-Service Claim Denial within the time frames above.

The Notice of Pre-Service Claim Denial shall include an explanation of the denial, including:

1. Information sufficient to identify the claim involved.
2. The specific reasons for the denial, to include:
   a. The denial code and its specific meaning, and
   b. A description of the ***Plan's*** standards, if any, used when denying the claim.
3. Reference to the ***Plan*** provisions on which the denial is based.
4. A description of any additional material or information needed and an explanation of why such material or information is necessary.
5. A description of the ***Plan's*** claim appeal procedure and applicable time limits.
6. A statement that if the ***covered person's*** appeal (Refer to *Appealing a Denied Pre-Service Claim* below) is denied, the ***covered person*** has the right to bring a civil action under section 502 (a) of the Employee Retirement Income Security Act of 1974.
7. If an internal rule, guideline, protocol or other similar criterion was relied upon, the Notice of Benefit Denial will contain either:
   a. A copy of that criterion, or
   b. A statement that such criterion was relied upon and will be supplied free of charge, upon request.
8. If denial was based on ***medical necessity***, ***experimental/investigational*** treatment or similar exclusion or limit, the ***Plan Administrator*** (or its designee) will supply either:

a. An explanation of the scientific or clinical judgment, applying the terms of the ***Plan*** to the ***covered person's*** medical circumstances, or
b. A statement that such explanation will be supplied free of charge, upon request.

APPEALING A DENIED PRE-SERVICE CLAIM

The "***named fiduciary***" for purposes of an appeal of a denied Pre-Service claim, as described in U.S. Department of Labor Regulations 2560.503-1 (issued November 21, 2000), is the ***Claims Processor***.

A ***covered person*** (or authorized representative) may request a review of a denied Pre-Service claim by making a verbal or written request to the ***named fiduciary*** within one hundred eighty (180) calendar days from receipt of notification of the denial and stating the reasons the ***covered person*** feels the claim should not have been denied. If the ***covered person*** (or authorized representative) wishes to appeal the denial when the services in question have already been rendered, such an appeal will be considered as a separate post-service claim. (Refer to *Post-Service Claim Procedure* discussion above.)

The following describes the review process and rights of the ***covered person***:

1. The ***covered person*** has the right to submit documents, information and comments and to present testimony.
2. The ***covered person*** has the right to access, free of charge, ***relevant information*** to the claim for benefits.
3. Before a final determination on appeal is rendered, the ***covered person*** will be provided, free of charge, with any new or additional rationale or evidence considered, relied upon, or generated by the ***Plan*** in connection with the claim. Such information will be provided as soon as possible and sufficiently in advance of the notice of final internal determination to give the ***covered person*** a reasonable opportunity to respond prior to that date.
4. The review takes into account all information submitted by the ***covered person***, even if it was not considered in the initial benefit determination.
5. The review by the ***named fiduciary*** will not afford deference to the original denial.
6. The ***named fiduciary*** will not be:
   a. The individual who originally denied the claim, nor
   b. Subordinate to the individual who originally denied the claim.
7. If original denial was, in whole or in part, based on medical judgment:
   a. The ***named fiduciary*** will consult with a ***professional provider*** who has appropriate training and experience in the field involving the medical judgment.
   b. The ***professional provider*** utilized by the ***named fiduciary*** will be neither:
      (i.) An individual who was consulted in connection with the original denial of the claim, nor
      (ii.) A subordinate of any other ***professional provider*** who was consulted in connection with the original denial.
8. If requested, the ***named fiduciary*** will identify the medical or vocational expert(s) who gave advice in connection with the original denial, whether or not the advice was relied upon.

NOTICE OF PRE-SERVICE DETERMINATION ON APPEAL

The ***Plan Administrator*** (or its designee) shall provide the ***covered person*** (or authorized representative) with a written Notice of Appeal Decision as soon as possible, but not later than thirty (30) calendar days from receipt of the appeal (not applicable to ***urgent care*** claims).

If the appeal is denied, the Notice of Appeal Decision will contain an explanation of the decision, including:

1. The specific reasons for the denial.
2. Reference to specific ***Plan*** provisions on which the denial is based.
3. A statement that the ***covered person*** has the right to access, free of charge, ***relevant information*** to the claim for benefits.

