

Member HIPAA Notification

MODOT/MSHP Medical and Life Insurance Plan

Your Privacy Matters

In compliance with the Health Insurance Portability and Accountability Act (HIPAA), Missouri Department of Transportation (MoDOT) and Missouri State Highway Patrol (MSHP) Medical and Life Insurance Planⁱ is sending you important information about how your medical and personal information may be used and about how you can access this information. Please review the Notice of Privacy Practices carefully. If you have any questions, please call the Participant Services number on the back of your membership identification card. You may also contact the designated privacy officer. The privacy officer for our Plan is Jeff Padgett, Director of Risk and Benefits Management, MoDOT, P.O. Box 270, Jefferson City, MO 65102.

Notice of Privacy Practices

Effective: 4/14/2003 (Revised 1/1/2011)

THIS NOTICE DESCRIBES HOW MEDICAL AND PERSONAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

A. Our Commitment to Your Privacy

We understand the importance of keeping your personal and health informationⁱⁱ secure and private. We are required by law to provide you with this notice. This notice informs you of your rights about the privacy of your personal information and how we may use and share your personal information. We will make sure that your personal information is only used and shared in the manner described. We may, at times, update this notice. Changes to this notice will apply to the information that we already have about you as well as any information that we may receive or create in the future. Our current notice is posted at www.modot.mo.gov/newsandinfo/benefits.htm. You may request a copy at any time. Throughout this notice, examples are provided. Please note that all of these examples may not apply to the services provided to your particular health Benefit plan.

B. What Types of Personal Information Do We Collect?

To best service your Benefits, we need information about you. This information may come from you, the Claims Administrator, or our affiliates. Examples include your name, address, phone number, Social Security number, date of birth, marital status, employment information, or medical history. We also receive information from health care Providers and others about you. Examples include the health care services you receive. This information may be in the form of health care claims and encounters, medical information, or a service request. We may receive your information in writing, by telephone, or electronically.

C. How Do We Protect the Privacy of Your Personal Information?

Keeping your information safe is one of our most important duties. We limit access to your personal information to those who need it. We maintain appropriate safeguards to protect it. For example, we protect access to our buildings and computer systems. Our Privacy Office also assures the training of our staff on our privacy and security policies.

D. How Do We Use and Share Your Information for Treatment, Payment, and Health Care Operations?

To properly service your Benefits, we may use and share your personal information for “treatment,” “payment,” and “health care operations.” Below we provide examples of each. We may limit the amount of information we share about you as required by law. For example, HIV/AIDS, substance abuse, and genetic information may be further protected by law. Our privacy policies will always reflect the most protective laws that apply.

- **Treatment:** We may use and share your personal information with health care Providers for coordination and management of your care. Providers include Physicians, Hospitals, and other caregivers who provide services to you.
- **Payment:** We may use and share your personal information to determine your eligibility, coordinate care, review Medical Necessity, pay claims, obtain external review, and respond to complaints. For example, we may use information from your health care Provider to help process your claims. We may also use and share your personal information to obtain payment from others that may be responsible for such costs.
- **Health care operations:** We may use and share your personal information as part of our operations in servicing your Benefits. Operations include credentialing of Providers; quality improvement activities; accreditation by independent organizations; responses to your questions, or grievance or external review programs; and disease management, case management, and care coordination. We may also use and share information for our general administrative activities such as prescription drug Benefits administration; detection and investigation of fraud; auditing; underwriting and rate-making; securing and servicing reinsurance policies; or in the sale, transfer, or merger of all or a part of the Claims Administrator with another entity. For example, we may use or share your personal information in order to evaluate the quality of health care delivered, to remind you about preventive care, or to inform you about a disease management program.

We may also share your personal information with providers and other health plans for their treatment, payment, and certain health care operation purposes. For example, we may share personal information with other health plans identified by you or your Plan Sponsor when those plans may be responsible to pay for certain health care Benefits.

E. What Other Ways Do We Use or Share Your Information?

We may also use or share your personal information for the following:

- **Medical home / accountable care organizations:** The Claims Administrator may work with your primary care Physician, Hospitals and other health care Providers to help coordinate your treatment and care. Your information may be shared with your health care Providers to assist in a team-based approach to your health.
- **Health care oversight and law enforcement:** To comply with federal or state oversight agencies. These may include, but are not limited to, your state department of insurance or the U.S. Department of Labor.
- **Legal proceedings:** To comply with a court order or other lawful process.
- **Treatment options:** To inform you about treatment options or health-related Benefits or services.
- **Plan sponsors:** To permit the sponsor of your health Benefit Plan to service the Benefit Plan and your Benefits. Please see your Employer’s Plan Documents for more information.
- **Research:** To researchers so long as all procedures required by law have been taken to protect the privacy of the data.
- **Others involved in your health care:** We may share certain personal information with a relative, such as your Spouse, close personal friend, or others you have identified as being involved in your care or payment for that care. For example, to those individuals with knowledge of a specific claim, we may confirm certain information about it. Also, we may mail an explanation of Benefits to the

subscriber. Your family may also have access to such information on our Web site. If you do not want this information to be shared, please tell us in writing.

- **Personal representatives:** We may share personal information with those having a relationship that gives them the right to act on your behalf. Examples include parents of an unemancipated minor or those having a Power of Attorney.
- **Business associates:** To persons providing services to us and who assure us that they will protect the information. Examples may include those companies providing your prescription drug or behavioral health Benefits.
- **Other situations:** We also may share personal information in certain public interest situations. Examples include protecting victims of abuse or neglect; preventing a serious threat to health or safety; tracking diseases or medical devices; or informing military or veteran authorities if you are an armed forces member. We may also share your information with coroners; for workers' compensation; for national security; and as required by law.

F. What About Other Sharing of Information and What Happens If You Are No Longer Enrolled?

We will obtain your written permission to use or share your health information for reasons not identified by this notice and not otherwise permitted or required by law. If you withdraw your permission, we will no longer use or share your health information for those reasons.

We do not destroy your information when your Coverage ends. It is necessary to use and share your information, for many of the purposes described above, even after your Coverage ends. However, we will continue to protect your information regardless of your Coverage status.

G. Rights Established by Law

- **Requesting restrictions:** You can request a restriction on the use or sharing of your health information for treatment, payment, or health care operations. However, we may not agree to a requested restriction.
- **Confidential communications:** You can request that we communicate with you about your health and related issues in a certain way, or at a certain location. For example, you may ask that we contact you by mail, rather than by telephone, or at work, rather than at home. We will accommodate reasonable requests.
- **Access and copies:** You can inspect and obtain a copy of certain health information. We may charge a fee for the costs of copying, mailing, labor, and supplies related to your request. We may deny your request to inspect or copy in some situations. In some cases denials allow for a review of our decision. We will notify you of any costs pertaining to these requests, and you may withdraw your request before you incur any costs. You may also request your health information electronically and it will be provided to you in a secure format.
- **Amendment:** You may ask us to amend your health information if you believe it is incorrect or incomplete. You must provide us with a reason that supports your request. We may deny your request if the information is accurate, or as otherwise allowed by law. You may send a statement of disagreement.
- **Accounting of disclosures:** You may request a report of certain times we have shared your information. Examples include sharing your information in response to court orders or with government agencies that license us. All requests for an accounting of disclosures must state a time period that may not include a date earlier than six years prior to the date of the request and may not include dates before April 14, 2003. We will notify you of any costs pertaining to these requests, and you may withdraw your request before you incur any costs.

H. To Receive More Information or File a Complaint

Please contact Participant Services to find out how to exercise any of your rights listed in this notice, or if you have any questions about this notice. The telephone number or address is listed in your Benefit documents or on your membership card. If you believe we have not followed the terms of this notice, you may file a complaint with us or with the Secretary of the Department of Health and Human Services. To file a complaint with the Secretary, write to 200 Independence Avenue, S.W. Washington, D.C. 20201 or call 1-877-696-6775. You will not be penalized for filing a complaint. To contact us, please follow the complaint, grievance, or Appeal process in your Benefit documents.

ⁱ For purposes of this notice, the pronouns "we", "us" and "our" and the name "MoDOT/MSHP" refers to Missouri Department of Transportation (MoDOT) and Missouri State Highway Patrol (MSHP) Medical and Life Insurance Plan. These entities abide by the privacy practices described in this Notice.

ⁱⁱ Under various laws, different requirements can apply to different types of information. Therefore we use the term "health information" to mean information concerning the provision of, or payment for, health care that is individually identifiable. We use the term "personal information" to include both health information and other nonpublic identifiable information that we obtain in providing Benefits to you.

Grandfathered Health Plan Disclosure

This Missouri Department of Transportation and Missouri State Highway Patrol Medical and Life Insurance Plan believes this Plan is a "grandfathered health plan" under the Patient Protection and Affordable Care Act (the Affordable Care Act). As permitted by the Affordable Care Act, a grandfathered health plan can preserve certain basic health coverage that was already in effect when that law was enacted. Being a grandfathered health plan means that your Plan may not include certain consumer protections of the Affordable Care Act that apply to other plans, for example, the requirement for the provision of preventive health services without any cost sharing. However, grandfathered health plans must comply with certain other consumer protections in the Affordable Care Act, for example, the elimination of lifetime limits on benefits. Questions regarding which protections apply and which protections do not apply to a grandfathered health plan and what might cause a plan to change from grandfathered health plan status can be directed to the plan administrator at MoDOT Employee Benefits, 877-863-9406. You may also contact the U.S. Department of Health and Human Services at www.healthreform.gov.

**THE MISSOURI DEPARTMENT OF TRANSPORTATION
AND
MISSOURI STATE HIGHWAY PATROL
MEDICAL AND LIFE INSURANCE PLAN**

Effective January 1, 2011, the Missouri Highway and Transportation Commission acting by and through the Board of Trustees of the Missouri Department of Transportation (MoDOT) and the Missouri State Highway Patrol (MSHP) Medical and Life Insurance Plan (the “Board of Trustees”), hereby adopts the amended and restated Missouri Department of Transportation and Missouri State Highway Patrol Medical and Life Insurance Plan, (herein after called Plan). This amended and restated Plan is the basis for calculating benefits for medical care services and supplies received.

The purpose of the Plan is to provide hospital, surgical, medical, and life insurance coverage for certain individuals and dependents who are eligible in accordance with the terms and conditions of the Plan.

NOTE: Prior authorization for certain health services is required as stated in Article IX, Section 9.02. Your participating provider is responsible for obtaining authorization from the Plan administrator for in-network services; however, non-participating providers are not obligated to request that authorization. Plan members are responsible for verifying whether the health service received out-of-network is covered under the Plan and the required prior authorization has been granted before receiving the health service. To verify coverage or prior authorization, you may call the Member Services number on the back of your identification card.

Failure to obtain prior authorization for in-patient hospitalization received out-of-network will result in a 20 percent penalty (not to exceed \$1,000) of the total allowed amount before plan benefits are determined. The penalty will be assessed on each in-patient occurrence where prior authorization is required but not obtained and will not apply to the participant’s deductible or maximum out-of-pocket benefit. Plan guidelines for benefit determination will apply to all claims including those requiring prior authorization. 100 percent of costs incurred for services not covered by the Plan for any reason will be deducted before plan payment is determined.

*First Printing - January 1, 1991
Second Printing - January 1, 1997
Third Printing – May 1, 1999
Fourth Printing – January 1, 2001
Fifth Printing – January 1, 2003
Sixth Printing – January 1, 2005
Seventh Printing – January 1, 2007
Eighth Printing – January 1, 2008
Ninth Printing – January 1, 2009
Tenth Printing – January 1, 2010
Eleventh Printing – January 1, 2011*

IF YOU NEED INFORMATION

To ensure that you receive accurate information regarding your medical and life insurance benefits you should direct your questions **ONLY** to the sources listed below. **NO ONE ELSE** is authorized to give you information.

For information about your medical benefits or prescription drug coverage or claims, call the toll-free number of the claims administrator listed on the back of your medical insurance identification card or prescription drug card.

For information regarding enrollment in the medical and life insurance plans, contact Employee Benefits or the insurance representative at your district, division or troop assignment as follows:

Employee Benefits Contacts -

Toll-free	(877) 863-9406
Benefits Specialist	(573) 522-2139
Benefits Specialist	(573) 522-8121

MoDOT Districts: Contact your district insurance representative.

District 1	- St. Joseph	(816) 387-2405
District 2	- Macon	(660) 385-8257
District 3	- Hannibal	(573) 248-2456
District 4	- Kansas City	(816) 622-6305
District 5	- Jefferson City	(573) 526-5139
District 6	- Chesterfield	(314) 453-1716
District 7	- Joplin	(417) 629-3318
District 8	- Springfield	(417) 895-7614
District 9	- Willow Springs	(417) 469-6250
District 10	- Sikeston	(573) 472-5368

MSHP Contact – Contact the insurance representative:

GHQ – Jefferson City	(573) 526-6136
	or (573) 526-6356

MSHP Troops: Contact your troop insurance representative.

Troop A	- Lee's Summit	(816) 622-0800, ext. 224
Troop B	- Macon	(660) 385-2132, ext. 220
Troop C	- Weldon Spring	(636) 300-2800, ext. 3333
Troop D	- Springfield	(417) 895-6868, ext. 229
Troop E	- Poplar Bluff	(573) 840-9508, ext. 228
Troop F	- Jefferson City	(573) 751-1000, ext. 233
Troop G	- Willow Springs	(417) 469-3121, ext. 226
Troop H	- St. Joseph	(816) 387-2345, ext. 220
Troop I	- Rolla	(573) 368-2345

The plan document is also available on the MoDOT/MSHP Employee Benefits website:
www.modot.mo.gov/newsandinfo/benefits.htm

CONTACT INFORMATION

For quick reference, we are providing you with selected telephone numbers, websites and addresses as follow:

Coventry Health Care – Claims and Network Administrator

Member Services Phone(800) 627-6406
Pre-Certification Phone (877) 824-4559
Nurse Line: (888) 936-2298
Mental Health or Chemical Dependency : Call MHNet (866) 313-2284
QuitNet Smoking Cessation:..... (866) 577-8210
Web address:.....www.modot-mshp-cvty.com

Medical Claims Mailing Address:

MoDOT/MSHP Claims
P. O. Box 7401
London, KY 40742

Mental Health Claims Mailing Address:

MHNet Claims
P. O. Box 7802
London, KY 40742

Catalyst Rx – Pharmacy Benefits Manager

Non-Medicare Members

Retail/Mail Order Pharmacy Questions (877) 235-2013

Medicare Members

Retail/Mail Order Pharmacy Questions.....(877) 235-1981

Web address:.....www.catalystrx.com (Mail Service Link)

Immediate Pharmaceutical Services, Inc. (IPS)– Mail Order Pharmacy

Mailing Address: IPS
 P.O. Box 166
 Avon Lake, OH 44012-9927

Non-Medicare Telephone Number.....(877) 235-2013
Medicare Telephone Number.....(877) 235-1981
Web address:..... www.catalystrx.com

Hartford Life Insurance Company – Optional and Basic Life Insurance

Portability and Conversion Questions..... (877) 320-0484

**THE MISSOURI DEPARTMENT OF TRANSPORTATION
AND MISSOURI STATE HIGHWAY PATROL
MEDICAL AND LIFE INSURANCE PLAN**

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ARTICLE I

DEFINITIONS

- 1.01 Allowed Amount means the charge for covered services provided to a participant for which benefits may be payable, as determined reasonable by the Plan. In the case of a physician or other professional provider, the allowed amount is the usual, customary and reasonable charge or the charge determined by other specified methods.
- 1.02 Ambulatory Care Facility means a provider with an organized staff of physicians that:
- (a) has permanent facilities and equipment for the primary purpose of performing surgical and/or medical procedures on an outpatient basis;
 - (b) provides continuous nursing services and treatment by physicians whenever the participant is in the facility;
 - (c) does not provide inpatient accommodations,
 - (d) is not, other than incidentally, a facility used as an office or clinic for the private practice of a physician; and
 - (e) is licensed as an ambulatory care facility.
- 1.03 Applied Behavior Analysis – the design, implementation, and evaluation of environmental modifications, using behavioral stimuli and consequences, to produce socially significant improvement in human behavior, including the use of direct observation, measurement, and functional analysis of the relationships between environment and behavior.
- 1.04 Autism Spectrum Disorders – a neurobiological disorder, an illness of the nervous system, which includes Autistic Disorder, Asperger’s Disorder, Pervasive Developmental Disorder Not Otherwise Specified, Rett’s Disorder, and Childhood Disintegrative Disorder, as defined in the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders of the American Psychiatric Association.
- 1.05 Benefit means the Plan’s payment or reimbursement for covered services as outlined in the Schedule of Benefits set forth in Article IV.
- 1.06 Benefit Acceleration Point (“BAP”) means the point at which the plan increases its co-insurance to 100 percent of the allowed amount for covered services. Expenses counted toward the BAP do not include:
- (a) deductible(s) and co-payment(s) for medical expenses;
 - (b) deductible and co-insurance for prescription drugs;
 - (b) cost of any service or supply that is not a covered service;
 - (c) charges in excess of the allowed amount; or
 - (d) amounts resulting from reductions in benefits due to the participant’s (or provider’s) failure to comply with the cost containment provisions

When the BAP is reached, the level of benefits is increased, as specified.

- 1.07 Board of Trustees means the body established by the Missouri Highways and Transportation Commission to provide for the general administration of the Plan. The Board consists of eight members as follows:
- (a) four MoDOT employees appointed by its Director;
 - (b) two MSHP employees appointed by its Superintendent;
 - (c) one retired MoDOT employee appointed by its Director; and
 - (d) one retired MSHP employee appointed by its Superintendent.

