Citizens Memorial Healthcare

Silver Benefit Program

Summary Plan Description
and
Plan Document

Citizens Memorial HealthCare
Silver Benefit Program
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Silver Benefit Program

Section 1
PLAN INTRODUCTION

This document serves as the Summary Plan Description and controlling Plan Document for the above-named organization and will herein be referred to as the "Plan." All eligible individuals who apply and are accepted as members of the Plan agree to abide by all terms and conditions set forth in this document. The Citizens Memorial HealthCare includes: The Citizens Memorial Hospital as a governmental, non-ERISA Plan and the Citizens Memorial Hospital Foundation as an ERISA health and welfare plan and the responsibility for the administration of the Plans is with the Plan Administrator. For names, addresses and other important information regarding the Plan Administrator, refer to the last section of the Plan.

HealthSmart Benefit Solutions is the Plan Supervisor for the Plan. For questions regarding claims and benefit determinations, contact the Plan Supervisor at: HealthSmart Benefit Solutions, 3121 Quail Springs Parkway, Oklahoma City, OK 73134, Telephone (918) 335-0387 or 1-800-824-5034, or the Plan Administrator.

The Plan reserves the right to terminate or modify the provisions of this Plan at any time without notice or the consent of any person. Such termination or modification will be made in writing and communicated to Plan Members by the Plan Administrator.

About Utilization Review: The Plan has contracted with a utilization review company to provide inpatient pre-certification. The Plan requires the Plan Member, Physician or Hospital to call the number found on the back of the Plan Members' identification card (1-877-202-6379) to pre-certify when an overnight Hospital admission occurs. **<u>Failure to pre-certify will result in a penalty reducing benefits by 20%.</u>**

About Preferred Provider Network (In-Network): The Plan participates in Preferred Provider Networks (In-Network). The Plan Member may use an In-Network provider or an Out-of -Network provider; the choice is that of the Plan participant. Always check the provider directory as copays and benefits vary between In-Network and Out-of -Network providers.

Section 2
MANAGED CARE

Preferred Provider Network (In-Network): In an effort to better control costs and provide quality service, employees and their Dependents are given the opportunity to utilize Physicians and Hospitals who have agreed to join networks which are called Preferred Provider Networks (CMH/In-Network). The Plan Member may choose to use any provider. If the Plan Member chooses to see a CMH or In-Network provider, the Plan may pay at a higher benefit percentage than if the member were to see an Out-of -Network provider. A directory of CMH and In-Network Hospitals and Physicians will be made available to the Plan Member through the Plan Administrator's benefits office, whose name and phone number can be found on the employee's identification card, or can be obtained from the Plan Supervisor. The Plan Member's personal identification card will notify the provider of membership within the In-Network.

Other Networks and Out of Network Discounts: The Plan also reserves the right to use PPO networks which are not listed on the Plan Member's identification card. At the discretion of the Plan, a claim may be presented to a case manager or a third-party discount negotiator to obtain a reduction in claim expenses for possible cost savings.

Indian Health and United States Uniformed Service providers: Claims submitted by Indian Health Service or United States Uniformed Service providers will be considered at the PPO copay, deductible and coinsurance rate as applicable for the specific service provided. The Usual and Customary Rate will be applied.

Pre-certification: Pre-certification is required for all inpatient Hospital stays lasting over 23 hours. Upon learning that he or she will be hospitalized, the covered Plan Member must notify the pre-certification service (at 877-202-6379) or the Citizen Memorial Hospital medical supervisor and case manager, (at 417-328-6702) prior to, or at the time of, his or her hospitalization. The Plan Member will be required to give the Physician's name, telephone number and group number.

The Physician or Hospital will provide notification but the responsibility to inform the pre-certification service of his or her hospitalization rests with the Plan Member. **<u>Failure to pre-certify will result in a penalty reducing benefits by 20%.</u>**

In the case of an emergency, pre-certification will not be affected if the patient or Physician notifies the pre-certification service within forty-eight (48) hours or the next business day following hospitalization. Longer stays, than were originally pre-certified, will require a follow-up review by the pre-certification service. If the service disagrees with the additional days recommended by the Physician, the patient, Hospital and Physician will be advised.

Where Pre-certification Is Required:

Inpatient Services: All inpatient services where an overnight stay in a Hospital or a surgical setting is required will need to be pre-certified by the Plan's pre-certification medical review company.

Outpatient Services Provided in a Hospital Setting: Outpatient services are defined as any service which would be provided in a Hospital or surgery setting where an overnight stay would not be required. Pre-certification is required for the following:

- **Maternity:** Admission for obstetrical care regardless of the reason. This will not apply to the inpatient delivery of a newborn as defined by Federal law.
- **Cancer Treatment:** Services which would include chemotherapy, radiation therapy or any other chemical therapy for the treatment of cancer.
- **Outpatient Surgery:** All outpatient surgery performed in a Hospital or surgical facility will require pre-certification.

Outside a Hospital Setting: Pre-certification is required for outpatient services whether provided in a Hospital setting or outside a Hospital setting, if such services consist of:

- **Braces and Prosthetics**: Any standard orthotic or prosthetic device.
- **Chemotherapy:** Services which would include chemotherapy, or any other chemical therapy, regardless of diagnosis.
- **Equipment and Supplies:** Any durable medical equipment and supplies where the purchase price of the product would exceed $300 must be pre-certified. Breast Pumps exceeding $400 must be pre-certified.
- **Therapy and Rehabilitation:** Any service for physical therapy, speech therapy, occupational therapy, cardiac, and pulmonary therapy.
- **Home Health & Skilled Nursing:** Any service for Home Health and Skilled Nursing.
- **Infusion Therapy:** Any service for infusion therapy.
- **Hospice Services:** Any service for Home Health care.
- **Radiation Therapy:** Services which would include radiation therapy, or any other radiation treatments, regardless of diagnosis.

Federal law generally prohibits the Plan from limiting Hospital stays for childbirth to less than 48 hours for normal deliveries and 96 hours for Cesarean sections. However, Federal law generally does not prohibit the mother's or newborn's attending Physician, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours as applicable). Pre-certification will not be necessary, if the inpatient stays are shorter than those described above. If the mother or baby's stay is longer than 48 hours for normal delivery or 96 hours for Cesarean section, pre-certification is required.

Where Pre-certification is Not Required:

- **Emergency Room:** Pre-certification will not be required if the service was a part of treatment received in the emergency room setting or as a part of outpatient emergency treatment.
- **Outpatient Service:** Pre-certification is not required for outpatient services unless defined in this section or other sections of the Plan.

Case Management: Case management helps Physicians and patients identify ways in which patients with serious Illnesses or special needs may be treated in a cost-effective manner in a Hospital or in-home setting, as well as assisting in negotiating discounts and identifying In-Network services. The case manager consults with the patient, the family and the attending Physician to develop a plan of care which is individually tailored to a specific patient. The Plan may provide benefits for a plan of care, such as Home Health care or other care, where the Case Manager approves a plan of care that is intended to obtain favorable treatment results while reducing the overall cost of treatment to the Plan.

Section 3
SUMMARY OF BENEFITS

This Summary of Benefits is only intended to provide an outline of some of the benefits provided in the Plan. For more information on what services are covered, refer to the Medical Benefit portion of this section. For information on what types of services are not covered or are limited, see the Exclusions and Limitation Section of this booklet.

BENEFIT SUMMARY

PLAN INFORMATION	BEST	BETTER	GOOD
Plan Type	CMH Network	In-Network	Out-of-Network
BASIC BENEFIT INFORMATION			
Deductible Individual (EE only) Dependent (EE+SP or EE +CH) Family (EE+SP+CH)	 $1,500 $3,000 $6,000	In-Network $3,000 $5,000 $7,000	Out-of-Network $6,000 $9,000 $12,000
Coinsurance Percentage	75%	65%	50%
Out-of-Pocket Maximum (Includes deductibles & copays) Individual Dependent Family	CMH + In-Network Total $5,000 $8,000 $10,000		Out-of-Network $14,000 $20,000 $26,000
After meeting the out-of-pocket maximum, some services may still require coinsurance. Read this booklet for details.			
Restricted Annual Maximum on Essential Benefits	None		
PHYSICIAN SERVICES & PREVENTIVE CARE			
Office Visits (includes X-ray & Lab performed in the Physician or Specialist office) Physician includes general practice, family practice, internal medicine, OBGYN, and pediatrics. Specialist Physician includes, but is not limited to, those specializing in oncology, cardiology, orthopedic, neurology, pulmonology and any other specialty visit.	$30 copay per physician visit $60 copay per specialist physician visit	65% after deductible	50% after deductible
Specific Preventative Services- No annual maximum for in network specific preventative care services. See the Covered Medical Section for a list of covered preventative care services.	Plan pays 100% with deductible and copay waived	Plan pays 100% with deductible and co-pay waived	Preventative Care not covered
Maternity Services-Global fee must be submitted by one physician on one claim for services rendered. Ultrasounds that are performed outside of the physician's office or that are performed in the physician's office but are billed outside of the global fee will apply to the applicable deductible and coinsurance.	$150 one time co-pay		

PLAN INFORMATION	BEST	BETTER	GOOD
Immunizations	Plan pays 100% with deductible and copay waived. No annual maximum for routine immunizations	Plan pays 100% with deductible and copay waived. No annual maximum for routine immunizations	Immunizations not covered
Annual Vision Exam (1 routine exam per calendar year)	Adults and Children- Plan pays 100%, deductible and co-pay waived. No annual maximum	Adults, after deductible, Plan pays 65%. No annual maximum. Dependent children age 21 and under-Plan pays 100%, deductible and co-pay waived. No annual maximum	Adults, after deductible, Plan pays 50% to a maximum payment of $50. Dependent children age 21 and under, after deductible, Plan pays 50% to a maximum payment of $50.
Chiropractic Services	75% after deductible	65% after deductible	50% after deductible
X-Ray and Lab performed in the Physician office for CMH $30 copay X-Ray and Lab performed in the Specialist office for CMH $60 copay	After a $30/$60 copay, Plan pays 100%	65% after deductible	50% after deductible
X-Ray and Lab performed outside of the Physician or Specialist office. (Plain films & ultrasound)	75% after deductible	65% after deductible	50% after deductible
CMH Health Clinic Wellness Benefit All employees who are eligible for group health insurance (to include Class I, Class II, or Class III) are eligible for the Citizens Memorial Hospital Wellness Benefit through a Citizens Memorial Hospital Health Clinic. This benefit will include a nurse office visit, height, weight, blood pressure and point of service testing (instant results) for cholesterol and glucose.	Plan pays 100% of the $15 charge Plan Member pays $0	No coverage	No coverage
HOSPITAL SERVICES			
Inpatient	75% after deductible	65% after deductible	50% after deductible
Outpatient (Surgery, MRI, MRA, CT, GI Lab, Lithotripsy, PET Scan, invasive nuclear medicine & observation)	75% after deductible	65% after deductible	50% after deductible
Emergency Room Services	75% after deductible	65% after deductible	65% after the out of network deductible & processed at the in-network allowable rate

PLAN INFORMATION	BEST	BETTER	GOOD
OTHER OUTPATIENT SERVICES			
Rehabilitation (Limit 60 visits/year)	75% after deductible	65% after deductible	50% after deductible
Radiation & Chemotherapy	75% after deductible	65% after deductible	50% after deductible
DME & Prosthetics	75% of billed charges after deductible	65% of billed charges after deductible	50% of billed charges after deductible
Autism Spectrum Disorders	75% after deductible	65% after deductible	50% after deductible
Temporomandibular Joint Disorder (TMJ)	75% after deductible	65% after deductible	50% after deductible
BEHAVIORAL HEALTH SERVICES			
Outpatient	100% after $30 copay	65% after deductible	50% after deductible
Inpatient	75% after deductible	65% after deductible	50% after deductible
SKILLED NURSING SERVICES			
Skilled Nursing Facility is limited to 60 days for in and out of network combined per calendar year.	75% after deductible	65% after deductible	50% after deductible
HOME HEALTH			
Home Health Visits	75% after deductible	65% after deductible	50% after deductible
Hospice	75% after deductible	65% after deductible	50% after deductible
Tobacco Cessation Physician Office Visit Tobacco Cessation Products are paid at 100% for CMH or In- Network providers for one cycle of recommended medication or tobacco cessation products. Out-of-Network providers are not covered.	100%, deductible waived	100%, deductible waived	Not Covered

PRESCRIPTION DRUGS		
Annual deductible... $100 Per person. Copays apply to the In-Network medical out-of-pocket maximum. Prescription deductible does not apply to the medical out-of-pocket maximum. **CMH Rx Service** - $15 copay on Generic/Tier I - $35 copay on Tier II or 30% whichever is greater. - $50 copay on Tier III or 45% whichever is greater.	Annual deductible of $100 Per person. Deductible and copays apply to the In-Network out-of-pocket maximum. **Rx Card Only** - $20 copay Generic/Tier I - $40 copay Tier II or 40%, whichever is greater. - $60 copay on Tier III, or 50%, whichever is greater.	**Non PPO** No coverage Non-Rx Card... Not covered
Maintenance Med Program - (90 day supply), 2 x retail copay (Generic & Tier 1 only)	Maintenance Med Program Not Covered	

BENEFIT INFORMATION – DENTAL	
Deductible	$50 (family up to 3 x $50)
Deductible is Waived for Preventive	Yes
BENEFIT INFORMATION – DENTAL	
Coinsurance:	
Preventive	100%
Basic	80%
Major	Not Covered
Orthodontia	Not Covered
Annual Maximum Benefit - Per person	$500

PLAN INFORMATION - LIFE
1 x salary to maximum of $300,000

PLAN INFORMATION - VOLUNTARY LIFE	
Employee	Multiple of salary to 5 x maximum of $500,000
Spouse	50%
Children	$2,000 increments up to $10,000

PLAN INFORMATION - LONG TERM DISABILITY
Full-time, Part-time, & Contract "D" employees are covered after one (1) year of employment

Section 4

DEDUCTIBLE / COINSURANCE / &
OUT OF POCKET MAXIMUMS

Individual & Family Deductible: You must pay, from your own monies, the deductible for the health care benefits you receive each Benefit Year. The deductible applies only once in any calendar year, even though the Plan Member may have several different sicknesses or injuries. The CMH Service and In-Network deductible apply toward each other. For family coverage, each family member must meet his or her deductible until the family deductible is met. The maximum deductible for a family will be no greater than three individual maximums. The deductible will be included in calculating the out-of-pocket maximum. PPO deductible credits will be applied to this Plan's PPO deductible accumulations for Plan members acquired through acquisition.

