

THE HUGHSTON CLINIC Health Plan

Summary Plan Description



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I. Benefits For You and Your Family

Health care benefits are probably the benefits employees believe are the most important, and with good reason. The cost of health care can take a major bite out of a household budget. Hughston Clinic offers you and your family health care benefits to help you pay for medical and dental care when you need it.

These benefits are provided under the Hughston Clinic Health Plan, and are described in this Summary Plan Description (SPD). Please read it carefully. The Hughston Clinic Health Plan is sometimes referred to in this SPD as the Medical Plan.

Benefits under the Plan are administered through North Star Health. North Star Health will work with you and your doctors, hospitals, and other health care providers to address your health care needs. North Star Health, as your health care advocate, may contact you, from time to time, to discuss prevention, wellness and care management in order to support your relationship with your physician.

The Plan has been amended effective January 1, 2007 to make certain changes. This SPD reflects the Plan as amended. For periods before January 1, 2007, please refer to the prior version of the SPD.

A. Who Is Eligible

You are generally eligible for the Plan benefits described in this SPD if you are:

- A full-time wage earning employee of The Hughston Clinic scheduled to work at least 32 hours per week on a regular (not temporary or seasonal) basis; who has had sixty (60) consecutive days of Active Employment. Coverage commences the first day of the Month following completion of the Waiting Period. The Waiting Period is counted in the Pre-Existing Conditions exclusion time;

Eligible dependents may also be covered under the Plan. Eligible dependents are:

- Your legal spouse;
- Your or your spouse's unmarried children, through the end of the month in which they turn Nineteen (19), who depend primarily on you for financial support;
- Your or your spouse's unmarried children from the end of the month in which they turn age Nineteen (19) until the end of the calendar month in which they turn Twenty-Five (25), but only while they attend an accredited school on a full-time basis, and only while they are primarily dependent on your or your spouse for financial support. Dependent status ends the last day of the month in which a child stops meeting any of these requirements;

- Your or your spouse's physically or mentally disabled dependent child(ren) of any age, provided the physical or mental disability began while they were eligible as explained above.

The Plan Administrator may require proof of any of the above qualifications at any time.

Children whom you may enroll must be your or your spouse's natural children, stepchildren, children legally adopted or placed for adoption, children covered by a Qualified Medical Child Support Order (QMCSO), and any other children for whom you are the legal guardian.

Please note: You may not cover a stepchild if the stepchild does not reside with you. Also, you may not cover your former spouse after the divorce has become final.

A dependent in active military service is not eligible for coverage, except to the extent required by law.

If your spouse also works for The Hughston Clinic, you cannot be covered as both an employee and a dependent. Likewise, if your eligible child also works for The Hughston Clinic, he or she cannot be covered as both an employee and a dependent. Please note that your eligible dependents may only be covered by one parent's plan.

If you have any questions about this coverage, please contact your Human Resources Department.

B. Qualified Medical Child Support Order (QMCSO)

You may enroll children who are not otherwise eligible as dependents (as described above) in your Medical Plan if required by a Qualified Medical Child Support Order (QMCSO). A QMCSO is a court order setting responsibility for health care expenses for non-custodial children. If you are served with a QMCSO, please send the court order to your Human Resources Department as soon as possible. Coverage will only be provided if the Plan Administrator determines that the QMCSO meets certain requirements imposed by law.

C. When Coverage Begins

Your Plan coverage begins on the 1st day of the month following a waiting period of sixty (60) consecutive days of Active Employment. You must complete and submit your enrollment form on or before that date. If you fail to properly complete and submit your enrollment form on or before that date, you will not be eligible for Plan coverage.

In order for coverage to be effective, you must be actively at work on the first day of coverage performing your usual duties during your usual working hours. If you are absent from work due to a Paid Time Off (PTO) day, vacation, holiday, jury duty, or

other similar reasons, you will still be considered actively at work and coverage will be effective.

Plan coverage for your dependents will begin at the same time as your own if you have enrolled them. If you have a new baby, adopt a child, or have a child placed with you for adoption, and you enroll this dependent within 31 days, your child's coverage becomes effective on the date of the birth or adoption. If you marry and you enroll your spouse within 31 days after your marriage, your spouse's coverage becomes effective on the date of your marriage.

D. Changing Your Membership

During the annual open enrollment period conducted in November, you may change your Plan coverage. After you complete your Plan enrollment application form, your initial benefit election will remain in effect indefinitely until you make a new benefit election by requesting, completing, and submitting a new Plan enrollment application form during any later enrollment period. Outside of the annual open enrollment period, you may obtain or cancel coverage, add new dependents, or drop a dependent from your coverage *only* if you have a qualifying family status change or a ***special enrollment*** situation (see heading **Special Enrollment Rights**). You must notify your Human Resources Department within 31 days of the change in status.

An employee, employed spouse, or dependent child whose coverage under any other group health plan suddenly or unexpectedly ends may be permitted coverage under the Plan provided appropriate contributions are made. Please notify your Human Resources Department about your situation to see if coverage is available.

Any change in your benefit enrollment must correspond directly to the change in family status. If you submit your enrollment/change form, and a copy of proof of the family status change (such as a marriage or birth certificate or adoption papers) within the 31 days after the change, coverage becomes effective on the date of the change. If you delay past 31 days, you must wait until the next annual open enrollment before Plan coverage can become effective or changed. A person otherwise qualifying as an eligible dependent will not receive any coverage under the Plan unless you have elected to pay and have paid the required additional contributions, if any, for dependent coverage. Please keep your Human Resources Department informed of any changes in family status.

E. Special Enrollment Rights For Coverage

If you did not enroll in the Plan because you had other coverage through another source (such as a spouse's employer or under COBRA), and you later lose that other coverage, you may enroll in the Plan. To do so, you must state in writing that you declined Plan coverage because you had coverage through another source. You will be given the opportunity to provide details concerning your situation in writing in order to preserve your special enrollment rights under the Plan in the future. You must request this ***special enrollment*** within 31 days of losing your other coverage. Plan coverage will become

effective on the day after you lost coverage, provided you have submitted the enrollment forms to your Human Resources Department within 31 days of the event.

The *special enrollment* provision does not apply if you lost your other coverage because you did not make required contributions or if you lost your other coverage for cause (such as submitting a fraudulent claim).

1. Dependent Special Enrollment

Dependents whom you acquire through marriage, birth, adoption, or placement for adoption may be granted a *special enrollment*, as long as you have requested coverage within 31 days following the date you acquired the dependent. If you do not have coverage for yourself, you may also enroll yourself when you enroll your new dependent. In the case of marriage, birth, adoption, or placement for adoption, Plan coverage will become effective on the date of the event, provided you have submitted the proper enrollment materials to your Human Resources Department within 31 days.

F. Certificates of Coverage

If you or a covered dependent lose your Medical Plan coverage (including COBRA coverage), be sure to notify North Star Health at (800) 470-1361 and request a certificate of coverage. This certificate of coverage is available at no cost to you. At a minimum, this certificate will state the length of time you (or your covered dependent) had uninterrupted medical coverage. It will also show the date coverage ended. This certificate of coverage may allow you to reduce any pre-existing condition limits that apply to future medical coverage.

Please note that certificates are not automatically provided for dependents until North Star Health is aware that the dependent has lost coverage (for example, when a dependent no longer qualifies for coverage because of age). You may request a certificate of coverage for up to 24 months from the date your coverage ended.

G. Coverage Costs

You and your Employer share the cost of your benefits. Any contributions you will be required to make to obtain the benefits will be determined by your Employer, and will be communicated to you from time to time. Generally, your contributions are made on a pre-tax basis and deducted from your salary. Because your contributions are deducted before taxes, you reduce your taxable income and save on federal income taxes and Social Security taxes.

For the exact cost of your contributions, please contact your Human Resources Department.

II. About Your Hughston Clinic Health Plan

The Medical Plan benefits described in this SPD are administered by North Star Health.

The Medical Plan is designed to provide you and your family with quality health care services in the most cost-effective settings. It offers you the security of a wide range of health care benefits, including coverage for inpatient and outpatient hospital care, medical and surgical services, and prescription drugs. The Medical Plan also offers vital preventive care benefits usually not provided under traditional health care plans. These include coverage for routine physicals; well-woman care, including Pap tests and mammograms; and well-child care, including immunizations and check-ups.

The Hughston Clinic Medical Plan is designed to reward members for taking steps to take care of their health. That is why the Medical Plan covers preventive services for children and adults (including routine physicals, routine immunizations, prostate screening, mammograms, and Pap Smears) at 100%. The Medical Plan encourages you to make the healthy choices and reduces costs for members who take an active, responsible role in their own health care.

A. The Hughston Clinic Healthy Choices Benefit

The Hughston Clinic Healthy Choices Benefit is built around the principle that individuals who take an active role in promoting good health will have a lower cost share in their health benefits plan.

The Healthy Choices Plan rewards plan members who obtain age and gender appropriate screenings for cancer prevention and promotion of good health. **The plan will notify you on an annual basis what tests are required for you to qualify for the Healthy Choices plan.**

The Medical Plan offers two ways to *receive* care, each and every time you *need* care. The two options are described next.

B. Option 1: In-Network Care

The Medical Plan incorporates the cost-efficiencies that result from using a network of highly qualified health care professionals and facilities, and offers you the reassurance of being treated by a participating doctor you choose, in a location convenient to you. There are two networks available for members: First Health Network for employees residing in Georgia and Multi Plan Network for employees residing in Alabama. Each network has a large selection of participating doctors.

To receive Option 1 benefits, you may go to any doctor in the **network**, and the Medical Plan will pay benefits for covered services.

Please note that some services are only available under Option 1.

1. About Network Hospitals

The Medical Plan also gives you access to and a network of local and regional community hospitals. For a complete listing, please contact North Star Health.

C. Option 2: Out-Of-Network Care

If you decide to seek services outside of the network, you may do so. To receive benefits, you must first pay a higher calendar year deductible. The calendar year deductible is waived for the following Out-Of-Network services: 1) Adult and Child Well Visits; 2) Childhood Immunizations and Vaccinations.

After meeting the calendar year deductible, the Medical Plan will pay a percent of the Usual, Customary, and Reasonable charge (see the heading **Payment Terms You Should Know**), and you pay the remaining amount, plus any amounts over the Reasonable & Customary (UCR) charge, until you reach the annual out-of-pocket maximum, as described later in this SPD. Then, your benefits for covered services are paid at 100% of UCR for the remainder of that calendar year. You will still be responsible for any amounts over UCR charges.

D. Providers

For the purposes of this Medical Plan, a provider is any hospital, skilled nursing facility, individual, organization, or agency licensed to provide professional services and acting within the scope of that license or certification. Benefits will be paid for covered services from providers who meet this definition, depending upon whether you access care through Option 1 or 2. Benefits will not be provided under the Medical Plan for any services and related charges provided by an immediate relative of the patient (spouse, child, brother, sister, in-law, grandparent, or parent).

E. When You Need To See A Specialist (Referrals)

Although you are not required to select a Primary Care Provider (PCP), you are encouraged to maintain a relationship with a network provider. This provider may assist in directing you to an appropriate network specialist. However, because referrals are not required under this plan, you may self-refer to any specialist in the network to receive Option 1 benefits.

Services provided by an out-of-network provider will be paid at the Out-of-Network benefit level.

Note: If a Covered Person receives care from a Network facility and as a direct result, also receives medical care from a Non-Network Provider, the benefits will be paid as if a Network Provider were utilized, as long as the Provider is the only Provider used by or through the facility for that service. Examples of qualifying

Non-Network Providers are Pathologists, Radiologists, Anesthesiologists, and Emergency Room physicians.

F. Payment Terms You Should Know

To help you fully understand how your benefits are processed and paid, please refer to the following terms and definitions:

- **Actual Charge** — This is the amount the hospital or doctor charges for the service or services you received.
- **Allowed Charge** — This is the maximum amount the Medical Plan will allow for coverage of specific health care services. Any co-pay and coinsurance amounts you are responsible for paying are deducted from the allowed charge.
- **Deductible** — This is the amount you must pay within the calendar year before the Medical Plan begins to pay benefits.
- **Usual, Customary, and Reasonable Charge (UCR)** — This is the usual fee charged by similar providers for the same services or supplies in the same geographic area. North Star Health determines what is a Usual, Customary, and Reasonable charge.
- **Cost Sharing Provision** — The terms *co-pay* and *coinsurance* describe ways that you share in the cost of your medical expenses.
 - **Co-pay:** The co-pay is the amount you pay services, supplies, and prescription drugs. Please refer to the **Medical Benefits At-A-Glance** chart, later in this SPD for specific co-pay amounts. The co-pay does not apply toward the annual out-of-pocket maximum or the annual deductible. You pay the co-pay directly to the pharmacy at the time of service.
 - **Coinsurance:** The coinsurance is your share for certain medical expenses.
 - **Out-of-Pocket Maximum:** Since you are responsible for a portion of the cost of your medical expenses, the Medical Plan includes an annual out-of-pocket maximum to protect you in the event of high medical bills. After you have paid the annual out-of-pocket maximum the Medical Plan pays any additional covered expenses at 100% (of the UCR charges under Option 2) for the rest of that calendar year.

The annual out-of-pocket maximum is calculated on a calendar year basis and includes the coinsurance but does not include the deductible, co-pays; penalties; prescription drug co-pays and expenses; amounts in excess of the provider's Usual, Customary, and Reasonable (UCR) charge; amounts in excess of plan maximums; any charges for services which are not covered, or mental health and

substance abuse charges, including treatment of alcoholism.

- Plan Year — The plan year is January 1 through December 31.
- Maximum Benefit — This is the maximum amount the Medical Plan will pay for a covered individual during a calendar year. There is a separate lifetime benefit maximum of 200 days/visits for outpatient mental health and substance abuse care. Certain other medical treatments or procedures may also have lifetime or annual maximums that are defined elsewhere in this SPD.

G. Pre-Treatment Education Program

The Medical Plan has several features designed to help both you and the Medical Plan manage health care costs, while still providing you with quality care. Before you receive benefits for certain medical services and supplies under the Medical Plan, you must contact (800) 470-1361 to begin the Pre-Treatment Education process. If you do not pre-cert, coverage for benefits may be limited or denied. Below is a list of services that require pre-cert.

For the Pre-Treatment Education Program, please call (800) 470-1361.

The program consists of:

1. Retrospective review of the Medical Necessity of the listed services provided on an emergency basis;
2. Concurrent review, based on the admitting diagnosis, of the listed services requested by the attending Physician; and
3. Planning for discharge from a Medical Care Facility or cessation of medical treatment.

Please notify North Star Health seven (7) business days prior to undergoing any of the following procedures, when performed on a non-emergency basis:

Angioplasty	Hysterectomy
Cardiac Catheterization	Inpatient Hospital Admission
Carpal Tunnel Surgery	Total Knee Replacement
Cataract Surgery	Laparoscopy
Cesarean Section	Low Back Pain Surgery
Cholecystectomy	Magnetic Resonance Imaging(MRI)
Colonoscopy	Medical Admission for Low Back Pain
Computerized Axial Tomography of the Spine	Meniscectomy
Coronary Artery Bypass Graft Surgery	Pacemaker Implantation
Dilatation and Curettage	Prostatectomy

Endoscopy	Septal Surgery and Rhinoplasty
Foot Surgery	Tonsillectomy and Adenoidectomy
Total Hip Replacement	Tympanostomy

The following services also require pre-certification:

Outpatient Surgery	Organ Transplant
Chiropractic Care	Inpatient Mental Health
Durable Medical Equipment	Skilled Nursing Facility
Home Health Care	Inpatient Substance Abuse
Hospice Care	Maternity
Outpatient Therapy (restorative speech, occupational and physical therapy)	

The purpose of the Pre-Treatment Education program is to assure you receive quality care that is medically necessary and appropriate. The program also strives to protect you from significant, and sometimes unnecessary, health care expenses. *The Pre-Treatment Education program is not intended to diagnose or treat your medical conditions or to guarantee benefits.* Rather, the Pre-Treatment Education program will coordinate the medical care services you receive across the continuum of care. The program may also suggest alternative care options and coordinate with providers to improve standards for the care you receive.

Any and all services which require pre-certification and are not pre-certified or authorized will result in a reduction of the benefits payable. Failure to pre-certify will result in a 50% reduction in eligible charges per occurrence; the covered Person's 50% responsibility will not be applied to the Calendar Year co-insurance (out-of-pocket) and will not include this Plan's deductible or co-payment where applicable.

H. Your Medical Plan Identification Card

A Medical Plan identification card will be issued to you and each of your covered dependents. Carry your identification card with you at all times and show it to any health care provider whenever you receive medical care.

Only you and your covered dependents are permitted to use these cards. It is illegal to lend your card to persons who are not covered under the Plan. If you lose your identification card, call a North Star Health Member Advocate immediately to request a new card.

Your identification card includes important information and phone numbers about the procedures to follow to receive the highest level of benefits.