The Missouri Highways and Transportation Commission must approve all appointees prior to performing any Board duties.

- 1.08 Claims Administrator means the person or entity duly authorized by the Board of Trustees, as contracted from time to time, to process claims.
- 1.09 Clinical Psychologist means a person who provides clinical psychological services in connection with the diagnosis or treatment of mental, psychoneurotic or personality disorders, and who is duly licensed as a psychologist.
- 1.10 Code means the Internal Revenue Code of 1986, as amended.
- 1.11 Common-Law Spouse means a spouse in a common-law marriage, which occurs prior to the parties residing in Missouri, in a state that recognizes common-law marriage. The Plan will permit the common-law spouse of the member to be a dependent under Section 1.18(a) as a lawful spouse. Proof common-law marriage will be required by the Board.
- 1.12 Co-insurance means the shared portion of payment between the Plan and the member where each pays a percentage of medical expenses (reference Appendix A, 31).
- 1.13 Co-payment means a fixed fee required by the Plan to be paid by the patient at the time services are rendered at a participating provider; such as office visit, emergency room visit, urgent care, etc.
- 1.14 Coverage Date means the date on which participation begins under the Plan provided all requirements and conditions for participation have been satisfied and performed.
- 1.15 Covered Service means a service or supply specified in Article VI for which benefits will be furnished, subject to the deductible(s) and other requirements for payment by the plan, when rendered by a provider (reference Section 1.46). A charge for a covered service will be considered to have been incurred on the date the service or supply was provided to the participant. Eligibility for payment of benefits, including obstetrical benefits without limitations, will be determined on the date the service is rendered.
- 1.16 Custodial Care means care provided primarily for the convenience of the participant or his family, maintenance of the participant, or which is designed essentially to assist the participant in meeting his activities of daily living and which is not primarily provided for its therapeutic value in the treatment of an illness, disease, bodily injury, or condition. Custodial care includes, but is not limited to:
- (a) help in walking, bathing, dressing, feeding;
 - (b) preparation of special diets;
 - (c) supervision over self-administration of medications not requiring constant attention of trained medical personnel; or

- (d) acting as a companion or sitter.

Unless a participant is receiving medical, surgical, or psychiatric treatment that is intended or designed to permit him to live outside a hospital or skilled nursing facility, the care being provided will be deemed custodial care.

1.17 Deductible(s) means a specified amount of allowed amounts for covered services per calendar year, expressed in dollars that must be incurred and paid by a participant before the plan will assume any benefit liability.

1.18 Dependent, as of actual date of board approval means:

- (a) subscriber's lawful spouse or common-law spouse (reference Section 1.11 for the definition of common-law spouse);
- (b) subscriber's children through the end of the month they turn 26 years of age, excluding any child 25 years of age who is eligible to enroll in their own employer-sponsored group health coverage, or any child who is a member of the armed forces of any country and eligible for military insurance coverage, as follows:
 - (i) biological child(ren);
 - (ii) legally adopted child(ren), legal documentation is required;
 - (iii) grandchild (ren); if the subscriber has legal guardianship (documentation required).
 - (iv) stepchild (ren), if the legal or biological parent is enrolled in the Plan, and legal documentation is provided;
 - (v) other children who qualify:
 - A. due to the subscriber's legal guardianship of the child (guardianship papers required);
 - (vi) child (ren) for whom you are required to provide coverage under a Qualified Medical Child Support Order (QMCSO).
- (c) dependents of a subscriber enrolled in the Plan and continue to meet the eligibility requirements stated above, regardless of age, who are mentally incapacitated and/or physically disabled, and incapable of self-support, during the continuance of such disability and incapacity. Periodic proof of disability status may be required by the Board.

1.19 Diagnostic Admission means an inpatient admission that occurs even though the participant's condition does not require the constant availability of medical supervision or skilled nursing care and could reasonably be diagnosed on an outpatient basis. The primary purpose of such an admission is to arrive at a diagnosis through the use of x-ray and laboratory tests, consultations, and evaluation, whether or not treatment is provided during the admission. The Board may rely on the hospital's medical records, among other evidence, to assist in determining the primary purpose of the admission.

1.20 Diagnostic Service means a test or procedure that is rendered because of specific symptoms and that is directed toward the determination of a definite condition or disease and its subsequent treatment. A diagnostic service must be ordered by a physician. Diagnostic services may include:

- (a) x-ray and other radiology services. Magnetic Resonance Imaging (MRI) is limited to examinations of the brain, spinal cord/spine, temporomandibular joint (TMJ), knee and shoulder;
- (b) laboratory and pathology services; or

(c) cardiographic, encephalographic, and radioisotope tests.

1.21 Election Period means the 31-day period beginning with the date an individual becomes an employee. However, this period will be extended for each day during this period the employee was incapacitated and unable to apply for coverage.

1.22 Emergency Care means:

- (a) the treatment of traumatic bodily injuries resulting from an accident; or
- (b) the treatment of a medical condition manifesting itself by the sudden onset of acute symptoms of sufficient severity that the absence of immediate medical attention could reasonably result in:
 - (i) permanently placing the participant's health in jeopardy;
 - (ii) causing other serious medical consequences to the participant;
 - (iii) causing serious impairment to the participant's bodily functions; or
 - (iv) causing serious and permanent dysfunction of any bodily organ or part of the participant.

1.23 Employee means an individual who is a member of the MoDOT & Patrol Employees' Retirement System, as defined by state law.

1.24 Employer means the Missouri Department of Transportation (MoDOT) or the Missouri State Highway Patrol (MSHP).

1.25 Employer or State Contribution means the contribution authorized by the State of Missouri and paid out of operating funds of the employer to fund the benefits provided under the Plan as defined in Section 13.02.

1.26 Experimental/Investigative means the use of any treatment, procedure, facility, equipment, drug, device, or supply not accepted by the claims administrator as standard medical treatment of the condition being treated, or any of such items requiring federal or other government agency approval not granted at the time services were rendered.

1.27 Freestanding Renal Dialysis Facility means a provider other than a hospital that is primarily engaged in providing renal dialysis treatment, maintenance or training to participants on an outpatient or home care basis.

1.28 Home Health Service means a program for continued care and treatment. Home health care benefits must be established and approved in writing by the physician and authorized by the administrator. The attending physician must certify that proper treatment of the condition would require continued confinement in a hospital.

1.29 Hospital means:

- (a) an institution that is operated pursuant to law and is primarily engaged in providing for compensation, on an inpatient basis, for the medical care and treatment of sick and injured persons through medical, diagnostic and surgical facilities, all of which facilities must be provided on its premises, under the supervision of a staff of one or more physicians and with 24 hour-a-day nursing service by a registered nurse (R.N.) on duty; or
- (b) an institution accredited as a hospital by the Joint Commission on Accreditation of Hospitals.

In no event will the term "hospital" include a convalescent nursing home or any institution or part thereof that is used principally as a convalescent facility, rest facility, nursing facility or facility for the aged.

- 1.30 Inpatient means a participant who receives treatment as a registered bed patient in a hospital and for whom a room and board charge is made.
- 1.31 Intensive Care Unit means a section, ward or wing within a hospital that meets all of the following requirements:
- (a) is solely for the treatment of patients who are in critical condition;
 - (b) provides within such area special nursing care and observation of a continuous and constant nature not available in the regular rooms and wards of the hospital;
 - (c) provides a concentration of special life-saving equipment immediately available at all times for the treatment of patients confined within such area;
 - (d) contains at least two beds for the accommodation of critically ill patients; and
 - (e) provides at least one registered nurse (R.N.) who continuously and constantly attends the patients confined in such area on a 24-hour-a-day basis.
- 1.32 Long-Term Disability Recipient means a subscriber who has been determined to be disabled and eligible to receive long-term disability benefits through the disability insurance carrier contracted through the MoDOT & Patrol Employees' Retirement System.
- 1.33 Marriage means state of being married; legal union between a male and a female.
- 1.34 Medically Necessary means, in connection with services or supplies furnished by a provider, required in the identification or treatment of a participant's condition as determined to be:
- (a) consistent with the symptom or diagnosis and treatment of the participant's condition, disease, ailment, or injury;
 - (b) appropriate with regard to standards of good medical practice;
 - (c) not solely for the convenience of a participant or provider; and
 - (d) the most appropriate supply or level of service that can be safely provided to the participant.

When applied to inpatient care, it means the participant's medical symptoms or condition requires that the services cannot be safely provided to the participant as an outpatient.

- 1.35 Medicare Member means an individual who is a participant under the Plan and eligible for coverage under Title XVIII of the Social Security Act of 1965, as amended (Medicare). Medicare member does not include an active employee or their dependent, (except when Medicare eligibility is for reasons of a kidney transplant or renal dialysis).
- 1.36 Mental Health means a disturbance of the mental processes of the human mind manifested in a psychotic or neurotic condition or reaction including but not limited to manic-depression, autism, and other such conditions. Alcoholism, drug addiction and overdose, for the purposes of the Plan and in determining any benefit due hereunder, are included.
- 1.37 Non-Participating Provider means no arrangement has been made with a health care service provider for cost containment. If the cost of a covered service exceeds the allowed amount, the subscriber will be responsible for such excess. Non-Participating Providers may also include, but are not limited to, lab and diagnostic centers, anesthesiologists, radiologists, and emergency room physicians used by a Participating Provider.

- 1.38 Out-of-Network means no arrangement has been made with a health care service provider for cost containment. If the cost of a covered service exceeds the allowed amount, the subscriber will be responsible for such excess. Some providers may be utilized by or associated with a Participating Provider but still be considered Out-of-Network.
- 1.39 Outpatient means a participant who receives services while not an inpatient.
- 1.40 Participant means an individual who is lawfully present in the United States with proof of citizenship, permanent residency, or lawful immigration status; enrolled in the plan; including an employee, retiree, vested member, work-related disability recipient, long-term disability recipient, surviving lawful spouse, any of their dependents, or such persons who are entitled to continued coverage under other provisions of the plan.
- 1.41 Physician means a licensed practitioner of the healing arts, acting within the scope of his license, limited to a doctor of medicine, doctor of osteopathy, podiatrist, doctor of dental medicine, and doctor of dental surgery.
- 1.42 Plan means the amended and restated Missouri Department of Transportation and Missouri State Highway Patrol Medical and Life Insurance Plan, herein after called Plan.
- 1.43 Plan Sponsor means the Missouri Highways and Transportation Commission.
- 1.44 Preferred Provider Organization (PPO) means an arrangement has been made with providers where reimbursements for health care services are furnished at discounted rates. Under this arrangement the subscriber is not responsible for charges above the allowed amount determination. The provider will file all claims for you and should not ask for payment at the time of service. You may encounter Non-Participating Providers while obtaining services from Providers within the PPO. In this case, the Non-Participating Providers will be reimbursed at the Out-of-Network rate and you may have additional responsibilities like filing claims, obtaining Prior Authorization for services, and paying additional charges.
- 1.45 Prior Authorization means the process for authorizing the non-emergency use of facilities, diagnostic testing and other health services before care is rendered. (Reference Article IX for additional information and services requiring prior authorization.)
- 1.46 Provider means a facility, person, or entity, including a hospital or physician that possesses a valid license to render covered services. Providers other than a hospital or physician include:
- (a) Ambulatory Care Facility
 - (b) Certified Nurse Practitioner
 - (c) Chiropractor
 - (d) Clinical Psychologist
 - (e) Clinical Social Worker
 - (f) Community or Hospital Home Healthcare Agency
 - (g) Doctor of Optometry
 - (h) Doctor of Surgical Chiropody
 - (i) Freestanding Renal Dialysis Facility
 - (j) Licensed Massage Therapist under direction of a physician (claim must be submitted by and payable to a physician)
 - (k) Occupational Therapist
 - (l) Physical Therapist
 - (m) Physiotherapist
 - (n) Private Duty Nurse (registered nurse (RN) or licensed practical nurse (LPN))
 - (o) Professional Counselor
 - (p) Psychiatric Facility
 - (q) Registered Pharmacist

- (r) Respiratory Therapist
- (s) Skilled Nursing Facility
- (t) Speech Therapist

1.47 Psychiatric Facility means a provider that for compensation from its patients is primarily engaged in providing diagnostic and therapeutic services for the treatment of nervous or mental disorders.

1.48 Retiree means an:

- (a) Individual who has retired from MoDOT or MSHP under the provisions of Sections 104.010 through 104.270, RSMo. and 104.1072 RSMo., provided such retired individual was, on the day preceding the effective date of the Plan, covered under the Plan that provided medical care benefits exclusively for employees who are members of the MoDOT & Patrol Employees' Retirement System; or
- (b) Former employee of MoDOT or MSHP retiring after the effective date of the Plan under the provisions Sections 104.010 through 104.270, RSMo. and 104.1072 RSMo, provided such former employee was in the Plan from the date of last employment until the date of retirement (vested member).

1.49 Skilled Nursing Facility means a provider that is primarily engaged in providing 24-hour-a-day skilled nursing and related services at the facility to patients requiring convalescent and rehabilitative care. Such care is rendered by or under the supervision of physicians and eligibility for payment is based on care rendered in compliance with the Medicare-established guidelines. A skilled nursing facility is not, other than incidentally, a place that provides:

- (a) minimal care, custodial care, ambulatory care, or part-time care services; or
- (b) care or treatment of a nervous or mental disorder, alcoholism, drug abuse, or pulmonary tuberculosis.

1.50 Special Enrollment Period means enrollment for the following reasons and as referenced in Section 3.02:

- (a) life events including marriage, birth, adoption;
- (b) loss of eligibility under other insurance coverage;
- (c) total loss of employer contribution to lawful spouse's plan;
- (d) enrolling dependents under court order;
- (e) COBRA coverage ends with previous employer;
- (f) loss of Medicaid or State Children's Health (CHIP) coverage;
- (g) loss of TriCare For Life (military coverage for Medicare members);
- (h) loss of eligibility during authorized FMLA leave;
- (i) gain eligibility for premium assistance to purchase coverage under Plan through Medicaid or CHIP plan.

The special enrollment period does not apply to a retiree, vested member, long-term disability recipient or surviving lawful spouse not enrolled in the Plan or if their coverage under the Plan terminates for any reason, **except if they lose coverage under Medicaid, TriCare for Life, or their coverage terminates due to active military duty.** Upon loss of Medicaid, TriCare for Life, or their return from active military duty, the participant can be reinstated in the Plan (reference Sections 2.06 and 3.02(d)(i)).

- 1.51 Spouse means a partner in marriage; one's husband or wife.
- 1.52 State means the state of Missouri.
- 1.53 Subscriber means the principal eligible individual from whom coverage under the Plan for dependents emanates.
- 1.54 Subscriber Contribution means the periodic contribution required from the subscriber for coverage under the plan.
- 1.55 Therapy Service means services or supplies used to promote the recovery of the participant. Therapy services are limited to the following:

- (a) Radiation Therapy;
The treatment of disease by X-ray, radium, or radioactive isotopes;
- (b) Chemotherapy;
The treatment of malignant disease by chemical or biological antineoplastic agents;
- (c) Renal Dialysis Treatment;
The treatment of an acute or chronic kidney ailment that may include the supportive use of an artificial kidney machine;
- (d) Physical Therapy;
The treatment by physical means includes:
 - (i) hydrotherapy, or similar modalities;
 - (ii) bio-mechanical and neurophysiological principles;
 - (iii) devices to relieve pain, restore maximum function, and prevent disability following disease, injury, or loss of body part;
 - (iv) massage therapy conducted by a physician (excluding chiropractors), or conducted by a licensed massage therapist under the direction of a physician and the bill is submitted by and payable to the physician; or
 - (v) cardiac rehabilitation as deemed medically necessary provided services are rendered:
 - (a) under the supervision of a Physician;
 - (b) in connection with a myocardial infarction, coronary occlusion (blockage) or coronary bypass surgery;
 - (c) initiated within 12 weeks after other treatment of the medical condition ends; and in a Medical Care Facility as defined by this Plan.

This benefit is limited to a combined total of 60 Physical, Occupational, and Speech Therapy visits per calendar year and is subject to applicable deductible(s) and co-insurance;

- (e) Respiratory Therapy;
Introduction of dry or moist gases into the lungs for treatment purposes;
- (f) Occupational Therapy;

Treatment of a physically disabled participant by means of constructive activities designed and adapted to promote the restoration of the participant's ability to satisfactorily accomplish the ordinary tasks of daily living and those tasks required by the participant's particular occupational role. This benefit is limited to a combined total of 60 Physical, Occupational, and Speech Therapy visits per calendar year and is subject to applicable deductible(s) and co-insurance;

(g) Speech Therapy;

Treatment by a qualified speech therapist for the correction of a speech impairment resulting from disease, surgery, injury, congenital and developmental anomalies, or previous therapeutic processes. This benefit is limited to a combined total of 60 Physical, Occupational, and Speech Therapy visits per calendar year and is subject to applicable deductible(s) and co-insurance.

1.56 Treatment for Autism Spectrum Disorders - care prescribed or ordered for an individual diagnosed with an autism spectrum disorder by a licensed physician or licensed psychologist, including, equipment medically necessary for such care, pursuant to the powers granted under such licensed physician's or licensed psychologist's license, including, but not limited to:

- (a) Psychiatric care – direct or consultative services provided by a psychiatrist licensed in the state in which the psychiatrist practices;
- (b) Psychological care –direct or consultative services provided by a psychologist licensed in the state in which the psychologist practices;
- (c) Habilitative or rehabilitative care – professional, counseling, and guidance services and treatment programs, including applied behavior analysis therapy, that are necessary to develop the functioning of an individual;
- (d) Therapeutic care – services provided by licensed speech therapists, occupational therapists, or physical therapists;
- (e) Pharmacy care – medications used to address symptoms of an autism spectrum disorder prescribed by a licensed physician, and any health-related services deemed medically necessary to determine the need or effectiveness of the medications only to the extent that such medications are included in the insured's health benefit plan.