4. A statement of the ***covered person's*** right to request an external review and a description of the process for requesting a review.
5. A statement that if the ***covered person's*** appeal is denied, the ***covered person*** has the right to bring a civil action under section 502 (a) of the Employee Retirement Income Security Act of 1974.
6. If an internal rule, guideline, protocol or other similar criterion was relied upon, the Notice of Appeal Decision will contain either:
   a. A copy of that criterion, or
   b. A statement that such criterion was relied upon and will be supplied free of charge, upon request.
7. If the denial was based on ***medical necessity***, ***experimental/investigational*** treatment or similar exclusion or limit, the ***Plan Administrator*** (or its designee) will supply either:
   a. An explanation of the scientific or clinical judgment, applying the terms of the ***Plan*** to the claimant's medical circumstances, or
   b. A statement that such explanation will be supplied free of charge, upon request.

CASE MANAGEMENT

In cases where the ***enrolled individual's*** condition is expected to be or is of a serious nature, the ***Health Care Management Organization*** may arrange for review and/or case management services from a professional qualified to perform such services. The ***Plan Administrator*** shall have the right to alter or waive the normal provisions of this ***Plan*** when it is reasonable to expect a cost-effective result without a sacrifice to the quality of care.

In addition, the ***Health Care Management Organization*** may recommend (or change) alternative methods of medical care or treatment, equipment or supplies that are ***covered expenses*** under this ***Plan*** but on a basis that differs from the alternative recommended by the ***Health Care Management Organization***.

The recommended alternatives will be considered as ***covered expenses*** under the ***Plan*** provided the expenses can be shown to be viable, ***medically necessary***, and are included in a written case management report or treatment plan proposed by the ***Health Care Management Organization***.

Case management will be determined on the merits of each individual case, and any care or treatment provided will not be considered as setting any precedent or creating any future liability with respect to that ***enrolled individual*** or any other ***enrolled individual***.

CareConnected is the Plan's ***Health Care Management Organization.*** Contact CareConnected via telephone at 1-833-584-1828.

COORDINATION OF BENEFITS

The *Coordination of Benefits* provision is intended to prevent duplication of benefits. It applies when the ***enrolled individual*** is also enrolled in any Other Plan(s). When more than one coverage exists, one plan normally pays its benefits in full, referred to as the primary plan. The Other Plan(s), referred to as secondary plan, may pay a reduced benefit. When coordination of benefits occurs, the standard method will apply in which the secondary plan payment is based on the balance left after the primary plan has paid but generally does not exceed the amount it would have paid as primary or the total allowed amount (i.e. rate established by the plan and/or negotiated rate accepted by the provider) of the claim. Only the amount paid by this *Plan* will be charged against the *maximum benefit*.

The *Coordination of Benefits* provision applies whether or not a claim is filed under the Other Plan(s). If another plan provides benefits in the form of services rather than cash, the reasonable value of the service rendered shall be deemed the benefit paid.

DEFINITIONS APPLICABLE TO THIS PROVISION

This ***Plan*** is not eligible to be elected as primary coverage in lieu of automobile benefits. Payments from automobile insurance will always be primary and this ***Plan*** shall be secondary only.

"Other Plan" means any plan, policy or coverage providing benefits or services for, or by reason of medical, dental or vision care. Such Other Plan(s) do not include flexible spending accounts (FSA), health reimbursement accounts (HRA), health savings accounts (HSA), or individual medical, dental or vision insurance policies. "Other Plan" also does not include Tricare, ***Medicare***, Medicaid or a state child health insurance program (CHIP). Such Other Plan(s) may include, without limitation:

1. Group insurance or any other arrangement for coverage for ***enrolled individuals*** in a group, whether on an insured or uninsured basis, including, but not limited to, ***hospital*** indemnity benefits and ***hospital*** reimbursement-type plans;

2. ***Hospital*** or medical service organization on a group basis, group practice, and other group prepayment plans or on an individual basis having a provision similar in effect to this provision;

3. A licensed Health Maintenance Organization (HMO);

4. Any coverage for students which is sponsored by, or provided through, a school or other educational institution;

5. Any coverage under a government program and any coverage required or provided by any statute;

6. Group automobile insurance;

7. Individual automobile insurance coverage;

8. Individual automobile insurance coverage based upon the principles of "No-fault" coverage;

9. Any plan or policies funded in whole or in part by an employer, or deductions made by an employer from a person's compensation or retirement benefits;

10. Labor/management trust, union welfare, employer organization, or employee benefit organization plans.

"This ***Plan***" shall mean that portion of the ***employer's Plan*** which provides benefits that are subject to this provision.