I. Customer Service

An important feature of your Medical Plan administered by North Star Health is the Member Advocates available to serve you. Trained North Star Health Member

Advocates are available to assist you by answering any questions you may have about covered benefits, using your Medical Plan, filing a claim, resolving complaints, etc.

If you have a question, North Star Health Member Advocates are available, 8:00 a.m. to 5:00 p.m. (Eastern Time) at (800) 470-1361.

III. Medical Covered Services

A. Medical Benefits At-A-Glance

The following chart summarizes most of the benefits and services available under the Medical Plan.

	HEALTHY CHOICES		CORE OPTION	
	<i>In-Network</i>	<i>Out-of-Network</i>	<i>In-Network</i>	<i>Out-of-Network</i>
Benefit Description			Benefit Description	
Lifetime Maximum	\$2,000,000 (combined)		\$2,000,000 (combined)	
Annual Deductible	\$500 Individual per calendar year \$1,000 Family aggregate per calendar year	\$1,500 Individual per calendar year \$3,000 Family aggregate per calendar year	\$1,000 Per Individual per calendar year	\$2,000 Per Individual per calendar year
Out-of-Pocket Maximums			Out-of-Pocket Maximums	
Eligible expenses applied to the deductible and/or coinsurance based on Usual, Customary, and Reasonable	\$4,000 Individual per calendar year \$8,000 Family Aggregate per calendar year (Excluding deductible)	\$8,000 Individual per calendar year \$16,000 Family Aggregate per calendar year (Excluding deductible)	\$20,000 Per Individual (Excluding deductible)	\$20,000 Per Individual (Excluding deductible)
Pre-Treatment Education			Pre-Certification/Surgical Review	
Pre-certification of Hospital Stays, Skilled Nursing Care, Home Health, Hospice Care, Private Duty Nursing	If inpatient stay is not pre-certified, benefits will be reduced by 50%. The penalty amount is not applied to the deductible or coinsurance maximums.		If inpatient stay is not pre-certified, benefits will be reduced by 50%. The penalty amount is not applied to the deductible or coinsurance maximums.	
Surgical Services	You must call before the following: Surgery, MRI/CAT Scans, therapies, and other selected care as noted in the Summary Plan Description. Benefits will be reduced by 50% if pre-certification is not done.		You must call before the following: Surgery, MRI/CAT Scans, therapies, and other selected care as noted in the Summary Plan Description. Benefits will be reduced by 50% if pre-certification is not done	
Facility Charges			Facility Charges	
Hospital Room & Board	90% after deductible	\$200 co-pay then 70% of UCR after deductible	80% after deductible	60% of UCR after deductible
Hospital Miscellaneous	90% after deductible	70% of UCR after deductible	80% after deductible	60% of UCR after deductible
Diagnostic Imaging/X-ray/Lab	90% after deductible	70% of UCR after deductible	80% after deductible	60% of UCR after deductible
Outpatient Hospital	90% after deductible	70% of UCR after deductible	80% after deductible	60% of UCR after deductible
Urgent Care Center	\$35 co-pay per visit, then 100% after deductible	\$35 co-pay per visit, then 80% after deductible	\$35 co-pay per visit, then 80% after deductible	\$35 co-pay per visit, then 60% after deductible
Ambulance	90% after deductible	70% of UCR after deductible	80% after deductible	60% of UCR after deductible
Birthing Center	90% after deductible	70% of UCR after deductible	80% after deductible	60% of UCR after deductible
Emergency Room (<u>non-emergent care not covered</u>)	\$100 co-pay per visit, then 100% after deductible	\$100 co-pay per visit, then 90% of UCR after deductible	\$200 co-pay then 80% after deductible	\$200 co-pay then 60% of UCR after deductible
Physician Charges			Physician Charges	

	HEALTHY CHOICES		CORE OPTION	
	<i>In-Network</i>	<i>Out-of-Network</i>	<i>In-Network</i>	<i>Out-of-Network</i>
Office Visits – Primary Care	\$20 co-pay per visit, then 100%	70% of UCR after deductible	80% after deductible	60% of UCR after deductible
Specialist	\$20 co-pay per visit, then 90%			
Physician Visit in Hospital	90% after deductible	70% of UCR after deductible	80% after deductible	60% of UCR after deductible
Surgical Fees	90% after deductible	70% of UCR after \$250 co-pay per confinement	80% after deductible	60% of UCR after \$250 co-pay per confinement
Emergency after hours Pediatric Services	\$35 co-pay after deductible	\$35 co-pay then 80% of UCR after deductible	\$35 co-pay per visit, then 80% after deductible	\$35 co-pay per visit, then 60% of UCR after deductible
Second Surgical Opinion	100%	100% of UCR	100%	100% of UCR
Emergency Room Physician	100% after deductible	90% of UCR after deductible	80% after deductible	60% of UCR after deductible
Spinal Manipulation Maximum of 20 visits or \$1,000 whichever comes first per calendar year	\$20 co-pay per visit then 90% after deductible	70% of UCR after deductible	80% after deductible	60% of UCR after deductible
Preventive Care			Preventive Care	
Services for children and adults (includes routine physicals, immunizations, Gyn/Pap, Prostate Screening, mammograms, and colorectal Screening)	100% deductible Waived	100% of UCR deductible waived	100% deductible waived	100% of UCR deductible waived
Other Charges			Other Charges	
Prescription Drugs	Pharmacy (30 day supply): \$15 generic/\$25 Formulary/\$50 Non-Formulary Mail Order (90 day supply): \$30 generic/\$50 Formulary/ \$100 Non-Formulary		Pharmacy (30 day supply): \$15 generic/\$25 Formulary/\$50 Non-Formulary Mail Order (90 day supply): \$30 generic/\$50 Formulary/ \$100 Non-Formulary	
Diabetic Supplies	Covered under pharmacy plan	Covered under pharmacy plan	Covered under pharmacy plan	Covered under pharmacy plan
Diabetic Training	100%	80% of UCR after deductible	80% after deductible	60% of UCR after deductible
Chemotherapy	90% after deductible	70% of UCR after deductible	80% after deductible	60% of UCR after deductible
Durable Medical Equipment Lifetime maximum of \$10,000	90% after deductible	70% of UCR after deductible	80% after deductible	60% of UCR after deductible
Allergy Testing and Treatment	90% after deductible	70% of UCR after deductible	80% after deductible	60% of UCR after deductible
Orthotics – maximum of \$500 per calendar year. Pre-Cert required	90% after deductible	70% of UCR after deductible	80% after deductible	60% of UCR after deductible
Home Health Care maximum of 20 visits per year	90% after deductible	70% of UCR after deductible	80% after deductible	60% of UCR after deductible
Hospice Care Maximum of 6 months per lifetime	90% after deductible	70% of UCR after deductible	80% after deductible	60% of UCR after deductible
Infertility Treatment	Not covered	Not covered	Not covered	Not covered
Lead Poisoning Screening and Treatment	\$20 co-pay, then 100%	80% of UCR, deductible waived	80% after deductible	60% of UCR after deductible
Outpatient Therapy –	90% after deductible	70% of UCR after	80% after deductible	60% of UCR after

	HEALTHY CHOICES		CORE OPTION	
	<i>In-Network</i>	<i>Out-of-Network</i>	<i>In-Network</i>	<i>Out-of-Network</i>
includes Speech, Physical, Occupational (limited to 60 visits for all types of therapy combined per calendar year)		deductible		deductible
Skilled Nursing Facility Maximum of 90 days per confinement	90% after deductible	70% of UCR after deductible	80% after deductible	60% of UCR after deductible
Smoking Cessation Program	Employer sponsored Seminar provided at no cost to plan members.	Employer sponsored Seminar provided at no cost to plan members.	Employer sponsored Seminar provided at no cost to plan members.	Employer sponsored Seminar provided at no cost to plan members.
Smoking Cessation Products - Over the Counter (OTC)	OTC products covered up to \$200 per year.	OTC products covered up to \$200 per year.	OTC products covered up to \$200 per year.	OTC products covered up to \$200 per year.
Pre-Admission Testing	100%	80% of UCR after deductible	80% after deductible	60% of UCR after deductible
Private Duty Nursing-Inpatient Pre-certification required	90% after deductible	70% of UCR after deductible	80% after deductible	60% of UCR after deductible
	Maximum of \$125 per day		Maximum of \$125 per day	
Mental Health and Substance Abuse (All Inpatient Admissions require pre-certification)			Mental Health and Substance Abuse (All Inpatient Admissions require pre-certification)	
Inpatient Care - Mental Health	\$200 co-pay, then 90% Annual maximum of 30 days after deductible	80% of UCR after deductible Annual maximum of 30 days	80% after deductible Annual maximum of 30 days	60% of UCR after deductible Annual maximum of 30 days
Inpatient Care - Substance Abuse	\$200 co-pay, then 90% after deductible lifetime maximum of 30 days	80% of UCR after deductible Maximum of 30 days per lifetime	80% after deductible Maximum of 30 days per lifetime	60% of UCR after deductible Maximum of 30 days per lifetime
Outpatient Care: Mental Health and Substance Abuse	Deductible then \$20 co-pay per visit, then 90% Maximum of 25 visits per calendar year and 200 visits per lifetime	Deductible then 80% of UCR Maximum of 25 visits per calendar year and 200 visits per lifetime	80% after deductible Maximum of 25 visits per calendar year and 200 visits per lifetime	60% of UCR after deductible Maximum of 25 visits per calendar year and 200 visits per lifetime

Network Providers have agreed to accept the Network fee schedule as full payment and will not balance bill you above the Network fee schedule. All benefits are subject to medical necessity. This is not a complete description of benefits. For more information, please refer to the rest of this SPD. Usual, Customary, and Reasonable (UCR) is the usual fee charged by similar providers for the same services or supplies in the same geographic area. North Star Health determines what is a Usual, Customary, and Reasonable charge.

Pre-Treatment education is required for all mental health and substance abuse services. If services are not pre-certified, benefits will be denied. Contact a Nurse Advocate at (800) 470-1361.

B. Services and Supplies

The Medical Plan provides benefits for the medically necessary services and supplies listed in this section.

A medically necessary service or supply is one that the Plan Administrator determines:

- Diagnoses, prevents, or treats a covered medical condition;
- Is appropriate for the symptoms, diagnosis, or treatment of the covered medical condition;
- Is supplied or performed in accordance with current standards of medical practice within the United States of America;
- Is not primarily for the convenience of the covered person, facility, or provider;
- Is the most appropriate supply or level of service that can safely be provided; and
- Is recommended or approved by the attending professional provider.

No benefits are provided for services and supplies that are not medically necessary.

Benefit limits, coinsurance, and co-pay amounts are described in detail in the **Medical Benefits At-A-Glance** chart. The chart highlights the major benefits that will be payable for Options 1 and 2. You will receive the highest level of benefits for services and care provided by Network providers (Option 1).

Medically necessary covered services and supplies include the following (subject to any conditions or limitations as described elsewhere in this SPD):

- Abortion - When Medically Necessary to protect the mother's health;
- Adult preventive services;
- Allergy testing and treatment to determine the nature of allergies and desensitization treatment including test of treatment materials;
- Ambulance service (professional) both air and ground transportation, to the nearest hospital where necessary care can be given if the emergency is life-threatening;
- Anesthetics and oxygen, and their administration;
- Attention Deficit Disorder (ADD);

- Birthing facilities — eligible provided the physician in charge is acting within the scope of his or her license and the birthing facility is a freestanding licensed facility for childbirth which meets state licensing requirements (all Option 2 birthing facility confinements must be pre-certified). Outpatient facility ancillary expenses for medically necessary services and supplies also are covered. These include: use of operating, delivery, and treatment rooms; prescribed drugs; medical and surgical dressings, supplies; diagnostic services and therapy services;
- Blood products, if not replaced;
- Casts, splints;
- Chiropractic care (out-of-network providers must be licensed and qualified to perform chiropractic services). Services are covered for initial examination, X-rays, manipulation, misalignment or partial dislocation of or in the vertebral column, and correction by manual or mechanical means of nerve interference;
- Colorectal screening;
- Consultation services by a specialist in the medical field for which the consultation relates. Staff consultation required by the facility is not covered;
- Convalescent facility care;
- Dental services (accident related) if rendered by a physician or dentist, that are required as a result of covered accidental injury to sound natural teeth or mouth and that are provided as part of initial emergency treatment within 48 hours of the accident;
- Diabetic supplies for insulin-dependent diabetics;
- Diagnostic medical procedures consisting of EKG or EEG, and other electronic diagnostic medical procedures;
- Diagnostic X-rays (including radiology, ultrasound, nuclear medicine, and magnetic resonance imaging, as well as laboratory services and pathology tests);
- Doctors' (including surgeons') fees for treatment of illness or injury;
- Doctors' fees and hospital charges for maternity care;
- Doctors' fees for office visits;
- Durable medical and surgical equipment (rental), including wheelchairs. Durable medical equipment is medical equipment which:

- Can withstand repeated use; and
 - Is primarily and customarily used to serve a medical purpose; and
 - Is generally not useful to a person in the absence of illness or injury; and
 - Is appropriate for use in the home; and
 - Is not primarily for the convenience of the patient;
- Emergency services;
 - Foot care for incision and drainage of infected tissues of the foot, removal of lesions, treatment of fractures and dislocations of bone in the foot, and capsular or bone surgery for treatment of bunions;
 - Foot orthotics that are integral to a brace;
 - Home health care;
 - Hospice care;
 - Hospital charges for covered semi-private room and board and other hospital-provided services and supplies (including inpatient rehabilitation). Private room, intensive care, coronary care, and other specialized care units of a facility are covered only when it is consistent with professional standards for the care of the patient's condition. Facility ancillary expenses for services and supplies also are covered. These expenses include the following:
 - Use of operating, delivery, and treatment rooms;
 - Prescribed drugs;
 - Medical and surgical dressings, supplies, casts and splints;
 - Diagnostic services and therapy services;
 - Outpatient hospital expenses eligible for outpatient hospital coverage;
 - Laboratory tests;
 - Mental health and substance abuse benefits;
 - Midwife delivery services, provided that the state in which such services are performed has a licensing or certification process for midwifery, and the midwife is licensed at the time delivery is performed;
 - Newborn care — newborn care, routine nursing care, prematurity services, preventive health care services, as well as coverage for illness or injury, including the necessary care and treatment of medically diagnosed congenital defects and birth abnormalities

if the baby is eligible for enrollment and the newborn is enrolled within 31 days of birth;

- Skilled nursing services (professional) by a Registered Nurse (R.N.) or Licensed Practical Nurse (L.P.N.) for home health care who is not a member of your family and who does not ordinarily live with you;
- Obesity — surgical treatment for morbid obesity when:
 1. the person is 18 years of age or older;
 2. Height and Weight are provided by a physician;
 3. Body Mass Index (BMI) is greater than 40 kilograms per meter squared for a minimum of 5 years;
 4. 2 or more co-morbid medical conditions, such as hypertension, a cardiopulmonary condition, sleep apnea, or diabetes;
 5. Services must be pre-certified by Pre-Treatment Education program;
 6. Documented previous weight loss attempts and results for the past 2 years;
 7. Psychological evaluation determining motivation and probability of compliance;
 8. Second surgical opinion as indicated;
 9. Nutritional classes and behavior modification billed separately are not covered;
 10. Surgical correction covered once per lifetime only.
- Pre-admission tests which are made before an inpatient or outpatient surgery;
- Preventive care — including but not limited to periodic physicals, prostate screenings, routine GYN visits, mammography screenings (Limited to 1 per year), routine PAP smears, well-child care, and immunizations; All services limited to 1 per year except well child care and immunizations to age 5.
- Prosthetic devices and orthotics (including artificial limbs and eyes);
- Reconstructive surgery when due to:
 - Accidental illness or injury occurring while covered under the Medical Plan; or
 - Correction of a congenital malformation of a child; or
 - A mastectomy (see the heading **Women’s Health and Cancer Rights Act of 1998**);
- Inpatient rehabilitation services;

A rehabilitation facility is a facility licensed to provide comprehensive rehabilitation services to patients recovering from an accident or an illness, and for evaluation and treatment of individuals with physical disabilities with emphasis on education and training. The program must be coordinated and provided by or under the supervision of physicians who are qualified and experienced in rehabilitation. These services (defined later under therapies) include, but are not limited to:

- Physical therapy;
 - Occupational therapy;
 - Speech and language therapy;
 - Psychotherapy;
 - Rehabilitation nursing; and
 - Respiratory therapy;
- Second surgical opinions for elective surgeries to determine medical necessity when provided by a board-certified specialist in the treatment of your particular medical condition, who is not associated professionally or financially with the physician that provided the first surgical opinion consultation. One additional consultation, as a third opinion, is eligible under this clause when the second opinion disagrees with the first. An elective surgery is surgery which is not of an emergency or life-threatening nature. A second surgical/medical opinion consultation is required to be pre-certified through the Pre-Treatment Education Program.

Consultation services by a physician will be paid if rendered to an inpatient member in a covered facility at the request of a professional provider and the consulting physician is a specialist in the medical field to which the consultation relates. Consultations do not include staff consultations which are required by a facility provider's rules and regulations that do not satisfy the requirements of the previous sentence.