CMH Services
Deductible per person is..$1,500
Employee and Dependent deductible is $3,000
Family deductible is...$6,000

In-Network
Deductible per person is..$3,000
Employee and Dependent deductible is $5,000
Family deductible is...$7,000

Out-of -Network Services
Deductible per person is..$6,000
Employee and Dependent deductible is $9,000
Family deductible is...$12,000

Coinsurance: After the deductible has been paid by you each Benefit Year, the Plan takes over and pays a percentage of all eligible charges. Unless otherwise indicated in the Explanation of Medical Benefits section, the following indicates the percentages paid by the Plan and the Plan Member:

CMH Services, when a CMH Provider is available, after the deductible and
Copay, the Plan pays.. 75%
In-Network Services, after deductible.. 65%
Out-of -Network Services, after deductible 50%

Copayments: The Plan Member may be required to pay a copayment or copay on a given benefit or service. Copayments are counted toward the deductible and out-of-pocket maximum.

Indian Health and United States Uniformed Service providers: Claims submitted by Indian Health Service or United States Uniformed Service providers will be considered at the PPO copay, deductible and coinsurance rate as applicable for the specific service provided. The Usual and Customary Rate will be applied.

Out-of-Pocket Maximum: Once the Plan Member's coinsurance has reached the applicable out-of-pocket maximum, the Plan pays 100% of the amount for covered services for the balance of the benefit period, unless indicated otherwise. For In-Network or Out-of-Network providers, each covered member must meet the applicable out-of-pocket maximum. The CMH Service and In-Network out-of-pocket apply toward each other. The deductible will be included in calculating the out-of-pocket maximum. Not all services are covered at 100% and payment is subject to limitations and exclusions within the Plan. PPO out-of-pocket maximum credits will be applied to this Plan's PPO out-of-pocket maximum accumulations for Plan Members acquired through acquisition.

CMH and In-Network Services:
Individual out-of-pocket $5,000
Employee and Dependent out-of-pocket $8,000
Family out-of-pocket $10,000

Out-of –Network:
Individual out-of-pocket $14,000
Employee and Dependent out-of-pocket $20,000
Family out-of-pocket $26,000

Always check the coverage provided for a specific service and the Medical Exclusions and Limitations section of the Plan.

Benefit Year: A Benefit Year is a twelve-month period during which a new deductible and a new maximum must be served. The Benefit Year begins January 1 and ends December 31 of each year.

Section 5
COVERED MEDICAL BENEFITS

PHYSICIAN'S SERVICES

Physician and Specialist fees, along with lab work and X-ray services which are actually performed in and billed by the Physician or Specialist office, will be covered at 100%, after the copay is met (copay is taken for in office services even if Physician or Specialist office visit is not billed). If the Physician or Specialist sends out the lab or X-ray work, those services will be covered under the outpatient services portion of the Plan.

Physician Office Visits: Physician includes general practice, family practice, internal medicine, OBGYN, and pediatrics.

The Plan Member will pay for his or her Physician office visit:
CMH services .... $30 copay per visit
In-Network services, after deductible, Plan pays..................................... 65%
Out-of -Network services, after deductible, Plan pays............................. 50%

Specialist Physician Office Visits: Specialist Physician includes, but is not limited to, those specializing in oncology, cardiology, orthopedic, neurology, pulmonology and any other specialty field.
The Plan Member will pay for his or her specialist office visit:
CMH services .... $60 copay per visit
In-Network services, after deductible, Plan pays..................................... 65%
Out-of -Network services, after deductible, Plan pays............................. 50%

Maternity Office Visits: Global fee must be submitted by one physician on one claim for services rendered. Ultrasounds that are performed outside of the physician's office or that are performed in the physician's office but are billed outside of the global fee will apply to the applicable deductible and coinsurance.

Routine obstetrical global services will be covered with one co-payment for the entire term of the pregnancy at CMH Providers of $150.
In-Network services, after deductible, Plan pays..................................... 65%
Out-of -Network services, after deductible, Plan pays............................. 50%

Urgent Care:
CMH services, after the deductible, Plan pays 75%
In-Network services, after deductible, Plan pays..................................... 65%
Out-of -Network services, after deductible, Plan pays............................. 50%

Advanced Practice Nurses/Mid-Level Providers: Advanced practice nurses/mid-level providers are covered providers under the Plan to include nurse practitioners, clinical nurse specialists, certified registered nurse anesthetists and physician assistants practicing under the direction and supervision of a Physician as required by the State of Missouri. The Plan will cover the charges incurred for a mid-wife who is supervised by a Physician, excluding home delivery charges.

Chiropractic Care: Services provided by a provider licensed in the field of chiropractic care are covered under this Plan.

Injectable Prescriptions: Injectable prescriptions may be obtained through the prescriptions Rx Card using one of the preferred pharmacies. The Rx Card co-pays and schedule will apply as defined under the Prescriptions Section of this Plan. In addition an injectable may be obtained at a Physician's office where the Plan Member would be subject to co-pays, deductible and co-insurance. The Plan will pay as follows:

CMH Network:
Physician office, Plan Member co-pay .... $30 copay per visit
The Plan will pay cost of injectable medication at 75%

In-Network:
Physician office charge, Plan deductible .... is applied
After the deductible is paid the Plan will pay 65%
Cost of Medication in the Physician office, Plan pays 65%

Out-of –Network:
Physician office charge, Plan deductible .... is applied
After the deductible is paid the Plan will pay 50%
Cost of Medication in the Physician office, Plan pays 50%

PREVENTIVE CARE SERVICES

Preventive Care/Routine Wellness Services: The following in network preventive care services as specifically stated are covered by the Plan as well as services recommended by the Patient Protection and Affordable Care Act and the American Academy of Pediatrics. A complete list of covered services may be found in the back of this Plan Document under the U.S. Preventive Services Task Force Recommendations and the Bright Futures/American Academy of Pediatrics.

The following preventative care services are subject to the specific guidelines as listed below under each benefit and are paid at the following rates:

CMH services, deductible & co-pay waived, Plan pays........ 100%
In-Network Services, deductible & co-pay waived, Plan pays 100%
Out-of -Network Services.. Not covered

- **Physician's Office Visit for Preventive Care:** Physician's fees, specific labs, annual pap/pelvic exam, and other preventative care services as recommended by the Patient Protection and Affordable Care Act and the American Academy of Pediatrics are covered.

- **Routine Colonoscopy, Sigmoidoscopy and Occult Blood Testing:** These routine services are covered under the above preventive care benefits for Plan Members age 50-75 at the following frequencies:

  1. Routine Colonoscopy every 10 years
  2. Routine Sigmoidoscopy every 5 years
  3. Routine Occult Blood Testing annually

  Services that are more frequent or prior to age 50 may be considered if the claim is submitted with a letter of medical necessity due to the Plan Members health risks or family history. Anesthesiology charges will apply to the deductible and coinsurance.

- **Routine Prostate Exam and PSA:** One routine prostate and PSA exam is covered per year.

- **Vasectomy** is covered as a preventive care service. Vasectomy reversals are not covered by the Plan.

- **Routine Mammogram:** One routine mammogram is covered per year for Plan Members of all ages.

- **Routine Immunizations:** Immunizations recommended by the Patient Protection and Affordable Care Act and the American Academy of Pediatrics that are conducted in a Physician's office are considered Medically Necessary for specific age ranges, frequencies, and/or other patient-specific indications, including gender by the U.S. Food and Drug Administration (FDA) and recommended by the Centers for Disease Control and Prevention (CDC) limited to these immunizations and paid as follows:
  - Diphtheria, Tetanus, Pertussis
  - Haemophilus Influenza Type B (Hib)
  - Hepatitis (types A and B)
  - Human Papillomavirus (HPV)
  - Inactivated Poliovirus
  - Measles, Mumps, Rubella

- Meningococcal
- Pneumococcal
- Rotavirus
- Seasonal Influenza and H1N1 Influenza
- Varicella
- Zoster

- **Additional Women's Preventive Services:**

  - **Contraception and Contraceptive Counseling**- All Food and Drug Administration-approved contraceptive methods (generic birth control pill), sterilization procedures that are solely performed for contraception, and patient education and counseling for all women with reproductive capacity. This excludes abortifacient drugs.

    Women's outpatient sterilization procedures (e.g. associated implantable devices, facility fee, as well as anesthesia, pathology, and physician fees) are considered to be related services and covered under the preventive benefit. The preventive benefit does not include a pre- or post- operative examination. If a woman is admitted to an inpatient facility for another reason, and has a sterilization performed during that admission, the sterilization surgical fees (surgical fee, device fee, anesthesia, pathologist and physician fees), are covered under the preventive benefit. However, the facility fees are not covered under preventive benefits since the sterilization is incidental to and is not the primary reason for admission. The benefit processing is contingent upon accurate claims submission by the provider, including diagnosis and procedure.

  - **Breastfeeding Support, Supplies and Counseling**- Comprehensive lactation support and counseling, by a trained provider during pregnancy and/or in the postpartum period, and costs for purchase or rental (up to the purchase price) for breastfeeding equipment. Breastfeeding equipment exceeding $400 will require pre-certification review.

  - **Screening and Counseling for Interpersonal and Domestic Violence**- Annual screening and counseling for interpersonal and domestic violence.

  - **Counseling and Screening for Human Immune-Deficiency Virus**- Annual counseling and screening for human immune-deficiency virus infection for all sexually active women.

  - **Counseling for Sexually Transmitted Infections**-Annual counseling on sexually transmitted infections for all sexually active women.

  - **HPV DNA Testing**- Human papillomavirus DNA testing in women with normal cytology results. Screening should begin at 30 years of age and should occur no more frequently than every three years.

  - **Screening for Gestational Diabetes**- In pregnant women between 24 and 28 weeks of gestation and at the first prenatal visit for pregnant women identified to be at high risk for diabetes.

  - **Well-Woman Visits**- Annual well-woman visit for adult women to obtain the recommended preventive services that are age and developmentally appropriate, including preconception and prenatal care.

Newborn Hearing- Infant hear screening, re-screening (if necessary), audiological assessment and follow-up, and initial amplification, including hearing aids is covered by the Plan from newborn through twelve months of age. The initial infant hear screening is paid at 100% for CMH and In Network Providers and is not covered for out-of-network Providers. All other services listed in this paragraph are applied to the applicable benefit sections of the Plan for the specific service performed.

Annual Vision Examination: The Plan will pay for one (1) vision examination per year.
Adult:
CMH services, deductible & co-pay waived), Plan pays 100%
In-Network services, after deductible, Plan pays 65%
Out-of -Network services, after deductible, Plan pays............................ 50%*
*Maximum payment for out-of-network services......................................$50

Dependent children age 21 and under:
CMH services, copay & deductible waived, Plan pays........................... 100%
In-Network services, deductible & co-pay waived, Plan pays................ 100%
Out-of -Network services, after deductible, Plan pays............................ 50%*
*Maximum payment for out-of-network services......................................$50

Tobacco Cessation: The Plan will pay for Physician Office Visits for tobacco cessation as follows:
CMH services, deductible and co-pay waived, Plan pays....................... 100%
In-Network services, deductible and co-pay waived, Plan pays 100%
Out-of -Network services.. Not Covered

Tobacco Cessation Products: The Plan will pay for once cycle of recommended medications or other tobacco cessation products under the Prescription Drug benefits at 100% for CMH and In-Network Providers. Tobacco cessation products for Out-of-Network Providers are not covered.

CMH Health Clinic Wellness Benefit: All employees who are eligible for group health insurance are eligible for the Citizens Memorial Hospital Wellness Benefit through a Citizens Memorial Hospital Health Clinic. This benefit will include a nurse office visit, height, weight, blood pressure and point of service testing (instant results) for cholesterol and glucose.
CMH services, Nurse Office visit, Plan Member cost $0
CMH services, The Plan will pay $15 charge at 100%
In-Network services...No Benefits
Out-of -Network services..No Benefits

HOSPITAL SERVICES

Inpatient and Outpatient Hospital Services: Inpatient (involving an overnight stay) and outpatient Hospital services are limited to services which are Medically Necessary as well as to reasonable and customary charges. Benefit schedules are as follows unless defined otherwise:

CMH services, after the deductible, Plan pays 75%
In-Network services, after deductible, Plan pays..................................... 65%
Out-of -Network services, after deductible, Plan pays............................. 50%

Inpatient Hospital Room Accommodations:
Semi-Private Room (two or more beds)
Approved Intensive and Cardiac Care Units
Private Room- If you use a private room, you will be responsible for the difference between the Hospital's charge for an average semi-private room and its private room charge
Maternity Benefits- available to employees and covered Dependents only
Nursery Care- pays the allowable charge on family coverage only
Drugs and Medicines- drugs approved by the Federal Food and Drug Administration (except Experimental or Investigative drugs)
Oxygen
Operating and Delivery Room
Dressings, Splints and Plaster Casts
Physical Therapy
Sterile Set-ups
Surgery and Anesthesia
Treatment of Fractures and Dislocations
Biopsies and Aspirations
Endoscopic Procedures
Emergency Care
Radiation Therapy, Isotope Studies

Outpatient Services: The following services are covered benefits when provided in an outpatient setting and when the service is considered Medically Necessary by the Plan:
Surgery
MRI

MRA
CT Scan
GI Lab
Lithotripsy
Pet Scan
Invasive Nuclear Medicine
Admission for observation
Surgery for the correction of bunions

The Plan will pay for the outpatient procedure at:
CMH services, after deductible, Plan pays 75%
In-Network services, after deductible, Plan pays.................................... 65%
Out-of -Network services, after deductible, Plan pays............................ 50%

Maternity:
CMH services, after $150 co-pay for physician services, Plan pays....... 100%
CMH services, after deductible, facility charges are paid at.................... 75%
In-Network services, after deductible, Plan pays.................................... 65%
Out-of -Network services, after deductible, Plan pays............................ 50%

Emergency Room Services (to include all services performed in the emergency room):
CMH services, after deductible, Plan pays 75%
In-Network services, after deductible, Plan pays.................................... 65%
Out-of -Network services, after out of network deductible, Plan pays…...65%*
*Services will be processed at the in-network allowable rate

Organ Transplants: The Plan covers charges for the cost of human organ and tissue transplants. All cost associated with a Plan of treatment for a transplant, to include the evaluation, work-up, transplantation, immunosuppressants, and follow-up treatment (the treatment which would not have occurred unless a transplant was to occur) will be considered. Donor expenses will be included and the order of payment for transplant expenses will be based on the date a claim is received.