"Claim Determination Period" means a plan year or that portion of a plan year during which the ***enrolled individual*** for whom a claim is made has been covered under this ***Plan***.

EFFECT ON BENEFITS

This provision shall apply in determining the benefits for an ***enrolled individual*** for each claim determination period. If this ***Plan*** is secondary, the benefits paid under this ***Plan*** may be reduced so that the sum of benefits paid by all plans does not exceed the amount it would have paid as primary or 100% of the total allowed amount of covered expenses.

If the rules set forth below would require this ***Plan*** to determine its benefits before such Other Plan, then the benefits of such Other Plan will be ignored for the purposes of determining the benefits under this ***Plan***.

ORDER OF BENEFIT DETERMINATION

Except as provided below in *Coordination with Medicare*, each plan will make its claim payment according to the first applicable provision in the following list of provisions which determine the order of benefit payment:

1. No Coordination of Benefits Provision
   If the Other Plan contains no provisions for coordination of benefits, then its benefits shall be paid before all Other Plan(s).

2. Member/Dependent
   The plan which covers the claimant directly pays before a plan that covers the claimant as a dependent.

3. Dependent Children of Parents not Separated or Divorced
   The plan covering the parent whose birthday (month and day) occurs earlier in the year pays first. The plan covering the parent whose birthday falls later in the year pays second. If both parents have the same birthday, the plan that covered a parent longer pays first. A parent's year of birth is not relevant in applying this rule.

4. Dependent Children of Separated or Divorced Parents
   When parents are separated or divorced, the birthday rule does not apply, instead:

   a. If a court decree has given one parent financial responsibility for the child's health care, the plan of that parent pays first. The plan of the stepparent married to that parent, if any, pays second. The plan of the other natural parent pays third. The plan of the spouse of the other natural parent, if any, pays fourth.
   b. In the absence of such a court decree, the plan of the parent with custody pays first. The plan of the stepparent married to the parent with custody, if any, pays second. The plan of the parent without custody pays third. The plan of the spouse of the parent without custody, if any, pays fourth.

5. Active/Inactive
   The plan covering a person as an active (not laid off or retired) employee or as that person's dependent pays first. The plan covering that person as a laid off or retired employee, or as that person's dependent pays second.

6. Longer/Shorter Length of Coverage
   If none of the above rules determine the order of benefits, the plan covering a person longer pays first. The plan covering that person for a shorter time pays second.

ELIGIBLE SPOUSE RULE

For eligible spouses who have other group health insurance provided by his or her employer, the Lancaster General Health medical program will provide secondary coverage only. "Eligible" means coverage is available and the spouse is required to contribute less than one half (50%) of the total cost of the employer's premium. The ***employee*** may still enroll his/her spouse, however, the spouse's employer group plan will be considered primary and the Lancaster General Health program will be considered secondary payor. When his/her spouse files a claim, he/she must follow the rules of his/her primary plan or risk no payment being made under the Lancaster General Health program.

The Lancaster General Health program will continue to provide primary coverage for your working spouse providing your spouse is not eligible for other group medical coverage from his or her employer. Reasons other coverage may not be available to your spouse:

1. The ***employee's*** spouse is not employed.

2. The ***employee's*** spouse's employer does not provide a group health plan.

3. The ***employee's*** spouse is self-employed.

4. The ***employee's*** spouse's employer subsidizes less than 50% of the group health coverage for its employees.

COORDINATION WITH MEDICARE

Individuals may be eligible for ***Medicare*** Part A at no cost if they: (i) are age 65 or older, (ii) have been determined by the Social Security Administration to be disabled, or (iii) have end stage renal disease. Participation in ***Medicare*** Part B and D is available to all individuals who make application and pay the full cost of the coverage.

1. When an ***employee*** becomes entitled to ***Medicare*** coverage (due to age or disability) and is still actively at work, the ***employee*** may continue health coverage under this ***Plan*** at the same level of benefits and contribution rate that applied before reaching ***Medicare*** entitlement.