1.57 Usual, Customary and Reasonable (allowed amount), for purposes of determining the amount of provider fees recognized by the Plan, have the following meanings:

- (a) Usual - the fee a physician or other provider most frequently charges the majority of his patients for the same or similar services;
- (b) Customary - the range of fees charged in a geographic area by physicians or other providers of comparable skills and qualifications for the same performance of a similar service. The customary maximum is the usual charge by 90 percent of the doctors or other providers for 90 percent of the medical services reported; and
- (c) Reasonable - the flexibility to take into account any unusual clinical circumstances involved in performing a particular service.

In practice, other billed charges are recognized, up to the physician's or provider's usual charge if it is less than the customary charge. Any extenuating circumstances are considered under the flexibility allowed by reasonable. If the physician or other provider substantiates the greater charge to the satisfaction of the claims administrator, it will be recognized.

- 1.58 Utilization Review Organization means a company, or division within a company, that employs qualified health care professionals and specializes in the business of evaluating medical records for prospective or retrospective determination of appropriateness of treatment.
- 1.59 Vested Member means an individual who, between April 1, 1984 and August 13, 1988, or after June 14, 1989, terminated employment with MoDOT or MSHP while participating in the Plan and after becoming vested in his right to a benefit at retirement from the MoDOT & Patrol Employees' Retirement System.
- 1.60 Work-Related Disability Recipient means a subscriber who has been determined to be disabled and eligible to receive work-related disability benefits through the disability insurance carrier contracted through the MoDOT & Patrol Employees' Retirement System.

ARTICLE II

ELIGIBILITY

2.01 Eligibility

Persons who meet the definition of a participant, Section 1.40, are eligible as follows:

(a) Employee Eligibility

Any new employee will be eligible to become a participant effective on the first day of the next calendar month following date of employment. Eligibility is subject to submission of proper application and payment of any required contribution.

(b) Dependent Eligibility

Eligible dependents of a subscriber will be eligible for coverage as follows:

- (i) During the same period of time the subscriber remains covered, unless age limitations apply.
- (ii) Eligible dependents not enrolled at the time of the subscriber's enrollment are eligible to enroll at a later date with a qualifying event as outlined in Section 1.50, except coverage will not be extended to any dependents not enrolled in the Plan at the time of the deceased subscriber's death.
- (iii) Surviving dependents enrolled at the time of a subscriber's death may continue coverage as follows:
 - A. A surviving spouse, however, coverage will not be extended to a new spouse or new children not enrolled prior to the death.
 - B. Surviving dependent children through the end of the month they turn 26 years of age, excluding any child 25 years of age who is eligible to enroll in their own employer-sponsored group health coverage, or any child who is a member of the armed forces of any country and eligible for military insurance coverage. Coverage will not be extended to a spouse or child of the surviving dependent.

(c) Retiree Eligibility

Employees retiring after the effective date of the Plan and their dependents may, at their option and under the eligibility provision stated herein, remain in the plan.

2.02 Application for Coverage

Any employee who is eligible to participate in the Plan must, during the election period, complete an enrollment form, which the Board of Trustees will furnish.

If application includes request for spouse/dependent coverage, employee must furnish social security number(s) and one copy of lawful presence documentation for each. Acceptable lawful presence documents include:

- U.S. Birth Certificate
- U.S. Passport (valid or expired)
- U.S. Passport Card (valid or expired)

- Certificate of Citizenship
- Certificate of Birth Abroad
- Certificate of Naturalization
- Valid Lawful Permanent Resident Card

An affidavit furnished by the Board of Trustees must be completed for each spouse/dependent whose documentation is not submitted at the time of enrollment. The affidavit allows a ninety-day extension for submission of required documentation. If documentation is not received within ninety days, the spouse/dependent(s) will no longer be eligible for coverage under the Plan.

2.03 Change of Employment Status

Subject to the continuation of coverage provisions of the Plan, a participant who ceases to be an eligible employee because of a change in employment status will cease to be a participant at the end of the month in which the change occurred; except if the participant is a vested member as defined in Section 1.59 and elects to continue coverage in the Plan.

If an employee who is not eligible as a participant becomes eligible, the employee's effective date of coverage will be on the first day of the next calendar month following date of employment.

2.04 Employee Leave of Absence Without Pay

An employee taking leave of absence without pay authorized by the employer for purposes of military, education, maternity, illness, emergency, etc., may continue the coverage by paying the required contribution without state participation. An employee on family medical leave will receive the state contribution for 12 weeks per calendar year. If the employee terminates coverage at the time of or during a leave of absence, reinstatement of coverage will not be permitted without a qualifying event as stated in Section 1.50, except for employees on an authorized military leave of absence as referenced in Section 3.02(d).

2.05 Medicare Eligibility

Medicare eligibility will apply as follows:

- (a) an active employee who is eligible for Medicare will continue to be a participant under the Plan unless he elects in writing to terminate Plan coverage and select Medicare, at which time his dependent coverage will also end;
- (b) an active employee's spouse reaches age 65, the spouse may choose between continuing as a participant or electing Medicare in lieu of the Plan; however, the spouse will continue to be a participant under the Plan unless the written election is received by the Board;
- (c) all participants, except active employees and their dependents, will be transferred to Medicare member status under the Plan when they become eligible for coverage under Medicare;
- (d) an active employee and/or their dependents become Medicare eligible for reasons of kidney transplant or renal dialysis, Medicare will be primary payer in accordance with the Medicare guidelines; or
- (e) a Medicare eligible individual, not previously enrolled in the MoDOT/MSHP Part D Prescription Drug benefit, becomes eligible for enrollment due to marriage or other event that meets the Plan's eligibility requirements, that individual will be required to provide proof they have maintained creditable prescription drug coverage since the end of their initial enrollment period (IEP) for Part D. The IEP for Part D is concurrent with the individual's IEP for Medicare Part B which is the 7-month period that begins 3 months before the month an individual first meets the eligibility requirements for Parts A & B

and ends 3 months after the month of first eligibility. Otherwise, the individual may be subject to the late enrollment penalty, which could increase their monthly premium. Proof of creditable prescription drug coverage can include, but is not limited to: copies of any disclosure notices provided to them by any entity(s) that provided prescription drug coverage.

2.06 Termination of Coverage

You may terminate medical coverage at any time during the year for you or your dependents if you have opted not to participate in the cafeteria plan or are not eligible to participate in the cafeteria plan. However, if you participate in the cafeteria plan, you will not be allowed to terminate medical coverage for you or your dependents unless you have a Change in Status event approved by the Cafeteria Plan Administrator. If you terminate coverage, you cannot re-enroll in the plan without a qualifying event as stated in Section 3.02.

(a) Termination of Coverage for Subscribers

Subject to the continuation of coverage provisions, coverage by the Plan will terminate on the earliest of the following:

- (i) at the end of the month in which active employment ends, unless the individual immediately qualifies and continues to participate as a non-employee subscriber under the Plan;
- (ii) at the end of the month in which a change in employment status longer qualifies the employee for coverage as a subscriber;
- (iii) as of the date of the participant's death;
- (iv) non-payment of any required contributions; or
- (v) the termination of the Plan.

(b) Termination of Coverage for Retirees, Vested, Long-Term Disability or Surviving Spouse

Should a retiree's, vested member's, long-term disability recipient's or surviving spouse's coverage or coverage of a participant under Article XI terminate for any reason other than death, such retiree, vested member, long-term disability recipient, surviving spouse or such participant and his dependents shall not be eligible for re-enrollment, except for participants eligible for coverage when returning from active military duty and losing coverage through the military (reference Section 1.50).

(c) Termination of Coverage for Dependents

Subject to the continuation of coverage provisions in Article XI and this section, all dependent coverage will terminate when the subscriber's coverage terminates. If a subscriber's coverage terminates because of death, dependents of a deceased subscriber may continue coverage under the Plan, providing the subscriber was enrolled in the Plan at the time of death and such dependents were covered and are eligible for coverage under the Plan. In the event the surviving spouse of a retiree does not receive a MoDOT & Patrol Employees' Retirement System benefit, coverage can be continued contingent upon payment of premium.

Also, if an active employee is over age 65 and elects to terminate the Plan and select Medicare, his dependent coverage will also terminate, subject to the continuation of coverage provisions in Article XI.

Further, any dependent will cease to be covered at the earliest of:

- (i) termination of dependent status;
- (ii) non-payment of any required contributions for such coverage;
- (iii) the effective date of an approved election or change of election which requests that the individual no longer be covered;
- (iv) plan termination; or
- (v) death.

ARTICLE III

ELECTION AND EFFECTIVE DATE OF COVERAGE

3.01 Election of Coverage

- (a) New employees shall have an election period of 31 days after their effective date of employment in which they may enroll themselves and their dependents.
- (b) If an employee makes application for enrollment or re-enrollment more than 31 days after his effective date of employment, he could only be enrolled if he has a qualifying event as stated in Section 1.50.
- (c) If an employee enrolls during his election period and elects not to enroll all eligible dependents at that time, and at a later date he wishes to enroll such dependents, the dependents could only be enrolled if they have a qualifying event as stated in Section 1.50 or during an Open Enrollment period offered every two years in October, with coverage to be effective on even numbered years.
- (d) Active employees not currently enrolled will have the option to enroll themselves and any eligible dependents during an Open Enrollment period offered every two years in October, with coverage to be effective on even numbered years.
- (e) Plan Groups - The following plan groups are established to provide coverage for eligible participants.
 - (i) Subscriber Only – A non-Medicare subscriber
 - (ii) Subscriber/Spouse – A non-Medicare subscriber and spouse
 - (iii) Subscriber/Family – Subscriber with spouse and one or more child dependents or subscriber with three or more child dependents
 - (iv) Subscriber/Child – Subscriber and one child
 - (v) Subscriber/2 Children – Subscriber and two children
 - (vi) Medicare Member – An individual as defined in Section 1.35
- (f) Each subscriber will be entitled to elect one of the plan groups provided the required subscriber contributions are paid. At the time the subscriber elects such coverage, he will specify the number of dependents covered, their names, date of birth, social security number, relationship and whether they are Medicare eligible.
- (g) Special Situations -
 - (i) Two subscribers employed by either MoDOT or MSHP who are married may choose to be enrolled separately, each taking subscriber coverage, or enrolled jointly under subscriber/spouse or subscriber/family coverage. Each subscriber will receive a state share contribution. It will be the responsibility of the subscribers to notify their insurance representatives of their marriage to an employee or the employment of their spouse and what type of coverage they desire for themselves

and any dependents. The open enrollment period to enroll in this category is within 31 days of date of marriage or during the month of October for January 1 coverage.

- (ii) The maximum plan rate for any plan group will not exceed the subscriber/family plan rate.

3.02 Special Enrollment Period

A Special Enrollment Period will be allowed for the following qualifying events:

- (a) A child who is born to or adopted by the subscriber, provided the subscriber makes application to enroll the child within 31 days of date of birth or adoption.
- (b) A child if the subscriber is enrolled in the subscriber/family plan prior to a new birth or adoption and the subscriber makes application within 31 days after the date of birth. Late enrollments will be subject to Board approval.
- (c) New eligible dependents of a subscriber who marries after the election period and makes application prior to or no later than 31 days after such event.
- (d) Subscribers and eligible dependents enrolled in the Plan immediately prior to the subscriber's authorized military leave, if application is made within 90 days of separation of the military and furnishes a copy of the discharge papers.
- (e) Non-active subscribers returning from full-time military duty and enrolled in the Plan immediately prior to military duty may enroll themselves and any eligible dependents if application is made within 60 days of loss of military coverage and proof of loss of coverage is provided.
- (f) Dependent children when a subscriber is court ordered to provide coverage and upon receipt of a copy of the court order.
- (g) Dependent children of a divorced subscriber and the divorce decree stipulates the subscriber must provide coverage, and application is made within 31 days of the signed divorce decree. A copy of the divorce decree must be received by the medical plan.
- (h) Employee, work-related disability recipients and dependents who lose eligibility under other insurance because:
 - (i) they are no longer eligible for coverage under spouse's plan;
 - (ii) spouse's employer-sponsored medical plan terminates;
 - (iii) the employer's total contribution toward the spouse's plan ceases;
 - (iv) dependents have a qualifying event as stated in Section 1.50, and meet the eligibility requirements of a dependent;
 - (v) dependent's COBRA coverage ends and, they meet the eligibility requirements of the plan;
 - (vi) they are no longer eligible for Medicaid or CHIP coverage; or
 - (vii) they are no longer eligible for military coverage

- (i) Loss of Medicaid or TriCare for Life applies to all subscribers and dependents enrolled in the plan immediately prior to their enrollment in Medicaid or TriCare for Life.
- (j) Dependents of employees, retirees, vested, work-related disability recipients and long-term disability recipients enrolled in the Plan, if the dependents meet the eligibility requirements of the Plan and have a qualifying event as stated in Section 1.50 and make application.
- (k) Non-active subscribers and eligible dependents enrolled in the Plan immediately prior to non-active subscribers authorized FMLA leave, if application is made within 31 days of return to work.
- (l) Employee and eligible dependents become eligible for premium assistance to purchase coverage in the Plan under applicable Medicaid or CHIP plan.

Under these provisions, application is required. If the qualifying event is due to loss of eligibility as stated in sections 3.02 (h) (i), or employee becomes eligible for premium assistance as stated in section 3.02 (l), application must be received within 60 days after other coverage ends. If qualifying event is loss of military coverage, application must be received within 90 days and requires copy of discharge papers. Documentation will be required from the previous insurance carrier or former employer stating:

- (i) coverage has been terminated;
- (ii) the reason for coverage termination;
- (iii) list of dependents covered;
- (iv) the date coverage was terminated; and
- (v) discharge papers (required for military only).

If the application is to enroll a Medicare eligible individual, not previously enrolled in the Plan, the applicant must furnish proof they have maintained creditable prescription drug coverage. Proof can include, but is not limited to, copies of any disclosure notices provided by an entity(s) that provided prescription drug coverage. (Please reference Section 2.05 for Medicare eligibility.)

3.03 Effective Date of Coverage

- (a) The effective date of coverage for a new employee and any eligible dependents will be on the first day of the next calendar month following date of employment. If the new employee was enrolled in the Plan as a dependent immediately prior to the date of employment, the creditable service requirement is waived. Effective date of coverage is subject to submission of proper application and payment of any required contribution.
- (b) Child(ren) of the subscriber born or adopted after the effective date of the subscriber's coverage under the Plan shall be covered automatically on the date of birth, adoption or on the date of physical placement if the petition for adoption is in place, provided:
 - (i) the subscriber enrolls the child(ren) in the appropriate plan category within 31 days of date of birth, adoption, or physical placement; and
 - (ii) payment of required contributions is received.

If application is made more than 31 days from the date of birth, adoption or first eligible date for coverage, the child(ren) must have a qualifying event as stated in Section 3.02 to be eligible for coverage. The effective date will be the first day following the date of the qualifying event. Additional

documentation, as stated in Section 3.02, will be required and receipt of payment of any required contributions.

If the subscriber is currently enrolled in a subscriber/family plan and submits a late enrollment application, coverage will be subject to Board approval.

- (c) If a subscriber marries after the effective date of his coverage, the spouse and/or spouse's dependents are eligible for coverage, if:
 - (i) they meet the eligibility requirements of the Plan;
 - (ii) application is made prior to or within 31 days after the date of marriage; and
 - (iii) required contributions are received.

The effective date of coverage will be the date of marriage.

If application is made more than 31 days from date of marriage, spouse and/or spouse's dependents must have a qualifying event as stated in Section 1.50, to be eligible for coverage. If spouse and/or spouse's dependent's have a qualifying event, coverage will be effective on the first day following the date of the qualifying event. Additional documentation as stated in Section 3.02, and receipt of payment of any additional contributions will be required.

- (d) The effective date of coverage for a non-active subscriber returning from authorized FMLA leave will be the return to work date.

No change in a subscriber's plan group or change in status of a person who may be covered under the Plan shall take effect until the first day following the date of the qualifying event, except as noted in Section 3.03.

ARTICLE IV

SCHEDULE OF BENEFITS

4.01 Plan Summary of Benefits

For a summary of benefits for the Coventry PPO Plan, reference Appendix A (Pages 31-32).

4.02 Medicare Member Benefits

Medicare members will be eligible for benefits described in Article VIII of the Plan.

4.03 Co-payment

Co-payments do not apply to annual deductible(s) or out-of-pocket maximum.

4.04 Coverage for Out-of-Country Services - Benefits are payable according to the Plan provisions. The subscriber will be responsible for filing the necessary forms for reimbursement.

4.05 Coverage for Out-of-State Services

- (a) When receiving out-of-state services, present your identification card to the provider of care.
- (b) If using a Non-Participating Provider, you may be required to file the claim with the claims administrator. These benefits are generally paid at out-of-network percent co-insurance up to the benefit acceleration points (reference Appendix A, Page 31). However, the member is also responsible for any amount that exceeds the allowed amount for services rendered.

4.06 Coverage for Veterans Administration (VA) Facilities

If a participant (non-Medicare) is confined in a VA hospital, the Plan will pay at the out-of-network benefit level on eligible charges after the Plan's yearly deductible(s) has been met. Only non-military service related medical expenses, or services and supplies, are eligible and only if benefits are not available under any governmental health plan, (except Medicaid), except to the extent required under existing state or federal laws and regulations. Payment will be made to the VA facility only.