Immunosuppressants, in connection with covered human organ and tissue transplants, are considered a part of the transplant benefit and will be a covered expense under this benefit up to the combined transplant maximum. The Plan will cover human organ transplants, limited to cornea, heart, lung or heart/lung, bone marrow, kidney, pancreas, and liver. All Experimental or Investigative transplants are excluded from coverage to include Experimental or Investigative bone marrow transplants. All transplants should be reviewed by the Plan's case manager, as a Special Transplant Provider may be available to the Plan Member. See the Exclusions and Limitations Section for additional information.

Special Transplant Providers: There may be a Special Transplant Provider available to the Plan. To qualify, you or your Physician must notify the pre-certification service within ten (10) days of the attending Physician's determination that the Plan Member is a candidate for a transplant. If the Special Transplant network is used, your deductible will be waived and, if approved in advance, up to $2,000 of travel and lodging expenses will be made available.

PPO Transplant Provider (who is not a Special Transplant Provider): If the Plan Member selects a provider who is not a Special Transplant Provider, but who is a member of the PPO network, benefits will be paid under the regular In-Network Plan benefits.

Non PPO Provider (who is not a Special Transplant Provider): If the Plan Member selects a Non PPO Provider who is not a Special Transplants Provider, one who is not in the Plans PPO network or one which does not provide a negotiated discount to the member and Plan, as determined by case management, there will be no benefit coverage under this Plan.

In-Patient Rehabilitation and Skilled Nursing: Benefits for all inpatient rehabilitation services and/or skilled nursing facility are subject to pre-certification and review by case management to identify medical criteria and cost-effective alternatives.

CMH services, after deductible, Plan pays 75%
In-Network services, after deductible, Plan pays.................................... 65%
Out-of -Network services, after deductible, Plan pays............................ 50%

OTHER OUTPATIENT SERVICES

Outpatient Services: Outpatient services are limited to services which are Medically Necessary. Benefit schedules is as follows unless defined otherwise:

CMH services, after deductible, Plan pays 75%
In-Network services, after deductible, Plan pays..................................... 65%
Out-of -Network services, after deductible, Plan pays............................. 50%

Rehabilitation: The Plan will cover physical, occupational, speech or respiratory therapy, and cardiac or pulmonary rehabilitation by a licensed therapist or a state certified athletic trainer. Speech therapy must follow either surgery for correction of a congenital condition of the oral cavity, throat or nasal complex, an injury, or a sickness other than a learning or mental disorder. The annual maximum benefit for all therapists and providers combined will be limited to 60 visits per year.

CMH services, after the deductible, Plan pays 75%
In-Network services, after deductible, Plan pays..................................... 65%
Out-of -Network services, after deductible, Plan pays............................. 50%

Pre-certification is required for the rehabilitation benefits along with a plan of treatment which can show a successful outcome within the 60 days after treatment is complete.

Radiation & Chemotherapy: Any services or prescriptions provided in an outpatient setting or purchased through a pharmacy will be applied toward the deductible and out-of-pocket maximums and are covered as follows:

CMH services, after deductible, Plan pays 75%
In-Network services, after deductible, Plan pays..................................... 65%
Out-of -Network services, after deductible, Plan pays............................. 50%

Durable Medical Equipment and Prosthetics: In order to be covered, the equipment must be Medically Necessary and prescribed by a Physician as a result of Illness, disease or injury. The Plan will pay:

CMH services, after deductible, Plan pays ....75% of billed charges
In-Network services, after deductible, Plan pays...........65% of billed charges
Out-of -Network services, after deductible, Plan pays...50% of billed charges

Newborn Care: The Plan pays the allowable charge for the newborn of an enrolled employee or his or her spouse, as long as the child has been enrolled within 30 days of birth. See Plan Eligibility and Membership section of the Plan for more information.

Mastectomy Coverage: In compliance with federal law, the Plan provides coverage due to Illness or injury for: (1) reconstruction of the breast on which a mastectomy has been performed; (2) surgery and reconstruction of the other breast to produce a symmetrical appearance; and (3) prostheses and physical complications at all stages of the mastectomy, including lymphedemas.

Obesity and Weight Reductions: There are no benefits paid for obesity or weight reduction programs under the medical benefits whether Medically Necessary or not. However, the Plan will cover counseling and behavioral interventions to promote sustained weight loss under the Preventative benefits of the Plan.

Mouth, Jaw and Teeth: The treatment of the mouth, jaw or teeth will be covered under the medical section of this Plan if the treatment is due to an injury or to cancer. If a Plan Member goes to a Physician, after hours clinic or emergency room due to pain or illness that is found to be associated with the teeth or gum, the Physician visit or emergency room visit will be a covered benefit to diagnose the problem. The Plan will also cover "general anesthesia" charges where such services are in a Hospital/medical facility and are deemed to be Medically Necessary. Determination of Medically Necessary will be made by a medical review company approved by the Plan. See Medical Exclusions as well as the Dental Section for more information.

Autism Spectrum Disorders. Psychiatric care, psychological care, habilitative or rehabilitative care (including applied behavior analysis (ABA) therapy), therapeutic and pharmacy care to covered children who have been diagnosed with autism spectrum disorder (ASD).

Sex Reassignment. The Plan covers the following sex reassignment services when ordered by a Provider or Physician.

1. Psychotherapy.
2. Pre- and post-surgical hormone therapy.
3. Sex reassignment surgery/ies. Surgery must be performed by a qualified Provider.

Temporomandibular Joint Disorder (TMJ): Covered Services related to TMJ under the medical benefits include removable appliances for TMJ repositioning and related surgery, medical care and diagnostic services.

Ambulance Services: The Plan pays for emergency transportation by local professional ground ambulance service or emergency helicopter transport to the nearest Hospital facility equipped to treat the emergency. Ambulance transportation to an in-network facility by any ambulance service will be processed at the in-network level of benefits. Such service must be Medically Necessary to quality for this benefit and is limited to a 300-mile radius. The Plan will pay:

CMH Services, after deductible, Plan pays... 75%
In-network Services, after deductible, Plan pays.................................... 65%
Out-of -Network Services, after deductible, Plan pays........................... 50%

Experimental or Investigative Treatment: Charges for care, treatment, services or supplies that are Experimental or Investigative in nature are not covered by this Plan. See Plan Medical Exclusions for details.

Clinical Trials: This Plan does not discriminate against individuals based on participation in the trial. This Plan will not deny a "Qualified Individual" participation in an "Approved Clinical Trial" or limit or impose additional conditions on coverage's for "Routine Patient Costs" for items and services in connection with the trial.

A "Qualified Individual" is a participant who is eligible, according to the trial protocol, to participate in an approved clinical trial for the treatment of cancer or other life-threatening diseases or conditions and either:

- The referring healthcare professional is a participation provider and has concluded that the participant's participation in the trial would be appropriate; or
- The participant provides medical and scientific information establishing that the individual's participation in the clinical trial would be appropriate.

"Routine Patient Costs" include items and services typically provided under the Plan for a participant not enrolled in a clinical trial. However, such items and services do not include (a) the investigational item, device, or service itself; (b) items and services not included in the direct clinical management of the patient, but instead provided in connection with data collection and analysis; or (c) a service clearly not consistent with widely accepted and established standards of care for the particular diagnosis.
"Approved Clinical Trial" is a phase I, phase II, Phase III, or phase IV clinical trial that is conducted in connection with the prevention, detection, or treatment of cancer or other "Life-Threatening Diseases or Conditions" and is federally funded through a variety of entities or departments of the federal government; is conducted in connection with an investigational new drug application reviewed by the FDA; or is exempt from investigational new drug application requirements.

A "Life Threatening Disease or Condition" is a disease or condition likely to result in death unless the disease or condition is interrupted.

Multiple Procedures and Assistant Surgeons: Multiple procedures for covered services through the same incision will be paid at 100% of the allowable charges (after the Plan's deductible is met) for the first procedure, 50% for the second, and 50% for the third. The assistant surgeon's allowable amount will not exceed 20% of the reasonable and customary charges of the surgeon.

Outpatient X-Ray and Lab Services: When X-ray and lab services consist of plain film and ultrasounds and are Medically Necessary, the Plan will pay as follows:

CMH services, after deductible, Plan pays 75%
In-Network services, after deductible, Plan pays..................................... 65%
Out-of -Network services, after deductible, Plan pays.............................. 50%

Blood Sugar Level Education: Classes and services provided to educate the Plan Member on the maintenance of proper blood sugar levels (e.g., diabetes) will be covered as follows:

CMH Services, deductible & co-pay waived, Plan pays........................ 100%
In-Network Services, deductible & co-pay waived, Plan pays 100%
Out-of-Network Services .... Not covered

BEHAVIORAL HEALTH SERVICES

Mental & Nervous Treatment: ***Outpatient:*** Eligible charges by a licensed mental health provider and under a treatment plan will be paid as follows:
CMH services, after $30 co-pay, Plan pays 100%
In-Network services, after deductible, Plan pays..................................... 65%
Out-of -Network services, after deductible, Plan pays............................. 50%

Inpatient**:** Eligible charges by a licensed mental health provider, and where the treatment has been pre-certified and meet utilization criteria, will be paid as follows:

CMH services 75%
In-Network services, after deductible, Plan pays..................................... 65%
Out-of -Network services, after deductible, Plan pays............................. 50%

SKILLED NURSING SERVICES

Skilled Nursing Facility: Benefits for all services in a Skilled Nursing Facility are limited to a maximum number of days per calendar year. This benefit is subject to pre-certification and review by case management to identify medical criteria and cost-effective alternatives.

CMH services, after deductible, Plan pays 75%
In-Network services, after deductible, Plan pays..................................... 65%
Out-of -Network services, after deductible, Plan pays............................. 50%
Skilled Nursing Facility maximum per calendar year................ 60 days/visits

HOME HEALTH

Home Health Care: Payments of these benefits are subject to review by case management to identify medical criteria and cost-effective alternatives. Benefit payments will be limited as follows:
CMH services, after deductible, Plan pays 75%
In-Network services, after deductible, Plan pays..................................... 65%
Out-of -Network services, after deductible, Plan pays............................. 50%

Hospice Care: The Plan will pay for covered Hospice charges, subject to a Lifetime Maximum, which is Medically Necessary for treatment if the Plan Member is totally disabled as a result of a terminal Illness and has a life expectancy of six months or less. Payment of benefits for Hospice care is subject to review by case management.

CMH services, after deductible, Plan pays 75%
In-Network services, after deductible, Plan pays..................................... 65%
Out-of -Network services, after deductible, Plan pays............................. 50%

Section 6
PRESCRIPTION DRUGS

Prescriptions require the written approval of a Physician and must be approved by the Federal Food and Drug Administration. The Plan will pay benefits after the deductible and copay is met. The CMH and In Network prescription drug copays apply to the In Network medical out-of-pocket maximum. The Prescription drug deductible does not apply to the medical out-of-pocket maximum.

Deductible
Combined and will apply to both options .... $100 per person

CMH Out-Patient Rx
After the deductible is met:
Generic Drugs/Tier I $15
Tier II .... $35 or 30% whichever is greater
Tier III.. $50 or 45% whichever is greater
Maintenance Med Program (90 day supply) .... 2 x Retail Copay

Rx Card
After the deductible is met:
Generic Drugs/Tier I $20
Tier II .... $40 or 40% whichever is greater
Tier III.. $60 or 50% whichever is greater
Maintenance Med Program .... not covered

Non PPO
Purchasing outside of CMH or the Rx Card .... not covered

If generic drugs are available and the Plan Member or his or her Physician chooses to obtain brand name drugs, the Plan will not provide coverage for the brand name prescription. The Plan reserves the right to utilize case management for large users of prescriptions. Prescriptions purchased outside the drug card will not be covered by this Plan unless recommended by case management and approved by the Plan Administrator.

In accordance with the Patient Protection and Affordable Care Act, Plan Members may obtain the following drugs at any contracted retail pharmacy. All covered over-the-counter items must be submitted with a prescription.

a. Generic contraceptives, Plan pays 100% with deductible waived, for oral, Injectable, patches, rings, diaphragms, and emergency contraceptives. (Brand names are subject to the applicable brand name copay).
b. Generic Aspirin, to include over-the-counter, Plan pays 100% with deductible waived, for males and females age 45 through 78. (Brand names are subject to the applicable brand name copay).
c. Fluoride Supplements, to include over-the-counter, Plan pays 100% with deductible waived for ages 6 months through 6 years.
d. Generic Folic Acid (400mcg and 800mcg only) to include over-the-counter, Plan pays 100% with deductible waived for females age 11 through 48 years. (Brand names are subject to the applicable brand name copay).
e. Generic Iron Supplements, to include over-the-counter, Plan pays 100% with deductible waived, for ages 6 months through 12 months. (Brand names are subject to the applicable brand name copay).
f. Tobacco deterrents, to include over-the-counter, Plan pays 100% with deductible waived for CMH and In Network providers for one cycle of recommended medications or other tobacco cessation products.
g. HPV, Influenza, and Shingles Vaccines, Plan pays 100% with deductible waived, to include up to $25 for administrative fee per vaccine.