2. When a ***dependent*** becomes entitled to ***Medicare*** coverage (due to age or disability) and the ***employee*** is still actively at work, the ***dependent*** may continue health coverage under this ***Plan*** at the same level of benefits and contribution rate that applied before reaching ***Medicare*** entitlement.

3. If the ***employee*** and/or ***dependent*** are also enrolled in ***Medicare*** (due to age or disability), this ***Plan*** shall pay as the primary plan. If, however, the ***Medicare*** enrollment is due to end stage renal disease, the ***Plan's*** primary payment obligation will end at the end of the thirty (30) month "coordination period" as provided in ***Medicare*** law and regulations.

4. If the ***employer*** (including certain affiliated entities that are considered the same employer for this purpose) has fewer than one hundred (100) ***employees***, when a covered ***dependent*** becomes entitled to ***Medicare*** coverage due to ***total disability***, as determined by the Social Security Administration, and the ***employee*** is actively-at-work, ***Medicare*** will pay as the primary payer for claims of the ***dependent*** and this ***Plan*** will pay secondary.

5. If the ***employee*** and/or ***dependent*** elect to discontinue health coverage under this ***Plan*** and enroll under the ***Medicare*** program, no benefits will be paid under this ***Plan***. ***Medicare*** will be the only payor.

6. For a ***retiree**** eligible for ***Medicare*** due to age, ***Medicare*** shall be the primary payor and this ***Plan*** shall be secondary. If the *retiree* does not elect *Medicare*, but is otherwise eligible due to age, this ***Plan*** will pay on a primary basis.

**** Retiree is an individual that has coverage through former employment.***

This section is subject to the terms of the ***Medicare*** laws and regulations. Any changes in these related laws and regulations will apply to the provisions of this section.

LIMITATIONS ON PAYMENTS

In no event shall the ***enrolled individual*** recover under this ***Plan*** and all Other Plan(s) combined more than the amount this plan would have paid as primary or the total amount of the claim.

Nothing contained in this section shall entitle the ***enrolled individual*** to benefits in excess of the total ***maximum benefits*** of this ***Plan*** during the claim determination period. The ***enrolled individual*** shall refund to the ***employer*** any excess payments.

RIGHT TO RECEIVE AND RELEASE NECESSARY INFORMATION

For the purposes of determining the applicability of and implementing the terms of this *Coordination of Benefits* provision, the ***Plan*** may, without the consent of or notice to any person, release to or obtain from any insurance company or any other organization any information, regarding other insurance, with respect to any ***enrolled individual***. Any person claiming benefits under this ***Plan*** shall furnish to the ***employer*** such information as may be necessary to implement the *Coordination of Benefits* provision.

FACILITY OF BENEFIT PAYMENT

Whenever payments which should have been made under this ***Plan*** in accordance with this provision have been made under any Other Plan, the ***employer*** shall have the right, exercisable alone and in its sole discretion, to pay over to any organization making such other payments any amounts it shall determine to be warranted in order to satisfy the intent of this provision. Amounts so paid shall be deemed to be benefits paid under this ***Plan*** and, to the extent of such payments, the ***employer*** shall be fully discharged from liability.

AUTOMOBILE ACCIDENT BENEFITS

The ***Plan's*** liability for expenses arising out of an automobile accident shall always be secondary to any automobile insurance, irrespective of the type of automobile insurance law that is in effect in the ***enrolled individual's*** state of residence. Currently, there are three (3) types of state automobile insurance laws.

1. No-fault automobile insurance laws

2. Financial responsibility laws

3. Other automobile liability insurance laws

No Fault Automobile Insurance Laws. In no event will the ***Plan*** pay any claim presented by or on behalf of an ***enrolled individual*** for medical benefits that would have been payable under an automobile insurance policy but for an election made by the principal named insured under the automobile policy that reduced covered levels and/or subsequent premium. This is intended to exclude, as a ***covered expense***, an ***enrolled individual's*** medical expenses arising from an automobile accident that are payable under an automobile insurance policy or that would have been payable under an automobile insurance policy but for such an election.

1. In the event an ***enrolled individual*** incurs medical expenses as a result of ***injuries*** sustained in an automobile
   accident while "covered by an automobile insurance policy," as an operator of the vehicle, as a passenger, or as a pedestrian, benefits will be further limited to medical expenses, that would in no event be payable under the automobile insurance.