4.07 Prescription Drug Card Program

A Prescription Drug Card Program for the benefit of non-Medicare and Medicare participants is provided under the Plan. By using the Prescription Drug Card Program, the participant implicitly consents to the Prescription Drug Card Program Administrator having access, as needed, to the medical records of the participant. Restrictions, prior authorizations, step therapy and exclusions do apply for some prescriptions.

The following apply to both Medicare and non-Medicare participants of the Plan.

- (a) A network pharmacy must be utilized for prescriptions to be covered, both in-state or out-of-state.
- (b) Prescription Drug Card must be presented to the retail pharmacy at the time of purchase.
- (c) Participants may obtain up to a 90-day supply of maintenance medications after they have filled a starter quantity of the medication. A starter quantity is required if the medication is new, has not been filled in the past six months or if the dosage or strength of the medication changes.

(d) Co-insurance on prescriptions purchased at retail pharmacies and the mail pharmacy will apply, with \$5 minimum co-insurance payment (reference Appendix A, Page 31). The Board of Trustees may limit the co-insurance payable by the participant to a maximum level if it is deemed that a specific covered prescription drug that is a special treatment medication would pose a significant financial burden to the participant. These are special treatment(s) where the physician has little or no option in treatment, other treatment options have been exhausted, and/or the member needs the drug to treat a potentially catastrophic or life threatening condition (i.e., organ transplant, cancer, AIDS, etc., and items related to these treatments). The drugs available under this benefit may change as new drugs become available or as drugs become available in generic formulation. Selection of special treatment drugs is at the sole discretion of the Board of Trustees. Neither the Board nor the Plan will incur liability to a participant/subscriber if a drug is not selected by the Board of Trustees to be a special treatment medication.

(e) Single Source Brand Medications (No Generic Equivalent Available)

- (i) Non-Medicare participants will pay thirty (30) percent co-insurance after the deductible is met.
- (ii) Medicare participants will pay as follows:
 - A. thirty (30) percent co-insurance after the deductible is met if they are not within the Medicare Part D coverage gap. For 2011, the coverage gap begins when the total cost for prescription drugs for the year reaches \$2,840.
 - B. sixty (60) percent co-insurance after the deductible is met and the participant is within the Medicare Part D coverage gap with the manufacturer paying fifty (50) percent of the participant's cost at the time of sale.
 - C. Enhanced Medications covered under the Plan, but not included in the Medicare Part D formulary as governed by the Center for Medicare and Medicaid Services (CMS), will be assessed a thirty (30) percent co-insurance after the deductible. These medications are not applicable to the Coverage Gap.
 - D. Once the Medicare participant reaches \$4,550 out-of-pocket expense, the cost sharing will be reduced to the greater of five (5) percent co-insurance or \$2.50 co-payment for generics and \$6.30 co-payment for brands.

(f) Brand Medications (Generic Equivalents Available)

The Plan requires filling generic medications when available or a penalty or increase in co-insurance may apply as follows:

(i) **Non-Medicare Participants**

- A. When a brand medication is dispensed, the participant will pay the thirty (30) percent co-insurance after the deductible plus the difference between the brand and generic costs of the drug, not to exceed the Plan's contracted discount rate.
- B. If a brand medication is deemed to be medically necessary by a physician, a letter of medical necessity describing the failure of the generic medication from the prescribing physician must be submitted to the Plan administrator for review. If approved, the member will pay thirty (30) percent of the total cost of the brand medication, after the deductible.

(ii) **Medicare Participants**

- A. If a brand medication, included in the Medicare Part D formulary as governed by the Center for Medicare and Medicaid Services (CMS), is dispensed and a generic medication is available, the Medicare participant will pay as follows:
- (1) fifty (50) percent co-insurance after the deductible for the cost of the brand medication, when the Medicare participant is not within the coverage gap for Part D, or
 - (2) One-hundred (100) percent of the cost of the drug during the coverage gap period, with fifty (50) percent to be reimbursed by the manufacturer as stated under the Patient Protection and Affordable Care Act. The manufacturer's participation in the cost will apply at the time of sale.
- B. Enhanced Medications covered under the Plan, but not included in the Part D formulary regulated by CMS, will be assessed a fifty (50) percent co-insurance.
- C. Once the Medicare participant reaches \$4,550 of out-of-pocket expense, the cost sharing will be reduced to the greater of five (5) percent coinsurance or \$2.50 co-payment for generics and \$6.30 co-payment for brands.
- (g) The prescription deductible(s) and co-insurance do not apply towards the medical deductible(s) and co-insurance. Reference Appendix A, Page 31, for prescription deductible(s) and co-insurance amounts.
- (h) The prescription deductible applied to a non-Medicare participant does not apply towards the prescription deductible of a Medicare participant in the year they become Medicare eligible.
- (i) The fact that a physician prescribes a specific drug does not make the drug a covered benefit. Following is a list of standard excluded drugs, which is not all inclusive:
- (i) any drug that is utilized to terminate a pregnancy or possible pregnancy is specifically excluded. This includes, but is not limited to, Plan B, Preven and RU-486;
 - (ii) OTC products or over-the-counter equivalents and state restricted drugs (unless specifically included);
 - (iii) therapeutic devices or appliances such as pulmo-aid pumps, mini-med pumps, etc. (check with the medical plan administrator);
 - (iv) implantable time-released medication (i.e. Norplant) unless otherwise noted as stated in Section 6.01(b)(i)(C)(4), (Zoladex is a Standard Covered Drug);
 - (v) experimental or investigational drugs; or drugs prescribed for experimental (non-FDA approved/unlabeled) indications (i.e. progesterone suppositories, Yocon, Erex);
 - (vi) drugs FDA approved for cosmetic use only (i.e. Renova, Propecia);
 - (vii) nutritional supplements, unless otherwise noted;
 - (viii) erectile dysfunction drugs;
 - (ix) fertility drugs;

- (x) weight loss medications.
 - (xi) immunization agents, biological serum, vaccines (except those vaccines covered for Medicare participants under Medicare Parts B or D), and biologicals;
 - (xii) extemporaneously prepared combinations of raw bulk chemical ingredients (i.e. progesterone, testosterone, or estrogen powders) or combinations of federal legend drugs in a non-FDA approved dosage form (i.e. capsules or suppositories made from DHEA, progesterone, testosterone or estrogen powders);
 - (xiii) hormone replacement therapies, including natural compounded hormones;
 - (xiv) homeopathic legend products;
 - (xv) lost, spilled, dropped, stolen etc. medications; and
 - (xvi) influenza treatments (except those treatments covered for Medicare participants
- (i) Some medications also require step therapy or an approved prior authorization before they are covered under the Plan. If your prescription fails to process, have your pharmacist contact the prescription drug card administrator to check why the claim did not process.
 - (j) Diabetic testing supplies for Medicare participants, including glucose testing monitors, blood glucose testing strips, lancet devices and lancets, will not be covered under the prescription drug plan. These supplies will be covered under Medicare Part B Plan. Insulin and syringes will continue to be covered under the prescription drug benefit of the Plan.
 - (k) The Plan will not coordinate benefits on prescription drugs purchased through another plan, or a VA facility.

Appendix A

**MoDOT/MSHP Medical Plan Summary of Benefits for Non-Medicare Participants
Effective January 1, 2011**

Listed below is a partial outline of health services covered under the MoDOT/MSHP Summary Plan Document (SPD). This summary should not be relied upon to fully determine coverage. See the MoDOT/MSHP SPD for applicable limits and exclusions to coverage for these health services. If differences exist between this summary of benefits and the SPD, the SPD governs.

Benefit	Coventry PPO PLAN Available Statewide	
	In Network Provider	Out of Network Provider *
	Member's Responsibility (per calendar year)	
Deductible Individual Family	\$ 350 \$ 1,050 maximum	\$ 350 \$ 1,050 maximum
Coinsurance	10% (up to out-of-pocket maximum)	20% (up to out-of-pocket maximum)
Out-of-Pocket Maximum	per calendar year (does not include deductible and copayment)	per calendar year (does not include deductible, copayment and cost above allowed amount)
Individual Family	\$825 \$2,475	\$1,650 \$4,950
Lifetime Maximum	Unlimited	Unlimited
Office Visit	\$25 copayment for office visit only Other services applied to deductible and coinsurance	20% coinsurance of allowed amount after deductible <u>Preventive care office visits not covered for participants 7 years of age or older</u>
Allergy Injections	10% coinsurance after deductible	20% coinsurance of allowed amount after deductible
Chiropractic Services	10% coinsurance after deductible; Benefit limited to 30 manual manipulation of the spine treatments per calendar year and 1 X-Ray by a chiropractor per calendar year <u>Office visit not covered</u>	20% coinsurance of allowed amount after deductible; Benefit limited to 30 manual manipulation of the spine treatments per calendar year and 1 X-Ray by a chiropractor per calendar year <u>Office visit not covered</u>
Emergency Room Services	\$75 copayment and 10% coinsurance after deductible Copayment waived if admitted or accidental injury	\$75 copayment and 20% coinsurance of allowed amount after deductible Copayment waived if admitted or accidental injury
Immunizations Dependent Children from Birth through 6 years of Age According to "Recommended Childhood Immunization Schedules" *	\$0 copayment or 0% coinsurance of eligible expenses	20% coinsurance of allowed amount after deductible
Immunizations Dependent Children from 7 years of Age through 18 According to "Recommended Adolescent Immunization Schedules" *	\$0 copayment or 0% coinsurance of eligible expenses <u>Office visit charge applied to preventive care benefit.</u>	20% coinsurance of allowed amount after deductible <u>Preventive care office visits not covered for participants 7 years of age or older</u>
Immunizations Enrolled Member 19 years of Age and older According to "Recommended Adult Immunization Schedules" *	Applied to Preventive Care Benefit up to allowed amount. If exhausted, applied to deductible, copayment and coinsurance	<u>Not covered</u>
Inpatient Hospital Care	10% coinsurance after deductible Pre-admission certification required	20% coinsurance of allowed amount after deductible Pre-admission certification required
Maternity	10% coinsurance after deductible	20% coinsurance of allowed amount after deductible
Mental Health (MH)/Chemical Dependency (CD) - Inpatient	10% coinsurance after deductible Pre-admission certification required	20% coinsurance of allowed amount after deductible Pre-admission certification required
Mental Health (MH)/Chemical Dependency (CD) - Outpatient	Outpatient office visit: \$25 copayment; Outpatient hospital: 10% coinsurance after deductible	20% coinsurance of allowed amount after deductible
Organ Transplants	100% coverage for transplant and 18 months following the transplant	20% of network cost to the closest in-network facility plus the difference between the network and actual cost
Preventive Care Dependent Children from Birth through 6 years of Age	\$0 copayment or 0% coinsurance for all well-child care visits	\$0 copayment or 0% coinsurance of allowed amount for all well-child care visits
Preventive Care Dependent Children 7 years of Age and Older (Non-Medicare)	\$200 (covered at 100% for preventive services only) Amount in excess of \$200 per calendar year is subject to deductible, copayment and coinsurance	<u>Not covered</u>
Preventive Care/ Cancer Screenings Subscriber and Enrolled Spouse (Non-Medicare)	\$350 (covered at 100% for preventive services only) Amount in excess of \$350 per calendar year is subject to deductible, copayment and coinsurance	<u>Not covered</u>
Surgery	10% coinsurance after deductible Pre-admission certification required, if inpatient	20% coinsurance of allowed amount after deductible Pre-admission certification required, if inpatient
Urgent Care	\$25 copayment for office visit only Other services applied to deductible and coinsurance	20% coinsurance of allowed amount after deductible

Pharmacy Benefit - Available Through Participating Pharmacies Only	
Deductible	\$100 per participant per calendar year
Coinsurance	30% of costs after deductible is met (minimum \$5 copay)
Starter Quantity	30 day starter quantity for new medication, including change in strength, or the medication has not been filled for the previous six months
Generic Policy	If a generic is available: 30% coinsurance of brand drug's cost plus the difference between the brand and generic after calendar year deductible at retail and mail order pharmacy with \$5 minimum copayment If no generic is available: 30% coinsurance after calendar year deductible at retail and mail order pharmacy with \$5 minimum copayment If brand is medically necessary and approved by Catalyst Rx: 30% coinsurance after calendar year deductible at retail and mail order pharmacy with \$5 minimum copayment
Quantity	Purchase 90 days at participating retail pharmacies or the mail order pharmacy for maintenance medications
Prior Authorization	Some drugs may require a prior authorization. Contact the pharmacy benefits number on your prescription drug card

* Out of Network Provider service insurance payments are subject to Allowed Amount only. The Member will be responsible 100% for amounts above Allowed Amount.

ARTICLE V

SPECIAL INCENTIVE BENEFITS

5.01 General Information

The features listed in this section are included in the Plan in order to provide incentives for participants to use cost-effective forms of treatment on a voluntary basis. No penalties apply for failure to use the special features described in this section.

5.02 Large Case Management

A participant who requires long-term care may be offered the option of receiving the care in a more cost effective setting, such as a skilled nursing facility or the participant's own home, if the utilization review organization, acting according to principles that preclude individual selection, determines that such an alternative method of delivery is appropriate for the participant's condition.

When the utilization review organization offers the participant a choice of setting, the offer will be set forth in writing and will specify the service and/or items of care that the Plan will cover. Under these circumstances, the benefits of the Plan may be expanded to meet the specific medical needs of the participant.

The participant will have no obligation to accept any alternative delivery system that may be offered. If the participant refuses the offer, plan benefits will be paid.

In the case of a participant who is a minor or whom the utilization review organization considers incapable of making a decision on his own behalf, the utilization review organization will make the offer to the parent or their nearest relative. Such parent or relative will have the right to accept or refuse on behalf of the participant.

ARTICLE VI

COVERED SERVICES AND EXCLUSIONS

6.01 Covered Services

The following are covered services in an amount up to the allowed amount. In order to be covered the services must be medically necessary and are subject to all other exclusions and limitations contained in the Plan.

(a) Hospital Services

(i) Inpatient or outpatient hospital services and supplies.

(A) Bed, board, and general nursing service when a participant occupies:

- (1) a room with two or more beds, known as a semi-private room or ward;
- (2) a private room. The allowed amount for a private room is an allowance equal to the hospital's most common semi-private room rate, unless a private room is the only room available or is required for medical reasons; or
- (3) a bed in an intensive care unit.

(B) Ancillary hospital services and supplies including, but not restricted to:

- (1) use of operating, delivery, and treatment rooms and equipment;
- (2) pharmacy services and supplies;
- (3) administration of blood and blood processing (including the cost of blood, plasma, or fractionalized blood products);
- (4) anesthesia, anesthesia supplies and services rendered by an employee of the hospital or through approved contractual arrangements;
- (5) medical and surgical dressings, supplies, casts, and splints;
- (6) diagnostic services;
- (7) therapy services; or
- (8) nursing services in an intensive care unit, other than the portion referenced in Section 6.01 (a)(i)(A).

(b) Surgical/Medical Services

(i) Surgical Services

Surgery performed by a physician, including normal pre-operative and post-operative care.

(A) Single Surgical Services

The allowance for a single surgical service will be the allowed amount. When surgical services are concurrently rendered by two or more physicians, the payment will be the same as if rendered by one physician.

(B) Multiple Surgical Services

The allowance for concurrent, successive, or other multiple surgical services will be limited to:

- (1) two or more surgical services performed at the same time for related conditions, the total allowance will be that of the major surgical service only;
- (2) two or more unrelated surgical services performed at the same time, the total allowance will be equal to the amount of the surgical procedure that has the greatest allowance, plus one-half of the allowance specified for each of the other surgical services performed; or
- (3) the allowance for two or more separate, distinct and unrelated surgical services performed at different times will be the allowed amount for each surgical service.

(C) Special Surgery

Special surgeries are limited to:

- (1) reconstructive surgery, while a participant in the Plan to correct:
 - (a) a disfiguration of the face or hands;
 - (b) reconstructive surgery of a diseased breast upon which surgery was performed;
 - (c) surgery and reconstruction of the non-diseased breast to produce a symmetrical appearance, with no time limit imposed on reconstructive surgery; or
 - (d) for the grafting of skin to any other part of the body;
- (2) elective surgery and related medical treatment provided such surgery or treatment is necessary to reduce or eliminate a physical endangerment to the participant's health;
- (3) elective sterilizations will be a covered service for subscribers and their spouse; or
- (4) implantation of contraceptive devices and injectables not covered under the prescription drug program will be covered at the co-insurance benefit level outlined in your pharmacy benefit. Benefit acceleration point(s) will not be applicable with regard to these services. This includes, but is not limited to, Norplant and IUD's.

(D) Human Organ and Tissue Transplants

Transplant benefits contained in Article VII.

(E) Anesthesia

Administration of anesthesia ordered by the attending physician and rendered by a physician or other professional provider.

(ii) Inpatient Medical Services

Care rendered by a physician or other professional provider to a participant who is a hospital inpatient for a condition not related to surgery or an obstetrical procedure.

(A) Concurrent Care

(1) Care rendered concurrently with surgery during a hospital stay by a physician other than the operating surgeon for treatment of a medical condition separate from the condition for which surgery was performed.

(2) Care rendered by two or more physicians concurrently during a hospital stay for separate medical conditions when the nature or severity of the participant's condition requires the skills of separate physicians.

(B) Consultation

Consultation services rendered to a participant by another physician at the request of the attending physician. Consultation does not include staff consultations that may be required by hospital rules and regulations.

(iii) Outpatient Medical Services

(A) Care rendered by a physician or other professional provider to a participant who is an outpatient for a condition not related to surgery or an obstetrical procedure.