PRESCRIPTION EXCLUSIONS & LIMITATIONS

Prescription Drug Exclusions: Benefit payments are limited or not provided for the following prescription drugs:

- Abortifacient drugs
- Accutane/Retin-A for participants over the age of 25

- Anorexiants/anti-obesity medications
- Artificial appliances
- Brand name prescriptions when generic drugs are available
- Charges for delivering any drugs
- Charges to administer or inject any drugs
- Dietary supplements
- Drugs approved for experimental use
- Drugs which can be purchased without a prescription
- Drugs for weight loss or weight control
- Growth hormones
- Hair growth medication
- Investigational or experimental drugs, including compounded medications for non-FDA approved use
- Injectable other than insulin, unless obtained through the Rx Card
- Not Medically Necessary
- Prescription drugs used in connection with drug addiction
- Prescriptions which a Plan Member is entitled to receive without charge under any workers' compensation law, or any municipal, state, or federal program
- Smoking deterrents unless meeting the Smoking Cessation requirements
- Supplies and equipment used in intravenous treatment
- Support garments and other non-medical substances
- Therapeutic devices or appliances
- Those for which normally (in professional practice) there is no charge
- Sexual dysfunction drugs or devices for sexual inadequacies that do not have psychological or organic basis.
- Vitamins except for prenatal vitamins prescribed by a Physician during pregnancy and up to one year after delivery
- All of the limitations and exclusions of the medical benefit program also apply. The Plan has the right to deny benefits for any drug prescribed or dispensed in a manner that does not agree with normal medical or pharmaceutical practice.

MEDICARE PART D, CREDITABLE COVERAGE

Medicare Part D: Certain Medicare regulations require the Plan Sponsor to inform Plan Members who are eligible for Medicare benefits that their health Plan meets the creditable coverage requirement of Medicare Part D. The Plan Member who is Medicare eligible should be advised the Plan has determined that the prescription drug coverage of this Plan is creditable. The Plan will provide notice of creditable coverage beyond the one found in this section: (1) Before the effective date of coverage for any Medicare eligible individual who joins the Plan; (2) Whenever prescription drug coverage ends or changes so that it is no longer creditable or becomes creditable; and (3) Upon a beneficiary's request for a copy of the notice.

Section 7
MEDICAL EXCLUSIONS & LIMITATIONS

Coverage under the Plan is limited to services incurred during the Benefit Year. The following are exclusions and limitations for which the Plan does not pay benefits, and these shall apply to services described herein:
Abortion is not a covered benefit, unless the treatment is Medically Necessary to save the life of the mother;
Acupuncture, Hypnotism, **Acupressure and Hypnotic Anesthesia** and admissions for such treatment;
Armed Forces Injuries occurring while engaged in the services of any branch of the United States Armed Forces, state militia, or foreign nation, or in any act of war whether declared or undeclared;
Alcohol and Substance Abuse Treatment unless provided for in the Plan;
Blood Donor's Expenses;
Blood Testing for a licensing procedure to include a marriage license;
Charges for which Payment is not Required or charges which the covered person is not legally obliged to pay;
Complications of Non-covered Treatments to include care, services or treatment required as a result of complications from a treatment not covered under the Plan;
Contraceptive devices services, drugs or supplies that are not approved by the Food and Drug Administration;
Cosmetic Treatment of any kind, to include treatment of complications due to cosmetic procedures, regardless of when the complication occurs. This includes reconstructive surgery, unless the surgery will significantly improve the functioning of a

malformed body part and the services are related to an injury, surgery, or illness which occurred while the Plan Member was covered under the Plan or at the time of birth in the event of a newborn congenital abnormality up to and including age of 18;

Criminal Activity which results in any loss associated with the Plan Member's commission or attempt to commit a felony or engaging in any illegal activity, including, but not limited to illnesses or injuries which were incurred as a result of the Plan Member's use of alcohol or drugs, in excess of a state or federal statute, or non-prescribed use. The Plan Administrator reserves the right to determine if there was an attempt to commit an illegal act where a citation or charge was not issued by a government authority;

Custodial Care such as sitters' or homemakers' services providing care in a place that serves the patient primarily as a residence and where skilled nursing or Physician supervision is not required;

Dental Care or dental implants unless provided for in the Plan;

Educational and/or Institutional Charges for training and/or education for the disabled or aged, whether inpatient or outpatient except as specified;

Examinations and Testing specifically for the purpose of entering school, obtaining employment, licensing, insurance, adoption, examinations precedent to engaging in recreational activities, camp physicals, or examinations or treatment ordered by a court or an employer;

Exercise or Wellness Programs unless provided for in the Plan. Medical or surgical treatment to include reduction of weight regardless of associated medical or psychological conditions;

Equipment and Supplies, including:

- Deluxe durable medical equipment such as motor-driven wheelchairs and beds;
- Items not primarily and customarily for medical purposes or medical in nature or that is provided for the Plan Member's comfort and convenience, including, but not limited to, equipment and supplies that condition or purify the air, bed boards, bathtub lifts, over-bed tables, telephone arms, raised toilet seats and shower bars;
- Physician's equipment, including, but not limited to, stethoscopes and blood pressure monitoring equipment;
- Exercise equipment and self-help equipment not primarily medical in nature, including, but not limited to, sauna baths, whirlpool baths, chairs and elevators;
- Supplies or equipment for household use, including, but not limited to, air purifiers, central or unit air conditioners, water purifiers, allergenic pillows or mattresses, and water beds;
- Replacement, repair or routine periodic maintenance of purchased durable medical equipment;
- Items obtained from a provider that is not a participating durable medical equipment supplier;
- Supplies that may be used incidental to cover services such as alcohol swabs, patches, cotton balls and other over-the-counter dressing and supplies.

Experimental Treatment to include charges for care, treatment, services or supplies that are experimental or investigational in nature, as determined by a medical review professional chosen by the Plan Administrator (decisions of the Plan Administrator shall be considered binding on all parties);

Foot Care of a routine nature to include treatment of calluses, toenails and corns, in addition to shoes or other items of normal wearing apparel;

Hair Loss Treatment including drugs promoting hair growth and wigs;

Hearing Aids, hearing devices, exams, fittings and repair; unless covered under the Newborn Hearing benefit of the Plan.

Immediate Family Charges from a provider who usually resides in the same household as the covered person, or who is a Plan Member of his or her immediate family or the family of his or her spouse;

Immunizations outside a Physician's office to include those required for travel or employment;

Infertility Services or any service associated with enhancing fertility or reproduction, including the reversal of sterilization;

Medically Unnecessary Charges for the care or treatment of an illness or injury. Even if Medically Necessary, benefits for treatment will be limited to the extent of coverage provided by the Plan.

Medical Records to include payment for any records or documents associated with a determination of eligible charges or any appeal by a Plan Member;

Mental Health Treatment for services related to and treatment of mental retardation or learning disabilities, including, but not limited to, music therapy, remedial reading, milieu therapy and forms of special education, except as specified;

Non-Emergency Care when traveling outside the United States;

Non-Insured Charges or charges which would not have been made had no coverage existed;

No Obligation to Pay due to third party liability of others unless defined elsewhere in this Plan (See COB and Subrogation Section of this booklet).

Non-covered Services or Items of Care not specifically provided for in the Plan;

Non-Physician Care or charges for care or services not provided by a licensed Physician;

Non-Reasonable and Customary Charges (for Non-PPO Providers) which are charges in excess of the Usual, Customary and Reasonable (UCR) charges for services and materials as determined by a national survey or competitive data or schedule available to the Plan. The Plan does not have an obligation to notify providers or Plan Members of a change in a service provider or schedule.

Obesity and weight reduction treatment under the medical benefits whether Medically Necessary or not, unless provided for in the Plan;

Orthopedic Devices arch supports, corrective shoes, and support hose even if prescribed by a Physician, unless defined otherwise by the Plan;
Other Charges such as charges for services or non-Physician consultations, missed appointments, requests for reports or filling out claim forms;
Personal Comfort Items such as television, telephone, air conditioning, humidifiers, physical fitness equipment and items generally useful outside the Hospital;
Physician Care which is not within the scope of his or her license;
Prescription Drugs and medicines to include vitamins and infertility drugs**,** unless provided under the Plan's prescription drug benefit (refer to the Plan's section on Prescription drugs) or unless defined elsewhere in the Plan;
Private Duty Nursing where it is for private duty nursing care except when provided pursuant to an individual case management plan approved by the Plan Administrator;
Routine Examinations to include diagnostic tests or immunizations, unless otherwise provided for in the Plan;
Rehabilitative Services for maintenance and custodial purposes. In addition, the diagnosis of developmental delay is not considered rehabilitative in nature; therefore, services for treatment of this condition are not considered covered services, except as specified;
Self-Inflicted and/or Intentional Injury, or an illness (unless caused by a medical condition as defined by HIPAA).
Service Covered by Other Insurance Policies to include an automobile policy, homeowner policy, or any policy belonging to a third party;
Sexual Dysfunctions for any services or supplies for the treatment of male or female social dysfunction such as, but not limited to, treatment of erectile dysfunction (including penile implants), anorgasmy, and premature ejaculation;
Sleep Disorders unless deemed Medically Necessary;
Smoking Cessation Programs, unless otherwise provided in the Plan;
Telephone Charges or telephone consultations;
Therapy Charges for speech, music, marriage, and/or reading therapy, except speech therapy when related to a cerebral vascular accident, a cerebral tumor, closed head trauma, external trauma to the larynx, or laryngectomy;
Travel or Accommodations of any kind unless provided elsewhere;
U. S. Government Charges for services or supplies furnished by an agency of the federal, state, or local government, or a foreign government agency, unless required by law;
Vision Care to include routine vision or eye examinations, eyeglasses or contact lenses or the fitting of either (unless otherwise provided in this Plan), and all services related to radial keratotomy procedures or other procedures to correct nearsightedness;
Vocational Rehabilitation under any name;
Work Related Injury or Illness which arises out of the course of any employment where income is reported by a W-2 or 1099 IRS Form or where an illness or injury should be covered by state regulated Worker's Compensation Insurance.

Section 8
PLAN ELIGIBILITY & MEMBERSHIP

Who is Eligible to Participate: Participation in the Plan shall be limited to the employees and their Dependents of the Plan Sponsor who were enrolled in the prior plan, and continue to be enrolled under this Plan as well as meeting the eligibility requirements set forth herein:

- Full-Time Employee (Class 1): All active regular, Full-Time Employees who are scheduled to work at least 36 hours a week on an annual basis who have completed the waiting period and an approved application form, and who meet the Actively-At-Work requirement.

- Part-Time/Full-Time Employee (Class 2): All active regular, Full-Time or Part-Time Employees who are scheduled to work at least 20 - 35 hours a week on an annual basis, who have completed the waiting period and an approved application form, and who meet the Actively-At-Work requirement.

- Contract "D" Employee (Class 3): All active regular, Full-Time Employees who are scheduled to work at least 20 hours a week on an annual basis, who have completed the waiting period and an approved application form, and who meet the Actively-At-Work requirement.

- A Dependent of an eligible employee, as defined in the Plan and by the Health Insurance Portability and Accountability Act of 1996 (HIPAA) regulations, in addition to Dependents designated as Alternate Recipients under Qualified Medical Child Support Orders.

- An employee Plan Member on an official company approved Leave of Absence, to include the Family Medical Leave Act (FMLA). Such leave shall not exceed six months.

- A terminated Plan Member who subsequently enrolled as a COBRA participant.

- All participants must be Full-Time residents of the United States residing within the 50 states or a U.S. territory.

Waiting Period: An individual who meets the eligibility criteria listed above must also complete the Plan's waiting period. Plan Members must submit an enrollment form and the form must be approved by the Plan Administrator. Full-Time and Part -Time Employees will be effective the first day of the month following their hire date as a Full-Time or Part-Time Employee. If the Full-Time or Part-Time Employee is hired the first day of the month, eligibility begins that day. The waiting period will be waived for Plan participants who join this Plan through an acquisition.

New Members and First Enrollment Period: If the eligible employee was a participant under the insurance contract in force before the Plan became effective, he or she will automatically be enrolled in the Plan. Otherwise, to be covered the eligible employee must complete the waiting period and elect to participate in the Plan by completing the required enrollment application form. The application form must be signed and submitted for either single or family coverage within 30 days after becoming eligible. Once the individual submits an enrollment form and the form is approved by the Plan Administrator, coverage will become effective on the first of the month following the end of the waiting period.

Special Enrollment: Special enrollment rules shall apply to individuals who are eligible but not enrolled for coverage in this Plan where the individual loses coverage in another health plan, or if COBRA coverage is exhausted. Special enrollment rules do not apply for loss of eligibility due to failure of the individual to pay premiums on a timely basis or termination of coverage for cause (e.g., making a fraudulent claim or intentional misrepresentation).

The employee and Dependents have 30 days from the loss of the coverage to make an application to become members in this Plan. Once the individual submits an enrollment form and the form is approved by the Plan Administrator, coverage will become effective on the first of the month following loss of coverage.

Additional Special Enrollment Rights: This Plan will permit employees and Dependents who are eligible but not enrolled for coverage to enroll in two additional circumstances:

1. The employee's or Dependent's Medicaid or CHIPRA coverage is terminated as a result of loss of eligibility and the employee requests coverage under the Plan within 60 days after the termination, or

2. The employee or Dependent become eligible for a premium assistance subsidy under Medicaid or CHIPRA, and the employee requests coverage under the Plan within 60 days after eligibility is determined.

Special Enrollment for New Dependents: If an eligible employee acquires a new Dependent and requests enrollment within 30 days after the event occurs, the effective date of coverage will be:

- On the date of marriage;
- On the date of the Dependent's birth;
- On the date of the Dependent's adoption or the date of placement of adoption.

Open Enrollment: Employees and Dependents will be allowed to enroll each year during the Plan's Open Enrollment period. The Open Enrollment period will be between October 15th and November 15th of each year with coverage effective January 1 of the following year once the application is accepted.

Family Coverage: Family coverage includes the eligible employee, his or her legal spouse and any married or unmarried Dependent children which qualify as a Dependent until they attain age 26 (coverage from newborn through age 25). Disabled, unmarried Dependent children may be covered regardless of age. A disabled Dependent child will be determined by a Physician and proof of the disability as defined by the Social Security administration. Proof of disability will be required for any Dependent over the age of 25. The eligible employee must apply for Dependent coverage on a form provided by the Plan and agree in writing to pay the required contributions for Dependents.