- Skilled nursing facility services;
- Smoking Cessation – Over the Counter (OTC) smoking cessation products are covered up to \$200 per year. You must pay for the product and submit a receipt to North Star Health for reimbursement. The Employer sponsored smoking cessation seminar is provided to all plan members at no cost;
- Surgical dressings and medical supplies — ordered by an appropriate professional provider in connection with medical treatment (except self-administered supplies or convenience items);
- Surgical procedures;

Separate payment will not be made for inpatient pre-operative care or post-operative care normally provided by the surgeon as part of the surgical procedure. For related operations or procedures performed through the same incision or in the same operative field, the plan will pay the surgical allowance for the highest paying procedure plus 50% of the surgical allowance for the second highest paying procedure and 25% of the surgical allowance for each additional procedure. When two or more unrelated operations or procedures are performed at the same operative session, the plan will pay the surgical allowance for each procedure.

Surgeon fees include fees for surgery for the treatment of disease or injury, and any incision or puncture which requires the use of surgical instruments.

An assistant surgeon's fees are eligible for coverage, up to 20% of the allowed charge for the primary surgeon, when it is determined that the condition of the patient or the type of surgical service requires such assistance.

- Temporomandibular Joint Syndrome (TMJ) and/or orthognathic surgery (treated same as any other condition), limited to physical therapy, surgery, and orthodontic devices such as mouth guards and intraoral devices (excludes orthodontics and prosthetics). Coverage is limited to \$1,000 per calendar year;
- Therapies, including:
 - Chemotherapy (inpatient and outpatient) — the treatment of malignant disease by chemical or biological antineoplastic agents, including the cost of the antineoplastic;
 - Dialysis treatment — the treatment of acute renal failure or chronic irreversible renal insufficiency for removal of waste materials from the body, to include hemodialysis or peritoneal dialysis;
 - Physical therapy — the treatment by physical means, hydrotherapy, heat, or similar modalities; physical agents; bio-mechanical and neuro-physical principles; and devices to significantly relieve pain, restore maximum function lost or impaired by disease or accidental injury, and prevent disability following disease, injury or loss of body part (does not include maintenance therapy);
 - Speech therapy — the treatment for the correction of a speech impairment when therapy is aimed at restoring the level of speech that the individual had attained before the onset of a disease, surgery, or occurrence of an accidental injury. Non-medical conditions such as stuttering, articulation disorders, tongue thrust, and lisping are not covered;
 - Occupational therapy — the treatment of a physically disabled person by means of constructive activities designed and adapted to significantly improving the functional restoration of the person's abilities lost or impaired by disease or accidental injury, to satisfactorily accomplish the ordinary tasks of daily living in the home setting (does not include maintenance therapy);
 - Radiotherapy (inpatient and outpatient) — the treatment of disease by X-ray, gamma ray, accelerated particles, mesons, neutrons, radium, or radioactive isotopes;

- Transplants;
- Vasectomies and tubal ligations;
- Well-child care;
- Wigs following chemotherapy limited to one per lifetime up to \$300;
- And other medically necessary services and supplies as described elsewhere in this SPD.

Following are descriptions of other services and supplies covered by the Medical Plan.

C. Prescription Drug Benefits

Benefits are paid for prescription drugs designated as such under federal law, as well as federal legend drugs, compound medications, legend oral contraceptives, AIDS-specific medications, prenatal vitamins, injectable insulin, and other medicines and supplies designated by North Star Health. You can receive a supply equal to 34 days.

1. Network Pharmacies

You *must* obtain prescription drugs from a network pharmacy to receive benefits under the Medical Plan. You may contact North Star Health for a complete list of network pharmacies. *No benefits are available if drugs are purchased from a non-network pharmacy.*

A network pharmacy has an arrangement to provide prescription drugs to you at an agreed price. When you buy covered drugs from any network pharmacy, present your Medical Plan identification card to the pharmacist. You should request and retain a paid receipt for your co-pay amount if you need it for income tax purposes.

Please note: Your pharmacist may need to obtain pre-certification before dispensing certain prescription drugs, which may delay filling your prescription.

a) Co-Pay

When you go to any in-network pharmacy, you pay a \$15 co-pay for each separate prescription or refill for a generic drug, \$25 for a preferred brand name drug or \$50 for a brand name (non-preferred) drug. For maintenance drugs, you may also use the Medical Plan's Mail Service Prescription Drug Benefit Program. Through this program, you can receive a 90-day supply of prescription drugs and refills each time you order. Your co-pay is \$30 for each separate prescription or refill of a generic drug; \$50 for brand name (preferred) and; \$100 of the cost for

brand name (non-preferred) drugs. If you have any questions about the Mail Service Program, call a North Star Health Member Advocate at (800) 470-1361.

2. What's Not Covered

No benefits will be paid for the following:

- Prescription drugs dispensed for any illness or injury eligible or covered by any federal, state, or local government Workers' Compensation act or occupational disability law;
- Prescription drugs to which you are entitled, with or without charge, under a plan or program of any government or governmental body;
- Any medication furnished by any other drug or medical service for which no charge is made to the patient;
- Drugs which are not considered to be medically necessary, in accordance with North Star Health-accepted medical and surgical practices and standards, including but not limited to, psoralens and tretinoin for cosmetic use, nicotine gum, anorexiant, minoxidil lotion, nystatin oral powder, and schedule v-exempt narcotics;
- Any prescription for more than a 34-day supply; for Mail Order benefits, not more than a 90-day supply;
- Any amounts you are required to pay directly to the network pharmacy for each prescription or refill;
- Any medication taken or administered at the place where it is dispensed (i.e., hospital, rest home, extended care facility, nursing home, etc.);
- Charges for a prescription refill in excess of the number specified by the physician, or any refill dispensed after one year from the order of the physician;
- Charges for a prescribed drug or medication that is not approved for treatment of the condition by the FDA;
- Replacement of lost or stolen medication;
- Drugs purchased outside the United States that are not legal inside the United States;

- Any charge for *administration* of drugs or insulin;
- Vitamins, except pre-natal vitamins and folic acid used during pregnancy;
- Hypodermic needles and syringes (except for Diabetes care);
- Support garments;
- Immunization agents, biological sera, blood, or blood plasma;
- Experimental drugs;
- Any other drug or medication that is available over the counter;
- Smoking cessation drugs that require a prescription;
- Any drug purchased from a non-network pharmacy.

D. Emergency Services

It is not easy to think clearly in a medical emergency. Knowing what to do before you are faced with an emergency can help you get appropriate care at the higher benefit level.

In an emergency medical situation, you should go to the nearest medical facility for immediate care. An emergency medical situation is one in which a prudent layperson determines that:

- immediate care is needed as the result of a sudden and serious illness or injury; and
- the care is required to prevent serious jeopardy to your life, health, or your ability to regain maximum function, or a physician with knowledge of your medical condition determines that you would be subject to severe pain that cannot be adequately managed without the care.

For treatment of an emergency medical situation, your care will be covered under Option 1 under the Healthy Choices Plan, regardless of whether or not the facility participates in the network. You (or someone on your behalf) must notify North Star Health at (800) 470-1361 within 48 hours (or 72 hours on the weekend) of the emergency medical situation in order to receive benefits. Under the Healthy Choices Plan, Option 1 emergency room care facility charges and physician charges are covered in full after a \$100 co-payment per visit and the annual deductible. After you are medically stable and if you are able to move to an in-network facility and you choose not to be transferred, benefits will be paid at Option 2. If you receive treatment in an emergency room for a condition that is not an emergency medical situation, the Medical

Plan will not pay benefits.

Under the Core Option Plan, in-network (Option 1) emergency room care facility charges and physician charges are covered at 80% after a \$200 co-pay per visit and the calendar year deductible. Out-of-Network (Option 2) emergency room care facility charges and physician charges are covered at 60% of UCR after a \$200 co-pay and the calendar year deductible. You will be responsible for any amounts over UCR charges.

1. Out-Of-Area Care

Medical care received while out of the network service area, including out-of-area emergency room care, will be considered as follows:

- *Unforeseeable* medical treatment (including *unforeseeable* prescription drugs) required while traveling outside the network service area will be paid at 100% for most services after the applicable co-payment and calendar year deductible (Option 1) under the Healthy Choices Plan or 80% for most services (Option 1) after the applicable co-payment and the calendar year deductible under the Core Option Plan. This provision only applies to services provided before it is safe to return to the network service area and does not include care that could have reasonably been anticipated before leaving the area. You (or someone on your behalf) must notify North Star Health within 48 hours (or 72 hours if the emergency falls on the weekend) after the care is received.
- *Foreseeable* medical treatment (including *foreseeable* prescription drugs) will be paid at 70% of the UCR charges, after the applicable co-payment and the calendar year deductible for most services (Option 2) under the Healthy Choices Plan or 60% of the UCR charges, after the applicable co-payment and the calendar year deductible for most services (Option 2) under the Core Option Plan. You will be responsible for any amounts over UCR charges.

2. Students

If your dependent child goes to school outside the network service area, care received for *unforeseeable* medical treatment and emergency medical situations is covered at 100% after the co-payment and deductible (Option 1) under the Healthy Choices Plan or 80% after co-payment and deductible for most services (Option 1) under the Core Option Plan. North Star Health must be notified within 48 hours after the care is received (or 72 hours if emergency care occurs on the weekend)). If your dependent child receives out-of-network care that could have reasonably been foreseen before leaving the area, claims will be paid at 70% of the UCR charges, after the co-payment and calendar year deductible for most services (Option 2) under the Healthy Choices Plan or 60% of the UCR charges, after the co-payment and the calendar year deductible for most services (Option 2) under the Core Option Plan. You are responsible for any amounts over UCR.

Routine care provided outside the service area will be considered under Option 2.

*North Star Health must be notified of all
emergency room care and out-of-area care within 48 hours.*

3. Immediate Care Centers

Under the Healthy Choices Plan, if you go directly to an in network immediate care center, your care will be covered at 100% (Option 1) after a \$35 co-payment per visit and the calendar year deductible. Under the Core Option Plan, if you go to an in network immediate care center, your care will be covered at 80%, after a \$35 co-pay per visit and the calendar year deductible (Option 1).

E. Ambulance Services

Your Medical Plan includes coverage for both air and ground professional ambulance transportation services, when the following criteria are met:

- Because of an accident or emergency medical situation, it is medically necessary to transport you to the hospital; or
- It is medically necessary to transport you from a hospital as an inpatient to another hospital, because;
 - the first hospital lacks the equipment or expertise necessary to care for you;
 - you are transported directly from a hospital as an inpatient to a skilled nursing facility or rehabilitation facility;
 - as determined medically appropriate through the Pre-Treatment Education program.

Air ambulance services are covered only if it is medically necessary to be transported by air and not by ground.

F. Maternity Benefits

Even if you were not enrolled in the Medical Plan before your first pre-natal visit, you may still receive benefits during your pregnancy and delivery.

Under the Healthy Choices Plan, the Medical Plan covers 100% of your prenatal care, routine tests, and delivery after the calendar year deductible and \$20 co-payment for your initial visit, when you receive care coordinated by a participating network OB/GYN. Care received from an out-of-network OB/GYN is covered at 70% of the UCR charges, after the calendar year deductible (Option 2). You will be responsible for any amounts over UCR. Hospital or birthing center expenses are treated just like any other covered hospital stay. Midwife delivery services provided by a licensed midwife are also eligible, payable in the option selected.

Under the Core Option Plan, the Medical Plan covers 80% of your prenatal care for routine tests, and delivery, after the calendar year deductible when you receive care coordinated by a participating network OB/GYN. Care received from an out-of-network OB/GYN is covered at 60% of the UCR charges, after the calendar year deductible (Option 2). You will be responsible for any amounts over UCR. Hospital or birthing center expenses are treated just like any other covered hospital stay. Midwife delivery services provided by a licensed midwife are also eligible, payable in the option selected.

The Medical Plan will provide maternity benefits for a mother and an eligible newborn child for hospital stays up to:

- 48 hours following a vaginal delivery; or
- 96 hours, if the delivery is performed by cesarean section.

If the doctor and new mother agree that the stay does not need to be 48 (or 96) hours, the new mother and baby may leave the hospital as soon as it is medically approved. If the stay is to be longer than 48 hours (or 96 hours), North Star Health must authorize the additional time.

G. Women's Health And Cancer Rights Act Of 1998

The Medical Plan provides benefits for participants electing breast reconstruction in connection with a mastectomy. These include:

- Reconstruction of the breast on which the mastectomy has been performed;
- Surgery and reconstruction of the other breast to provide a symmetrical appearance; and
- Prosthesis and physical complications for all stages of a mastectomy, including lymphedemas (swelling associated with the removal of lymph nodes).

The manner of coverage is determined in consultation with the attending physician and patient. Based on the option selected, normal Medical Plan calendar year deductibles, co-pays, coinsurance, and any annual or lifetime maximums will apply.

H. Alternative Care

Sometimes, following a serious illness or major surgery, you may need follow-up care. Generally, this care does not need to be provided in a hospital. Alternative care includes home health care and/or skilled nursing care. In the case of a terminal illness, hospice care is often an alternative to a hospital setting. The Medical Plan pays benefits toward a variety of these alternative care services.

1. Home Health Care Benefits

Please note: All home health care benefits must be pre-certified by the Pre-Treatment Education program described earlier in this SPD.

Home health care is often recommended when you are able to handle tasks like feeding and bathing yourself, but still require skilled nursing care. It also offers the comfort of receiving care in familiar surroundings, rather than a hospital room.

The following services and supplies must be provided by a licensed health care organization. No benefits are paid for services performed by a relative or anyone living in your household. Please note that each visit is limited to four hours. Covered home health care services include but are not limited to:

- Part-time or intermittent skilled nursing care by a nurse;
- Part-time or intermittent home health aide services for a patient who is receiving covered nursing or therapy services;
- Physical, respiratory, occupational, and speech therapy when provided by a home health care agency;
- Medical and surgical supplies when provided by a home health care agency (excluding prescription drugs);
- Oxygen and its administration; and
- Medical social service consultations.

Covered home health care services **do not** include the following:

- Domestic or housekeeping services;
- Rental or purchase of equipment or supplies;
- Meals-on-wheels or other similar food arrangements;
- Home care provided in a nursing home or skilled nursing facility (see the heading ***Skilled Nursing Facility Benefits***, next);
- More than 20 home health care visits per calendar year;
- Home care for mental health conditions; and
- Custodial care.

2. Skilled Nursing Facility Benefits

Please note: Your stay in a skilled nursing facility must be pre-certified under the Pre-Treatment Education program described earlier in this SPD.

Extended care is provided by a special facility that offers 24-hour nursing care outside of a traditional hospital setting.

A physician may recommend continuing care in a skilled nursing facility. The Medical Plan covers all medically necessary eligible charges. A skilled nursing facility is an institution which is:

- accredited as a skilled nursing facility by The Joint Commission or Accreditation of Health Care Organizations;
- recognized and eligible for payment under Medicare as a skilled nursing facility; and
- recognized by the Medical Plan as a skilled nursing facility;

If you are confined in a licensed skilled nursing facility, the Healthy Choices Plan pays 90% of the cost of medical services for care received from network providers (Option 1), and 70% of the UCR charges, after the calendar year deductible, for care received outside of the network (Option 2). You will be responsible for any amounts over UCR.

If you are confined in a licensed skilled nursing facility, the Core Option Plan pays 80% of the cost of medical services for care received from network providers (Option 1) after the calendar year deductible, and 60% of the UCR charges, after the calendar year deductible, for care received outside of the network (Option 2). You will be responsible for any amounts over UCR. Covered services include:

There is a limit of 90 days per confinement under both the Healthy Choices and Core Option Plans.

- Room and board;
- Use of special treatment rooms;
- X-ray and laboratory examinations;
- Physical, occupational, or speech therapy;
- Oxygen and other gas therapy; and
- Drugs, biological solutions, dressings, and casts.

A physician must prescribe care in a skilled nursing facility and the patient must be under a physician's supervision throughout the stay.

In order to be covered by the Medical Plan, a skilled nursing facility may not:

- Be used mainly as a place for rest or a place for the aged;
- Provide treatment primarily for such mental disorders as drug addiction, alcoholism, chronic brain syndrome, mental retardation, or senile deterioration; or
- Provide custodial, hospice, or educational care of any kind.

3. Hospice Care Benefits

Please note: Hospice care must be pre-certified under the Pre-Treatment Education program described earlier in this SPD.

Hospice care is often recommended for terminally ill patients who are diagnosed to have six months or less to live. Hospice care helps keep the patient as comfortable as possible and provides supportive services to the patient and his or her family. Patients who can no longer be helped by a hospital, but require acute medical care, can be moved to a hospice facility, if available.

Under the Healthy Choices Plan, Hospice care is covered at 90% after the calendar year deductible when provided by a network provider (Option 1); and at 70% of the UCR charges, after the calendar year deductible, when care is provided outside the network (Option 2). You will be responsible for any amounts over UCR.