(B) Organ donor search charges, reference Article VII.

(c) Diagnostic Services

(d) Therapy Services – Refer to Section 1.55 or check with the claims administrator for coverage of therapy services.

(e) Obstetrical Services

Obstetrical care and care for conditions of pregnancy for the subscriber or the enrolled spouse of a subscriber. Routine nursery care, including circumcision will also be considered if billed to the newborn child who is enrolled in the Plan. Routine nursery care is limited to the length of the mother's hospital stay.

(f) Mental Health

Services for the treatment for mental health rendered by an appropriate provider will be provided on the same basis as the services and medical care for physical conditions. (Reference Section 1.36 for the definition of mental health.)

(g) Ambulance Services

Ambulance service providing emergency air or land transportation by means of a specially designed and equipped vehicle used only for transporting the sick and injured. These services will be covered at the in-network level of benefits provided by the Plan as follows:

- (i) from a participant's home or scene to a hospital when emergency care is necessary;
- (ii) between hospitals; or
- (iii) to or from a medical clinic.

Benefits will be paid for air ambulance services to the nearest hospital capable of providing medically necessary treatment when ground transportation would endanger the safety of the participant.

In no event will ambulance services include any service rendered for convenience of the patient.

(h) Private Duty Nursing Services

Private duty nursing services performed by an actively practicing private duty nurse when prescribed by a physician and limited to the time such services are deemed medically necessary.

(i) Dental Services

- (i) Evaluations and office visits when associated with covered dental services.
- (ii) Charges for injury to or care of the mouth, teeth, gums and alveolar processes will be covered charges under medical benefits if that care is for the following oral surgical procedures:
 - (A) repair due to injury to sound natural teeth; initial care must be rendered within 90 days of the injury (injury to the teeth while eating are not considered accidental injuries);
 - (B) surgery needed to correct accidental injuries to the jaws, cheeks, lips, tongue, floor and roof of the mouth. Accidental injury is defined as an injury caused by an external force or element such as a blow or fall;
 - (C) excision of tumors and cysts of the jaws, cheeks, lips, tongue, roof and floor of the mouth when pathological examination is necessary;
 - (D) removal of impacted teeth;
 - (E) excision of benign bony growths of the jaw and hard plate;
 - (F) external incision of and drainage of cellulites;
 - (G) incision of sensory sinuses, salivary glands or ducts; and
 - (H) reduction of dislocations and surgical repair of temporomandibular joints.
- (iii) A dental examination prescribed by a physician prior to joint replacement, valve replacement or transplant surgery to verify an infection/bacteria is not present, which could jeopardize the success of the surgery. The coverage will not include any dental services required as a result of the check-up. Proof of surgery will be required from your physician.
- (iv) The administration of general anesthesia and hospital charges for dental care to children under 5, the severely disabled, or a person with a medical or behavioral condition that requires

hospitalization. The general anesthesia will also apply whether in a hospital or surgical center.
Actual dental work affiliated with these services will not be covered.

(j) Durable Medical Equipment (DME)

Covered Service when determined to be necessary and reasonable for the treatment of an illness or injury, or to improve the functioning of a malformed body part, and when all of the following circumstances apply:

1. it can withstand repeated use;
2. it is primarily and customarily used to serve a medical purpose;
3. it is generally not useful to a person in the absence of illness or injury; and
4. it is appropriate for use in the home.

There is coverage for the initial rental and purchase of durable medical equipment when authorized in advance by the plan, and ordered by or provided by a physician for use outside a hospital or skilled nursing facility. Coverage is provided for durable medical equipment that meets the minimum specifications that are medically necessary.

Coverage includes, but is not limited to the following:

- (i) trusses; crutches; and braces;
- (ii) equipment for the administration of oxygen;
- (iii) custom wheelchair;
- (iv) electric wheelchair or electric scooter (with approved predetermination of medical necessity);
- (v) hospital-type bed;
- (vi) insulin pumps and related supplies;
- (vii) continuous glucose monitors and related supplies;
- (viii) One pair of therapeutic shoes, including fitting of shoes and/or inserts, per calendar year for diabetic foot disease or peripheral neuropathy.
- (ix) TENS unit (with approved letter of medical necessity).

Services for repair and replacement of durable medical equipment will be covered under the plan if deemed medically necessary. A letter of medical necessity will be required from the provider for review prior to coverage. The member must seek repair of the equipment prior to replacement, unless the repair cost is greater than the replacement cost. The plan will not cover replacement batteries or routine maintenance or maintenance agreements.

Members with durable medical equipment that is covered under a manufacturer's warranty should address any repairs and replacements with the manufacturer before contacting the plan. If it is determined that the issue is not covered under the manufacturer's warranty, coverage may be provided for replacement of durable medical equipment which has become non-functional and non-repairable due to normal, routine wear and tear.

(k) Prosthetic Appliances

The initial purchase, fitting, and necessary adjustments of prosthetic devices and supplies that replace all or part of an absent body organ or limb, (including contiguous tissue) or replace all or part of the function

of a permanently inoperative or malfunctioning body organ or limb. A time limit cannot be imposed for prosthetic appliances received for a mastectomy; and if the mastectomy was not performed while a participant was enrolled in the plan, the prosthetic appliance must be provided.

Services for repair and replacement of durable medical equipment will be covered under the plan if deemed medically necessary. A letter of medical necessity will be required from the provider for review prior to coverage. The member must seek repair of the equipment prior to replacement, unless the repair cost is greater than the replacement cost. The plan will not cover replacement batteries or routine maintenance or maintenance agreements.

The following appliances are excluded:

- (i) electrical continence aids, either anal or urethral;
- (ii) implants for cosmetic or psychological reasons;
- (iii) penile prostheses for psychogenic impotence;
- (iv) dental appliances;
- (v) replacement of cataract lenses except when new cataract lenses are needed because of a prescription change. Replacement lenses must be traditional intraocular lenses, regardless of the grade of lenses being replaced. Implant of a Crystalens or any lens classified as a deluxe accommodating intraocular lens following replacement cataract surgery is considered to be a deluxe prosthetic device and will only be reimbursed not to exceed the cost of traditional intraocular lenses following initial or replacement cataract surgery;
- (vi) remote control devices;
- (vii) devices employing robotics; or
- (viii) all mechanical organs.

(l) Orthotic Devices

The initial purchase and fitting of orthotic appliances such as braces, splints or other appliances which are required for support of an injured or deformed part of the body as a result of a disabling congenital condition or an injury or sickness, excluding the following:

- (a) arch supports and other foot support devices;
- (b) elastic stockings;
- (c) garter belts;
- (d) orthopedic shoes;
- (e) special braces; or
- (f) shoe inserts unless the member has diabetes with demonstrated peripheral neuropathy or the insert is needed for a shoe that is part of a brace. If all necessary criteria is present, one (1) shoe insert will be covered per calendar year.

Services for repair and replacement of durable medical equipment will be covered under the plan if deemed medically necessary. A letter of medical necessity will be required from the provider for review prior to coverage. The member must seek repair of the equipment prior to replacement, unless the repair

cost is greater than the replacement cost. The plan will not cover replacement batteries or routine maintenance or maintenance agreements.

(m) Administrative Costs

The completion and filing of claim forms, medical reports, and invoices by a physician or hospital.

(n) Chiropractic Services

The manual manipulation of the spine by a licensed chiropractor to correct a subluxation. The plan allows coverage for one X-ray by a chiropractor per calendar year. Covered services for manual manipulations will be limited to 30 treatments per calendar year.

(o) Therapeutic Abortion

Allowed only if the life of the mother would be endangered if the fetus were carried to term. Includes treatment of the complications of any abortion. Further, these covered services are only available to a participant who is the subscriber or the spouse of a subscriber.

(p) Well-Baby and Well-Child Checks

Includes normal, periodic examinations through 6 years of age. This service is covered at 100% and is not subject to deductible(s).

(q) Immunizations

(i) Children 0 through 6 years of age:

Immunizations for children through 6 years of age will be covered at 100% for in-network provider services according to the recommended immunization schedule referenced in Appendix B, page 48. Out-of-network costs for immunizations will be covered up to the allowed amount, subject to deductible(s) and coinsurance.

(ii) Children 7 through 18 years of age:

Immunizations for children 7 through 18 years of age will be covered at 100% for in-network provider services, according to the recommended immunization schedule referenced in Appendix C, Page 49. Out-of-network costs for immunizations will be covered up to the allowed amount, subject to deductibles and coinsurance. **Routine office visit costs associated with the immunization will not be covered if received out-of-network.**

(ii) Adults 19 years of age or older:

Immunizations will be covered in accordance with the Adult Immunization Schedule located in Appendix D, Page 50. The costs will be applied to the Preventive Care benefit for in-network provider services only. **Out-of-network provider services for adult immunizations will not be a covered benefit.**

(r) Newborn Screening, Diagnosis and Treatment

Every infant shall have the following coverage:

(i) phenylketonuria (PKU) and such other metabolic or genetic disease as prescribed by the Department of Health;

- (ii) special dietary products for treatment of metabolic and genetic diseases who is less than six (6) years of age;
- (iii) formula for the treatment of inherited diseases of amino acids and organic acids;
- (iv) potentially treatable or manageable disorders, including cystic fibrosis, galactosemia, biotinidase deficiency, congenital adrenal hyperplasia, maple syrup urine disease (MSUD) and other amino acid disorders, glucose-6-phosphate dehydrogenase deficiency (G-6-PD), MCAD and other fatty acid oxidation disorders, methylmalonic academia, propionic academia, isovaleric academia and glutaric academia Type I;
- (v) newborn hearing screening, necessary re-screening, audiological assessment and follow-up, and initial amplification. If delivered in an ambulatory surgical center or hospital, the newborn must be screened prior to discharge. If delivered in a place other than an ambulatory surgical center or hospital, the screening must be performed within three (3) months of the date of birth. Covered physiological technologies are: automated or diagnostic auditory brainstem response (ABR); otoacoustic emissions (OAE) or other technologies approved by the Department of Health; and
- (vi) office visit related to newborn screening.

(s) Emergency Room Services

Eligible expenses incurred for treatment rendered in a hospital's emergency room will be payable on the same basis as any other illness or injury after satisfaction of a separate \$75 emergency room co-payment. This emergency room co-payment must be satisfied each time a covered individual receives emergency room services, and must be satisfied in addition to the plan's calendar year deductible(s) and co-insurance. The emergency room co-payment will be waived if the emergency room visit is necessitated by an accident or injury or if the patient is admitted as a hospital inpatient directly from the emergency room.

(t) Cancer Screenings

Cancer screenings shall include the following screenings and office visits related to the screening for in-network provider services only:

- (i) pelvic exam and pap smear every calendar year for any non-symptomatic woman age 18 and over;
- (ii) a prostate exam and PSA blood test every calendar year for any non-symptomatic man over the age of 50 years or for younger men who are at high risk and/or have a family history of prostate cancer; or
- (iii) men and women age 50 years or older or if a doctor prescribes at a younger age or greater frequency because of high risk or family history:
 - (A) a fecal occult blood test every calendar year and sigmoidoscopy every 5 years;
 - (B) a colonoscopy every 10 years;
 - (C) a digital rectal exam, sigmoidoscopy, colonoscopy or barium test; or
- (iv) mammograms
for any nonsymptomatic woman covered under the plan is provided as follows:
 - (A) a baseline mammogram for women age 35 to 39, inclusive;
 - (B) a mammogram every calendar year for women age 40 and over;

- (C) a mammogram for any woman, upon the recommendation of a physician, where such woman, her mother or her sister has a prior history of breast cancer; and
- (D) office visit related to mammogram.

Coverage and benefits for mammography shall be subject to the same dollar limits, deductible(s) and co-payments as other radiological examinations.

Nonsymptomatic cancer screenings are applied to your Preventive Care benefit (reference "Preventive Care" in Appendix A, page31).

(u) Equipment, Supplies and Self-Management Training for Diabetes

Covered services for diabetes will include:

- (i) related office visit;
- (ii) equipment and supplies not covered under the prescription drug card program, including insulin pumps and related supplies and continuous glucose monitors and related supplies; and
- (iii) self-management training used in the management and treatment of diabetes.

Coverage shall include persons with gestational, Type I or Type II diabetes and will be subject to deductible(s), co-payment(s) and co-insurance.

(v) Osteoporosis

Coverage for services, including office visits, related to diagnosis, treatment and appropriate management for enrollees with a condition or medical history for which bone mass measurement is medically indicated.

(w) Lead Poisoning Testing

Lead poisoning testing shall include:

- (i) testing of pregnant women for lead poisoning;
- (ii) testing of all children, enrolled in the plan, less than six (6) years of age; and
- (iii) related office visit.

Coverage for testing shall be in accordance with the provisions of the Department of Health's Childhood Lead Testing Program.

(x) Hearing Aids

Hearing aids and screenings will be covered for dependent children with developmental delays up to twenty-six (26) years of age as follows:

- (a) covered once every twenty-four (24) months per ear;
- (b) covered for in-network benefit services only and will be applied to the participant's applicable deductible and coinsurance amounts;
- (c) one hearing screening and/or audiogram to determine hearing loss per twelve (12) month period; and

- (d) will cover the following types of hearing aids:
 - (i) conventional
 - (ii) programmable
 - (iii) digital
 - (iii) bone anchored hearing aids (BAHA)
 - (iv) cochlear implants

The purchase of hearing aids will require a prior authorization with the claims administrator.

(y) Genetic Testing

Genetic Testing is a covered service if it meets medical necessity as determined by the claims administrator.

- (z) Autism Spectrum Disorders – Notwithstanding any other provision of the Plan, coverage is provided for the diagnosis and medically necessary treatment for Autism Spectrum Disorders when ordered by your treating physician or licensed psychologist in accordance with a treatment plan. Except for inpatient services, the Plan has the right to review the treatment plan of a Member receiving treatment for autism spectrum disorder not more than once every six months unless the treating physician or psychologist and the Plan agree that a more frequent review is necessary. The cost of obtaining the review or treatment plan will be borne by the Plan.

Coverage provided for Applied Behavior Analysis shall be for Members up to nineteen (19) years of age and limited as allowed by law. Authorization for services may be required. Treatment plans may be required.

(aa) Preventive Care Services

Preventive Care services (including office visits, x-rays, laboratory tests and routine preventive immunizations) are covered as provided in Appendix A, page 31 , under “Preventive Care” and “Immunizations”.

6.02 Exclusions

The services and supplies specified in this section will **not** be considered covered services.

(a) Services or supplies provided for dental services as follows:

- (i) oral implants and transplants;
- (ii) surgical procedures that involve the teeth or their supporting structures (such as the periodontal membrane, gingival, and alveolar bone), except as provided in Section 6.01(i);
- (iii) surgical procedures involving orthodontic care, dental implants, or preparation of the mouth for the fitting or the continued use of dentures, except as specifically provided in Section 6.01(i);
- (iv) injuries to the teeth while eating are not considered accidental injuries; and
- (v) other services not provided under Section 6.01(i).

(b) Services or supplies provided before the coverage date or after coverage under the Plan ends.

(c) Services and supplies and days of care that are not medically necessary for the diagnosis or treatment of an injury, illness, or symptomatic complaint. The fact that a physician may prescribe, order, recommend,

or approve a service or supply does not, of itself, make it medically necessary or make the charge a covered service, even though the service or supply is not specifically listed as an exclusion. The authority for determining whether services or supplies or days of care are medically necessary lies with the claims administrator.

- (d) Services and supplies for any condition, disease, ailment or accidental injury arising out of and in the course of employment if benefits or compensation is available, in whole or in part, under any worker's compensation or occupational disease statutes or other similar law (the "Statutes"). This exclusion applies whether or not the participant claims the benefits or compensation and whether or not the participant recovers compensation from any third party. However, if a dispute arises between the participant and the insurance carrier for any coverage under one of these Statutes, the Plan may pay the covered services, pending settlement of the workers' compensation claims, and if the insurance carrier for benefits or compensation under these Statutes should later be held responsible, the participant or carrier would be required to reimburse the Plan.
- (e) Treatment in any sanatorium or any state or federal hospital, including any Veterans Administration hospital, for military service-related medical expenses, or services and supplies for which the participant is eligible or for which benefits are available under any governmental health plan besides Medicaid, except to the extent required under existing state or federal laws and regulations.
- (f) Any hospital service or supply not ordered by a physician.
- (g) Charges in excess of the allowed amount, or in excess of the value of the service or supply as determined by the claims administrator.
- (h) The services of a provider who ordinarily resides in the participant's home or is a member of the participant's immediate family.
- (i) Services and supplies for diseases contracted or injuries sustained as a result of war, declared or undeclared, or any act of war, for military personnel or others while participating in the armed forces and covered under other medical insurance.
- (j) Expenses in connection with cosmetic or transplant surgery, except as provided in Sections 6.01(b)(i)(C) and (D) and Article VII.
- (k) Expenses incurred for and in connection with procedures, drugs, or devices that are considered by the claims administrator to be experimental/investigative.
- (l) Hearing Aids

Coverage will not be provided for services relating to hearing aids as follows:

- (a) Routine hearing tests, audiograms, and hearing aids except as stated under covered services;
 - (b) adjustments, batteries, and other services relating to hearing aids; and
 - (c) all out-of-network services.
- (m) Eyeglasses, contact lenses, and examinations, whether or not prescribed, except for prosthetic lenses or traditional intraocular lenses following initial cataract surgery. Implant of a Crystalens or any lense classified as a deluxe accommodating intraocular lens following initial cataract surgery is considered to be a deluxe prosthetic device and will only be reimbursed not to exceed the cost of traditional intraocular lenses following initial or replacement cataract surgery. Replacement of cataract lenses is also excluded, except when new cataract lenses are needed because of a prescription change and will also be reimbursed not to exceed the cost of traditional intraocular lenses, regardless of the grade of lenses being replaced.