Who is a Dependent: A Dependent will include a participant's legal spouse (if not legally separated from the covered employee). The term "spouse" excludes non-married or common law spouses, unless such relationship is provided for in state or case law for the state of residence. Common law marriage must be documented as requested by the Plan Supervisor to include proof of an ongoing common law marriage relationship.

A Dependent will include the covered employee's married or unmarried children by birth or marriage, including a stepchild, legally adopted children, children under legal guardianship as defined by the Plan, and Dependent children placed for adoption as defined by a court order. If a husband and wife are both covered under the Plan as participants, their Dependent children may be covered Dependents of either the husband or the wife. Spouses and children of the adult Dependent child are not eligible under the Plan.

Adopted Child: A child who is adopted by the Plan Member under the state laws in which the Member resides, or placed with a Plan Member in anticipation of adoption, will be considered a Dependent for the purposes of enrollment in the Plan. To become and remain covered, proof of adoption or proof that the adoption legal process has commenced must be provided to the Plan, as requested.

Court Ordered Guardianship: The Plan will accept the application of a Dependent child who is under the legal guardianship of the Plan Member. The Plan will accept the application of such a child if the Plan member can show that the child is a Dependent of the employee Plan Member, or if his or her spouse has legal guardianship of the child. The enrollment will be treated as a Special Enrollment. The Plan will require proof of legal guardianship and Dependent status.

Dependent Coverage Ends: An eligible and enrolled Dependent will be eligible for coverage from live birth until the end of the month following the date the child attains age 26. There will be no coverage beginning the first of the month after they attain age 26 (coverage will be provided up to and through age 25).

Qualified Medical Child Support Order: This Plan will provide Dependent coverage (to the extent such coverage is provided under the Plan) for any child of an employee who is recognized under an eligible Qualified Medical Child Support Order (QMCSO) as having a right to enrollment in the group health Plan. Such coverage is contingent on the employee completing the appropriate enrollment form and making the appropriate contribution for Dependent coverage. A copy of the QMCSO may be obtained at no cost to the Plan Member.

Court Order: If an employee or the employee is spouse is required by court order to obtain coverage for a Dependent child due to divorce, the Dependent child listed on the court order will be allowed to enroll in the Plan on the date as specified in the court order. If the Employee is not currently covered by the Plan, the Employee will be added to the Plan along with the applicable Dependent child.

Medicare and its Effect on the Plan: Coverage under this Plan is available to Full-Time or eligible employees age 65 and over, and to their spouses age 65 and over under the same conditions as coverage available to eligible employees and their spouses under age 65. Nonetheless, persons over age 65 are entitled to select primary coverage under Medicare. To do so, he or she must decline all coverage under the Plan.

Medicare and Kidney Disease: Medicare may provide benefits for a covered member of this Plan who would have a kidney disease to include renal failure. The Plan will conform to the regulations and any waiting period which may be associated with the benefits. The Plan Member should always check with his or her Social Security office for detailed information.

Premium & Employee Contributions: The employer reserves the right to have employees contribute, in full or in part, premiums to the Plan. Coverage for persons under COBRA is solely the responsibility of the covered person(s). Employees on unpaid Leave of Absence or other leave are responsible for paying their portion of the premiums to the Plan on a timely basis, as determined by the employer.

Section 9
TERMINATION OF COVERAGE

Termination of Plan Membership: A Plan Member's coverage will terminate with the Plan for any one of the reasons outlined in this section. The Plan member may continue coverage and that of his or her eligible Dependents for a limited time. This termination language will apply to each class of eligible employee or Dependent. Coverage under this Plan will terminate on the last day of the month unless defined otherwise herein:

- ***Termination of Employment or Reduction in Hours:*** The employee and Dependents are terminated the last day of the month that the employee is no longer considered a Full-Time employee.

- ***Voluntary Termination of Coverage for Qualifying Events:*** Coverage will end the last day of the month for a Plan Member who voluntarily ends coverage due to a qualifying event.

- ***Dependent Eligibility and Notice:*** Coverage will end the last day of the month that the Dependent child ceases to be an eligible Dependent.

- ***Death:*** Spouse and Dependent children's coverage will end on the date of death of the Plan Member.

- ***Legal Separation or Divorce:*** Coverage will end on the date designated by a court order.

- ***Contributions:*** If the covered Plan member or beneficiary fails to remit required contributions within thirty (30) days when such payment is due, then coverage will terminate at the end of the period for which a contribution is made.

- ***Leave:*** At the end of a company approved Leave of Absence or the end of an approved period of disability. Such leave shall not exceed six months.

- ***COBRA*****:** The day the COBRA Plan Member is no longer eligible for COBRA or after electing COBRA, the day the Plan Member becomes eligible for Medicare or another insurance plan (unless defined otherwise by federal regulations).

- ***Military Duty:*** The date the Plan Member becomes a full-time member of the Armed Forces of any United States on a Full-Time active duty basis, or a government unit covered by or Uniformed Services Employment and re-employment Rights Act of 1993 (USERRA). Reserve duty, drills and summer camp shall be excluded from the definition of active duty unless such duty lasts over 30 days as defined by the act. Once eligibility in the Plan ends, the participant and eligible dependents may have continuation rights with the Plan under COBRA as defined by USERRA.

- ***Plan Termination:*** The date the Plan is terminated.

Rehiring a Terminated Employee: A terminated employee who is rehired will be treated as a new hire and will be required to satisfy all of the Plan's eligibility and waiting period requirements. This does not apply to terminated employees who return to work without a lapse in coverage due to COBRA.

Section 10
CONTINUATION OF COVERAGE - COBRA RIGHTS

The employer sponsoring your group health Plan offers employees and their families the opportunity for a temporary extension of health coverage under the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA) called "continuation coverage" at group rates in certain instances where coverage under the Plan would otherwise end. **This notice is intended to inform you, in a summary fashion, of your rights and obligations under COBRA. Both you and your spouse or Dependents should take the time to read this notice carefully.**

If you are an employee covered by this Plan, you have a right to choose this continuation coverage if:

- You lose your group health coverage because of a reduction in your hours of employment; or
- Your employment ends for any reason other than gross misconduct on the part of the employee.

If you are the spouse of an employee covered by this Plan, you have a right to choose continuation coverage for yourself if you lose group health coverage under this Plan for any of the following reasons:

- Your spouse dies;
- Your spouse's hours of employment are reduced, or your spouse's employment ends for any reason other than his or her gross misconduct;
- Your spouse becomes enrolled in Medicare (Part A, Part B, or both); or
- You become divorced or legally separated from your spouse.

Dependent children of an employee covered by this Plan have the right to continuation of coverage if group health coverage is lost for any of the following reasons:

- The parent-employee dies;
- The parent-employee's hours of employment are reduced, or parent-employee's employment ends for any reason other than his or her gross misconduct;
- The parent-employee becomes enrolled in Medicare (Part A, Part B, or both);
- The parents become divorced or legally separated; or

- The child stops being eligible for coverage under the Plan as a “Dependent child”.

A child who is born to or placed for adoption with the covered employee during a period of COBRA coverage will be eligible to become a qualified beneficiary. In accordance with the terms of the Plan and the requirements of federal law, these qualified beneficiaries can be added to COBRA coverage upon proper notification to the Plan Administrator of the birth or adoption. The maximum coverage period for such a child is measured from the same date as for other qualified beneficiaries and not from the date of the child's birth or placement for adoption.

Under COBRA, the employee or family member has the responsibility to provide notice of a divorce, legal separation, or a child losing Dependent status under the Plan within 60 days of the date of the event. Notice should be provided to the Plan Administrator listed in the information section of this document or to the company’s benefit department. In the case of divorce or legal separation, the Plan Member should provide written documentation of the qualifying event (e.g., a court issued divorce decree). If notice is not provided within 60 days, COBRA coverage will not be offered. The employer has the responsibility to notify the Plan Administrator of the employee's death, termination, reduction in hours of employment or Medicare entitlement.

When the Plan Administrator is notified that one of these events has happened, the Plan Administrator will in turn notify you that you have the right to choose continuation of coverage. **Under the law, you have at least 60 days from the date you would lose coverage because of one of the events described above, or the date the notice of the employee's election rights is sent to you, whichever is later, to inform the Plan Administrator that you want continuation coverage. If you do not choose continuation coverage on a timely basis, your group health insurance will end.**

If you choose continuation coverage, the employer is required to give you coverage which, as of the time coverage is being provided, is identical to the coverage provided under the Plan to similarly situated employees or family members. If group health coverage is lost because of a termination of employment or reduction in hours of employment, the law requires that you be afforded the opportunity to maintain continuation coverage for 18 months.

The 18 months may be extended to 29 months if an individual is determined by the Social Security Administration to be disabled (for Social Security Disability purposes) at any time during the first 60 days of COBRA coverage. **To benefit from this extension, a qualified beneficiary must notify the Plan Administrator within 60 days from the disability determination, the qualifying event, or the date coverage was lost (whichever is later); and before the end of the original 18 month period.** To qualify for the extension, Plan Members must provide a copy of the SSA determination letter. This 11-month extension is available to all disabled and non-disabled individuals who are qualified beneficiaries due to a termination or reduction in hours of employment. You must notify the Plan Administrator within 30 days of any final determination that the individual is no longer disabled.

In the case of other qualifying events, qualified beneficiaries will be afforded the opportunity to maintain continuation coverage for up to 36 months. You should notify the Plan Administrator immediately if a second qualifying event (such as death, divorce, legal separation, or Medicare entitlement) occurs during your continuation coverage period. However, in no event will continuation coverage last beyond 36 months from the date of the event that originally made a qualified beneficiary eligible to elect coverage.
The law provides that continuation coverage may be terminated for any of the following reasons:

- The employer no longer provides group health coverage to any of its employees;
- The premium for continuation coverage is not paid on time;
- After electing COBRA, the qualified beneficiary becomes covered by another group plan that does not contain any exclusions or limitations with respect to any pre-existing condition that he or she may have;
- The qualified beneficiary becomes entitled to Medicare (Part A, Part B, or both) after the date he or she elects COBRA coverage;
- The qualified beneficiary extends coverage for up to 29 months due to a disability, and there has been a final determination that the individual is no longer disabled.

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) restricts the extent to which group health plans may impose pre-existing condition limitations. HIPAA coordinate’s COBRA's other coverage cut off rules with these new limits as follows. If you become covered by another group health plan and that plan contains a pre-existing condition limitation that affects you, your COBRA coverage cannot be terminated. However, once the other plan's pre-existing condition rule does not apply to you by reason of HIPAA's restrictions on pre-existing condition clauses, your COBRA coverage will terminate.

Continuation coverage under COBRA is provided subject to your eligibility for coverage, and the Plan Administrator reserves the right to terminate your COBRA coverage retroactively if you are determined to be ineligible. Once your continuation coverage terminates for any reason, it cannot be reinstated.

Under the law, you may be required to pay up to 102 percent of the applicable premium during the 18 or 36-month period of continuation coverage. However, should you become eligible for the additional 11 months of continuation coverage for disability; you may be required to pay up to 150 percent of the applicable premium.

This notice is a summary of the law and is therefore general in nature. The COBRA law and regulations must be consulted with respect to the Plan's provisions and the specific facts and circumstances. If you have any questions about COBRA, please contact the Plan Administrator listed in the Information Section of this document.

Marketplace

HHS regulations provide special enrollment periods for plans in the Marketplace to individuals eligible for COBRA when: 1) such individuals initially are eligible for COBRA due to a loss of other minimum essential coverage; and 2) when such individual's COBRA coverage is exhausted. In addition, COBRA beneficiaries are able to choose plans in the Marketplace during the annual open enrollment period and if they are determined eligible for any other special enrollment periods outside of the open enrollment period.

Section 11
CLAIMS REVIEWS & PROCESSING

Filing a Claim: To be eligible for payment, HealthSmart Benefit Solutions will accept the original or a copy of the provider's billing. The patient or insured individual should retain copies for his or her personal files. When an In-Network provider is utilized, the provider may file the claim directly with the Network or with HealthSmart Benefit Solutions. Additional information may be requested to determine medical necessity, or in the event claims are filed for accident-related benefits. All claims can be filed with the employee submitting the itemized bill directly to the Plan Supervisor:

HealthSmart Benefit Solutions, 3121 Quail Springs Parkway, Oklahoma City, OK 73134
Telephone (918) 335-0387 or 1-800-824-5034

Payment of Claims: When the first claim is filed or received in the given Benefit Year, the covered employee and/or Dependent will be required to file one signed claim form so the Plan Supervisor may update authorization records and the signature on file. Claims will not be processed until such claim form and authorizations are obtained. Payments will not be made to the employee if the Sponsor has entered into an agreement whereby payments will be made directly to the provider.

Proof of Claims and Filing Period: Claims will not be accepted for services incurred during the Benefit Year if those claims are received (or postmarked) later than the end of the filing period. The claims submission period or filing period will end on the last day of the 3rd month following the close of the Plan year. Proof of any loss must be received by HealthSmart Benefit Solutions before the end of the filing period.

If proof of any claim is not given within the filing period after the end of the Benefit Year in which the claim(s) was incurred, the claim will be denied.

Allocation of Charges: The Plan reserves the right to allocate the deductible amount to any eligible charges and to apportion the benefits to the covered person and/or to any assignees. Such actions will be binding on the covered person and on his or her assignees.

Claim Procedure: The Plan follows U.S. Department of Labor rules known as the "Patient's Rights Claims Procedure Regulations." The purpose of these regulations is to provide Plan Members with timely benefit determinations as they relate to medical treatment. If the Plan requires pre-service determinations such as pre-authorization of medical services or pre-certification of Hospital stays, the regulations require determinations no later than:

Pre-Service Claims: For non-urgent and urgent care claims where the Plan requires a medical service be pre-certified or pre-authorized:

Time allowed for response to a non-urgent care .... 15 days
Time allowed for non-urgent extension .... 15 days
Time allowed for urgent care additional data request ....48 hours

Time allowed for an urgent care claim ....72 hours

Post-Service Claims: Once a request for payment is submitted, it is considered a post-service claim. The time period for making a determination on a post- service claim is:

Time allowed for determination .... 30 days
Time allowed for an extension .... 30 days
Time allowed for additional data .... 45 days
The maximum time allowed for a determination .... 105 days

Please contact the Plan Supervisor for questions or additional information regarding these regulations. A copy of the Labor Department claims rules will automatically be provided to you on request.