Under the Core Option Plan, Hospice care is covered at 80% after the calendar year deductible when provided by a network provider (Option 1); and at 60% of the UCR charges, after the calendar year deductible, when care is provided outside the network (Option 2). You will be responsible for any amounts over UCR.

There is a maximum of 6 months per lifetime for Hospice Care under both the Healthy Choices and Core Option Plans.

The patient is cared for by a team of professionals and volunteer workers, which generally includes a doctor and a registered nurse, and may include a dietary counselor, home health aide, medical social worker, and others.

The goals of the hospice are to provide an alert and pain-free existence for the patient and to keep the family actively involved in the care. Covered hospice care services include:

- Inpatient care;
- Nutritional counseling and special meals;
- Part-time nursing;
- Homemaker services;
- Durable medical equipment;
- Doctor home visits; and
- Bereavement and counseling services.

Covered hospice care services ***do not*** include the following:

- Any curative or life prolonging procedures;
- Services of a family member or individual who normally resides in your home; and
- Any period when the individual receiving hospice care is not under a physician's care.

Certain benefits may be paid for outpatient (in-home) hospice care. For details, please call North Star Health Customer Service.

I. Transplants

Please note: All transplants must be pre-approved and pre-certified under the Pre-Treatment Education program described earlier in this SPD. Procurement of the organ and performance of the transplant must take place at designated transplant center in the United States.

The Medical Plan will pay benefits for non-experimental and non-investigational transplants of the human heart, kidney, lung, heart/lung, bone marrow, liver, pancreas, and cornea. No benefits are paid for experimental or investigational (as described earlier in this SPD) transplants. A transplant surgery will be treated as any other illness when you (or a covered dependent) are the organ recipient during a transplant benefit period that begins five days before and ends 18 months after the transplant date. Coverage is contingent upon continuing to meet the criteria for North Star Health transplant approval until the date of the transplant. Covered services include:

- Inpatient or outpatient hospital charges for treatment and surgery by a North Star Health designated transplant center;
- Tissue typing;
- Removal of organ;
- Obtaining, storing, and transporting the organ (Benefits are still paid for the cost of obtaining the organ if the recipient dies before the transplant has been completed.); and
- Travel expenses for the recipient, if medically necessary, to and from the transplant center.

Please note that no benefits will be paid for the following:

- Organ transplant charges incurred without prior approval by the Pre-Treatment Education Program, or at a transplant center which was not designated by North Star Health;
- The transplant of an organ which is synthetic, artificial, or obtained from other than a human body;
- An organ transplant or organ procurement performed outside the United States;
- An organ transplant which the Plan Administrator determines to be experimental; and
- Expenses of an organ donor, except when the recipient is a participant in this Plan who receives the organ in a covered organ transplant. When coordinating with the donor's health plan, the Medical Plan will be secondary. If an organ is sold (i.e., not donated), no benefits are paid for the donor's expenses.

J. Mental Health and Substance Abuse Services

The Medical Plan provides benefits for inpatient mental health and substance abuse care, including detoxification. Outpatient treatment includes psychotherapy and counseling for substance abuse.

There is a total lifetime maximum benefit of 200 visits for outpatient mental health and substance abuse treatment. There is a total lifetime maximum benefit of 30 days for inpatient alcohol and substance abuse care. These maximums include benefits for all care received, whether or not your care is coordinated by a Nurse Advocate. The role of the Nurse Advocate is discussed next.

To receive a higher level of benefits, a Nurse Advocate must coordinate your care. A Nurse Advocate is a mental health professional who will help you determine the best course of treatment for you. Your Nurse Advocate will refer you to a provider, or you may refer yourself to a different provider in or out of the network. The choice is yours. ***However, if you refer yourself to a provider without pre-certification from a Nurse Advocate, coverage will not be provided.***

You can contact a Nurse Advocate at (800) 470-1361.

1. About The Network

The network includes a variety of specialists to meet your needs, including psychiatrists, psychologists, and licensed certified social workers. All network providers are experienced professionals, licensed in the state where they practice. They share the network's philosophy of quality care provided in the least restrictive manner. Mental health and substance abuse network providers offer a full range of counseling services, including individual therapy, family counseling, group therapy, addiction recovery programs, and special therapy sessions.

2. Care Coordinated By A Nurse Advocate

Outpatient mental health and substance abuse care: If you obtain outpatient mental health or substance abuse care that is coordinated by a Nurse Advocate, covered services are paid at 90% after the annual deductible and a \$20 co-payment per visit up to 25 visits per calendar year and 200 visits per lifetime under the Healthy Choices Plan or 80% after the calendar year deductible up to 25 visits per calendar year and 200 visits per lifetime under the Core Option Plan . Please note that this limit is in combination with any care you receive that is not coordinated by a Nurse Advocate. *However, please note that services that are not pre-certified will not be covered.*

Inpatient mental health care: If you obtain inpatient mental health care that is coordinated by a Nurse Advocate, covered services are paid at 90% after a \$200 co-payment and the annual deductible for up to 30 days of treatment per year under the Healthy Choices Plan or 80% after the calendar year deductible for up to 30 days of treatment per year under the Core Option Plan. *However, please note that services that are not pre-certified will not be covered.* Eligible expenses include certain charges for semi-private room and board, and all medically necessary services and supplies. Certain inpatient doctor visits are also covered. Psychiatric day care is considered the same as inpatient care. Each day of day care will count as one half day of inpatient care. The care must meet all Pre-Treatment Education requirements.

Inpatient substance abuse care: If you obtain inpatient substance abuse care that is coordinated by a Nurse Advocate, covered services are paid at 90% after a \$200 co-payment and the annual deductible for up to 30 days of treatment per

lifetime under the Healthy Choices Plan or 80% after the calendar year deductible for up to 30 days of treatment per lifetime.. *However, please note that services that are not pre-certified will not be covered.* Eligible expenses include certain charges for semi-private room and board, and all medically necessary services and supplies. Certain inpatient doctor visits are also covered. Psychiatric day care is considered the same as inpatient care. Each day of day care will count as one half day of inpatient care. The care must meet all Pre-Treatment Education requirements.

Covered substance abuse charges include:

- Emergency care and detoxification services in a general hospital or licensed non-hospital detoxification facility;
- Residential rehabilitation services in a licensed and certified facility. Services include:
 - Semi-private room and board charges;
 - Medical and nursing services;
 - Individual and group therapy;
 - Individual, group, and family counseling;
 - Drugs, biologicals, and solutions dispensed by the facility;
 - Psychological testing;
 - Outpatient rehabilitation services in a licensed outpatient alcoholism treatment facility.

3. Care Not Coordinated By A Nurse Advocate

You may choose to refer yourself for care by contacting a licensed psychiatrist, psychologist, or certified social worker who is practicing within the scope of his or her license. ***However, you must still call a Nurse Advocate at one of the confidential numbers (800) 470-1361 for pre-certification before receiving any outpatient or inpatient mental health, alcohol or substance abuse care or no coverage will be provided.*** When you refer yourself, you pay the required deductible and coinsurance amounts before the Medical Plan will pay benefits, as described in the **Medical Benefits At-A-Glance** chart earlier in this SPD.

Note: *You must receive pre-certification from a Nurse Advocate before receiving any treatment for outpatient, inpatient, inpatient residential, and outpatient facility treatment programs for mental health, alcohol, or substance abuse services. The confidential number to call is (800) 470-1361. Failure to obtain pre-certification will result in a complete denial of coverage.*

Please note: Coinsurance and co-pays for all mental health, alcohol and substance abuse treatments do not count toward your annual out-of-pocket maximum.

K. Limitation for Pre-Existing Condition

Benefits for this coverage shall not be payable for a Pre-Existing Condition. A Pre-Existing Condition is a condition for which a Covered Person has been medically diagnosed, treated by, or sought advice from, or consulted with, a Physician during the six (6) months before he or she became insured.

This provision will cease to apply to any expenses incurred in connection with a Pre-Existing Condition after the earliest of:

1. The end of a continuous period of 12 months of coverage, the final day of which must occur after the Covered Person's effective date of insurance, during which:
 - a. No expense is incurred;
 - b. No diagnosis or treatment or advice is received; and
 - c. A Physician is not consulted as the result of the Pre-Existing Condition or any related condition;
2. 12 months of continuous coverage; or 18 months of continuous coverage for Late Enrollees.

The Pre-Existing Condition Limitation above does not apply to newborn or adopted children, or to any pregnancy. Any Pre-Existing Condition Limitation can be reduced by that period of time the Covered Person was previously insured for the condition causing claim, provided such Covered Person:

1. Was validly insured under his prior plan with Creditable Coverage immediately prior to becoming covered under this policy; and

Became covered under this policy within 63 days after termination of his prior coverage, and a certificate of Credible Covered is received.

L. What's Not Covered

The Medical Plan does not cover the following:

- Any condition arising from or occurring while engaged in any illegal activity;
- Any injury sustained or disease resulting from war, act of war, act of terrorism, riot, rebellion, civil disobedience, or from military service in any country;

- Charges covered by no-fault auto insurance, or any other federal or state-mandated law;
- Charges by a provider who is a close relative of the covered person (spouse, child, brother, sister, in-law, grandparent, or parent) or who resides in a covered person's home;
- Charges for administration of any drug, including insulin;
- Charges for equipment that does not meet the definition of Durable Medical Equipment provided earlier in this SPD, including air conditioners, humidifiers, dehumidifiers, purifiers, or physical fitness equipment, whether or not recommended by a doctor;
- Charges otherwise payable, but excluded under the Coordination of Benefits provisions set forth in this SPD;
- Charges that would not be made if no coverage existed;
- Charges which you are not legally required to pay;
- Claims filed more than 12 months after the expenses were incurred (This applies to services and supplies rendered by non-network providers for which you will need to submit the claims. Network providers have agreed to submit claims for you within 180 days of the date of service.);
- Confinement, treatment, services, or supplies received *before* your (or your eligible dependent's) effective date or *after* the termination date;
- Controlled substances, hallucinogens, or narcotics not administered on the advice of a doctor;
- Convenience items, such as telephone and television rental, slippers, meals for family members, or first aid kits and supplies;
- Cosmetic surgery except:
 - when resulting from an accidental injury or illness occurring while covered under the Medical Plan; or
 - because of a congenital malformation of a child; or
 - because of a mastectomy (see the heading **Women's Health And Cancer Rights Act Of 1998**);
- Coverage's refused by another plan as a penalty for non-compliance with that plan's requirements;
- Custodial care, residential care, or rest cures;

- Dental treatment except in connection with an accidental injury to sound natural teeth that is part of the initial emergency treatment within 48 hours of the accident or injury;
- Drugs that are non-prescription, non-legend, or over-the-counter;
- Emergency room services or treatments in cases other than in emergency situations (facility charges are not covered in non-emergency situations);
- Collection and subsequent storage of umbilical cord blood for the procurement of stem cells;
- Charges in connection with:
 - an injury arising out of, or in the course of, any employment for wage or profit; or
 - a disease covered with respect to employment, by any Workers' Compensation law, occupational disease law, or similar legislation;
- Expenses related to third party liability, unless otherwise payable as described under the heading **When The Medical Plan May Recover Payment (Subrogation)**;
- Exercise programs for the treatment of any condition;
- Experimental and investigational treatment defined as the use of any treatment, procedure, facility, equipment, drug or drug usage, device or supply which the Plan Administrator determines, in its sole and absolute discretion, is being studied for safety, efficiency, and effectiveness and/or which has not received or is awaiting endorsement for general use within the medical community by government oversight agencies, or other appropriate medical specialty societies at the time services are rendered;

The Plan Administrator will make a determination on a case by case basis, using the following principles as guidelines:

- If the drug or device cannot be lawfully marketed without approval of the U.S. Food and Drug Administration and approval for marketing has not been given at the time the drug or device is furnished;
- If the drug, device, medical treatment, or procedure, or the patient informed consent document utilized with the drug, device, treatment, or procedure, was reviewed and approved by the treating facility's Institutional Review Board or other body serving a similar function, or if Federal law requires such review or approval;
- If reliable evidence shows that the drug, device, medical treatment, or procedure is the subject of ongoing Phase I or II clinical trials; is the subject of research,

experimental study or the investigational arm of ongoing Phase III clinical trials; or is otherwise under study to determine its maximum tolerated dose, its toxicity, its safety its efficacy or its efficacy as compared with a standard means of treatment or diagnosis;

- If reliable evidence shows that the prevailing opinion among experts regarding the drug, device, medical treatment, or procedure is that further studies or clinical trials are necessary to determine its maximum tolerated dose, its toxicity, its safety, its efficacy or its efficacy as compared with a standard means of treatment or diagnosis.

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

- Hearing aids, glasses, contact lenses;
- Infertility services, fertility drugs, birth control devices, artificial insemination, GIFT (Gamete Intrafallopian Transfer), in vitro fertilization, services of a surrogate mother and diagnosis and treatment of infertility;
- Services and supplies used to treat conditions related to:
 1. Autism, except for diagnostic testing up to \$10,000 per year
 2. Hyperkinesis
 3. Learning disabilities
 4. Developmental delay
 5. Behavioral problems
 6. Mental Retardation
 7. Senile deterioration beyond the period necessary for diagnosis
- Hypnosis or biofeedback training;
- Immunizations related to travel unless approved by the Center for Disease Control guidelines of the countries to visited;
- Injuries sustained or an illness contracted while committing a criminal act;
- Intentionally self-inflicted injury, sickness, or suicide while sane or insane;
- Marital counseling;
- Maternity care for persons other than you or your spouse;

- Motorcycle-related injury expenses, unless the covered person was wearing a helmet approved by state law; this exclusion applies even if wearing a helmet would not have prevented or reduced the injury;
- Myopia or hyperopia correction by means of corneal microsurgery, such as keratomileusis, keratophakia, and radial keratotomy or laser surgery and all related services;
- Obesity treatment, except for surgical treatment of morbid obesity, as described earlier in this SPD;
- Private room charges beyond the amount normally charged for a semi-private room, unless a private room is medically necessary;
- Reversals of vasectomies and tubal ligations;
- Routine foot care (i.e., any service or supply related to corns, calluses, flat feet, fallen arches, non-surgical care of toenails, and other symptomatic complaints of the feet where surgery is performed) and orthotics used for sport and leisure activities;
- Routine Hearing Exams
- Services and supplies not recommended and approved by a doctor;
- Charges paid in full or in part under any other plan of benefits provided by Hughston Clinic, a school, or a government, or for services you are not required to pay;
- Services, facilities, or supplies not specifically listed or described in this SPD;
- Services performed by a doctor or other professional provider enrolled in an education, research, or training program when such services are primarily provided for the purposes of the education, research, or training program;
- Sexual dysfunction treatment not related to organic disease;
- Surrogate motherhood treatment;
- Telephone consultation charges, missed appointment charges, or charges for the completion of claim forms;
- Transsexualism, gender dysphoria, or sexual reassignment or change, including medication, implants, hormone therapy, surgery, medical, or psychiatric treatment;
- Treatment of educational and development disorders, including but not limited to mental health services, diagnostic testing, physical, speech, or occupational therapy;
- Treatment which is not medically necessary or charges in excess of the Usual,

Customary, and Reasonable charge or above the allowable lifetime or annual maximums;

- Treatment which is not performed by an appropriate licensed professional provider acting within the scope of the provider's license;
- Vision training or eye exercises to increase or enhance visual activity or coordination;
- Routine maintenance or repair of owned or rented durable medical equipment;
- Expenses incurred outside of the United States if the covered person traveled to such location for the sole purpose of obtaining medical care, services, supplies or drugs;
- Travel expenses other than necessary ambulance charges;
- Recreational or diversional therapy;
- Radioallergosorbent (RAST) testing for allergies
- Chelation therapy;
- Hypnotism, acupuncture or goal oriented or behavior modification therapy;
- Wigs and artificial hair pieces (except in cases of baldness resulting from chemotherapy, radiation therapy, or surgery, in which case benefits are limited to one wig once per lifetime limited to \$300.

Please note: This is not a complete list. If you are not sure if an expense is covered after reviewing this list, please call North Star Health Customer Service at (800) 470-1361

IV. Dental Covered Services

A. Dental Benefits at a Glance

The following chart summarizes most of the benefits and services available under the Dental Plan.

Dental	Premium Plan	Basic Plan
Annual Max per year	\$1,000	\$1,000
Annual Deductible	\$50 per person \$150 per family	\$50 per person \$150 per family
Coinsurance	Level I – Preventative Care (no deductible) 100% Level II – Basic Restorative 80% Level III – Major Restorative 50%	Level I – Preventative Care (no deductible) 100% Level II – Basic Restorative 50% Level III – Major Restorative not covered
Orthodontic (Employee and covered dependent under 19)	Premium Plan	Basic Plan (not covered)
Annual Max per year	\$1,000	n/a
Annual Deductible	\$50 per person \$150 per family (includes dental)	n/a
Coinsurance	50%	n/a

B. Services and Supplies

The Dental Plan provides benefits for the necessary dental services and supplies listed in this section.