- (n) The following Orthotic Devices are excluded as Covered Services as specified in Article 6.01(l):
 - (i) arch supports and other foot support devices;
 - (ii) elastic stockings;
 - (iii) garter belts;
 - (iv) orthopedic shoes;
 - (v) special braces; or
 - (vi) shoe inserts unless the member has diabetes with demonstrated peripheral neuropathy or the insert is needed for a shoe that is part of a brace. If all necessary criteria is present, one (1) shoe insert will be covered per calendar year.
- (o) The following Prosthetic Appliances are excluded as Covered Services as specified in Article 6.01 (k):
 - (i) electrical continence aids, either anal or urethral;
 - (ii) implants for cosmetic or psychological reasons;
 - (iii) penile prostheses for psychogenic impotence;
 - (iv) dental appliances;
 - (v) replacement of cataract lenses except when new cataract lenses are needed because of prescription change;
 - (vi) remote control devices;
 - (vii) devices employing robotics; or
 - (viii) all mechanical organs.
- (p) Services and supplies for personal hygiene and convenience items including, but not limited to, air conditioners, humidifiers, or physical fitness equipment; and personal items such as a TV, telephone, cots, and visitors' meals. Services in connection with the treatment of:
 - (i) weak, strained, flat, unstable or unbalanced feet, metatarsalgia or bunions, except for open cutting operations or laser surgery; or
 - (ii) corns, callouses, toenails, except for the partial or complete removal of nail roots or for services for metabolic peripheral vascular disease or diabetes.
- (q) Preventive care services when utilizing out-of-network providers except as provided in preventive care provisions in Appendix A, Page 31 .
- (r) Services and supplies in rest homes, health resorts, homes for the aged, or places primarily for domiciliary or custodial care, except as otherwise specifically provided.
- (s) Services for or in connection with custodial care, education or training of the participant, whether or not prescribed by a physician, except as otherwise specifically provided.

- (t) Services not specified as covered. Non-traditional medical services, treatments and supplies, which are not specified as covered under the Plan. These services, treatments and supplies, etc. include, but are not limited to the following:
 - (i) acupuncture, acupressure, hypnosis;
 - (ii) biofeedback therapy;
 - (iii) blood pressure cuff;
 - (iv) donor expenses for obtaining blood from a blood bank or supplier; or
 - (v) massage therapy (except as provided under Section 1.44 (j)).
- (u) Circumcision if not performed within 30 days of birth except when medically necessary.
- (v) Drugs, medicines, vitamins, minerals and tonics purchased for use outside of a hospital for which a written prescription is not required.
- (w) Services and supplies for which the participant has no legal obligation to pay.
- (x) Services and supplies rendered prior to the effective date of the plan or after the termination date of the plan, or services and supplies rendered prior to the participant's coverage date or after the participant's termination date.
- (y) Transportation charges, except as covered under ambulance services and transplant coverage.
- (z) Injuries or illnesses resulting from taking part in the commission of a felony.
- (aa) Services or supplies for reversal of voluntary sterilization. Services or supplies related to sex transformation, sexual therapy or counseling, or sexual dysfunctions or inadequacies except conditions resulting from injury or organic disease.
- (bb) Care and treatment for obesity, weight loss or dietary control, regardless of medical necessity, including, but not limited to:
 - (i) bariatric, gastric bypass, or related surgeries;
 - (ii) removal of excess fat or skin following weight loss;
 - (iii) services at a health spa or similar facility; or
 - (iv) prescription drugs prescribed for weight loss.
- (cc) Services in connection with the treatment and diagnosis of fertility or infertility.
- (dd) Services and supplies for conditions related to milieu therapy, learning disabilities, mental retardation, or for inpatient admission for environmental change.
- (ee) Services rendered by non-covered providers, including, but not limited to, the following providers and facilities:
 - (i) naturopaths;
 - (ii) licensed counselors (except as specifically provided in Section 1.44);

- (iii) mid-wives;
 - (iv) marital counselors; or
 - (v) sanatoriums.
- (ff) Services in connection with an abortion, except as provided in Section 6.01(o).
 - (gg) Taxes on covered expenses such as crutches, braces, etc., that the participant purchases.
 - (hh) Chiropractic services, except as specifically provided in Section 6.01(n).
 - (ii) Services or supplies not specifically listed as covered.
 - (jj) Services and supplies for treatment not rendered in accordance with locally acceptable standards of medical practice, as determined by the claims administrator.
 - (kk) Long-term physical therapy and rehabilitation or other physical therapy or rehabilitation when, in the judgment of the Board, no significant improvement has occurred or is likely to occur.
 - (ll) Physical, Occupational, and Speech Therapy visits over the sixty (60) combined visits per calendar year.
 - (mm) Diagnostic admissions.
 - (nn) Services or supplies rendered or prescribed by a provider outside the scope of his or its license.
 - (oo) Repair, replacement or maintenance of durable medical equipment, prosthetics or braces unless there is sufficient change in the participant's physical condition to make the original device no longer functional.
 - (pp) More than one (1) pair of therapeutic shoes, including fitting of shoes and/or inserts, per calendar year for diabetic foot disease or peripheral neuropathy.
 - (qq) Services for obstetrical care and care for conditions of pregnancy for any participant other than the subscriber or the enrolled spouse of the subscriber.
 - (rr) Services and supplies rendered by a Christian Science Sanatorium accredited by the Department of Care of the First Church of Christ, Scientist, Boston, Massachusetts, or an institution of substantially similar nature to that operated by the First Church of Christ, Scientist; or comparable organizations.
 - (ss) Hormone replacement therapies, including natural compounded hormones.
 - (tt) Treatment for disorders relating to learning, motor skills, and communication;
 - (uu) Cancer screenings when utilizing out-of-network providers (reference in Appendix A, Page 31.)

Appendix B

Recommended Immunization Schedule for Persons Aged 0 Through 6 Years—United States • 2010

For those who fall behind or start late, see the catch-up schedule

Vaccine ▼	Age ►	Birth	1 month	2 months	4 months	6 months	12 months	15 months	18 months	19–23 months	2–3 years	4–6 years
Hepatitis B ¹		HepB	HepB			HepB						
Rotavirus ²				RV	RV	RV ²						
Diphtheria, Tetanus, Pertussis ³				DTaP	DTaP	DTaP	^{see footnote³}	DTaP				DTaP
<i>Haemophilus influenzae</i> type b ⁴				Hib	Hib	Hib ⁴		Hib				
Pneumococcal ⁵				PCV	PCV	PCV		PCV			PPSV	
Inactivated Poliovirus ⁶				IPV	IPV			IPV				IPV
Influenza ⁷							Influenza (Yearly)					
Measles, Mumps, Rubella ⁸							MMR		^{see footnote⁸}			MMR
Varicella ⁹							Varicella		^{see footnote⁹}			Varicella
Hepatitis A ¹⁰							HepA (2 doses)				HepA Series	
Meningococcal ¹¹												MCV

Range of recommended ages for all children except certain high-risk groups

Range of recommended ages for certain high-risk groups

This schedule includes recommendations in effect as of December 15, 2009. Any dose not administered at the recommended age should be administered at a subsequent visit, when indicated and feasible. The use of a combination vaccine generally is preferred over separate injections of its equivalent component vaccines. Considerations should include provider assessment, patient preference, and the potential for adverse events. Providers should consult the relevant Advisory

Committee on Immunization Practices statement for detailed recommendations: <http://www.cdc.gov/vaccines/pubs/acip-list.htm>. Clinically significant adverse events that follow immunization should be reported to the Vaccine Adverse Event Reporting System (VAERS) at <http://www.vaers.hhs.gov> or by telephone, 800-822-7967.

1. Hepatitis B vaccine (HepB). (Minimum age: birth)

At birth:

- Administer monovalent HepB to all newborns before hospital discharge.
- If mother is hepatitis B surface antigen (HBsAg)-positive, administer HepB and 0.5 mL of hepatitis B immune globulin (HBIG) within 12 hours of birth.
- If mother's HBsAg status is unknown, administer HepB within 12 hours of birth. Determine mother's HBsAg status as soon as possible and, if HBsAg-positive, administer HBIG (no later than age 1 week).

After the birth dose:

- The HepB series should be completed with either monovalent HepB or a combination vaccine containing HepB. The second dose should be administered at age 1 or 2 months. Monovalent HepB vaccine should be used for doses administered before age 6 weeks. The final dose should be administered no earlier than age 24 weeks.
 - Infants born to HBsAg-positive mothers should be tested for HBsAg and antibody to HBsAg 1 to 2 months after completion of at least 3 doses of the HepB series, at age 9 through 18 months (generally at the next well-child visit).
 - Administration of 4 doses of HepB to infants is permissible when a combination vaccine containing HepB is administered after the birth dose. The fourth dose should be administered no earlier than age 24 weeks.
- 2. Rotavirus vaccine (RV).** (Minimum age: 6 weeks)
- Administer the first dose at age 6 through 14 weeks (maximum age: 14 weeks 6 days). Vaccination should not be initiated for infants aged 15 weeks 0 days or older.
 - The maximum age for the final dose in the series is 8 months 0 days
 - If Rotarix is administered at ages 2 and 4 months, a dose at 6 months is not indicated.
- 3. Diphtheria and tetanus toxoids and acellular pertussis vaccine (DTaP).** (Minimum age: 6 weeks)
- The fourth dose may be administered as early as age 12 months, provided at least 6 months have elapsed since the third dose.
 - Administer the final dose in the series at age 4 through 6 years.
- 4. *Haemophilus influenzae* type b conjugate vaccine (Hib).** (Minimum age: 6 weeks)
- If PRP-OMP (PedvaxHIB or Comvax [HepB-Hib]) is administered at ages 2 and 4 months, a dose at age 6 months is not indicated.
 - TriHibit (DTaP/Hib) and Hiberix (PRP-T) should not be used for doses at ages 2, 4, or 6 months for the primary series but can be used as the final dose in children aged 12 months through 4 years.
- 5. Pneumococcal vaccine.** (Minimum age: 6 weeks for pneumococcal conjugate vaccine [PCV]; 2 years for pneumococcal polysaccharide vaccine [PPSV])
- PCV is recommended for all children aged younger than 5 years. Administer 1 dose of PCV to all healthy children aged 24 through 59 months who are not completely vaccinated for their age.
 - Administer PPSV 2 or more months after last dose of PCV to children aged 2 years or older with certain underlying medical conditions, including a cochlear implant. See *MMWR* 1997;46(No. RR-8).

6. Inactivated poliovirus vaccine (IPV). (Minimum age: 6 weeks)

- The final dose in the series should be administered on or after the fourth birthday and at least 6 months following the previous dose.
- If 4 doses are administered prior to age 4 years a fifth dose should be administered at age 4 through 6 years. See *MMWR* 2009;58(30):829–30.

7. Influenza vaccine (seasonal). (Minimum age: 6 months for trivalent inactivated influenza vaccine [TIV]; 2 years for live, attenuated influenza vaccine [LAIV])

- Administer annually to children aged 6 months through 18 years.
- For healthy children aged 2 through 6 years (i.e., those who do not have underlying medical conditions that predispose them to influenza complications), either LAIV or TIV may be used, except LAIV should not be given to children aged 2 through 4 years who have had wheezing in the past 12 months.
- Children receiving TIV should receive 0.25 mL if aged 6 through 35 months or 0.5 mL if aged 3 years or older.
- Administer 2 doses (separated by at least 4 weeks) to children aged younger than 9 years who are receiving influenza vaccine for the first time or who were vaccinated for the first time during the previous influenza season but only received 1 dose.
- For recommendations for use of influenza A (H1N1) 2009 monovalent vaccine see *MMWR* 2009;58(No. RR-10).

8. Measles, mumps, and rubella vaccine (MMR). (Minimum age: 12 months)

- Administer the second dose routinely at age 4 through 6 years. However, the second dose may be administered before age 4, provided at least 28 days have elapsed since the first dose.

9. Varicella vaccine. (Minimum age: 12 months)

- Administer the second dose routinely at age 4 through 6 years. However, the second dose may be administered before age 4, provided at least 3 months have elapsed since the first dose.
- For children aged 12 months through 12 years the minimum interval between doses is 3 months. However, if the second dose was administered at least 28 days after the first dose, it can be accepted as valid.

10. Hepatitis A vaccine (HepA). (Minimum age: 12 months)

- Administer to all children aged 1 year (i.e., aged 12 through 23 months). Administer 2 doses at least 6 months apart.
- Children not fully vaccinated by age 2 years can be vaccinated at subsequent visits
- HepA also is recommended for older children who live in areas where vaccination programs target older children, who are at increased risk for infection, or for whom immunity against hepatitis A is desired.

11. Meningococcal vaccine. (Minimum age: 2 years for meningococcal conjugate vaccine [MCV4] and for meningococcal polysaccharide vaccine [MPSV4])

- Administer MCV4 to children aged 2 through 10 years with persistent complement component deficiency, anatomic or functional asplenia, and certain other conditions placing them at high risk.
- Administer MCV4 to children previously vaccinated with MCV4 or MPSV4 after 3 years if first dose administered at age 2 through 6 years. See *MMWR* 2009;58:1042–3.

The Recommended Immunization Schedules for Persons Aged 0 through 18 Years are approved by the Advisory Committee on Immunization Practices (<http://www.cdc.gov/vaccines/recs/acip>), the American Academy of Pediatrics (<http://www.aap.org>), and the American Academy of Family Physicians (<http://www.aafp.org>).

Department of Health and Human Services • Centers for Disease Control and Prevention

Appendix C

Recommended Immunization Schedule for Persons Aged 7 Through 18 Years—United States • 2010

For those who fall behind or start late, see the schedule below and the catch-up schedule

Vaccine ▼	Age ►	7–10 years	11–12 years	13–18 years
Tetanus, Diphtheria, Pertussis ¹			Tdap	Tdap
Human Papillomavirus ²		<i>see footnote 2</i>	HPV (3 doses)	HPV series
Meningococcal ³		MCV	MCV	MCV
Influenza ⁴		Influenza (Yearly)		
Pneumococcal ⁵		PPSV		
Hepatitis A ⁶		HepA Series		
Hepatitis B ⁷		Hep B Series		
Inactivated Poliovirus ⁸		IPV Series		
Measles, Mumps, Rubella ⁹		MMR Series		
Varicella ¹⁰		Varicella Series		

Range of recommended ages for all children except certain high-risk groups

Range of recommended ages for catch-up immunization

Range of recommended ages for certain high-risk groups

This schedule includes recommendations in effect as of December 15, 2009. Any dose not administered at the recommended age should be administered at a subsequent visit, when indicated and feasible. The use of a combination vaccine generally is preferred over separate injections of its equivalent component vaccines. Considerations should include provider assessment, patient preference, and the potential for adverse events. Providers should consult the relevant Advisory

Committee on Immunization Practices statement for detailed recommendations: <http://www.cdc.gov/vaccines/pubs/acip-list.htm>. Clinically significant adverse events that follow immunization should be reported to the Vaccine Adverse Event Reporting System (VAERS) at <http://www.vaers.hhs.gov> or by telephone, 800-822-7967.

1. **Tetanus and diphtheria toxoids and acellular pertussis vaccine (Tdap).** (Minimum age: 10 years for Boostrix and 11 years for Adacel)
 - Administer at age 11 or 12 years for those who have completed the recommended childhood DTP/DTaP vaccination series and have not received a tetanus and diphtheria toxoid (Td) booster dose.
 - Persons aged 13 through 18 years who have not received Tdap should receive a dose.
 - A 5-year interval from the last Td dose is encouraged when Tdap is used as a booster dose; however, a shorter interval may be used if pertussis immunity is needed.
2. **Human papillomavirus vaccine (HPV).** (Minimum age: 9 years)
 - Two HPV vaccines are licensed: a quadrivalent vaccine (HPV4) for the prevention of cervical, vaginal and vulvar cancers (in females) and genital warts (in females and males), and a bivalent vaccine (HPV2) for the prevention of cervical cancers in females.
 - HPV vaccines are most effective for both males and females when given before exposure to HPV through sexual contact.
 - HPV4 or HPV2 is recommended for the prevention of cervical precancers and cancers in females.
 - HPV4 is recommended for the prevention of cervical, vaginal and vulvar precancers and cancers and genital warts in females.
 - Administer the first dose to females at age 11 or 12 years.
 - Administer the second dose 1 to 2 months after the first dose and the third dose 6 months after the first dose (at least 24 weeks after the first dose).
 - Administer the series to females at age 13 through 18 years if not previously vaccinated.
 - HPV4 may be administered in a 3-dose series to males aged 9 through 18 years to reduce their likelihood of acquiring genital warts.
3. **Meningococcal conjugate vaccine (MCV4).**
 - Administer at age 11 or 12 years, or at age 13 through 18 years if not previously vaccinated.
 - Administer to previously unvaccinated college freshmen living in a dormitory.
 - Administer MCV4 to children aged 2 through 10 years with persistent complement component deficiency, anatomic or functional asplenia, or certain other conditions placing them at high risk.
 - Administer to children previously vaccinated with MCV4 or MPSV4 who remain at increased risk after 3 years (if first dose administered at age 2 through 6 years) or after 5 years (if first dose administered at age 7 years or older). Persons whose only risk factor is living in on-campus housing are not recommended to receive an additional dose. See *MMWR* 2009;58:1042–3.