2. For the purposes of this section the following people are deemed "covered by an automobile insurance policy."

    a. An owner or principal named insured individual under such policy.
    b. A family member of an insured person for whom coverage is provided under the terms and conditions of the automobile insurance policy.
    c. Any other person who, except for the existence of the ***Plan***, would be eligible for medical expense benefits under an automobile insurance policy.

Financial Responsibility Laws. The ***Plan*** will be secondary to any potentially applicable automobile insurance even if the state's "financial responsibility law" does not allow the ***Plan*** to be secondary.

Other Automobile Liability Insurance. If the state does not have a no-fault automobile insurance law or a "financial responsibility" law, the ***Plan*** is secondary to automobile insurance coverage or to any other person or entity who caused the ***accident*** or who may be liable for the ***enrolled individual's*** medical expenses pursuant to the general rule for *Subrogation/Reimbursement*.

SUBROGATION/REIMBURSEMENT

The ***Plan*** is designed to only pay ***covered expenses*** for which payment is not available from anyone else, including any insurance company or another health plan. In order to help an ***enrolled individual*** in a time of need, however, the ***Plan*** may pay ***covered expenses*** that may be or become the responsibility of another person, provided that the ***Plan*** later receives reimbursement for those payments (hereinafter called "Reimbursable Payments").

Therefore, by enrolling in the ***Plan***, as well as by applying for payment of ***covered expenses***, an ***enrolled individual*** is subject to, and agrees to, the following terms and conditions with respect to the amount of ***covered expenses*** paid by the ***Plan***:

1. Assignment of Rights (Subrogation). The ***enrolled individual*** automatically assigns to the ***Plan*** any rights the ***enrolled individual*** may have to recover all or part of the same ***covered expenses*** from any party, including an insurer or another group health program (except flexible spending accounts, health reimbursement accounts and health savings accounts), but limited to the amount of Reimbursable Payments made by the ***Plan***. This assignment includes, without limitation, the assignment of a right to any funds paid by a third party to an ***enrolled individual*** or paid to another for the benefit of the ***enrolled individual***. This assignment applies on a first-dollar basis (*i.e.*, has priority over other rights), applies whether the funds paid to (or for the benefit of) the ***enrolled individual*** constitute a full or a partial recovery, and even applies to funds actually or allegedly paid for non-medical or dental charges, attorney fees, or other costs and expenses. This assignment also allows the ***Plan*** to pursue any claim that the ***enrolled individual*** may have, whether or not the ***enrolled individual*** chooses to pursue that claim. By this assignment, the ***Plan's*** right to recover from insurers includes, without limitation, such recovery rights against no-fault auto insurance carriers in a situation where no third party may be liable, and from any uninsured or underinsured motorist coverage.

2. Equitable Lien and other Equitable Remedies. The ***Plan*** shall have an equitable lien against any rights the ***enrolled individual*** may have to recover the same ***covered expenses*** from any party, including an insurer or another group health program, but limited to the amount of Reimbursable Payments made by the ***Plan***. The equitable lien also attaches to any right to payment from workers' compensation, whether by judgment or settlement, where the ***Plan*** has paid ***covered expenses*** prior to a determination that the ***covered expenses*** arose out of and in the course of employment. Payment by workers' compensation insurers or the employer will be deemed to mean that such a determination has been made.

   This equitable lien shall also attach to any money or property that is obtained by anybody (including, but not limited to, the ***enrolled individual***, the ***enrolled individual's*** attorney, and/or a trust) as a result of an exercise of the ***enrolled individual's*** rights of recovery (sometimes referred to as "proceeds"). The ***Plan*** shall also be entitled to seek any other equitable remedy against any party possessing or controlling such proceeds. At the discretion of the ***Plan Administrator***, the ***Plan*** may reduce any future ***covered expenses*** otherwise available to the ***enrolled individual*** under the ***Plan*** by an amount up to the total amount of Reimbursable Payments made by the ***Plan*** that is subject to the equitable lien.