Adverse Benefit Determination: If the Plan has declined to provide benefits (to include rescission of coverage), in whole or in part, for a requested post or pre-treatment or service and you believe the denial to be an error; you have the right to appeal. See the Appeal Procedures Section in this Plan Document.

Full and Fair Review: This Plan takes special precautions to ensure that claims and appeals are decided independently and impartially. Plan Members have the right to:

- Receive, free of charge, any new additional evidence relied upon, considered or generated by the Plan in connection with the claim sufficiently in advance of the due date of the notice of final adverse benefit determination to give the Plan Member a reasonable opportunity to respond; and

- If a final adverse benefit determination is based on new or additional rationale, provide the Plan Member with the rationale, free of charge, sufficiently in advance of the due date of the notice of the final adverse benefit determination in order to give the claimant a reasonable opportunity to respond.

Usual, Customary and Reasonable Charges (UCR): The Plan reserves the right to use various tables and methods to determine UCR charges, billed by a medical provider and occurring in the same general geographical area for services. The Plan will reimburse the actual eligible charge at the UCR rate or as billed if it is lesser than the UCR Charge. The Plan Administrator may set limits on provider’s charges and fees at its discretion without giving advance notice to the provider.

Overpayment: Payment made for charges in excess of the charges covered by the Plan will be recovered from either the person the Plan has paid, the person for whom it was paid, or any other third party in receipt of such excess payment. The Plan reserves the right to collect any overpayment from a provider or Plan Member. This right includes placing a lien or obtaining a judgment on an individual, provider or Plan Member, or reducing future payments of eligible charges.

Date of Service: Any charge for service or purchase will be deemed to have been incurred on the date the service is performed or the date the purchase occurs.

No Obligation to Pay: If this Plan receives a claim where documents or testimony shows a third party was responsible, this Plan reserves the right to forward those claims back to the sender or third party representative. If this Plan pays claims where a third party was shown to be responsible, this Plan will exercise its right to recovery under its Subrogation and Reimbursement rules. See Coordination of Benefits (COB) section of this Plan.

Responsibility of the Plan Supervisor: The Plan Supervisor will act at the direction of the Plan Administrator and will make all decisions regarding the day-to-day administration of the Plan based on this Plan and in accordance with the standards set forth in the TPA Guide book. Any claims payment determination or administrative decision not defined by the Plan will be at the direction of the Plan Administrator and in accordance with applicable ERISA regulations for the CMH Foundation Plan Members. At no time will the Plan Supervisor act as a fiduciary of the Plan or make decisions outside the Plan. The Plan Supervisor has no authority to change the Plan, approve new benefits, decide payment dates, banking arrangements, funding options, filing dates or any other responsibilities associated with the funding and management of the Plan. The Plan Supervisor’s authority shall be limited to the procedures set forth in the Plan as approved by the Plan Administrator. If a claim dispute cannot be resolved with the claim office, a disputed claim review and an appeal procedure can be requested by the Plan Member.

Section 12
REVIEW & APPEAL PROCEDURES

Review By Claims Management: A Plan Member can request that the Plan Supervisor's Claims Manager review a processor decision, should the Plan Member dispute a claim(s) determination. The request should be in writing and submitted to the manager within 180 days of the receipt of the claim office denial notification. Please include all the reasons for requesting a review in writing, stating as specifically as possible why it is believed the denial is incorrect. The Plan Supervisor's determination will be rendered as soon as possible, but no later than 30 days after receipt of the request for review. The determination will be sent directly to the Plan Member. The determination will reference the particular Plan provision(s) and facts upon which it is based. A provider cannot appeal an adverse determination unless the Plan Member delegates such rights to the provider in writing. The Plan Member has the right to bypass the Plan Supervisor Review and request an Appeal directly to the Plan Administrator. See Appeal to Plan Administrator in this section.

Appeal to Plan Administrator: If the decision of the Plan Supervisor is unsatisfactory or the Plan Member wishes to bypass the Plan Supervisor Review, a written request for an appeal may be submitted to the Plan Administrator. The individual must notify the Plan Administrator in writing within 180 calendar days of receipt of the first adverse determination by the Plan Supervisor. If there is any supplemental material which has not been previously submitted, it must be submitted along with the notice of appeal. The Plan Administrator will render a decision within 30 calendar days after the Plan Administrator has received the request, but no longer than 105 days as defined by HIPAA. Any determination or decision by the Plan Administrator will be considered final. A provider cannot appeal an adverse determination unless the Plan Member delegates such rights to the provider in writing.

Right to External Review: For any adverse benefit determination other than a determination that a claimant failed to satisfy the eligibility requirements of this Plan, if a claim denial is upheld after the Second Appeal level, the claimant may have a right to have the decision reviewed by independent health care professionals who have no association with the Plan. A request for external review must be made within 4 months after receipt of the Final Internal Adverse Benefit Determination and must be sent to:

HealthSmart Benefit Solutions, 3121 Quail Springs Parkway, Oklahoma City, OK 73134
Telephone (918) 335-0387 or 1-800-824-5034

For standard external review, a decision will be made within **45 days** of receiving the request. If the claimant has a medical condition that would seriously jeopardize their life or health or would jeopardize their ability to regain maximum function if treatment is delayed, the claimant may be entitled to request an **expedited external review** of the denial.
Any external review procedures will comply with the standards for federal external review as may be established from time to time by the United States Department of Labor.

Effect of Decisions by Plan Administrator: Any decision by the Plan Administrator or other appropriate named fiduciary of the Plan on review will be afforded the maximum deference permitted by law.

Limitations Period: Any legal action for the recovery of any benefits must be commenced within one year after the Plan's claim review procedures, including any applicable external review procedures, have been exhausted.

Additional Information: Whenever, in the Plan Administrator's opinion, a person entitled to receive any payment of a benefit or installment thereof is under a legal disability or is incapacitated in any way so as to be unable to manage his financial affairs, the Plan may make payments to such person or legal representative or to a relative or friend of such person for such person's benefit, or the Plan Administrator may apply the payment for benefit of such person in such manner as the Plan Administrator considers advisable. Any payment of a benefit or installment thereof in accordance with the provisions of this section shall be a complete discharge of any liability for the making of such payment under the provisions of the Plan.

All claims and appeals will be adjudicated and decided in a fair and impartial manner, and financial considerations or implications to the Plan Administrator will NOT be taken into account when claims and/or appeals are adjudicated/decided.

Judicial Relief: The CMH Foundation is a self-funded plan and is governed by the federal law as an ERISA employee welfare plan, not an insurance plan. ERISA requires that no lawsuit can be brought against the Plan until the Plan Member has exhausted the claims appeal process as outlined above. The Plan is exempt from state insurance regulations and Subrogation provisions. ERISA preempts state common law insurance claims such as bad faith, breach of contract, punitive damages, etc. See Pilot Life Ins. Co. v. Dedeaux, 481 U.S. 41 (1987).

Section 13
COORDINATION OF BENEFITS

Affect on Benefits: Coordination of Benefits (COB) means that the benefits provided by the Plan will be coordinated with the benefits provided by any other plans covering the person for whom a claim is made. If the Plan is a secondary plan, the benefits payable under the Plan may be reduced so that a covered Plan Member's total payment from all plans will not exceed 100% of his or her total eligible expenses.

"Primary plan" means the plan which pays benefits or provides services first under the order of benefit determination rules below. The primary plan does not reduce its benefits because of duplicate coverage.

"Secondary plan" means any plan which provides coverage for the individual for whom a claim is made and is not a primary plan.

Eligible Expenses: "Eligible expenses" mean only those that are Medically Necessary, usual, customary and reasonable items of expense which are covered, in whole or in part, under this Plan as if it were the primary plan.

Plans Considered for COB: The Plan will coordinate benefits with any plan or arrangement which provides coverage for the individual, except as required by state or federal law. The Plan is always a secondary plan to benefits provided under any mandatory no-fault auto insurance.

Order of Benefit Determination: Any plan which does not have a COB or similar provision will pay its benefits first. All plans which have a COB or similar provision will pay benefits in the order determined by the following rules:

- A plan which covers the individual as an employee/member will be considered before a plan which covers the individual as a Dependent.
- For Dependent children, the plan which pays first is determined by the parents' birthdays. The plan which covers the parent whose month and day of birth occur earlier in the calendar year will be considered first. (If a plan which is being considered for COB does not have a birthday rule for Dependent children, then the COB rules in the other plan will be used and this rule will not apply.)

The following exception applies to the birthday rule: When the natural parents of a Dependent child are divorced or legally separated, the following rules apply:

- If the parent with custody of the child has not remarried, the benefits of a plan which covers the child as a Dependent of the parent with custody of the child will be considered first.
- If the parent with custody of the child has remarried, the benefits of a plan which covers the child as a Dependent of the parent with custody of the child will be considered before the benefits of a plan which covers the child as a Dependent of his or her stepparent. The benefits of a plan which covers the child as a Dependent of the parent without custody of the child will be considered last.
- If there is a court decree which establishes financial responsibility for the medical, dental or other health care expenses of the child, rules 1. and 2. above will not apply, and the plan which covers the parent with such financial responsibility will be considered before the benefits of any other plan which covers the child as a Dependent.

If the above rules do not establish an order of benefit determination (such as when two plans cover the individual as an employee/member), the plan which has covered the individual for the longest continuous period of time will be considered first.

Operation of COB: Upon request, the covered Plan Member is required to furnish to HealthSmart Benefit Solutions complete information concerning all plans which cover the individual for whom a claim is made.

Right of Recovery: Where the plan has paid benefits which result in payment in excess of the amount necessary under the Plan, the Plan has the right to recover such excess payment from any person, any other insurance company, or any other organization to whom such payments were made. Further, if payments which should have been made by this plan have been made under any other plan, the Plan may reimburse such other plans to the extent necessary. Any such payment will be considered a benefit paid under the Plan.

Subrogation and Reimbursement: This subrogation section describes the rights of the Plan Administrator to recover benefits payments which were paid by the plan but were the responsibility or liability of a third party. This Plan is not intended to provide the Plan Member with benefits greater than his or her medical expenses. If you are entitled to payment of your medical expenses by another person, plan, or entity, whether you request payment or not, this Plan has the right to reduce its payments accordingly so that you are not paid more than you actually owe for your medical expenses. If the Plan Member has a right against any other person, firm, or organization for an injury or Illness, the Plan has the right to subrogate all benefits paid, or that will be paid, by the Plan

because of the Illness or injury. If the Plan pays for benefits which are the responsibility or liability of a third party, the Plan has the right to recover any benefits paid.

Once the Plan Supervisor determines that third party liability may be involved with a claim, the Plan Member will be asked to sign a subrogation and reimbursement agreement, protecting the Plan against any loss where other parties may be responsible. The Plan Supervisor must have received the signed subrogation agreement before any claims may be considered for payment. If a signed subrogation agreement is not received within 90 days after requested by the Plan Supervisor, the claims will be denied and the Plan will have no future responsibility for consideration of payment.

By accepting membership in this Plan, and in exchange for the benefits provided, each Plan Member also grants a lien to the Plan. The lien is the amount of benefits paid or to be paid by the Plan because of the claim. All amounts the covered Plan Member receives, or will receive, from the claims are subject to the lien. By being a member of the Plan, the covered Plan Member agrees to the following terms:

The Plan Member agrees that the Plan Supervisor and/or Plan Administrator, immediately upon receiving a request for payment and/or subsequent payments of a benefit under the Plan, will be subrogated to all rights of recovery against any person or organization whose course of conduct or action caused or contributed to the loss for which payment was made under the Plan.

- The covered person and persons acting on his or her behalf will do nothing to prejudice the Plan's subrogation rights and will, when requested, provide the Plan with accident-related information and cooperate with the Plan in the enforcement of its subrogation rights. In the event the covered person fails to cooperate with the Plan in the enforcement of its subrogation rights, the Plan has no obligation to pay benefits and may seek recovery of any benefits previously paid.

- The covered person acknowledges that the Plan's subrogation rights are a first priority claim against any potentially liable third party to be paid before any other claim for the covered person's general damages. The Plan will be entitled to reimbursement even if the payments received by a covered person from a third party are insufficient to compensate a covered person in part or whole for all damages sustained.

- For purposes of this provision, any recovery from a third party paid to the covered person by way of judgment, settlement, or otherwise to compensate for any losses will be deemed to be a recovery for medical, dental, vision and/or prescription drug expenses incurred to the extent of any actual loss due to injury, Illness or disability involved.

The Plan will not pay any attorney's fees or costs of collecting such reimbursement or third party payments unless payment is specifically approved in writing by the Plan Administrator. All questions regarding the interpretation of the Plan (including subrogation provisions) shall be the exclusive right of the Plan Administrator who will have the final authority where a dispute exists.

In the event of a motor vehicle accident, the Plan shall be considered secondary to any other coverage including, but not limited to, automobile medical, no-fault automobile coverage, casualty or liability coverage.

The Plan reserves the right to enforce its subrogation and recovery rights by all available means, including constructive trusts, equitable liens, and any other injunctive or equitable relief available under ERISA (ERISA is applicable to the CMH Foundation Plan Members only).

No Obligation to Pay: The Plan will have no obligation to pay claims where a third party is involved and will direct any claims to the third party for payment. Any claims made where the individual identified the claims as occurring in a work related environment will not be covered under this Plan (see Medical Exclusions). The determination as to whether a claim should be paid under the rules for subrogation will be at the sole discretion of the Plan Administrator. The Plan has no obligation to pay for charges or services which:

- Would not normally be made, had it not been for this Plan;
- A person, company or any other entity has indicated responsibility, where the Plan Member believes there is third party responsibility, or where a reasonable person would believe a third party to be responsible;
- Where the claim may become the responsibility or the liability of a third party, even if the Plan Administrator has agreed to pay for benefits in the past.