4. **Influenza vaccine (seasonal).**
 - Administer annually to children aged 6 months through 18 years.
 - For healthy nonpregnant persons aged 7 through 18 years (i.e., those who do not have underlying medical conditions that predispose them to influenza complications), either LAIV or TIV may be used.
 - Administer 2 doses (separated by at least 4 weeks) to children aged younger than 9 years who are receiving influenza vaccine for the first time or who were vaccinated for the first time during the previous influenza season but only received 1 dose.
 - For recommendations for use of influenza A (H1N1) 2009 monovalent vaccine. See *MMWR* 2009;58(No. RR-10).
5. **Pneumococcal polysaccharide vaccine (PPSV).**
 - Administer to children with certain underlying medical conditions, including a cochlear implant. A single revaccination should be administered after 5 years to children with functional or anatomic asplenia or an immunocompromising condition. See *MMWR* 1997;46(No. RR-8).
6. **Hepatitis A vaccine (HepA).**
 - Administer 2 doses at least 6 months apart.
 - HepA is recommended for children aged older than 23 months who live in areas where vaccination programs target older children, who are at increased risk for infection, or for whom immunity against hepatitis A is desired.
7. **Hepatitis B vaccine (HepB).**
 - Administer the 3-dose series to those not previously vaccinated.
 - A 2-dose series (separated by at least 4 months) of adult formulation Recombivax HB is licensed for children aged 11 through 15 years.
8. **Inactivated poliovirus vaccine (IPV).**
 - The final dose in the series should be administered on or after the fourth birthday and at least 6 months following the previous dose.
 - If both OPV and IPV were administered as part of a series, a total of 4 doses should be administered, regardless of the child's current age.
9. **Measles, mumps, and rubella vaccine (MMR).**
 - If not previously vaccinated, administer 2 doses or the second dose for those who have received only 1 dose, with at least 28 days between doses.
10. **Varicella vaccine.**
 - For persons aged 7 through 18 years without evidence of immunity (see *MMWR* 2007;56[No. RR-4]), administer 2 doses if not previously vaccinated or the second dose if only 1 dose has been administered.
 - For persons aged 7 through 12 years, the minimum interval between doses is 3 months. However, if the second dose was administered at least 28 days after the first dose, it can be accepted as valid.
 - For persons aged 13 years and older, the minimum interval between doses is 28 days.

Recommended Adult Immunization Schedule

UNITED STATES • 2010

Note: These recommendations *must* be read with the footnotes that follow containing number of doses, intervals between doses, and other important information.

Figure 1. Recommended adult immunization schedule, by vaccine and age group

VACCINE ▼	AGE GROUP▶	19–26 years	27–49 years	50–59 years	60–64 years	≥65 years
Tetanus, diphtheria, pertussis (Td/Tdap) ^{1,*}		Substitute 1-time dose of Tdap for Td booster; then boost with Td every 10 yrs				Td booster every 10 yrs
Human papillomavirus (HPV) ^{2,*}		3 doses (females)				
Varicella ^{3,*}		2 doses				
Zoster ⁴					1 dose	
Measles, mumps, rubella (MMR) ^{5,*}		1 or 2 doses		1 dose		
Influenza ^{6,*}		1 dose annually				
Pneumococcal (polysaccharide) ^{7,8}		1 or 2 doses				1 dose
Hepatitis A ^{9,*}		2 doses				
Hepatitis B ^{10,*}		3 doses				
Meningococcal ^{11,*}		1 or more doses				

*Covered by the Vaccine Injury Compensation Program.

 For all persons in this category who meet the age requirements and who lack evidence of immunity (e.g., lack documentation of vaccination or have no evidence of prior infection)

 Recommended if some other risk factor is present (e.g., on the basis of medical, occupational, lifestyle, or other indications)

 No recommendation

Report all clinically significant postvaccination reactions to the Vaccine Adverse Event Reporting System (VAERS). Reporting forms and instructions on filing a VAERS report are available at www.vaers.hhs.gov or by telephone, 800-822-7967.

Information on how to file a Vaccine Injury Compensation Program claim is available at www.hrsa.gov/vaccinecompensation or by telephone, 800-338-2382. To file a claim for vaccine injury, contact the U.S. Court of Federal Claims, 717 Madison Place, N.W., Washington, D.C. 20005; telephone, 202-357-6400.

Additional information about the vaccines in this schedule, extent of available data, and contraindications for vaccination is also available at www.cdc.gov/vaccines or from the CDC-INFO Contact Center at 800-CDC-INFO (800-232-4636) in English and Spanish, 24 hours a day, 7 days a week.

Use of trade names and commercial sources is for identification only and does not imply endorsement by the U.S. Department of Health and Human Services.

ARTICLE VII

HUMAN ORGAN TRANSPLANT COVERAGE

7.01 Human Organ Transplant Coverage

Covered transplant procedure means the transfer of an organ(s) and associated tissue from a donor to a transplant recipient in order to replace or restore function to a diseased part of the body. Coverage is based on Plan's schedule of benefits and procedures covered under the Plan. Contact your claims administrator for additional information on transplant coverage and to be assigned a transplant case manager. The transplant case manager must direct all care relative to the transplant for the services to be considered a covered benefit.

Transplant services must be pre-certified through the claims administrator and the transplant case manager must direct all care relative to the transplant for the services to be considered a covered benefit?

Transplants and related services covered under the Plan and performed in a Designated Transplant Network Facility will be covered at 100% up to eighteen (18) months. After the eighteen (18) month period, covered services will be applied to the applicable deductible and co-insurance benefits.

Transplants performed in a facility other than the Designated Transplant Network Facility through our transplant administrator, will be considered as out-of-network benefits. The payment for these services will be paid at 80% based on the allowed amount of the closest Designated Transplant Network Facility, which performs the same type transplant.

7.02 Donor Organ and Tissue Procurement

Donor covered expenses include the reasonable and customary expenses for services and supplies which are covered under this provision, and which are medically necessary and appropriate to the transplant.

Procurement includes evaluation, removal, preservation and transportation of donor organ and associated tissue. We will only pay covered charges for transportation of the donor organ to the location where the proposed surgical transplant procedure is to be performed that is within a 500 mile radius of the site at which the donor organ was procured. In the case of an emergency, when a suitable donor organ is not reasonably available within the 500 mile radius, benefits will be paid for transportation of the donor organ from outside the 500 mile radius. **Benefits will only be provided for procurement of a donor organ from the United States or Canada.**

Coverage for organ procurement from a non-living donor will include costs for removing, preserving, and transporting the organ.

Coverage for organ procurement from a living donor will include costs involved in screening the potential donor, transporting the donor to and from the site of the transplant, medical expenses associated with removal of the donated organ and the medical services provided to the donor in the interim and for follow-up care based on the Summary of Benefits included under Article VII.

For bone marrow transplants, coverage will be provided for the cost involved in the removal of the patient's bone marrow (autologous) or donated marrow (allogenic). Coverage will also be provided for the search charges to identify an unrelated match, treatment and storage costs of the marrow, up to the time of reinfusion.

Coverage for human leukocyte antigen (HLA) testing for bone marrow transplantation is included once per lifetime. Reimbursement shall be no greater than seventy-five (\$75) dollars and the member must sign an

informed consent, which authorizes the results of the test to be used for participation in the National Marrow Donor Program.

7.03 Transportation, Meals, and Lodging

The Plan will pay the covered charges incurred by the recipient and a companion for transportation to and from the site of the hospital where the procedure is performed. If the recipient is a minor, transportation benefits will be provided for up to two persons who travel with such recipient. All trips and means of transportation must be approved by the transplant case manager. Benefits will be limited as stated in the Transplant Summary of Benefits. Itemized receipts are required to support all such expenses.

The Plan will also pay the covered charges incurred for lodging and meals incurred by the recipient's companion(s) during the time the recipient is confined to the hospital due to the covered transplant procedure. Benefits will not exceed the transportation, lodging and meals maximum shown in the Transplant Summary of Benefits. Itemized receipts are required to support all such expenses.

7.04 Exclusions

No benefits will be paid for expenses incurred for the following:

- (a) Any service received or supplies furnished outside the United States or Canada.
- (b) Treatment while the participant is not under the regular care of a physician or for a service or supply which is not authorized by a physician.
- (c) Treatment arising out of or in the course of a participant's employment with an employer or self-employment.
- (d) Services or supplies for which there would be no payment required if the Plan did not provide a benefit; or benefits are available through any governmental program which provides or pays for health services, whether or not such benefits are applied for, except benefits received from Medicaid.
- (e) Air ambulance transportation, unless approved by the case manager.
- (f) Travel time and related expenses charged by a provider of service.
- (g) Services and supplies, which are not medically necessary.
- (h) A covered transplant procedure using fetal tissue.
- (i) Any services or supplies not pre-certified by the Claims Administrator.

ARTICLE VIII

MEDICARE MEMBER PROVISIONS

8.01 Eligibility

The Medicare member provisions of the Plan as stated in Section 2.05 apply to the following participant classes:

- (a) retirees and their dependents;
- (b) vested members and their dependents;
- (c) surviving spouses and their dependents; and
- (d) long-term, and work-related disability recipients and their dependents.

Medicare member provisions do not apply to active employees and their dependents.

Plan benefits for covered services received on and after the date Medicare member status begins will be paid according to the terms of this Article.

8.02 Deductible(s)

The deductibles are as follows:

- (a) \$350 per calendar year per Medicare member applied to all covered medical services rendered to the Medicare member;
- (b) \$50 for Private Duty Nursing Services; and
- (c) \$100 calendar year deductible per Medicare member for the Prescription Drug Card Program, unless the member qualifies for low income subsidy and is not subject to the deductible.

Amounts credited toward a participant's prescription drug deductible under the non-Medicare provisions of the Plan in the calendar year in which the participant becomes a Medicare member will not be credited toward the Medicare member prescription drug deductible.

8.03 Benefits

The Medicare member benefits of the Plan are designed to supplement the benefits of Parts A and B of Medicare. For purposes of calculating Medicare member benefits under the Plan, each Medicare member will be deemed to be enrolled in both Part A and Part B of Medicare, and no plan benefits will be paid for services covered by Medicare Part B if the Medicare member is not enrolled in Medicare Part B.

Once the Medicare approved amount has been determined, the claim is reduced by the amount payable by Medicare. On Medicare assigned claims, benefits are paid up to the Medicare approved amounts. On Medicare nonassigned claims, benefits are paid up to the lesser of the provider's actual fee or the allowed amount for the type of services rendered.

Prescription benefits, which are not covered by Medicare Parts A or B, will be covered under the Plan's Part D Prescription Drug Plan, as stated in the guidelines of the Plan document. Reference Section 4.07 and Appendix A, Page 31.

Other specific benefits the Plan will cover include the first three (3) pints of blood, which are not covered by Medicare Parts A and B; and one (1) x-ray of the spine by a chiropractor per calendar year subject to your annual deductible(s) and co-insurance requirements under the Plan.

8.04 Coordination of Benefits

If a Medicare member receives benefits from any other group health plan that is intended to supplement Medicare, the Plan will coordinate its benefits with those of the other health plan as described in Article X; however, the Plan will always calculate its Medicare member benefits after Medicare has paid.

8.05 Services by Non-Medicare Provider

If a Medicare member is confined in a hospital or treated by a provider that does not participate in Medicare, and if Medicare benefits are not recoverable by individual filing, plan benefits for such confinement or treatment will be calculated under the regular non-Medicare member provisions of the Plan. If Medicare benefits are recoverable by individual filing, plan benefits for such confinement or treatment will be calculated according to these Medicare member provisions. The responsibility for filing the forms necessary for Medicare reimbursement will be with the Medicare member.

8.06 Coverage for Out-of-Country Services - Benefits are payable as stated in Section 8.05.

8.07 Coverage for Veterans Administration (VA) Facilities

- (a) If a Medicare member is confined in a VA hospital, the Plan will consider the equivalent of the current Medicare Part A deductible(s) as an eligible expense, which will be paid to the VA hospital at 100 percent after the Plan's yearly deductible(s) has been met; and
- (b) services received from a VA doctor or facility will be covered at either the patient responsibility based on Medicare equivalent remittance advice (if provided) or 20 percent of the billed eligible expense. This coverage will be provided after the Plan's yearly deductible(s) has been met. Payment will be made to the doctor or facility only. This coverage is equivalent to eligible expenses covered by the Plan for Medicare Part B; and
- (c) the Plan will not coordinate benefits on prescription drugs purchased through another plan or a VA facility.

8.08 Coverage for Medicare Denied Claims

If Medicare denies a claim for services considered a covered service under the Plan for non-Medicare members, the services will be paid in accordance with the Plan's usual co-payments, deductible(s) and co-insurance.

8.09 Diabetic Testing Supplies (effective January 1, 2009)

Diabetic testing supplies, including glucose testing monitor, blood glucose testing strips, lancet devices and lancets will be covered under Medicare Part B, and will no longer be covered under your prescription drug benefit. Insulin and syringes will continue to be covered under your Part D prescription drug plan.

MoDOT/MSHP Medicare Supplement Plan Summary of Benefits Effective January 1, 2011

Listed below is a partial outline of coverage under the MoDOT/MSHP Summary Plan Document (SPD). This summary should not be relied upon to fully determine coverage. See the MoDOT/MSHP SPD for applicable limits and exclusions to coverage for health services. If differences exist between this summary of benefits and the SPD, the SPD governs.

Benefit	MEDICARE SUPPLEMENT PLAN Available Nationwide			
	Medicare Assigned Claims	Medicare Non-Assigned Claims	Medicare Non-Covered Claims For Services That The Plan Covers	
	Member's Responsibility			
			In-Network	Out-of-Network
Individual Deductible per CY	\$350	\$350	\$350	\$350
Coinsurance	0%	0%	10% (up to out-of-pocket maximum)	20% of out-of-network rate (up to out-of-pocket maximum)
Individual Out-of-Pocket Maximum per CY	\$0	\$0	\$825	\$1,650, plus any costs above the out-of-network rate
Lifetime Maximum	Unlimited	Unlimited	Unlimited	Unlimited
Prescription Benefit - Available Through Participating Pharmacies Only				
Individual Deductible per CY	\$100			
Generic	30% coinsurance after deductible per calendar year at retail and mail order pharmacy with \$5 minimum copayment.			
Single Source Brand Medications (No generic equivalent available)	30% coinsurance after deductible per calendar year at retail and mail order pharmacy with \$5 minimum copayment.			
Single Source Brand Medications in Part D Coverage Gap* (No generic equivalent available)	30% coinsurance after deductible per calendar year and participant is in Part D Coverage Gap* with the manufacturer also paying 30% at the time of sale.			
Brand Medications (Generic equivalent available)	50% coinsurance after deductible per calendar year at retail and mail order pharmacy with \$5 minimum copayment.			
Brand Medications in Part D Coverage Gap* (Generic equivalent available)	50% coinsurance after deductible per calendar year and participant is in Part D Coverage Gap* with the manufacturer also paying 50% at the time of sale.			
Catastrophic Copayment Level per calendar year	Once an individual reaches \$4,550 of out-of-pocket expense the cost sharing will be reduced to the greater of 5% coinsurance or \$2.50 copayment for generics and \$6.30 copayment for brands.			

*In 2011, the Part D Coverage Gap begins when the total cost for prescription drugs for the year reaches \$2,840.

ARTICLE IX

COST CONTAINMENT

9.01 General Information

The requirements listed in this Article are incorporated into the Plan to reduce or eliminate costs for services and supplies not provided in a cost-effective manner.

Coverage for certain health services requires prior authorization through the Plan administrator. (Reference Section 9.02) Your participating provider is responsible for obtaining authorization from the Plan administrator for in-network services; however, non-participating providers are not obligated to request that authorization. Plan members are responsible for verifying whether the health service received out-of-network is covered under the Plan and the required prior authorization has been granted before receiving the health service. To verify coverage or prior authorization, you may call the Member Services number on the back of your identification card.

Failure to obtain prior authorization for in-patient hospitalization received out-of-network will result in a 20 percent penalty (not to exceed \$1,000) of the total allowed amount before plan benefits are determined. The penalty will be assessed on each inpatient occurrence where prior authorization is required but not obtained and will not apply to the participant's deductible or maximum out-of-pocket benefit. Plan guidelines for benefit determination will apply to all claims including those requiring prior authorization. 100 percent of costs incurred for services not covered by the Plan for any reason will be deducted before plan payment is determined.

The Board of Trustees and claims administrator are only providing benefits in accordance with the Plan and their determinations as to benefits are not intended to control the decisions of the participant's provider. Accordingly, they are not responsible for the quality or availability of services or supplies received by participants.

9.02 Services Requiring Prior Authorization

Prior authorization is the process for authorizing the non-emergency use of facilities, diagnostic testing, and other health services before care is provided

- All Inpatient Hospital Admissions
- All Observation Admissions
- Outpatient Surgeries done by a non participating provider
- All Skilled Nursing Facility, Acute Inpatient Rehabilitation, and Inpatient Hospice Admissions
- All Inpatient Mental Health and Substance Abuse Admissions*
- Cosmetic Services
- Transplants
- Global OB Notification
- Pain Management
- Hospice
- Wound Care Clinics
- **Orthotics >\$1000****
- Prosthetics >\$1000
- Durable Medical Equipment >\$1000
- Home Health - (Skilled Nursing, PT,OT)
- Physical and Occupational Therapy
- Home Infusion Services
- Cardiac Rehab
- Private Duty Nursing
- Genetic Testing

- CTA
- IMRT/SIRS
- Brachytherapy/Mammosite
- Proton Beam Radiation
- LINAC
- Realtime Cardiac Monitors Codes – 93228 and 93229

** Mental Health and Substance Abuse managed by MHNet*

**** Plan excludes coverage for special braces, orthopedic shoes, garter belts, elastic stockings and arch supports, and other foot support devices.**

9.03 Pre-Admission Certification and Concurrent Review Requirements

- (a) Elective hospital admissions, except those for obstetrical care, must be approved by the administrator in advance. Elective admissions are defined as admissions that do not involve emergency care.
- (b) Elective hospital admissions will not be approved for any Saturday, Sunday, or nationally recognized legal holiday that occurs on Friday or Monday unless, on the day of admission, the participant receives medically necessary services that can only be rendered in a hospital and cannot be postponed.
- (c) Further, admission will not be approved for the day before a surgical procedure is scheduled to be performed unless, on the day of admission, the participant receives medically necessary services that can only be rendered in a hospital.
- (d) When an admission is approved, the administrator will determine a length of stay appropriate to the nature and severity of the participant's condition.
- (e) During the confinement, the administrator will monitor the participant's medical chart for appropriateness of treatment. Toward the end of the assigned length of stay, the administrator will contact hospital personnel to ensure discharge is scheduled to occur as planned. If the attending physician believes additional days of confinement are necessary, he may request an extension on the number of days, and will be required to submit medical data to substantiate the request.