A necessary dental service or supply is one that the Plan Administrator determines:

- Diagnoses, prevents, or treats a covered Dental condition;
- Is appropriate for the symptoms, diagnosis, or treatment of the covered Dental condition;
- Is supplied or performed in accordance with current standards of Dental practice within the United States of America;
- Is not primarily for the convenience of the covered person, facility, or provider;
- Is the most appropriate supply or level of service that can safely be provided; and
- Is recommended or approved by the attending professional provider.

No benefits are provided for services and supplies that are not necessary dental

services or supplies.

Necessary dental covered services and supplies include the following (subject to any conditions or limitations as described elsewhere in this SPD):

C. Covered Expenses

Covered expenses are the reasonable and customary charges made by a dentist for necessary dental treatment listed here. Each covered expense is deemed incurred on the date the service or supply is provided to the covered person, except that:

- As to dentures: all expenses will be deemed incurred on the date the first impression is taken.
- As to fixed bridge: all expenses will be deemed to be incurred when the first impressions are taken or the abutment teeth are fully prepared.
- As to crowns, inlays, and onlays: all expenses will be deemed incurred on the date the teeth are first prepared.
- As to root canal therapy; all expenses will be deemed incurred on the later of the date that the pulp chamber is opened or canals are explored to the apex.
- As to periodontal surgery: all expenses will be deemed incurred on the date that the surgery is actually performed.

Except for the exclusions that follow this list, the covered expenses are:

Type I Expenses—Diagnostic and Preventive Care

- Dental exams, scaling, and cleaning of teeth or gums; but not more than twice each calendar year.
- Dental X-rays. However, an entire dental series of at least 14 films, including bitewings are limited to one series every 36 months and all other bitewings films are limited to 1 series every 6 months.
- Topical application of sodium fluoride or stannous fluoride to the teeth; but only if the covered person has not attained 15 years of age. Limited to twice a year.
- Periodontal prophylaxis two times per year.
- Space maintainers, fixed unilateral, and limited to non-orthodontic treatment used in place of prematurely lost teeth.

- Sealants for permanent teeth (limited to covered dependent children between the ages of 6 and 15 years old, once per tooth every three years.)
- Emergency treatments for relief of dental pain on a day for which no other benefit, other than for x-rays is payable.

Type II Expenses—Basic Restorations, Endodontics, Periodontics, Prosthodontics, Maintenance, and Oral Surgery

- Amalgam, silicate, acrylic or composite fillings to restore diseased or broken teeth. Multiple fillings on one tooth surface will be deemed a single filling.
- Replacement of amalgam, silicate, acrylic or composite fillings, provided that, unless an additional tooth surface is involved, a continuous period of at least (12) twelve consecutive months has past since the last date on which the filling was provided or replaced for the individual by any person
- Problem focused exam and x-rays
- Local anesthetic, analgesic, and routine post-operative care for extractions and other oral surgery.
- General anesthesia; such service shall be in connection with oral surgery or other covered dental treatment.
- Simple extraction of erupted teeth.
- Endodontic treatment; this includes root canal therapy. X-ray test, laboratory exam, or follow-up care is part of the allowance for root canal therapy and not a separate dental service.
- Injection of antibiotic drugs by a dentist.
- Osseous surgery — Flap entry and closure is part of the allowance for osseous surgery and osseous graft and not a separate Dental Service.
- Cutting Procedures in the mouth
- Treatment of periodontal and other diseases of the gums and tissues of the mouth.
- Periodontal scaling once a year.
- Apicoectomy.
- Pulpotomy for dependent children only.

- Repair or recementing of crowns, inlays, bridgework, or dentures.
- Relining of dentures.
- Frenulectomy

If more than one periodontal surgical service is performed per quadrant only the one with the largest Maximum Covered Expense is a Dental Service.

Level II Dental Limitation: If a covered person becomes covered under this Level II dental care benefit later than (30) thirty days after such person's eligibility date under the plan, no payment shall be made for and level II (Restorative) treatment which commences within (6) six months thereafter. This limitation does not apply to special enrollees who declined coverage at the time of enrollment because of alternative dental coverage.

Type III Expenses

- Initial provision of crowns or gold inlays or onlays
- Restoration of crowns, if a (12) twelve month period has elapsed since the last date on which the crown was provided
- Initial installation of full dentures, partial dentures, or fixed bridgework, if required to replace one or more natural teeth
- Repair of Dentures
- Relining or adjustments to dentures if (6) six months have elapsed since the last date on which the dentures were provided
- Addition of teeth to existing dentures or fixed bridgework, if required to replace one or more natural teeth
- Replacement of
 - a) An existing full denture with a new full denture
 - b) An existing partial denture with a new partial denture; or
 - c) An existing fixed bridgework or denture with a new fixed bridgework or denture, if such replacement is required to replace one or more natural teeth, or the existing bridgework or denture was installed (5) five years or more prior to its replacement and can not be made serviceable

Charges for specialized techniques involving precision attachments, personalization or characterization and additional charges for adjustments within (6) six months from installation are not included as covered dental charges. Covered charges for both a temporary and permanent prosthesis will be limited to the charge for the permanent one.

Level III Dental Limitation: If a covered person becomes covered under this Level III dental care benefit later than (30) thirty days after such person's eligibility date under the plan, no payment shall be made for and level III (Major Restorative) treatment which commences within (6) six months thereafter. This limitation does not apply to special enrollees who declined coverage at the time of enrollment because of alternative dental coverage.

Pretreatment Estimate of Major Restorative Services

A covered person should obtain a written estimate from the plan supervisor of the maximum amount of charges for which payment will be made for any proposed course of dental care by submitting, prior to the commencement of treatment x-rays, if and when requested and written notice on a form supplied by the plan supervisor outlining such course and including itemized charges.

Orthodontics—PREMIUM PLAN ONLY

The following shall be considered a covered dental expense under the orthodontia benefit under the premium plan.

The charges of a licensed orthodontist for the orthodontic correction of the following conditions of a covered person under age (19) nineteen.

1. Overbite or overjet of at least 4 millimeters.
2. Maxillary and mandibula arches in either protrusive or retrusive relation of at least one cusp (entire upper jaw at least one cusp out of line with the lower jaw).
3. Cross-bite (upper and lower teeth do not meet in proper relation to each other).
4. Functional/myofunctional therapy, when provided in conjunction with appliance therapy by a dentist or other qualified provider when referred by a dentist.

Condition of Payment of Orthodontia benefits

The orthodontist must furnish to the plan, prior to the commencement of treatment, x-rays, study models and treatment plan which describes the course of treatment, duration of treatment and total charge.

At the time of placement of an appliance, the plan allows the orthodontic co-insurance percentage for the initial down payment (down payment not to exceed one third of total charges). The balance of the charge is then divided into the number of months of the treatment duration. The plan then allows the orthodontic co-insurance percentage of the

monthly payment amount until the orthodontic plan maximum has been met. Claims are paid upon receipt of paid monthly receipts.

The plan does not pay the entire maximum benefit at the time of appliance placement. Payment is spread out of the duration of the treatment.

Orthodontia Limitations

The following limitations apply to orthodontia treatment in addition to the limitations listed in the “What is Not Covered” Section.

1. If the coverage of a covered person terminates during the course of treatment the only subsequent payment shall be the current monthly installment. Monthly installments due after the termination date are not covered.
2. If a covered person becomes covered under this benefit later than (30) thirty days after such person’s eligibility date under the plan, no payment shall be made for and orthodontic treatment which commences within (12) twelve months thereafter. This limitation does not apply to special enrollees who declined coverage at the time of enrollment because of alternative dental coverage.

D. What Is Not Covered

No benefits will be paid for the following:

Any part of a dental expense that: (a) is paid by a Medical Expense Insurance provided by the plan sponsor; or (b) is not paid by such other coverage solely because of a deductible or co-payment provision. As used here, the word “deductible” means a provision that a certain amount of expenses must be incurred before the benefits begin;

- Charges that a covered person has no legal obligation to pay; but, this does not exclude the cost of services or supplies provided by a state’s Medicaid program.
- Treatment not performed in person by a dentist or doctor; but this does not exclude scaling and cleaning of teeth done by a licensed dental hygienist while supervised by a dentist.
- Treatment that does not have a reasonably favorable prognosis.
- Treatment that is wholly cosmetic in nature, such as charges to personalize or characterize a denture.
- Teeth whitening procedure and/or products.
- Dentures and bridgework when treatment began while a person was not covered by this dental benefit plan or by a group dental benefit plan of the plan sponsor that this

coverage replaced. If a bridge is excluded, crowns, and inlays installed as abutments are also excluded.

- Purchase and fitting of prosthetic devices, bridges, and crowns that: (a) were ordered while a person was not covered by this dental benefit plan or by a group dental benefit of the plan sponsor that this coverage replaced; or (b) are finally installed more than 60 days after a person's dental plan coverage ceased.
- Replacement of a prosthetic device, bridge, or crown within five years of its last placement. The duplication of any prosthetic device either as a spare or to replace a lost or stolen device is also excluded.
- Charges to adjust a prosthetic device that are incurred within six months after it was first installed, but were omitted in the first price of the device.
- Dentures, crowns, inlays onlays, bridgework, or other devices or services if their sole purpose is to increase vertical dimension or to restore occlusion.
- Charges in connection with:
 - an injury arising out of, or in the course of , any employment for wage or profit; or
 - a disease covered with respect to employment by any Workers' Compensation law, occupational disease law, or similar legislation;
- Pulp caps, veneers, and implants including any prosthetic device attached to it.
- Instructions for plaque control.
- Any condition arising from or occurring while engaged in any illegal activity;
- Any injury sustained or disease resulting from war, act of war, act of terrorism, riot, rebellion, civil disobedience, or from military service in any country;
- Charges covered by no-fault auto insurance, or any other federal or state-mandated law;
- Charges by a provider who is a close relative of the covered person (spouse, child, brother, sister, in-law, grandparent, or parent) or who resides in a covered person's home;
- Charges otherwise payable, but excluded under the Coordination of Benefits provisions set forth in this SPD;
- Charges that would not be made if no coverage existed;

- Charges which you are not legally required to pay;
- Claims filed more than 12 months after the expenses were incurred
- Coverage refused by another plan as a penalty for non-compliance with that plan's requirements;
- Expenses related to third party liability, unless otherwise payable as described under the heading **When The Dental Plan May Recover Payment (Subrogation)**;
- Charges paid in full or in part under any other plan of benefits provided by employer, a school, or a government, or for services you are not required to pay;
- Treatment which is not a necessary dental treatment or charges in excess of the Usual and Customary charge or above the allowable lifetime or annual maximums;
- Treatment which is not performed by an appropriate licensed professional provider acting within the scope of the provider's license;

Please note: This is not a complete list. If you are not sure if an expense is covered after reviewing this list, please call North Star Health Customer Service at (800)470-1361.

V. Payment of Benefits Under the Medical & Dental Plan and Termination of Benefits

A. What Happens When You Have Duplicate Coverage

You and members of your family could be covered under more than one group health plan or health insurance coverage. These other plans may include health care insurance available through your spouse's employer. You may also qualify under certain conditions for benefits from state no-fault automobile laws.

The Medical Plan, like most group health plans, includes a Coordination of Benefits (COB) provision. The purpose of this provision is to limit the total amount you may receive from all medical plans to no more than 100% of the covered charges.

The plan that pays first is the Primary Plan. The Secondary Plan makes up the difference between the benefit paid (or deemed paid) by the Primary Plan and the maximum amount that would be paid under the Secondary Plan if there were no Primary Plan.

If the Medical Plan is your Secondary Plan, only covered expenses up to the Medical Plan's fee schedule may be covered. Any applicable co-pays, coinsurance, or deductibles under the two plans still apply.

The Medical Plan will be primary for you and your covered dependents unless your spouse is covered by his/her employer's plan. If your spouse is covered by his/her

employer's plan then your spouse's plan is primary for him/her. If both you and your spouse are covered by each of your respective employer's plans, and both plans cover dependent children, benefits for the dependent children will be handled as follows: The plan of the parent whose birthday falls earlier in the year will be the Primary Plan for children. However, if the other health care plan does not include this "birthday rule" on children's coverage, or if both parents have the same birthday, the plan of the parent that has covered the dependent for a longer period of time is the Primary Plan and pays first. The other parent's plan will be secondary.

The Coordination of Benefits rules usually do not apply in cases where parents are divorced or legally separated. The plan of the parent with a court order setting responsibility for health care expenses will usually be the only plan that covers a child. Coordination of Benefits rules only apply when a child is actually covered under the separate plans of both parents. If you have enrolled your spouse in the Medical Plan and your spouse lose coverage under his or her other plan, the Medical Plan becomes primary for both of you and any covered dependent children.

Please note that the Medical Plan is the Secondary Plan to any other plan covering a qualified beneficiary who has elected COBRA.

The Medical Plan is the Primary Plan if you are covered under the Medical Plan as an active employee and you are also covered by Medicare. Similarly, the Medical Plan is the Primary Plan for your covered spouse if your spouse is covered by Medicare and if you are an active employee. The Medical Plan is Secondary to Medicare if you are covered by Medicare. If you have retiree coverage under the Medical Plan and are eligible for Medicare, then the Medical Plan is your Secondary Plan. Remember, if you are eligible for Medicare but do not enroll for Medicare, the Medical Plan will pay secondary benefits as though you had enrolled for Medicare.

When the Medical Plan is the Secondary Plan, it will deem the Primary Plan to have made all benefit payments that would have been made had you complied with all the rules of the Primary Plan. For example, if you fail to submit a claim on time to the Primary Plan or if you do not get the required pre-certification for treatment, the Medical Plan will make its Secondary Plan payment based on the payment the Primary Plan would have made if you submitted the claim on time or if you obtained the required pre-certification.

B. Automobile Limitations

This Plan will provide no coverage on the first \$250,000 of medical expenses incurred as a result of a motor vehicle accident for which No-Fault coverage would or could apply. If the Covered Person is driving without automobile insurance coverage, as required by law, this Plan will not pay any benefit unless the total expense exceeds \$250,000.

When medical payments are available under vehicle insurance, this Plan shall pay excess benefits only, without reimbursement for vehicle plan deductibles. This Plan shall

always be considered the secondary carrier regardless of the individual's election under PIP (Personal Injury Protection) coverage with the auto carrier.

C. When The Medical Plan May Recover Payment (Subrogation and Reimbursement)

1. Payment Condition

- a. In those situations where an injury, sickness, disease, or disability is caused in whole or in part by, or results from, the acts or omissions of a third party, or from the acts or omissions of covered persons and their dependents ("Plan Beneficiary") where any insurance coverage, no-fault, uninsured motorist, underinsured motorist, medical payment provision, or other insurance policies or funds ("Coverage") is available, the Plan has no obligation to pay benefits, but may elect to advance payment or extend credit in the form of medical benefits, subject to the Plan's rights and the Plan Beneficiary's obligations as set forth in these Subrogation and Reimbursement Provisions.
- b. Plan Beneficiary, his or her attorney, and/or legal guardian of a minor or incapacitated individual agrees, by acceptance of the Plan's payment of medical benefits, to maintain one hundred percent (100%) of the Plan's payment of benefits or the full extent of payment from any one or combination of first and third party sources in trust and without dissipation except for reimbursement to the Plan or its assignee. By accepting benefits under the Plan, the Plan Beneficiary recognizes this property right or equitable interest of the Plan in any cause of action the Plan Beneficiary may have or the proceeds thereof.
- c. In the event a Plan Beneficiary settles, recovers, or is reimbursed by any third party or Coverage, the Plan Beneficiary agrees to reimburse the Plan for all benefits paid or that will be paid as a result of said injury or condition. The Plan Beneficiary acknowledges that the Plan has the first priority right of recovery and a first lien to the extent of benefits provided by the Plan and shall be paid before any other claims for the Plan Beneficiary as the result of the illness or injury. Notice of said right and/or lien may be filed with any person or organization responsible, or potentially responsible, to the Plan Beneficiary, the Plan Beneficiary's attorney, or the Court. If the Plan Beneficiary fails to reimburse the Plan for all benefits paid or to be paid, as a result of said injury or condition, out of any recovery or reimbursement

received, the Plan Beneficiary will be liable for any and all expenses associated with the Plan's attempt to recover such money from the Plan Beneficiary.

2. Subrogation

- a. The Plan Beneficiary agrees to subrogate the Plan to any and all claims, causes of action or rights that the Plan beneficiary has or may have against any person, corporation and/or other entity, and to any Coverage to which the Plan Beneficiary claims an entitlement, regardless of how classified or characterized, and to reimburse the Plan for any benefits paid by the Plan when recovery is made. If there is a failure to make reimbursement, the Plan will be legally presumed to be included in such action or recovery. In the event the Plan Beneficiary decides not to pursue any third parties or Coverage the Plan Beneficiary authorizes the Plan to pursue, sue, compromise, or settle any such claims in the Plan beneficiary name, to execute any and all documents necessary to pursue said claims in the Plan Beneficiary's name, and agrees to fully cooperate with the plan in the prosecution of any such claims.
- b. Right of Reimbursement
 1. The Plan shall be entitled to recover 100% of the benefits paid, without deduction for attorneys' fees and costs, or application of the common fund doctrine, make whole doctrine, Rimes doctrine, or any other similar legal theory, or other deductions, without regard to whether the Plan Beneficiary is fully compensated by his/her net recovery from all sources. The obligation exists whether or not the judgment or settlement specifically designates the recovery or a portion of it as including medical, disability, or other expenses. If the Plan Beneficiary's recovery is less than the benefits paid, then the Plan is entitled to be paid all of the recovery achieved.
 2. The Plan will not pay or be responsible, without its written consent, for any fees or costs associated with a Plan Beneficiary pursuing a claim against any Coverage. The Plan Beneficiary agrees to hold the Plan harmless against any claims made against the Plan by the attorneys retained by the Plan Beneficiary.