Section 14
HIPAA PRIVACY & SECURITY RIGHTS

The Plan will at all times comply with the HIPAA privacy regulation requirements, and all other federal and state laws governing privacy. As required under HIPAA, the Plan Sponsor agrees to:

- Not use or further disclose Protected Health Information (PHI) other than as permitted or required by the Plan or as required by law;
- Ensure that any agents, including a subcontractor, to whom it provides PHI received from the Plan agree to the same restrictions and conditions that apply to the Plan Sponsor with respect to such information;
- Not use or disclose PHI for employment related actions and decisions or in connection with any other benefit or employee benefit plan of the Plan Sponsor;
- Report to the Plan Administrator any use or disclosure of PHI that is inconsistent with the uses or disclosures provided for of which it becomes aware;
- Make available PHI to the Plan Member at his or her request;
- Make available PHI for amendment and incorporate any amendments to PHI;
- Make available the information required to provide an accounting of disclosures;
- Make its internal practices, books, and records relating to the use and disclosure of PHI received from the Plan available to the Secretary of HHS for purposes of determining compliance by the Plan with HIPAA; and
- If feasible, return or destroy all PHI received from the Plan that the Plan Sponsor still maintains in any form and retain no copies of such information when no longer needed for the purpose for which disclosure was made, except that, if such return or destruction is not feasible, limit further uses and disclosures to those purposes that make the return or destruction of the information infeasible.

The Plan Sponsor shall ensure that adequate separation between the Plan and the Plan Sponsor's other functions is established and maintained as follows:

- That control and distributions of PHI will be limited to the Plan Administrator and employees who work in the benefit's department.
- Access to and use of PHI by such employees and other persons described in the preceding paragraph shall be restricted to the Plan administration functions that the Plan Sponsor performs for the Plan, and;
- The Plan Sponsor shall provide an effective mechanism for resolving any issues of noncompliance by persons described above, including but not limited to special training, counseling or disciplinary action.

Plan Sponsor shall implement administrative, physical, and technical safeguards that reasonably and appropriately protect the confidentiality, integrity, and availability of the Electronic PHI that Plan sponsor creates, receives, maintains, or transmits on behalf of the Plan;

- Plan Sponsor shall ensure that the adequate separation that is required by the HIPAA privacy regulation is supported by reasonable and appropriate security measures;
- Plan Sponsor shall ensure that any agent, including a subcontractor, to whom it provides Electronic PHI agrees to implement reasonable and appropriate security measures to protect such information; and
- Plan Sponsor shall report to the Plan any security incidents of which it becomes aware that results in unauthorized access, use, disclosure, modification, or destruction of the Plan's Electronic PHI within a reasonable period of time after learning of the security incident.

For an eligible employee or Dependent to become a member or the Plan and remain a member, he or she must agree to allow his or her PHI to be disclosed for treatment, payment or health care operations as permitted under the HIPAA privacy regulations, including but not limited to disclosure to individuals or organizations responsible for receiving and investigating claims, determining payments, underwriting expenses, and investigating appeals.

Section 15
ERISA RIGHTS

The Citizens Memorial HealthCare includes: The Citizens Memorial Hospital as a governmental, non-ERISA Plan and the Citizens Memorial Hospital Foundation as an ERISA health and welfare plan and the responsibility for the administration of the Plans is with the Plan Administrator.

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

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

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

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

Continue health care coverage for yourself, spouse or Dependents if there is a loss of coverage under the Plan as a result of a qualifying event. You or your Dependents may have to pay for such coverage. Review this summary Plan description and the documents governing the Plan on the rules governing your COBRA continuation coverage rights.

Reduction or elimination of exclusionary periods of coverage may occur for pre-existing conditions under your group health Plan if you have creditable coverage from another Plan. You should be provided a certificate of creditable coverage free of charge from your group health Plan or health insurance issuer when you lose coverage under the Plan, when you become entitled to elect COBRA continuation coverage, when your COBRA continuation coverage ceases, if you request it before losing coverage, or if you request it up to 24 months after losing coverage. Without evidence of creditable coverage, you may be subject to a pre-existing condition exclusion for 12 months (18 months for late enrollees) after your enrollment date in your coverage.

In addition to creating rights for Plan participants, ERISA imposes duties upon the people who are responsible for the operation of the employee benefit plan. The people who operate your Plan, called "fiduciaries" of the Plan, have a duty to do so prudently and in the interest of you and other Plan participants and beneficiaries. No one, including your employer, your union, or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a (pension, welfare) benefit or exercising your rights under ERISA. If your claim for a (pension, welfare) 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 review and reconsider your claim.
Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request materials from the Plan and do not receive them within 30 days, you may file suit in a federal court. In such a case, the court may require the Plan Administrator to provide the materials and pay you up to $110 a day until you receive the materials unless the materials were not sent because of reasons beyond the control of the 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. In addition, if you disagree with the Plan's decision or lack thereof concerning the qualified status of a domestic relations order or a medical child support order, you may file suit in federal court. If it should happen that Plan fiduciaries misuse the 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 your Plan, you should contact the Plan Administrator. If you have any questions about this statement or about your rights under ERISA, you should contact the nearest office of the Pension and Welfare Benefits Administration, U.S. Department of Labor, listed in your telephone directory or the Division of Technical Assistance and Inquiries, Pension and Welfare Benefits Administration, U.S. Department of Labor, 200 Constitution Avenue N.W., Washington, D.C. 20210.

Section 16
DENTAL BENEFITS

Employees and their Dependents who have chosen to enroll in the Medical Plan will also be entitled to a separate fully insured Dental Plan, which is not part of this ERISA plan. Information about the Dental Plan will be provided by your benefits representative.

Section 17
LIFE INSURANCE
&
LONG TERM DISABILITY

As a member of this Plan, you will be eligible to enroll in a fully insured Life Insurance and/or Accidental Death & Dismemberment policy. In addition, you will have the option of selecting a voluntary life policy. Claims and administration are not covered under the Medical Plan and the details pertaining to the benefits will be found in a separate booklet provided by your employer benefit representative.

Section 18
DEFINITIONS

Actively at Work: The active expenditure of time and energy in the service of the Plan Sponsor. An individual will be considered actively at work on each day of a regular paid vacation or on a regular non-working day on which he or she is on a paid or unpaid Leave of Absence, provided he or she was Actively at Work on the last preceding regular working day.

Ambulatory Surgical Center: A facility operating under appropriate state laws performing surgery, and which has permanent operating rooms, a recovery room and all medical equipment necessary for surgery; and access to a Hospital for immediate acceptance of patients requiring postoperative confinement.

Benefit Year: A Benefit Year is a twelve-month period during which a new deductible and a new maximum must be served. The Benefit Year is referenced in the Other Information section of the Plan.

Dependent: A Dependent will include a participant's legal spouse (if not legally separated from the covered employee). The term "spouse" excludes non-married or common law spouses, unless such relationship is provided for in state or case law for the state of residence. Common law marriage must be documented as requested by the Plan Supervisor to include proof of an ongoing common law marriage relationship.

A Dependent will include the covered employee's married or unmarried children by birth or marriage, including a stepchild, legally adopted children, children under legal guardianship as defined by the Plan, and Dependent children placed for adoption as defined by a court order. If a husband and wife are both covered under the Plan as participants, their Dependent children may be covered Dependents of either the husband or the wife. Spouses and children of the adult Dependent child are not eligible under the Plan.

Experimental or Investigative Treatment: Charges associated with a plan of treatment, devices, pharmacal or related services to the treatment which the Plan determines are Experimental or Investigative will include such factors as:

- 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; or
- 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 position, or if federal law requires such review or approval; or
- if reliable evidence shows that the drug, device, medical treatment or procedure is the subject of an on-going phase I or phase II clinical trials, is the research experimental, study or investigational work for on-going phase III clinical trial, 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; or
- 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 as compared with a standard means of treatment or diagnosis.

The Plan Administrator may select a medical review professional to help determine whether a proposed treatment is Experimental or Investigative, but in any event the decision of the Plan Administrator as to whether a treatment is Experimental or Investigative shall be considered final and binding on all parties.

Family and Medical Leave Act: If the employer meets the criteria of an eligible employer under the guidelines set forth by the Family and Medical Leave Act of 1993 and the Plan Member is an eligible employee under this Act, the Plan will abide by the rules adopted by the eligible employer for compliance with the Act's requirements for health care coverage.

Full-Time Employee: A Full-Time Employee is one who is considered Actively at Work with the employer, who works an average of 36 hours per week or more on an annual basis, and who is considered an employee under the U. S. Internal Revenue Service. An individual will be considered a Full-Time or eligible employee while on paid vacation or on a regular non-working day on which he or she is on approved paid or unpaid Leave of Absence, provided he or she was Actively at Work on the last preceding regular working day. All class two active, regular, Full-Time and Part-Time Employees who are scheduled to work at least 20 - 35 hours a week on an annual basis, who have completed the waiting period and an approved application form, and who meet the Actively-At-Work requirement are eligible.

HIPAA: The Health Insurance Portability and Accountable Act of 1996 as passed by Congress and the rules and regulations promulgated by the Department of Labor and other federal agencies.

Home Health: An agency which is primarily engaged in furnishing home nursing care and other therapeutic services for persons recovering from a sickness or injury, and which is qualified for payment under Medicare or operated under applicable state law.

Hospice: A facility providing a coordinated program of home and inpatient care for a terminally ill patient. To qualify, the Hospice must meet the standards of the National Hospice Organization and any state licensing requirements.

Hospital: A facility which operates pursuant to state and federal law and is recognized by Medicare as a Hospital facility.

Illness: Any disorder or disease of the body or mind; an accidental bodily injury or a pregnancy. All Illnesses due to the same cause, or to a related cause, will be deemed to be an Illness. The donation of an organ or of tissue by a covered person for transplanting into another person is considered to be an Illness of the covered person making the donation.

Leave of Absence: Any employee who is off work or temporarily working less than a normal schedule with the approval of the employer for medical leave, vacation or personal time off will be on a Leave of Absence. The length of leave will be defined by the employer, but shall not exceed 12 months.

Medical Emergency: Medical Emergency refers to a sudden onset of a condition with acute symptoms requiring immediate medical care and which would not normally be treated in a non emergency setting.

Medically Necessary: To be considered for payment under the Plan, any service or charges submitted to the Plan must meet the conditions of being Medically Necessary. Care and treatment will be considered Medically Necessary if:

- it is consistent with the patient's condition or accepted standards of good medical practice and is medically proven to be effective treatment of the condition;
- and is the most appropriate level of services which can be safely provided to the patient.

Medicare guidelines may be one of the factors used in determining appropriate use, necessary procedures, devices or services.
Being approved by the FDA does not mean a prescription, devise or plan of treatment is Medically Necessary for the treatment or condition. Any appeal as to whether care or treatment is Medically Necessary may be referred to a medical reviewer chosen by the Plan Administrator. The decision of the Plan Administrator will be final and binding on all parties.

Medicare: Medicare is a medical benefit program sponsored by the Federal Government. Coverage under this Plan is available to Medicare eligible employees who are Full-Time Employees and to their spouses, under the same conditions as coverage available to non Medicare employees and their spouses. Persons who are Medicare eligible do have the option of selecting Medicare as their primary coverage. To select Medicare as primary coverage, the individual must decline all coverage under the Plan.

Nurse: A provider of health services who is licensed, operating within the scope of his or her license and is recognized by Medicare and as specified in the Plan.

Physician/Doctor: A Physician or Doctor recognized by Medicare. Additionally the Plan will cover clinical psychologists, licensed professional counselors and licensed clinical social workers operating within the scope of their license and as specified in the Plan.

Plan: Defined as the CMH Advantage Plan, Employee Group Health Plan as presented in this Plan.

Plan Member: An eligible employee of the employer or his or her Dependent who has submitted an enrollment form and has been accepted as a Member of the Plan.

Plan Year: A Plan Year is a twelve-month period defining the term of the Plan as required by various regulations and is referenced in the Other Information section of the Plan.

In-Network or PPO Provider: The Plan is utilizing a Preferred Provider Organization or network who offers discounts to the Plan Members and the Plan. A listing of In-Network or PPO Providers will be made available to the Plan Member at no cost through the Plan Administrator. The Plan Member's personal identification card will notify the provider of membership in the network.

Out-of-Network or Non-PPO Provider: Providers who are not members of this Plan's PPO are called Out-of-Network or Non- PPO Providers. A Non-PPO Provider does not offer discounts to the Plan Members and the Plan. The Plan may cover benefits at a lower or different level for Non-PPO Providers than for PPO providers.

Qualified Medical Child Support Order: This Plan will provide Dependent coverage for any child of an employee who is recognized under an eligible Qualified Medical Child Support Order as having a right to enrollment in the group health Plan.

Skilled Nursing Facility: A facility considered as such under Medicare.

Usual, Customary and Reasonable (UCR) Charge (for Non-PPO Providers): The UCR charge will be determined by use of tables and data for the provider services area, as determined by the Plan. A provider charge shall be considered a reasonable charge or UCR, if it does not exceed the Usual, Customary & Reasonable fee schedule for like service in the same area. A provider charge above what is considered the Usual, Customary and Reasonable charge, or UCR, will not be covered by the Plan. The Plan will reimburse the eligible charge billed if the charge is less than the Usual, Customary and Reasonable Charge, as defined by schedules and tables used by the Plan Administrator.

Section 19
OTHER INFORMATION

Name of Plan:	Citizens Memorial HealthCare Silver Benefit Program
Type of Plan:	Health & Welfare Plan
Sponsor:	Citizens Memorial Hospital
EIN:	43-114-2176
Affiliates of Plan Sponsor:	Citizens Memorial Health Care Foundation EIN: 43-1425356
Group Number:	#0713CMH
Plan Administrator:	Citizens Memorial Hospital 1500 North Oakland Bolivar, Missouri 65613 Service of legal process may be made upon the Plan Administrator
Plan Cost:	Contributions to this Plan are made by employer and employees. Contributions are based on the amount necessary to provide the coverage required by the Plan.
Agent for Service of Process:	Citizens Memorial Hospital 1500 North Oakland Bolivar, Missouri 65613
Plan Year:	January 1 through December 31.
Benefit Year:	January 1 through December 31.
Plan Financing:	The Plan is financed by Citizens Memorial Hospital and from participant contributions.