3. Assisting in ***Plan's*** Reimbursement Activities. The ***enrolled individual*** has an obligation to assist the ***Plan*** to obtain reimbursement of the Reimbursable Payments that it has made on behalf of the ***enrolled individual***, and to provide the ***Plan*** with any information concerning the ***enrolled individual's*** other insurance coverage (whether through automobile insurance, other group health program, or otherwise) and any other person or entity (including their insurer(s)) that may be obligated to provide payments or benefits to or for the benefit of the ***enrolled individual***. The ***enrolled individual*** is required to (a) cooperate fully in the ***Plan's*** (or any ***Plan*** fiduciary's) enforcement of the terms of the ***Plan***, including the exercise of the ***Plan's*** right to subrogation and reimbursement, whether against the ***enrolled individual*** or any third party, (b) not do anything to prejudice those enforcement efforts or rights (such as settling a claim against another party without including the ***Plan*** as a co-payee for the amount of the Reimbursable Payments and notifying

the ***Plan***), (c) sign any document deemed by the ***Plan Administrator*** to be relevant to protecting the ***Plan's*** subrogation, reimbursement or other rights, and (d) provide relevant information when requested. The term "information" includes any documents, insurance policies, police reports, or any reasonable request by the ***Plan Administrator*** or ***Claims Processor*** to enforce the ***Plan***'s rights.

The ***Plan Administrator*** has delegated to the ***Claims Processor*** for medical claims the right to perform ministerial functions required to assert the ***Plan's*** rights with regard to such claims and benefits; however, the ***Plan Administrator*** shall retain discretionary authority with regard to asserting the ***Plan's*** recovery rights.

GENERAL PROVISIONS

ADMINISTRATION OF THE PLAN

The ***Plan*** is administered through the Human Resources Department of the ***employer***. The ***employer*** is the ***Plan Administrator***. The ***Plan Administrator*** shall have full charge of the operation and management of the ***Plan***. The ***employer*** has retained the services of an independent ***Claims Processor*** experienced in claims review.

The ***employer*** is the ***named fiduciary*** of the ***Plan*** except as noted herein. Except as otherwise specifically provided in this document, the ***Claims Processor*** is the ***named fiduciary*** of the ***Plan*** for pre-service and post-service claim appeals (this may be different if an outside vendor is involved). As the ***named fiduciary*** for appeals, the ***Claims Processor*** maintains discretionary authority to review all denied claims under appeal for benefits under the ***Plan***. The ***employer*** maintains discretionary authority to interpret the terms of the ***Plan***, including but not limited to, determination of eligibility for and entitlement to ***Plan*** benefits in accordance with the terms of the ***Plan***; any interpretation or determination made pursuant to such discretionary authority shall be given full force and effect, unless it can be shown that the interpretation or determination was arbitrary and capricious.

APPLICABLE LAW

All provisions of the ***Plan*** shall be construed and administered in a manner consistent with the requirements under the Employee Retirement Income Security Act of 1974 (ERISA), as amended.

ASSIGNMENT

The ***Plan*** will pay benefits under this ***Plan*** to the ***employee*** unless payment has been assigned to a ***hospital***, ***physician***, or other provider of service furnishing the services for which benefits are provided herein. No assignment of benefits shall be binding on the ***Plan*** unless the ***Claims Processor*** is notified in writing of such assignment prior to payment hereunder.

Preferred providers normally bill the ***Plan*** directly. If services, supplies or treatments have been received from such a provider, benefits are automatically paid to that provider. The ***enrolled individual's*** portion of the ***negotiated rate***, after the ***Plan's*** payment, will then be billed to the ***enrolled individual*** by the ***preferred provider***.

This ***Plan*** will pay benefits to the responsible party of an ***alternate recipient*** as designated in a Qualified Medical Child Support Order (QMCSO) or National Medical Support Notice (NMSN).

BENEFITS NOT TRANSFERABLE

Except as otherwise stated herein, no person other than an eligible ***enrolled individual*** is entitled to receive benefits under this ***Plan***. Such right to benefits is not transferable.

CLERICAL ERROR

No clerical error on the part of the ***employer*** or ***Claims Processor*** shall operate to defeat any of the rights, privileges, services, or benefits of any ***employee*** or any ***dependent(s)*** hereunder, nor create or continue coverage which would not otherwise validly become effective or continue in force hereunder. An equitable adjustment of contributions and/or benefits will be made when the error or delay is discovered. However, if more than six (6) months has elapsed prior to discovery of any error, any adjustment of contributions shall be waived. No party shall be liable for the failure of any other party to perform.