3. No Further Acknowledgment Necessary

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

4. Excess Insurance

- a. If at the time of injury, sickness, disease, or disability there is available, or potentially available, to the Plan Beneficiary any other Coverage, including but not limited to judgment at law or settlements, the benefits under this Plan shall apply only as excess insurance over such other sources of indemnification.

5. Plan Beneficiary's Obligations

- a. It is the Plan Beneficiary's obligation to:
 1. provide the Plan with pertinent information regarding the injury or sickness, including various forms of documentation, accident reports, settlement reports, and any other requested additional information;
 2. do nothing to prejudice the Plan's rights of subrogation and reimbursement;
 3. not settle, without the prior consent of the Plan, any claim that the Plan Beneficiary may have against any legally responsible party or insurance carrier; and
 4. refrain from releasing any party, person, corporation, entity, insurance company, insurance policies, or funds that may be liable for or obligated to the Plan Beneficiary for the injury or condition without obtaining the Plan's written approval.
- b. Failure to comply with any of these requirements by the Plan Beneficiary, his or her attorney, or guardian may, at the Plan's discretion, result in a forfeiture of payment by the Plan of medical benefits and any funds or payments due under this Plan may be withheld to satisfy the Plan Beneficiary's obligation.

D. When Medical Coverage Ends

Your medical coverage under the Medical Plan as described in this SPD will end on the earliest of the following dates:

- The end of the month in which you are no longer an eligible employee because of a decrease in the number of hours worked or you end your employment. However, you may be eligible for COBRA Continuation Coverage, described later in this SPD;

- The date the Medical Plan (or some of its provisions) is discontinued or when contributions by your employer are discontinued;
- The date when you report for active duty as a member of the armed forces of any country, except to the extent required by law;
- The date on which you cease to make the required contributions for your coverage;
- The date when you have exhausted your maximum lifetime benefit.
- The end of the month during which the Employee ceases active work on a Full-Time basis due to Total Disability. This time period runs concurrent with the Family and Medical Leave Act of 1993 (FMLA) and does not run in addition to leave granted under the FMLA;
- The date an approved leave of absence ceases (maximum leave of absence is 12 months including leave granted under the Family and Medical Leave Act of 1993 (FMLA), unless the Employee resumes employment and meets the eligibility requirements of the Plan.

Coverage for a dependent will end on the earliest of:

- The end of the month in which your coverage stops because you end your employment or no longer qualify as an eligible employee;
- The date when he/she no longer qualifies as an eligible dependent as explained earlier in this SPD under **Who is Eligible**, (but see **COBRA Continuation Coverage** described next);
- The date the Medical Plan (or some of its provisions) is discontinued *or* when contributions by your employer are discontinued;
- The date when you stop making contributions for your dependents; or
- The date your dependent enters military service, except to the extent required by law.

For certain of the above events, you or your dependents may be able to continue coverage by self-payment under COBRA, as explained next. If you take an unpaid leave of absence from your employment (including a leave covered by the Family and Medical Leave Act (FMLA)), you must continue making your required contributions if you want your Medical Plan coverage to remain in effect. If you do not make your required contributions, your Medical Plan coverage will end. If your leave is covered under FMLA, you may be allowed to resume coverage upon your return from leave.

Regardless of any termination provision described above, if you take a leave of absence from employment with the Employer because of military service, you may elect to continue coverage under the Plan to the extent required by the Uniformed Services Employment and Reemployment Rights Act of 1994 (“USERRA”) for you and your covered spouse or dependents. You will be required to pay for such coverage in an amount determined under USERRA. Such coverage will end on the earlier of: (1) the last day of the 18 month period beginning on the date your absence begins; or (2) the day after the date on which you fail to apply for or return to a position of employment with the Employer. Please contact the Employer if you have questions about coverage during periods of military service.

E. COBRA Continuation Coverage

COBRA allows you, your spouse or former spouse, and your dependents to continue your Medical Plan coverage for a specified period of time after certain qualifying events take place. Except as explained next for newborn or adopted children, only persons who are actually covered under the Medical Plan on the date of the qualifying event may continue coverage under COBRA. You, your spouse, and your adult dependents have separate election rights. To continue coverage under COBRA, the covered person must pay the full premium rates, plus a 2% administrative charge.

Coverage under the Medical Plan may be continued under COBRA for up to 18 months for you, your spouse, and your eligible dependents, if coverage is lost due to one of the following qualifying events:

- Your employment ends for reasons other than gross misconduct; or
- Your work hours are reduced so that you are no longer eligible.

Dependent children include children born to you, adopted by you, or placed with you for adoption while you are covered under COBRA. For this child to qualify for COBRA, you must notify your Human Resources Department and elect COBRA coverage for the new child as soon as possible, but in no case later than 31 days after the event. If notice is given and the election is made on a timely basis, the newborn or adopted child will be covered as of the date of the birth, adoption, or placement for adoption.

Please be aware that if you, your spouse, or any of your dependents is Social Security disabled at any time during the first 60 days of COBRA coverage, coverage for the disabled individual and each of the individual’s family members may be extended an additional 11 months, for a total of 29 months. Premiums for the additional 11 months will increase from 102% to 150% of the full cost. Your Human Resources Department must be notified of Social Security Disability within 60 days of the determination and within 18 months of the qualifying event. If Social Security notifies you or any of your dependents that he or she is no longer disabled, then the additional 11 months of COBRA

coverage no longer applies and you must notify your Human Resources Department within 31 days of the final determination.

Please contact your Human Resources Department if you have any questions about your eligibility.

Your spouse and dependent children may individually elect COBRA continuation coverage for up to 36 months if coverage ends because of:

- Your divorce;
- Your legal separation;
- Your entitlement to Medicare; or
- Your death.

Please note: You may not elect coverage on behalf of a divorced spouse, but he or she may personally elect to continue coverage.

Your dependent children may individually elect continuation coverage for 36 months if they stop being eligible for dependent coverage. Eligibility for dependent coverage is explained in the section **General Information About Your Benefits**, under the heading **Who Is Eligible**.

If one of the above events that allows COBRA coverage to be continued for 36 months occurs after an event that allows COBRA coverage to be continued for 18 months and before 18 months has expired, then COBRA coverage may be elected for up to 36 months, measured from the first event.

In the case of divorce, separation, or a dependent child no longer eligible for dependent coverage, you, your spouse, or your child must notify your Human Resources Department in writing within 60 days after that event occurs. If that notice is given on time, your spouse or child will be notified of the right to continue coverage under COBRA. If written notice of the event is not given on time, then your spouse and child will have no rights to continue coverage under COBRA.

You, your spouse, or your dependents will be informed of the right to continue coverage under COBRA in the event:

- Your employment ends for reasons other than gross misconduct;
- Your work hours are reduced so that you are no longer eligible; or
- Your death.

1. Electing COBRA Coverage

You or your spouse or dependents will have 60 days from the date coverage would otherwise end or from the time notice of COBRA rights is given (whichever is later) to elect to continue your Medical Plan coverage under COBRA.

If COBRA coverage is elected on a timely basis, you, your spouse, or your dependents will have an additional 45-day period to pay the first premium, starting on the date the election was made.

All premium payments must be made directly to the address shown on your COBRA election notice.

Each individual who elects to continue coverage must pay the full premium cost, plus 2% for administrative expenses. You will be advised of the monthly cost of COBRA coverage per person at the appropriate time. After you, your spouse, or dependents have elected to continue coverage and have paid the required premiums, coverage will be reinstated back to the date regular coverage was lost. The Medical Plan will not pay any claims made in the interim. Upon reinstatement of coverage, invoices may be submitted or re-submitted to the Medical Plan for payment.

If the Medical Plan changes, or if the coverage costs change, the COBRA continuation coverage benefits and their costs will change as well. Covered persons will be notified of such changes.

The right to COBRA continuation coverage will end before the conclusion of the 18- or 36- month period, whichever applies, if:

- A covered individual becomes covered under another group medical plan after COBRA coverage is elected (unless a pre-existing condition limitation would prevent the individual from receiving benefits from the new plan for a particular illness or injury);
- A covered individual becomes covered by Medicare after COBRA coverage is elected (*Please note: your dependent is entitled to continuation coverage for 36 months in the event **you** become covered by Medicare after COBRA coverage is elected — the 36-month period begins with the date your COBRA coverage began*);
- The premium is not received on a timely basis; or
- Hughston Clinic stops providing group medical coverage for all active employees.

F. COBRA And FMLA

Under the Family and Medical Leave Act (FMLA), you may be eligible to take up to 12 weeks of time off, as determined by your Human Resources Department. If you are approved for FMLA leave, there are certain rules that apply should you become eligible for benefits under COBRA.

1. Eligibility For COBRA

You will be eligible for COBRA coverage following an FMLA leave if:

- you (or your covered dependent) are covered on the day before the first day of FMLA leave (or become covered during the FMLA leave) under the Medical Plan; and
- you do not return to employment with Hughston Clinic at the end of the FMLA leave.

2. When COBRA Coverage Begins

If properly elected, your COBRA continuation coverage will begin at the end of your FMLA leave. For example, if you take all your FMLA leave and do not return to work, your COBRA continuation coverage (if properly elected) would begin on the first day of the month after your *last* day of FMLA leave. If you notify your Human Resources Department before your FMLA leave is over that you do not plan to return to work, your COBRA continuation coverage (if properly elected) will begin on the first day of the month after you notify your Human Resources Department.

3. Health Care Premiums

While you are on FMLA leave, you will be billed for your premiums. If you pay the required premiums, you will remain active with the Medical Plan. If you do not pay the required premiums, you will be terminated from the Medical Plan.

4. Additional Information

Please note that these COBRA/FMLA regulations also apply to any covered dependents you may have under the Medical Plan. For more information about the Family and Medical Leave Act, please contact your Human Resources Department.

G. When You Become Eligible For Medicare

If you are still an active employee when you reach age 65 and become covered by Medicare, your Medical Plan coverage will continue as your Primary Medical Plan.

1. Steps To Take Before Your 65th Birthday

- a. Obtain an explanation of Medicare Parts A and B from the Social Security Administration.
- b. Make sure that you are enrolled for Medicare when you turn age 65.

If you do not enroll in Medicare Part A when first eligible, you may incur penalties and delays in obtaining coverage. You may delay enrolling in Medicare Part B without penalty as long as you remain actively employed with the Hughston Clinic.

2. Benefits You Will Receive From Medicare

When you reach age 65, you will be eligible for Medicare hospital and medical benefits. You will not be covered by Medicare until you enroll. You may become eligible for Medicare benefits at an earlier date in the event you become permanently disabled. The exact amount of the benefits you receive is determined by the government, and may be adjusted in future years to reflect changes in medical costs.

H. Basic Administrative Information About Your Benefits

This section of your SPD contains information regarding the administration and funding of the Medical Plan. Some of this information is required under the Employee Retirement Income Security Act (ERISA) of 1974, as amended.

1. Plan Administrator and Sponsor

Hughston Clinic is the Plan Administrator within the meaning of 29 USCA, Section 1002(16)(A) of the Employee Retirement Income Security Act of 1974 and the Health Plan Sponsor of the Plan (subject to delegation of ministerial duties associated therewith to North Star Health).

2. Claims Administrator and Health Care Management Coordinator

The Claims Administrator and Health Care Management Coordinator is North Star Health. If you have questions about your benefits and how they are administered, you should contact:

P.O. Box 550
Eatontown, NJ 07724
(800) 470-1361

2. Plan Year

Records for the Medical Plan described in this SPD are kept on a plan year basis. The plan year is January 1st through December 31st.

4. Plan Number

The Medical Plan's plan number 501.

I. Claiming Benefits

To receive benefits under the Medical Plan, you or your provider must file a claim. A summary of the Medical Plan's procedures for filing claims and appealing claim denials follows. The Medical Plan's complete Claims and Appeals Procedures are available on request free of charge by calling your North Star Health Member Advocate at (800) 470-1361 or by writing to North Star Health at:

P.O. Box 550
Eatontown, NJ 07724

The filing requirements, and other procedures related to claims and appeals, differ depending on whether you have an "Urgent Care Claim," a "Pre-Service Claim," or a "Post-Service Claim." Special rules apply if a pre-approved course of treatment is reduced or terminated, or if you want to extend a pre-approved course of treatment.

1. Urgent Care Claims, Pre-Service Claims, and Post-Service Claims

Certain services and supplies must be "pre-certified" through the Pre-Treatment Education Program in order to be covered or to avoid a penalty. See the earlier discussion in this SPD about the Pre-Treatment Education Program and the Benefits at a Glance chart. If a service or supply must be pre-certified, a request for pre-certification is a "**Pre-Service Claim**".

If service or supply must be pre-certified and it is needed for urgent care, it is an "**Urgent Care Claim**". A service or supply is for Urgent Care if following the time limits (set forth below) for Pre-Service Claims:

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

In general, whether a service or supply is for Urgent Care is determined by North Star Health based on the standards of a prudent layperson with average

knowledge of health and medicine. However, if a physician with knowledge of the patient's medical condition determines that the service or supply is for Urgent Care, it will be treated as such.

If a service or supply does not need to be pre-certified, a claim for payment is a **"Post-Service Claim"**.

2. Filing a Claim

- a. See the Pre-Treatment Education Program discussion earlier in this SPD for how to request pre-certification (for either a Pre-Service or Urgent Care Claim).
- b. To file a Post-Service Claim, you or your provider must complete and submit a claim form and attach itemized bills with the information described below. Claims should be reported promptly, and no claims will be accepted more than 12 months after the treatment was provided. Unless a different address is shown on the top of the form, send all Post-Service Claims to:

North Star Health
P.O. Box 550
Eatontown, NJ 07724

Itemized bills must include the following information:

- The date(s) the services, drugs, or supplies were received;
- The diagnosis;
- A description of the treatment received;
- The charge for each service, drug, or supply;
- The name, address, and professional status of the provider; and
- The full name of the patient.

Claim forms are available at your Benefits Office or through your provider. To avoid delay in handling your claim, answer all questions completely and accurately. *Claims cannot be processed without your signature where required on the form.*

c. Reducing or Terminating an Approved Course of Treatment

If the Pre-Treatment Education Program pre-certifies a specific period or number of treatments, it may in rare cases later determine that the pre-certified period or number of treatments should be reduced or terminated. If that happens, Pre-Treatment Education will notify you in advance and give you time to file an appeal and receive a determination before the

reduction or termination takes effect. *Special time limits apply – see “Claims and Appeals Procedures” below.*

d. Extending an Approved Course of Treatment

If Pre-Treatment Education pre-certifies a specific period or number of treatments, and you or your provider want the period or number to be extended, you or your provider must file a request to extend the approved course of treatment. A request that is filed before the additional treatment is provided is a Pre-Service Claim. A request that is filed after the additional treatment is provided is a Post-Service Claim. *Special time limits apply – see “Claims and Appeals Procedures” below.*

3. Authorized Representative

An authorized representative may file a claim or appeal a denial of benefits for you. To name an authorized representative, you must use a Designation of Authorized Representative form which you can get from North Star Health by calling a North Star Health Member Advocate. You do not need to file a Designation of Authorized Representative for your provider to file your initial claim. However, you must file a Designation of Authorized Representative for your provider to file an appeal for you.

A health care professional with knowledge of your medical condition will be allowed to act as your authorized representative, without a Designation of Authorized Representative form, if the health care professional is acting for you with regard to an Urgent Care Claim.

J. Claims and Appeals Procedures

If your claim for benefits (Urgent Care, Pre-, or Post-Service) is denied in whole or in part, you must follow the procedures in this section and exhaust your appeal rights before you may file suit in court. Once your claim has been filed and North Star Health has all of the necessary information, your claim will be processed as set forth below and you will be notified of the decision.

1. Urgent Care Claims

If an Urgent Care Claim is improperly filed, North Star Health will notify you within 24 hours. The notice may be oral, unless you request that it be in writing.

Unless additional information is needed, you will be notified of an Urgent Care Claim decision within 72 hours after the claim is properly filed.

2. Pre-Service Claims

If a Pre-Service Claim is improperly filed, North Star Health will notify you within five days. The notice may be oral, unless you request that it be in writing.

Unless additional information is needed, you will be notified of a Pre-Service Claim decision within 15 days after the claim is properly filed. If there are matters beyond North Star Health's control, this period may be extended up to 15 more days. If an extension is needed, you will be told before the initial 15 day period ends why an extension is needed and when a decision is expected.