Plan Supervisor: HealthSmart Benefit Solutions
3121 Quail Springs Parkway,
Oklahoma City, OK 73134,
Telephone: (918) 335-0387
Toll Free: (800) 824-5034

Loss of Benefits: Participant must continue to be an eligible member of the class to which the Plan pertains to qualify for benefits.

Fiduciary Name: Citizens Memorial Hospital
1500 North Oakland
Bolivar, Missouri 65613

Re-Insurance: The employer carries reinsurance for this Plan. The reinsurance company does not provide claims administration services.

Plan Amendment or Termination: Citizens Memorial Hospital has the right to amend, modify, or terminate the Plan in any way, at any time, by written notification to Plan Members from the Plan Administrator.

Plan Interpretations: All interpretations of the Plan and all questions concerning its administration and application, including eligibility determinations, shall be the Plan Administrator's at his or her sole and absolute discretion. Such determinations shall be conclusive and binding on all persons. The Plan Supervisor will not have the authority to make Plan interpretations or make judgment decisions for the Plan and will at all times follow the rules of the Plan as defined in the Summary Plan Description and Plan Document. All discretionary questions regarding the payment of claims or the interpretation of the Plan shall be the exclusive right of the Plan Administrator who will have the final authority to authorize or disallow benefit payments in cases where a dispute exists.

ERISA Information: As a Plan participant of the Citizens Memorial Hospital Foundation, the Plan Member is entitled to certain rights and protections under ERISA. For a description of those rights, see "ERISA Rights" of the Plan.

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Plan Administrator
Effective Date of this Document: January 1, 2017

U.S. Preventive Services Task Force

USPSTF A and B Recommendations

The following is a list of preventive services that have a rating of A or B from the U.S. Preventive Services Task Force that are relevant for implementing the Affordable Care Act. The preventive services are listed by date of release of the current recommendation. For an alphabetical list, please go to http://www.uspreventiveservicestaskforce.org/Page/Name/uspstf-a-and-b-recommendations/

For more information about the Affordable Care Act and preventive services, go to https://www.healthcare.gov/what-are-my-preventive-care-benefits/.

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http://www.uspreventiveservicestaskforce.org/Page/Name/uspstf-a-and-b-recommendations-by-date/\

Topic	Description	Grade	Release Date of Current Recommendation
Abdominal aortic aneurysm screening: men	The USPSTF recommends one-time screening for abdominal aortic aneurysm by ultrasonography in men ages 65 to 75 years who have ever smoked.	B	June 2014*
Alcohol misuse: screening and counseling	The USPSTF recommends that clinicians screen adults age 18 years or older for alcohol misuse and provide persons engaged in risky or hazardous drinking with brief behavioral counseling interventions to reduce alcohol misuse.	B	May 2013*
Anemia screening: pregnant women	The USPSTF recommends routine screening for iron deficiency anemia in asymptomatic pregnant women.	B	May 2006

Aspirin to prevent cardiovascular disease: men	The USPSTF recommends the use of aspirin for men ages 45 to 79 years when the potential benefit due to a reduction in myocardial infarctions outweighs the potential harm due to an increase in gastrointestinal hemorrhage.	A	March 2009
Aspirin to prevent cardiovascular disease: women	The USPSTF recommends the use of aspirin for women ages 55 to 79 years when the potential benefit of a reduction in ischemic strokes outweighs the potential harm of an increase in gastrointestinal hemorrhage.	A	March 2009
Bacteriuria screening: pregnant women	The USPSTF recommends screening for asymptomatic bacteriuria with urine culture in pregnant women at 12 to 16 weeks' gestation or at the first prenatal visit, if later.	A	July 2008
Blood pressure screening in adults	The USPSTF recommends screening for high blood pressure in adults age 18 years and older.	A	December 2007
BRCA risk assessment and genetic counseling/testing	The USPSTF recommends that primary care providers screen women who have family members with breast, ovarian, tubal, or peritoneal cancer with one of several screening tools designed to identify a family history that may be associated with an increased risk for potentially harmful mutations in breast cancer susceptibility genes (*BRCA1* or *BRCA2*). Women with positive screening results should receive genetic counseling and, if indicated after counseling, BRCA testing.	B	December 2013*
Breast cancer preventive medications	The USPSTF recommends that clinicians engage in shared, informed decision-making with women who are at increased risk for breast cancer about medications to reduce their risk. For women who are at increased risk for breast cancer and at low risk for adverse medication effects, clinicians should offer to prescribe risk-reducing medications, such as tamoxifen or raloxifene.	B	September 2013*

Breast cancer screening	The USPSTF recommends screening mammography for women, with or without clinical breast examination, every 1 to 2 years for women age 40 years and older.	B	September 2002†
Breastfeeding counseling	The USPSTF recommends interventions during pregnancy and after birth to promote and support breastfeeding.	B	October 2008
Cervical cancer screening	The USPSTF recommends screening for cervical cancer in women ages 21 to 65 years with cytology (Pap smear) every 3 years or, for women ages 30 to 65 years who want to lengthen the screening interval, screening with a combination of cytology and human papillomavirus (HPV) testing every 5 years.	A	March 2012*
Chlamydia screening: women	The USPSTF recommends screening for chlamydia in sexually active women age 24 years or younger and in older women who are at increased risk for infection.	B	September 2014*
Cholesterol abnormalities screening: men 35 and older	The USPSTF strongly recommends screening men age 35 years and older for lipid disorders.	A	June 2008
Cholesterol abnormalities screening: men younger than 35	The USPSTF recommends screening men ages 20 to 35 years for lipid disorders if they are at increased risk for coronary heart disease.	B	June 2008
Cholesterol abnormalities screening: women 45 and older	The USPSTF strongly recommends screening women age 45 years and older for lipid disorders if they are at increased risk for coronary heart disease.	A	June 2008
Cholesterol abnormalities screening: women younger than 45	The USPSTF recommends screening women ages 20 to 45 years for lipid disorders if they are at increased risk for coronary heart disease.	B	June 2008
Colorectal cancer screening	The USPSTF recommends screening for colorectal cancer using fecal occult blood testing, sigmoidoscopy, or colonoscopy in adults beginning at age 50 years and	A	October 2008

	continuing until age 75 years. The risks and benefits of these screening methods vary.		
Dental caries prevention: infants and children up to age 5 years	The USPSTF recommends the application of fluoride varnish to the primary teeth of all infants and children starting at the age of primary tooth eruption in primary care practices. The USPSTF recommends primary care clinicians prescribe oral fluoride supplementation starting at age 6 months for children whose water supply is fluoride deficient.	B	May 2014*
Depression screening: adolescents	The USPSTF recommends screening adolescents (ages 12-18 years) for major depressive disorder when systems are in place to ensure accurate diagnosis, psychotherapy (cognitive-behavioral or interpersonal), and follow-up.	B	March 2009
Depression screening: adults	The USPSTF recommends screening adults for depression when staff-assisted depression care supports are in place to assure accurate diagnosis, effective treatment, and follow-up.	B	December 2009
Diabetes screening	The USPSTF recommends screening for type 2 diabetes in asymptomatic adults with sustained blood pressure (either treated or untreated) greater than 135/80 mm Hg.	B	June 2008
Falls prevention in older adults: exercise or physical therapy	The USPSTF recommends exercise or physical therapy to prevent falls in community-dwelling adults age 65 years and older who are at increased risk for falls.	B	May 2012
Falls prevention in older adults: vitamin D	The USPSTF recommends vitamin D supplementation to prevent falls in community-dwelling adults age 65 years and older who are at increased risk for falls.	B	May 2012
Folic acid supplementation	The USPSTF recommends that all women planning or capable of pregnancy take a daily supplement containing 0.4 to 0.8 mg (400 to	A	May 2009

	800 µg) of folic acid.		
Gestational diabetes mellitus screening	The USPSTF recommends screening for gestational diabetes mellitus in asymptomatic pregnant women after 24 weeks of gestation.	B	January 2014
Gonorrhea prophylactic medication: newborns	The USPSTF recommends prophylactic ocular topical medication for all newborns for the prevention of gonococcal ophthalmia neonatorum.	A	July 2011*
Gonorrhea screening: women	The USPSTF recommends screening for gonorrhea in sexually active women age 24 years or younger and in older women who are at increased risk for infection.	B	September 2014*
Healthy diet and physical activity counseling to prevent cardiovascular disease: adults with cardiovascular risk factors	The USPSTF recommends offering or referring adults who are overweight or obese and have additional cardiovascular disease (CVD) risk factors to intensive behavioral counseling interventions to promote a healthful diet and physical activity for CVD prevention.	B	August 2014*
Hearing loss screening: newborns	The USPSTF recommends screening for hearing loss in all newborn infants.	B	July 2008
Hemoglobinopathies screening: newborns	The USPSTF recommends screening for sickle cell disease in newborns.	A	September 2007
Hepatitis B screening: non-pregnant adolescents and adults	The USPSTF recommends screening for hepatitis B virus infection in persons at high risk for infection.	B	May 2014
Hepatitis B screening: pregnant women	The USPSTF strongly recommends screening for hepatitis B virus infection in pregnant women at their first prenatal visit.	A	June 2009
Hepatitis C virus infection screening: adults	The USPSTF recommends screening for hepatitis C virus (HCV) infection in persons at high risk for infection. The USPSTF also recommends offering one-time screening for HCV infection to adults born between 1945 and 1965.	B	June 2013

HIV screening: non-pregnant adolescents and adults	The USPSTF recommends that clinicians screen for HIV infection in adolescents and adults ages 15 to 65 years. Younger adolescents and older adults who are at increased risk should also be screened.	A	April 2013*
HIV screening: pregnant women	The USPSTF recommends that clinicians screen all pregnant women for HIV, including those who present in labor who are untested and whose HIV status is unknown.	A	April 2013*
Hypothyroidism screening: newborns	The USPSTF recommends screening for congenital hypothyroidism in newborns.	A	March 2008
Intimate partner violence screening: women of childbearing age	The USPSTF recommends that clinicians screen women of childbearing age for intimate partner violence, such as domestic violence, and provide or refer women who screen positive to intervention services. This recommendation applies to women who do not have signs or symptoms of abuse.	B	January 2013
Iron supplementation in children	The USPSTF recommends routine iron supplementation for asymptomatic children ages 6 to 12 months who are at increased risk for iron deficiency anemia.	B	May 2006
Lung cancer screening	The USPSTF recommends annual screening for lung cancer with low-dose computed tomography in adults ages 55 to 80 years who have a 30 pack-year smoking history and currently smoke or have quit within the past 15 years. Screening should be discontinued once a person has not smoked for 15 years or develops a health problem that substantially limits life expectancy or the ability or willingness to have curative lung surgery.	B	December 2013
Obesity screening and counseling: adults	The USPSTF recommends screening all adults for obesity. Clinicians should offer or refer patients with a body mass index of 30 kg/m^2 or higher to intensive, multicomponent behavioral interventions.	B	June 2012*

Obesity screening and counseling: children	The USPSTF recommends that clinicians screen children age 6 years and older for obesity and offer them or refer them to comprehensive, intensive behavioral interventions to promote improvement in weight status.	B	January 2010
Osteoporosis screening: women	The USPSTF recommends screening for osteoporosis in women age 65 years and older and in younger women whose fracture risk is equal to or greater than that of a 65-year-old white woman who has no additional risk factors.	B	January 2012*
Phenylketonuria screening: newborns	The USPSTF recommends screening for phenylketonuria in newborns.	B	March 2008
Preeclampsia prevention: aspirin	The USPSTF recommends the use of low-dose aspirin (81 mg/d) as preventive medication after 12 weeks of gestation in women who are at high risk for preeclampsia.	B	September 2014
Rh incompatibility screening: first pregnancy visit	The USPSTF strongly recommends Rh (D) blood typing and antibody testing for all pregnant women during their first visit for pregnancy-related care.	A	February 2004
Rh incompatibility screening: 24–28 weeks' gestation	The USPSTF recommends repeated Rh (D) antibody testing for all un-sensitized Rh (D)-negative women at 24 to 28 weeks' gestation, unless the biological father is known to be Rh (D)-negative.	B	February 2004
Sexually transmitted infections counseling	The USPSTF recommends intensive behavioral counseling for all sexually active adolescents and for adults who are at increased risk for sexually transmitted infections.	B	September 2014*
Skin cancer behavioral counseling	The USPSTF recommends counseling children, adolescents, and young adults ages 10 to 24 years who have fair skin about minimizing their exposure to ultraviolet radiation to reduce risk for skin cancer.	B	May 2012

Tobacco use counseling and interventions: non-pregnant adults	The USPSTF recommends that clinicians ask all adults about tobacco use and provide tobacco cessation interventions for those who use tobacco products.	A	April 2009
Tobacco use counseling: pregnant women	The USPSTF recommends that clinicians ask all pregnant women about tobacco use and provide augmented, pregnancy-tailored counseling to those who smoke.	A	April 2009
Tobacco use interventions: children and adolescents	The USPSTF recommends that clinicians provide interventions, including education or brief counseling, to prevent initiation of tobacco use in school-aged children and adolescents.	B	August 2013
Syphilis screening: non-pregnant persons	The USPSTF strongly recommends that clinicians screen persons at increased risk for syphilis infection.	A	July 2004
Syphilis screening: pregnant women	The USPSTF recommends that clinicians screen all pregnant women for syphilis infection.	A	May 2009
Visual acuity screening in children	The USPSTF recommends vision screening for all children at least once between the ages of 3 and 5 years, to detect the presence of amblyopia or its risk factors.	B	January 2011*

†The Department of Health and Human Services, in implementing the Affordable Care Act under the standard it sets out in revised Section 2713(a)(5) of the Public Health Service Act, utilizes the 2002 recommendation on breast cancer screening of the U.S. Preventive Services Task Force. To see the USPSTF 2009 recommendation on breast cancer screening, go to http://www.uspreventiveservicestaskforce.org/Page/Topic/recommendation-summary/breast-cancer-screening.
*Previous recommendation was an "A" or "B."