3. Request for Extension of an Approved Course of Treatment

If you request an extension of an approved course of treatment, and it is an Urgent Care Claim, you will be notified of the Plan's decision within 24 hours after the Plan receives the request if North Star Health receives your request at least 24 hours before the end of the approved course of treatment. If your request for an extension is an Urgent Care Claim, but it is received less than 24 hours before the end of the approved course of treatment, the request will be subject to the Urgent Care Claim time limits.

If you request an extension of an approved course of treatment, and it is not an Urgent Care Claim, the request will be subject to the Pre- or Post-Service time limits, depending on the nature of the claim.

4. Post-Service Claims

Unless additional information is needed, if a Post-Service Claim is denied, you will be notified within 30 days after the claim is properly filed. If there are matters beyond North Star Health's control, this period may be extended up to 15 more days. If an extension is needed, you will be told before the initial 30 day period ends why an extension is needed and when a decision is expected.

5. If Additional Information is Needed

a) Pre-Service and Post-Service Claims

If North Star Health needs more information to decide a Pre-Service or Post- Service Claim, you will be told what additional information is needed and you will have 45 days to supply it. The time limit for North Star Health to decide your claim is suspended until you supply the additional information. If you do not supply the information within 45 days, your claim will be denied.

b) Urgent Care Claims

If North Star Health needs more information to decide an Urgent Care Claim, you will be told within 24 hours what additional information is needed and you will have 48 hours to supply it.

You will be notified of North Star Health's decision on your Urgent Care Claim within 48 hours after the earlier of when (1) you supply the additional information or (2) the time for you to supply the additional information expires. If you do not supply the information within 48 hours, your claim will be denied.

6. If Your Claim is Denied

You will be notified in writing if your claim (Urgent, Pre-, or Post-Service) is denied in whole or in part. The notice will tell you why the claim was denied and the specific Plan provisions on which the denial is based. It will also describe any additional information that could change the decision. The notice will tell you how and when you can appeal the denial.

The notice will tell you if an internal rule or guideline was relied on to deny your claim, and how to request a free copy of the rule or guideline. The notice will tell you if your claim was denied because the treatment is not medically necessary or is experimental, and how to request a free explanation of the scientific or clinical judgment relied upon.

For an Urgent Care Claim, the notice will explain the expedited review process.

7. First Level Appeal

If you think North Star Health made a mistake in denying your claim, or in reducing, terminating, or refusing to extend an approved course of treatment, or if you are otherwise dissatisfied with a claim decision, you may file a First Level Appeal.

Except for a First Level Appeal of a proposed reduction or termination of an approved course of treatment, your First Level Appeal must be filed within 180 days after you are notified that your claim has been denied.

If you are notified of a proposed reduction or termination of an approved course of treatment and you wish to appeal the proposed action and have a decision on your appeal before the proposed action takes effect, your First Level Appeal must be filed within 10 days after you are notified. If you file a First Level Appeal more than 10 days after you are notified of a proposed reduction or termination, the reduction or termination will probably take effect before you have a decision on your Appeal.

If you do not file a First Level Appeal within the time allowed, you lose all rights to appeal.

Except for an appeal of a denial of an Urgent Care Claim, your First Level Appeal must be in writing. You may hand deliver it to North Star Health or file by mail. If you file by mail, a notice of receipt will be sent to you. The address for First Level Appeals is:

North Star Health
P.O. Box 550
Eatontown, NJ 07724

A First Level Appeal of a denial of an Urgent Care Claim may be made orally or in writing. You should supply all information for an Urgent Care Claim appeal by telephone, fax, hand delivery, or other similar method. You may appeal a denial of an Urgent Care Claim by hand delivery to the address above, or by telephone, or fax to:

Telephone: (800) 470-1361
Fax: (732) 676-2653

All First Level Appeals will be submitted to the Complaint and Grievance Committee. You may submit written comments, documents, records, and other information relating to your claim. The Complaint and Grievance Committee will consider everything you submit, regardless of whether it was submitted or considered in the initial claim determination. Upon written request and free of charge, you will be provided with reasonable access to and copies of all Medical Plan documents, records, and other information relevant to your claim.

If the denial of your claim involved a medical judgment (such as whether a treatment is experimental or medically necessary), the Complaint and Grievance Committee will consult with a health care professional with training and experience in the field of medicine involved.

If medical or vocational experts were consulted when your claim was denied, they will be identified upon your request.

8. When Your First Level Appeal Will Be Decided

The time in which your First Level Appeal will be decided depends on whether it involves an Urgent Care Claim, a Pre-Service Claim, a Post-Service Claim, or a reduction, termination, or denial of a request to extend an approved course of treatment.

- **Urgent Care Claim** — You will be notified of the decision within 36 hours after your appeal is filed.
- **Pre-Service Claim** — You will be notified of the decision within 15 days after your appeal is filed.
- **Post-Service Claim** — You will be notified of the decision within 30 days after your appeal is filed.
- **Reduction or termination of an approved course of treatment** — You will be notified of the decision within 30 days after your appeal is filed. However, if you filed your appeal within 10 days after being notified of the proposed action, the course of treatment will not be reduced or terminated before your appeal is decided. (See below for additional Final Appeal rights you may have before treatment is reduced or terminated.)
- **Request to extend an approved course of treatment** — If your appeal is filed before the additional treatment has been provided, the Pre-Service Claim time applies. If your appeal is filed after the additional treatment has been provided, the Post-Service Claim time applies.

You will be sent a written notice of the Complaint and Grievance Committee's decision. If your appeal is denied, the notice will tell you why and the specific Plan provisions on which the denial is based. The notice will tell you if an internal rule or guideline was relied on to deny your appeal, and how to request a free copy of the rule or guideline. The notice will tell you if your appeal was denied because the treatment is not medically necessary or is experimental, and how to request a free explanation of the scientific or clinical judgment relied upon. The notice will also tell you how and when you can file a Final Appeal. If your claim is an Urgent Care Claim, the notice will explain the expedited Final Appeal process.

If you disagree with the appeal decision, you may bring a civil action against the Plan under ERISA Section 502.

9. Final Appeal

If your First Level Appeal is denied, you may make a Final Appeal to the Plan Administrator. Except for an appeal of a denial of an Urgent Care claim, your Final Appeal must be in writing and must include details about your claim and why you think it should not be denied. You must submit your Final Appeal to the Plan Administrator in care of North Star Health at the address shown above.

A Final Appeal of a denial of an Urgent Care Claim may be made orally or in writing. You should supply all information for an Urgent Care Claim appeal by telephone, fax, hand delivery, or other similar method. You may make a Final

Appeal of a denial of an Urgent Care Claim by hand delivery to the address above, or by telephone or fax to:

Telephone: (800) 470-1361
Fax: (732) 676-2653

Except for an appeal of a reduction or termination of an approved course of treatment, a Final Appeal to the Plan Administrator must be filed within the later of (1) 90 days after you are notified of the Complaint and Grievance Committee's denial of your First Level Appeal or (2) 180 days after you were initially notified that your claim was denied.

If the Complaint and Grievance Committee denied your First Level Appeal of a proposed reduction or termination of an approved course of treatment and you wish to file a Final Appeal and have a decision on your appeal before the proposed action takes effect, your Final Appeal must be filed within five days after you are notified of the Committee's decision. If you file a Final Appeal more than five days after you are notified of the Committee's decision, the reduction or termination will probably take effect before you have a decision on your Final Appeal.

If you do not file a Final Appeal within the time allowed, you lose all rights to appeal.

Your Final Appeal will be submitted to the Plan Administrator. You may submit written comments, documents, records, and other information relating to your claim. The Plan Administrator will consider everything you submit, regardless of whether it was submitted or considered in the initial benefit determination or your First Level Appeal. Upon written request and free of charge, you will be provided with reasonable access to and copies of all Plan documents, records, and other information relevant to your claim.

If the denial of your claim or the First Level Appeal decision involved a medical judgment (such as whether a treatment is experimental or medically necessary), the Plan Administrator will consult with a health care professional with training and experience in the field of medicine involved.

If medical or vocational experts were consulted when your First Level Appeal was decided, they will be identified upon your request.

The time limit for deciding your Final Appeal depends on whether it involves an Urgent Care Claim, a Pre-Service Claim, a Post-Service Claim, or a reduction, termination, or denial of a request to extend an approved course of treatment.

- **Urgent Care Claim** — You will be notified of the decision within 36 hours after your Final Appeal is filed.

- **Pre-Service Claim** — You will be notified of the decision within 15 days after your Final Appeal is filed.
- **Post-Service Claim** — You will be notified of the decision within 30 days after your Final Appeal is filed.
- **Reduction or termination of an approved course of treatment** — You will be notified of the decision within 30 days after your Final Appeal is filed. However, if you filed your final appeal within five days after being notified of the Complaint and Grievance Committee’s decision on your First Level Appeal, the approved course of treatment will not be reduced or terminated before your Final Appeal is decided.
- **Request to extend an approved course of treatment** — If your Final Appeal is filed before the additional treatment has been provided, the Pre-Service Claim time applies. If your Final Appeal is filed after the additional treatment has been provided, the Post-Service Claim time applies.

You will be sent a written notice of the Plan Administrator’s decision. If your Final Appeal is denied, the notice will contain the same type of information as the notice from the Complaint and Grievance Committee. If you disagree with the Plan Administrator’s decision, you may bring a civil action against the Plan under ERISA Section 502.

K. Legal Action

The agent for the service of legal process is:

Angela Buchanan
 Hughston Clinic
 6262 Veterans Parkway
 Columbus, GA 31909-3540

L. Your Rights Under ERISA

As a participant in the Medical Plan, you are entitled to the following rights and protections under the Employee Retirement Income Security Act of 1974, commonly called ERISA:

- You can examine, free of charge, all of the official documents related to the Medical Plan (such as insurance contracts, annual reports, SPDs, any other plan agreements, or any other documents filed with the U.S. Department of Labor). You can examine copies of these documents in the Plan Administrator’s office.

- If you wish, you can get your own copies of these documents by writing to the Plan Administrator. You may have to pay a reasonable charge to cover the cost of photocopying.

1. Additional ERISA Rights

In addition to creating rights for Medical Plan participants, ERISA imposes duties upon the people who are responsible for the operation of the Medical Plan. These people are called fiduciaries. ERISA requires that fiduciaries act prudently and solely in the interest of you and other Medical Plan participants and beneficiaries.

Moreover, no one, including your employer or any other person, may fire you or otherwise discriminate against you in any way for the purpose of preventing you from obtaining a benefit under this Medical Plan or exercising your rights under ERISA.

If your claim for a benefit is denied in whole or in part, you must receive a written explanation of the reason for the denial. You have the right to have the Plan Administrator review and reconsider your claim.

Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request certain materials from the Medical Plan and do not receive them within 31 days, you may file suit in a federal court to enforce your rights. In such a case, the court may require the Plan Administrator to pay you up to \$110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the Plan Administrator. If you have a claim for benefits which is denied or ignored in whole or in part, you may file suit in a state or federal court. If it should happen that Medical Plan fiduciaries misuse the Medical Plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a federal court.

The court will decide who should pay court costs and legal fees. If you are successful, the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, for example if it finds your claim is frivolous.

If you have any questions about the Medical Plan, you should contact the Plan Administrator. If you have any questions about this statement or your rights under ERISA, you should contact the nearest Area Office of the Pension and Welfare Benefits Administration, U.S. Department of Labor, as listed in the telephone directory, or contact the Division of Technical Assistance and Inquiries, Pension and Welfare Benefit Administration, U.S. Department of Labor, 200 Constitution Ave., N.W., Washington D.C. 20210.

M. Hughston Clinic's Rights

Hughston Clinic expects to continue the Medical Plan indefinitely, but reserves the right to modify, amend, suspend, or terminate the Medical Plan at any time, and for any reason without prior notification. You will be notified of any changes to the Medical Plan and how they affect your benefits, if at all. We have attempted to make the explanation of the Medical Plan in this SPD as accurate as possible. You should not rely on any oral descriptions of the Medical Plan, since the written description in this SPD will always govern. To the extent any benefit under the Medical Plan is provided by an insurance policy, no benefits are provided by the Medical Plan except for those benefits, if any, which are paid by the insurance company which issues the policy.

1. Not A Contract Of Employment

It is also important to understand that this SPD does not constitute a contract of employment. You have the right to terminate your employment at any time. Hughston Clinic retains the same right regardless of any other documents or oral or written statements issued by the employer or its representatives.

The Plan Administrator has discretionary authority to interpret the terms of the Medical Plan and to decide any questions of fact which relate to entitlement to benefits under the Medical Plan.

N. For More Information

Please see your Medical Plan enrollment materials for additional information about the benefits administered by North Star Health. If you have any questions, you can speak with a North Star Health Member Advocate by calling (800) 470-1361. Or, contact your Human Resources Department.

O. Disclosure of Information to Plan Sponsor

1. Protected Health Information

The Medical Plan may create or obtain information that relates to your physical or mental health condition, treatment, or payment for your health care. When this information is individually identifiable to you, it is called "Protected Health Information" (PHI).

The provisions set forth in this section of this SPD relating to PHI took effect April 14, 2003.

2. Disclosure of PHI to The Hughston Clinic

The Medical Plan may disclose PHI to The Hughston Clinic, and The Hughston Clinic may use or disclose that PHI, as follows.

a) Permitted and Required Uses and Disclosures

The Medical Plan may disclose PHI to The Hughston Clinic, and The Hughston Clinic may use or disclose PHI obtained from the Medical Plan, only for the following purposes:

- To decide Final Appeals;
- To select and monitor Medical Plan service providers;
- To evaluate Medical Plan design and modify, amend, or terminate the Medical Plan;
- To consult with the Medical Plan’s service providers regarding administrative functions, including treatment, payment, and health care operations;
- As otherwise required by law.

b) The Hughston Clinic’s Certification

The Hughston Clinic has certified to the Medical Plan that it agrees to:

- Not use or further disclose the PHI other than as permitted above;
- Ensure that any agents or subcontractors who receive PHI from The Hughston Clinic that was obtained from the Medical Plan will agree to the same restrictions and conditions that apply to The Hughston Clinic;
- Not use or disclose PHI for employment-related actions and decisions or in connection with any other benefit or employee benefit plan of The Hughston Clinic;
- Report to the Medical Plan any known use or disclosure of PHI that is inconsistent with the uses or disclosures allowed by this SPD;
- Make PHI available to the Medical Plan for response to a participant’s request for access to the participant’s PHI, as provided by the Privacy Regulations;
- Make PHI available to the Medical Plan for amendment, and incorporate any amendments to PHI, as provided by the Privacy Regulations;
- Make available to the Medical Plan the information needed to provide an accounting of disclosures as provided by the Privacy Regulations;
- Make its internal practices, books, and records relating to use and disclosure of PHI received from the Medical Plan available to the Secretary of the United States Department of Health and Human Services, for purposes of determining the Medical Plan’s compliance with the Privacy Regulations;
- If feasible, return or destroy all PHI received from the Medical Plan when The Hughston Clinic no longer needs the PHI for the purpose for which it was disclosed to The Hughston Clinic or, if return or destruction is not feasible, limit further uses and disclosures to those purposes that make the return or destruction infeasible; and
- Ensure adequate separation between the Medical Plan and The Hughston Clinic.

The Privacy Regulations are set forth at 45 CFR Subtitle A, Subchapter C, Part 164.

c) Separation Between Medical Plan and The Hughston Clinic

Only the following persons under the control of The Hughston Clinic may be given access to PHI received from the Medical Plan:

- Persons who, in the ordinary course of business, receive PHI relating to treatment, payment, or health care operations under the Medical Plan;
- The Hughston Clinic’s Chief Financial Officer, Director of Human Resources, and Human Resources Specialists; and
- The President and Chief Executive Officer to decide final appeals.

These persons may have access to and may use PHI received from the Medical Plan only for Medical Plan administration functions performed by The Hughston Clinic. These persons will be trained in the limits on access to, and the proper use of, PHI received from the Medical Plan. In addition, these persons will be subject to appropriate sanctions, as provided by The Hughston Clinic's policies, for improper access to, or use of, PHI received from the Medical Plan, and for any failure to comply with any provision of The Hughston Clinic's certification. If a complaint filed with the Medical Plan relates to a violation by the Plan Sponsor or any person or class of persons under the control of The Hughston Clinic, The Hughston Clinic will cooperate with the Medical Plan to investigate and resolve the complaint.

VI. Definitions

Active Employee. An employee whose employment has not terminated and who is not on leave of absence.

Benefits. Medical Care Coverage and Non-Medical Coverage as described in the Benefits at a Glance sections of this Summary Plan Description and Plan Document.

Charges Incurred or Expenses Incurred or Incurred. An expense or charge will be considered to be incurred at the time the service or supply to which it related is provided.

Child. Child includes your natural children. It also includes adopted children, stepchildren, and other children provided: they depend upon you for support and they have a parent-child relationship with you. If both parents of a Child are Covered persons, the Child will be considered as a Dependent of either parent. The Child may not be considered a dependent of both parents.

Close Relative. Means the spouse, parent, brother, sister, child or Spouse's parent of a Covered Person.

Code. The term "Code" means the Internal Revenue Code of 1986, as amended from time to time. Reference to any section or sub-section of the Code includes reference to any comparable or succeeding provisions of any legislation which amends, supplements or replaces such section or sub-section.

Coinsurance. The sharing of expenses for eligible charges on a percentage basis with the Plan.

Complications of Pregnancy. Conditions whose diagnoses are distinct from pregnancy, but are adversely affected by pregnancy or are caused by pregnancy. Examples are acute nephritis, nephrosis, cardiac decomposition, missed abortion, and similar medical and surgical conditions of comparable severity. Conditions associated with the management of a difficult pregnancy are not considered "complications;" non-elective cesarean section; and ectopic pregnancy. Complications of pregnancy, as defined above, are covered under the policy to the same extent as any other Sickness.

Comorbidity. The presence of disease processes that may ultimately affect one's survival.

Contract Month. Any one of the 12 months of the Contract Year.

Contract Year. 12 months or 365 days commencing on the first of the month that the administrator assumes benefit administration and ending at the end of the 12th month or 365th day.

Continuous Period of Confinement. A period of time when a Covered Member is continuously confined as a bed patient in a hospital, skilled nursing facility, rehabilitation facility, or hospice.

Co-payment. A fixed-dollar charge which may be collected directly by the Provider at the time of service as additional payment for eligible charges.

Cosmetic Surgery. Cosmetic procedures/surgery and any related services or supplies done primarily to improve the appearance of any portion of the body, and from which no significant improvements in physiological function could be reasonably expected.

Covered Employee. An employee whose coverage under this plan has become effective and not terminated.

Covered Member/Person/. You and Your Qualified Dependents whose health benefits under the Plan are in effect.

Creditable Coverage. Prior health benefits coverage that may include any of, or a combination of the following:

1. A group health plan;
2. A health insurance plan or health maintenance organization plan;
3. An individual health insurance policy;
4. COBRA continuation of coverage;
5. A health plan under Chapter 55, Title 10, United States Code pertaining to members of the uniformed services of the United States
6. Medicare or Medicaid
7. A medical care program of the Indian Health Service or of a tribal organization;
8. A State health benefit risk pool;
9. A health plan covered under FEHPB 9Chapter 89 of Title 5, United States Code);
10. A health plan under section 5(e) of the Peace Corps Act; or
11. A public health plan

Custodial Care. Care which provides a level of routine maintenance for the purpose of meeting personal and medical needs. This is care that can be provided by a lay person who does not have professional qualifications, skills or training. Custodial Care includes, but is not limited to, help in walking and getting into or out of bed; help in bathing, dressing, and eating; help in using or applying medications; routine care of a patient, including changes of dressings, diapers, and protective sheets; routine care and maintenance of casts and medical equipment; general supervision of exercise programs including carrying out of maintenance exercise programs that do not need the skills of a therapist.

Dependent. Your spouse; unmarried children who are under 19 years of age; and unmarried children who are 19 years of age through 25 years of age if the child is attending an accredited school full-time; and is financially dependent upon you for support and for whom you have elected Coverage under this plan.

Deductible. A specified dollar amount of covered expenses which must be paid by the Covered Person during a calendar year before any other covered expenses can be considered for payment according to the applicable benefit percentage.

- **Durable Medical Equipment.** Durable medical equipment is medical equipment which:
 - Can withstand repeated use; and
 - Is primarily and customarily used to serve a medical purpose; and
 - Is generally not useful to a person in the absence of illness or injury; and
 - Is appropriate for use in the home; and
 - Is not primarily for the convenience of the patient;

Earnings. Regular income received by a Covered Employee from the Employer/Plan Sponsor.

Emergency Medical Services. An emergency is an accident or sudden illness that a person with an average knowledge of medical science believes needs to be treated right away or it could result in loss of life, serious medical complications, or permanent disability.

- **What do you do in an emergency?**

In an emergency, always seek medical care immediately. Go directly to the nearest emergency facility or call 911 you can go to any emergency facility or hospital, anywhere. You do not need a referral from your PCP or any authorization before receiving emergency care. You should call your PCP (or have someone call for you) for further assistance and directions on follow-up care. When possible, you should call within 48 hours.

- **What are some examples of emergencies?**

Some examples of emergencies could include:

- Seizure or loss of consciousness
- Uncontrolled bleeding
- Inability to breathe or shortness of breath
- Poisoning or suspected overdose of medication
- Chest pain or oppressive squeezing sensation in the chest
- Numbness or paralysis of an arm or leg
- Sudden slurred speech
- Broken bones
- Severe pain

- **What's urgent care?**

Many situations are not emergencies, but do require immediate medical attention. These situations require what is referred to as urgent care. Examples of urgent care needs include ear infections, sprains, high fevers, vomiting, and urinary tract infections. Participants should consult their doctors for urgent care.

Employee (You and Your). A person is employed on a full-time basis by the corporation; and is in a class eligible for insurance.

Employer/Plan Sponsor. The Hughston Clinic, its Subsidiaries, or Affiliates.

Enrollment Date. The first day of coverage under this Plan, or if earlier, the beginning of any applicable waiting period hereunder.

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

Evidence of Insurability. Satisfactory proof, as determined by your Plan Administrator or insurance company that a person is acceptable for non-medical coverage.

Experimental. The use of any treatment, procedure, facility, equipment, drug or drug usage, device or supply which the Plan Administrator determines, in its sole and absolute discretion, is being studied for safety, efficiency, and effectiveness and/or which has not received or is awaiting endorsement for general use within the medical community by government oversight agencies, or other appropriate medical specialty societies at the time services are rendered;

Extended Care Facility. An institution which is eligible to participate and is eligible to receive payments under and in accordance with the provisions of the United States Medicare Program, but which is not a Hospital or a part of a Hospital and which is not, other than incidentally, a home for the aged or a domiciliary care home.

Full Time Basis. Active Employment at least (32) thirty-two hours per week.

Full Time Student. A Covered Person's Dependent child who is enrolled in and regularly attending a secondary school, technical or trade school, and accredited college or university, or institution of higher learning for the minimum number of credit hours required by that institution in order to maintain full time student status. An accredited college, university or institution of higher learning is an educational program accredited by the Council for Higher Education Accreditation.

Government Plan. Any plan of insurance provided by or under the administrative control of any government or agency thereof in accordance with any law (other than the insurance act of Canada), or any plan providing coverage pursuant to the regulatory power of any government.

Grace Period. A (30) thirty day period which begins on the day following the due date of any contribution due other than the first contribution. During this period the contribution must be paid in order to prevent the coverage under the plan from ending.

Home Health Agency. An organization that has been licensed or certified as a Home Health Agency.

Home Health Care. A program prescribed in writing by a Covered Member's Physician and delivered by a Home Health Agency, or other Home Health Care Providers consisting of registered nurses, licensed practical nurses, and licensed rehabilitation therapists (i.e., physical therapist, occupational therapist, or Speech Therapist) which provides for the care and treatment of a Covered Member's sickness or injury in the Covered Member's home.

Home Health Visit. A visit by a Home Health Care Team consisting of either a registered nurse, licensed practical nurse or rehabilitation therapist for the provision of skilled nursing or rehabilitation services. The service of each member of a Home Health Care Team counts as one visit.

Hospice Facility. A facility which provides short periods of stay for a terminally ill person in a home-like setting for either direct care or respite care. This facility may be either free-standing or affiliated with a Hospital providing services 24 hours a day, seven days a week. A facility is required by law to be licensed, certified or registered; it must also meet those requirements as well as standards set by the National Hospice Organization. At a minimum, a Hospice must meet all of the following requirements:

1. It must have a full-time administrator, registered nurse coordinator, and licensed social worker.
2. It must maintain written records of services provided to patients.

Hospital. An institution operated pursuant to law for the care and treatment of sick and injured persons which meets all of the following requirements:

1. It maintains organized facilities for medical and diagnostic care for sick and injured persons on an inpatient basis for which a charge is made that the Covered Member is legally obligated to pay in the absence of a health benefits program.
2. It is legally operated, is supervised by a staff of Physicians and provides 24-hour-a-day nursing care by or under the supervision of a registered nurse (R.N.).
3. It is accredited by the Joint Commission on Accreditation of Health Care Organizations.

The term Hospital does not include:

1. Any institution which is used principally as a nursing home or facility for care of the aged, drug addicts, custodial care, educational care, rest, or convalescence;
2. Any military Hospital, soldier's home or any Hospital contracted for or operated by the Federal Government or any agencies thereof for treatment of members or former members of

the Armed Forces, unless the Covered Member is legally required to pay for services in the absence of this coverage.

Hospital Inpatient Stay. A Hospital confinement for which a Room and Board Charge is made by the Hospital.

Hospital Miscellaneous Expense.

1. Eligible charges, other than for room and board, made by a Hospital on its own behalf for necessary medical and surgical treatment, services and supplies actually administered during Hospital Inpatient or Outpatient confinement, including but not limited to operating room, x-ray examination (except x-ray of teeth), laboratory analysis, drugs, medicines, dressings and other services rendered by the Hospital.
2. Eligible charges for the administration of anesthetics during hospital confinement (unless otherwise specified in this Plan Document).
3. Eligible charges for the administration and interpretation of a Medically Necessary diagnostic procedure (excluding surgery) during Hospital Confinement.

Hospital Outpatient Services. Any Hospital services rendered on an outpatient basis which do not involve an overnight stay.

Hospice. Any agency which provides health care services and social services for the palliative and supportive care and treatment of terminally ill individuals. The agency must: provide 24 hours, 7 day a week service; provide a program of services under direct supervision of a Physician or licensed R.N.; maintain full and complete records of all services provided to all Covered Persons; and be established and operated in accordance with the applicable laws or regulations of the jurisdiction in which it is located.

Immediate family. Spouse, children, brothers, sisters, parents, or in-laws of a Covered Person.

Illness or Sickness.

1. A disorder or disease of the body or mind.
2. An accidental bodily injury.
3. Pregnancy
4. Well baby care for a newborn child, born while the mother is covered, who becomes covered as a dependent in accordance with the terms of the Plan, will be covered for routine room and board (or nursery charges); routine Inpatient Hospital Physician charges; and circumcision until the earlier of the date the child is discharged from the Hospital, or the last day of the UCR length of stay for vaginal or cesarean section delivery.
5. Well care as specifically stated in this Plan Document.

All illnesses due to the same cause, or to a related cause, will be deemed to be (1) one illness. The donation of an organ or of tissue by a Covered Person for transplanting into another person is considered to be an Illness for the Covered Person making the donation. When only the donor

is a Covered Person under this Plan, Benefits will be provided for eligible expenses of the donor to the extent that Benefits to the donor are not provided under any other coverage available to the transplant recipient.

Inactive Participant. An Employee or former Employee who no longer satisfies any portion of the Employed, Actively Employed and Active Employment definition and whose coverage has not terminated, including the following: (1) a person on leave of absence, (2) a terminated employee receiving COBRA coverage and (3) a Retired Employee, as defined, who is eligible for and has elected retiree coverage, if any, under this Plan.

Individual. An Employee

Infertility. Infertility means the condition of a presumably healthy individual who is unable to conceive or produce conception during a period of one (1) year.

Injury. Accidental bodily harm sustained by a Covered Member which is the direct and independent cause of loss and occurs while coverage is in force.

Intensive Care Unit. That section of the hospital which is operated exclusively for critically ill patients. It must provide special supplies, equipment, and close observation and care by registered nurses or other highly trained hospital personnel. It does not include any hospital facility maintained for the purpose of providing normal post-operative recovery treatment or service.

Interdisciplinary Hospice Team. The primary care unit which develops the overall plan of care and provides the services for patient and his Immediate Family. The team must consist of a licensed R.N. and Physician. The team may also include, but is not limited to an R.N., or L.P.N. utilized as a visiting nurse in the patient's home; and a licensed Social Worker. The Social Worker must have a minimum of 1 year's experience in working with the terminally ill and their families.

Key Employee. Any person who is a Key Employee as defined in section 416(i) (1) of the Internal Revenue Code.

Late Enrollee/Applicant. An Employee or Dependent or "Special Enrollee" who does not enroll for coverage within 30 days of being eligible to do so, but subsequently requests enrollment into the plan.

Lifetime or Maximum Lifetime Benefit. The period of time a Covered Person is covered by this Plan for the benefits described in this Summary Plan Description.

Marriage. A legal union between one man and one woman as husband and wife.

Medical Benefits. Medical Coverage provided under this plan.

Medical Care. Amounts paid for:

1. The diagnosis, cure, mitigation, treatment or prevention of disease, or amounts paid for the purpose of affecting any function or structure of the body;
2. transportation primarily for and essential to Medical Care referred to on number (1) of this definition; and
3. Insurance covering Medical Care referred to in numbers (1) and (2) of this definition.

Medically Necessary. Medical or surgical services or supplies which a Covered Member requires as determined by one or more physicians. To be considered Medically Necessary, a service or supply must meet all of these requirements:

1. It must be rendered in accordance with medical and surgical practices and standards prevailing in the community at the time of treatment; and
2. It must be commonly and customarily recognized throughout the physician's specialty as appropriate in the treatment and diagnosis of the sickness or injury; and
3. It must be in conformity with the professional and technical standards adopted by the Quality Assurance and Utilization Management Committees of North Star Health and in effect at the time of treatment; and
4. It must be furnished to the Covered Member at an appropriate level of care; and
5. It must not be educational, experimental, investigational, or custodial in nature; and
6. It must not be mainly for the purpose of medical or other research; and
7. It must not be provided to the Covered Member for the convenience of the physician, hospital, or other provider or any other individual.

Medicare. Medical benefits provided by Title XVIII of the Federal Social Security Act.

Mental Illness or Nervous Conditions. A psychoneurosis, psychopathology, psychosis, or a mental or emotional disease or disorder without demonstrable organic origin.

Out-of-Network. Provisions for Employees or Retirees residing outside the Preferred Provider Network.

Participant. Covered Employees and Inactive Participants

Physician. A legally qualified, licensed practitioner of the healing arts who provides care within the scope of his or her license.

Plan. The Hughston Clinic Health Benefits Plan

Policyholder. The legal entity named as Policyholder in the Group Policy who provides benefits for the provision of health benefits for its Employees and their Qualified Dependents.

Pregnancy. The physical state which results in childbirth, abortion or miscarriage and any medical complications arising out of or resulting from such a state.

Provider. Licensed Physicians, Hospitals, Skilled Nursing Facilities, Home Health Agencies, or other providers of health care services.

Room and Board Charges. Charges made by a Hospital or Skilled Nursing Facility for the room, meals, and routine services for Covered Members confined as bed patients.

Sickness. A disorder or disease of the body or mind, or pregnancy. All sicknesses due to the same cause, or to a related cause, unless separated by a period of six (6) months or more are deemed to be one sickness.

Skilled Nursing Facility. An institution which meets all of the following requirements:

1. It is legally operated; and
2. It mainly provides services for persons recovering from a sickness or injury. The services are provided for a fee from its patients, and include both:
 - a. room and board; and
 - b. 24-hour-a-day nursing service; and
3. It provides these services under the full-time supervision of a Physician or registered nurse (R.N.); and
4. It keeps adequate medical records; and
5. It has the services of a Physician available under a fixed agreement.

A Skilled Nursing Facility does not include an institution or any part of an institution which is used mainly as a place of rest for the aged.

Speech Therapist. Someone who is licensed as such.

Spouse. A person of the opposite sex who is a husband or a wife.

Social Services. Those services rendered in connection with the terminal illness of a Covered Person by a Social Worker under the direction of a Physician. Such services include, but will not be limited to: assessment of the social, psychological, and family problems related to or arising from the illness and treatment; and appropriate action and utilization of community resources to assist in resolving such problems.

Special Enrollee. An Employee or Dependent who previously declined health coverage under the plan, but has experienced one of the following events: loss of other health insurance coverage; became a Dependent, or acquired a Dependent, due to marriage; became a Dependent, or acquired a Dependent, due to a birth, adoption, or placement for adoption in the Employee's home; or has a court order requiring coverage be provided for a spouse or Dependent Child.

Total Disability or Totally Disabled. During the first 24 months of a continuous disability, Total Disability or Totally Disabled means the inability of the Covered Member to perform all of the substantial and material duties of his or her regular occupation.

After 24 months of continuous disability, Total Disability or Totally Disabled means the inability of the Covered Member to perform all of the substantial and material duties of any occupation for which he or she is reasonably suited by reason of education, training, or experience.

Usual, Customary, and Reasonable (UCR) means the lesser of:

The Usual fee (the charge most frequently made for the covered services or supplies by a Physician or Hospital;

The Customary fee (the charge made for covered services or supplies by those of similar professional standing in the same geographic area);

The Reasonable fee (the charge determined by considering the complexity involved, the degree of professional skill required, and other pertinent factors, if Usual or Customary above cannot be easily determined.)