9.04 Admission Review

Hospital admissions for obstetrical care and/or emergency care require admission review. In all cases, the administrator must be notified of the admission within 48 hours or on the next working day, if later. The administrator will assign an appropriate length of stay and will monitor the participant's care as outlined above.

ARTICLE X

COORDINATION OF BENEFITS

10.01 Applicability

- (a) The Coordination of Benefits (“COB”) provision applies to the Plan when a participant has health care coverage under more than one health plan. Health plan, for purposes of this Article, is defined in Section 10.02 (a).
- (b) If this COB provision applies, Section 10.03 should be examined. Those rules determine whether the benefits of the Plan are determined before or after those of another health plan. The benefits of the Plan:
 - (i) shall not be reduced when, under Section 10.03, the Plan determines its benefits before another health plan; but
 - (ii) may be reduced when, under Section 10.03, another health plan determines its benefits first. This reduction is described in Section 10.04.
- (c) Other insurance coverage on dependents will be verified annually by the plan administrator.

10.02 Definitions

- (a) Health plan means any of these that provide benefits or services for, or because of, medical or dental care or treatment:
 - (i) Group insurance or group-type coverage, whether insured or uninsured. This includes prepayment, group practice or individual practice coverage. This provision does not include individual contracts, hospital indemnity-type coverages that are written on a non-expense incurred basis, student accident coverages, or automobile medical insurance plans.
 - (ii) Coverage under a governmental plan required or provided by law. This does not include a state plan under Medicaid (Title XIX, Grants to States for Medical Assistance Programs, of the United States Social Security Act as amended from time to time). It also does not include any plan when, by law, its benefits exceed those of any private insurance program or other non-governmental program.

Each contract or other arrangement for coverage under Section 10.02 (a) (i) or (ii) is a separate health plan. Also, if an arrangement has two parts and COB rules apply to only one of the two, each of the parts is a separate health plan.

(b) Primary Plan/Secondary Plan

Section 10.03 states whether the Plan is a primary plan or secondary plan as to another health plan covering the person.

When the Plan is a primary plan, its benefits are determined before those of the other health plan and without considering the other health plan’s benefits.

When the Plan is a secondary plan, its benefits are determined after those of the other health plan and may be reduced because of the other health plan’s benefits.

When there are more than two health plans covering the person, the Plan may be a primary plan as to one or more other health plans, and may be a secondary plan as to a different health plan.

- (c) Allowable Expense means a necessary, reasonable, and customary item of expense for health care, when the item of expense is covered at least in part by one or more plans covering the person for whom the claim is made.

The difference between the cost of a private hospital room and the cost of a semi-private hospital room is not considered an allowable expense under the above definition unless the patient's stay in a private hospital room is medically necessary either in terms of generally accepted medical practice, or as specifically defined in the health plan.

When a health plan provides benefits in the form of services, the reasonable cash value of each service rendered will be considered both an allowable expense and a benefit paid.

- (d) Claim Determination Period means a calendar year. However, it does not include any part of a year during which a person has no coverage under the Plan, or any part of a year before the date this COB provision or a similar provision takes effect.

10.03 Order of Benefit Determination Rules

- (a) General - When there is a basis for a claim under the Plan and another health plan, the secondary plan is one whose benefits are determined after those of the other health plan, unless:
- (i) the other health plan has rules coordinating its benefits with those of the Plan; and
 - (ii) both those rules and the Plan's rules, in the subparagraph below, require that the Plan's benefits be determined before those of the other health plan.
- (b) Rules - The Plan determines its order of benefits using the first of the following rules that applies:
- (i) Subscriber - The benefits of the health plan that covers the person as a subscriber (that is, other than as a dependent) are determined before those of the health plan that covers the person as a dependent.
 - (ii) Dependent Child/Parents not Separated or Divorced - Except as stated in the subparagraph below, when the Plan and another health plan cover the same child as a dependent of different persons, called parents:
 - (A) the benefits of the health plan of the parent whose birthday falls earlier in a year are determined before those of the health plan of the parent whose birthday falls later in that year; but
 - (B) if both parents have the same birthday, the benefits of the health plan that covered the parent longer are determined before those of the health plan that covered the other parent for a shorter period of time.
 - (iii) Dependent Child/Separated or Divorced Parents - If two or more health plans cover a person as a dependent child of divorced or separated parents, benefits for the child are determined in this order:

- (A) first, the health plan of the parent with custody of the child;
- (B) then, the health plan of the spouse of the parent with custody of the child; and
- (C) finally, the health plan of the parent not having custody of the child.

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

- (iv) Active/Inactive Employee - The benefits of a health plan that covers a person as an employee who is neither laid off, terminated, on long-term disability, nor retired (or as that employee's dependent) are determined before those of a health plan that covers that person as a laid-off, terminated, disabled, or retired employee (or as that employee's dependent). If the other health plan does not have this rule, and if, as a result, the health plans do not agree on the order of benefits, this rule (iv) is ignored.
- (v) Longer/Shorter Length of Coverage - If none of the above rules determine the order of benefits, the benefits of the health plan that covered a subscriber longer are determined before those of the health plan that covered that person for the shorter time.

10.04 Effect on the Benefits of the Plan

This section applies when, in accordance with Section 10.03, the Plan is a secondary plan as to one or more other health plans. In that event the benefits of the Plan may be reduced under this section. Such other health plans are referred to as "the other health plans" in (a) immediately below.

- (a) Reduction in the Plan's Benefits -The benefits of the Plan will be reduced when the sum of:
 - (i) the benefits that would be payable for the allowable expenses under the Plan in the absence of this COB provision; and
 - (ii) the benefits that would be payable for the allowable expenses under the other health plans, in the absence of provisions with a purpose like that of this COB provision, whether or not claim is made, exceeds those allowable expenses in a claim determination period. In that case, the benefits of the Plan will be reduced so that they and the benefits payable under the other health plans do not total more than those allowable expenses. When the benefits of the Plan are reduced as described above, each benefit is reduced in proportion. It is then charged against any applicable benefit limit of the Plan.

10.05 Right to Receive and Release Needed Information

Certain facts are needed to apply these COB rules. The claims administrator has the right to decide which facts are needed, and may get needed facts from or give them to any other organization or person. The claims administrator need not tell, or get the consent of, any person to do this. Each person claiming benefits under the Plan must give the claims administrator any facts needed to pay the claim.

10.06 Facility of Payment

A payment made under another health plan may include an amount that should have been paid under the Plan. If that occurs, the claims administrator may pay that amount to the organization that made that payment. That

amount will then be treated as though it were a benefit paid under the Plan. The claims administrator will not have to pay that amount again. The term “payment made” includes providing benefits in the form of services, in which case “payment made” means reasonable cash value of the benefits provided in the form of services.

10.07 Right of Recovery

If the amount of the payments made by the claims administrator is more than should have been paid under this COB provision, recovery of the excess may be made from one or more of:

- (a) the persons paid or for whom paid;
- (b) insurance companies; or
- (c) other organizations.

The “amount of the payments made” includes the reasonable cash value of any benefits provided in the form of services.

ARTICLE XI

COBRA CONTINUATION COVERAGE RIGHTS

11.01 General Information

The right to COBRA continuation coverage was created by a federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA). COBRA continuation of coverage can become available to you when you would otherwise lose your group health coverage. It can also become available to other members of your family who are covered under the Plan when they would otherwise lose their group health coverage.

COBRA continuation coverage is a continuation of Plan coverage when coverage would otherwise end because of a life event known as a “qualifying event.” Specific qualifying events are listed later in this Plan document. After a qualifying event, COBRA continuation coverage must be offered to each person who is a “qualified beneficiary.” You, your spouse and your dependent children could become qualified beneficiaries if coverage under the Plan is lost because of the qualifying event. Under the Plan, qualified beneficiaries who elect COBRA continuation coverage must pay for the coverage.

11.02 Qualified Beneficiary

For purposes of this Article, the term “qualified beneficiary” means any individual who, on the day before the qualifying event, is a participant under the Plan as:

- (a) the non-Medicare subscriber;
- (b) the non-Medicare spouse of the subscriber; or
- (c) the non-Medicare dependent child of the subscriber.

11.03 Qualifying Events

- (a) If you are the **employee**, you will become a qualified beneficiary if you lose your coverage under the Plan because either of the following events happens:
 - (i) your hours of employment are reduced, or
 - (ii) your employment ends for any reason other than your gross misconduct and you do not qualify as a vested employee under the MoDOT Patrol Employees’ Retirement System.
- (b) If you are the **spouse of a subscriber**, you will become a qualified beneficiary if you lose coverage under the Plan because one of the following qualifying events happens:
 - (i) your spouse’s hours of employment are reduced;
 - (ii) your spouse’s employment ends for any reason other than his or her gross misconduct; or
 - (iii) you become divorced or legally separated from your spouse.
- (c) If you are a **dependent child**, you will become a qualified beneficiary if you lose coverage under the Plan because one of the following qualifying events happens:
 - (i) the parent-employee’s hours of employment are reduced;

- (ii) the parent-employee's employment ends for any reason other than his or her gross misconduct;
- (iii) the child stops being eligible for coverage under the Plan as a "dependent child."

11.04 Non-Qualifying Events

The following are non-qualifying events for which the Plan is not required to offer COBRA coverage:

- (a) participants eligible for Medicare;
- (b) participants eligible for continuation of coverage as Vested members of the MoDOT and Patrol Employees' Retirement System;
- (b) participants electively cancelling their medical insurance coverage;
- (d) participant's loss of coverage is due to gross misconduct; or
- (c) dependent children age twenty-five (25) years of age who fail to submit an "Attestation for Dependent Child" form to the Employee Benefits' office attesting they do not have medical insurance coverage through his/her employer and they are not eligible for coverage through active military. These guidelines are in accordance with the new Patient Protection Affordable Care Act (PPACA), effective January 1, 2011.

11.05 Vested Status vs. COBRA

Terminated employees with Vested status, can continue our medical coverage for himself and any eligible dependents as long as premiums are paid and for dependents as long as they are eligible.

11.06 Applicable Premium

For purposes of this Article, the term "applicable premium" means the cost of the coverage as determined pursuant to the code.

11.07 COBRA Election Period

For purposes of this Article, the term "COBRA election period" means the 60-day period beginning on the later of the date on which coverage terminates under the Plan by reason of a qualifying event or the date notice is given to a participant pursuant to Section 11.11.

11.08 Maximum Coverage Period

In the case of a qualifying event specified in Section 11.03, coverage may be continued, pursuant to this Article:

- (a) for a maximum period of 18 months when the qualifying event is the end of employment or reduction of the employee's hours of employment and the employee is no longer eligible for benefits;
- (b) if the qualified beneficiary is determined, under Title II or Title XVI of the Social Security Act, to have been disabled at the time of a qualifying event specified in Section 11.03, coverage may be extended from 18 to 29 months and the disability would have to have started at some time before the 60th day of COBRA continuation coverage and must last at least until the end of the 18-month period of continuation coverage;
- (c) If your family experiences another qualifying event while receiving 18 months of COBRA continuation coverage, the spouse and dependent children in your family can get up to 18 additional months of

COBRA continuation coverage, for a maximum of 36 months, if notice of the second qualifying event is properly given to the Plan. This extension may be available to the spouse and any dependent children receiving continuation coverage if the qualifying event is a divorce or legal separation, or if the dependent child stops being eligible under the Plan as a dependent child, but only if the event would have caused the spouse or dependent child to lose coverage under the Plan had the first qualifying event not occurred;

- (d) The maximum period of 36 months applies to any qualifying event other than the termination of employment or reduction of employee's hours so that the employee is not eligible for benefits.

11.09 Terminating Events

The 18-, 29- and 36-month periods specified in Section 11.07 are the maximum continuation periods required by law. However, in no event may coverage be continued beyond:

- (a) the first day, after the qualified beneficiary elects to continue coverage, on which the qualified beneficiary is covered under another employer's medical plan provided the new plan does not contain any exclusion or limitation with respect to any pre-existing condition of such beneficiary;
- (b) the day the qualified beneficiary is entitled to Medicare coverage, except for former spouses who are Medicare eligible;
- (c) the end of the last period for which timely premium payments are made pursuant to Section 11.10; or
- (d) termination of the Plan.

11.10 Rights and Privileges during Continuation Period

During the continuation period, each qualified beneficiary will be afforded the same rights and privileges, with respect to bringing in new dependents and choosing a Plan option as regular subscribers; however, the only dependents who will be considered qualified beneficiaries in their own right are those who were enrolled in the Plan on the day immediately preceding the initial qualifying event.

11.11 Premium Requirements

The applicable premium for any continuation of coverage pursuant to this Article will be paid by the qualified beneficiary in a timely manner and in monthly installments. Continuation of coverage will cease pursuant to this Article upon the failure to make timely payment of any applicable premium with respect to the participant for whom coverage has been continued. The initial payment will be deemed timely if received within 45 days of the date the election is made; subsequent payments will be due on the first day of the month for which they apply, with a grace period of 30 days following such due date.

11.12 Notice Requirements

- (a) The Board of Trustees will provide, at the time of commencement of coverage, written notice to each employee subscriber and to the spouse (if any) of the subscriber, of the rights provided under this Article.
- (b) The Board of Trustees will provide, at the time of a qualifying event specified in Sections 11.03 written notice to each employee subscriber and to the enrolled spouse and eligible dependents (if any) of the subscriber, of the rights provided under this Article.
- (c) The subscriber or the qualified beneficiary is responsible for notifying the Board of Trustees of a divorce or legal separation, or cessation of dependent eligibility within 60 days after the date of such qualifying event. The qualified beneficiary who is determined under Title II or Title XVI of the Social Security Act, to have been disabled at the time of a qualifying event specified in Section 11.03 is responsible for

notifying the Board of Trustees of such determination within 60 days after the date of the determination and for notifying the Board of Trustees within 30 days of the date of any final determination under such titles that the qualified beneficiary is no longer disabled.

- (d) The Board of Trustees will notify any qualified beneficiary of such qualified beneficiary's rights under this Article within 14 days of receiving the notice pursuant to Section 11.11(a) or within 14 days of the qualifying event, whichever is applicable. Any notification to an individual who is a qualified beneficiary as the spouse of the subscriber will be treated as notification to all other qualified beneficiaries residing with such spouse at the time such notification is ma

ARTICLE XII

CLAIM PROCEDURE AND ARBITRATION RIGHTS

12.01 Claim for Benefits

Initial Determination - Any claim for benefits will be made to the claims administrator. If the claims administrator denies a claim, the claims administrator will provide notice to the subscriber, in writing, within 60 days after the claim is filed. The notice will set forth the reasons for the denial or adjustment.

12.02 Payment of Benefits

- (a) When services are received from a participating network provider, the provider will file all necessary claims and the claims administrator will make payment directly to the provider. The claims administrator is authorized to make payments directly to providers furnishing covered services for which benefits are provided under the Plan, provided the charges are submitted on an approved claim form along with an assignment of payment to the provider. The claims administrator reserves the right in all instances to make payments directly to the subscriber. Any payments made by the claims administrator will discharge the Plan's obligation with respect to the amounts so paid.

All claims must be submitted within 12 months after covered services are rendered to be eligible for payment.

- (b) The claim must include the data necessary for the claims administrator to determine benefits. Itemized bills must be filed with the claim form and such bills will not be returned. Benefits will be paid directly to the subscriber or provider.
- (c) The rights of a participant and the benefits to which he is entitled or for which he applies under the Plan are not assignable, except for assignment of payments to a provider, or in accordance with the subrogation provisions of the Plan.
- (d) After covered services are rendered, the claims administrator will have no liability to any person because of the refusal of a request to pay or withhold payment for such services.
- (e) All benefits owed to the participant at death will be paid to the participant's estate. If there is no estate, the Plan reserves the right to make payment to a relative by blood or by marriage who appears to be equitably entitled to payment. The participant and his estate will hold the Plan harmless for any improper payments. This provision will be binding on all successors, administrators and assigns acting on behalf of the participants.
- (f) The Board of Trustees, at its own expense, will have the right and opportunity to have a physician of its choice examine the participant who is requesting payment, when and as often as it may reasonably require, during the pendency of a request. The Board will also have the right to have an autopsy performed in case of death, where it is not forbidden by law.

12.03 Arbitration Rights

- (a) The Missouri Department of Transportation and Missouri State Highway Patrol shall maintain the Arbitration Committee for the purpose of resolving disputed claims. The membership of the committee shall be appointed by the respective chief administrative officers.

The committee may be contacted as follows:

MoDOT and MSHP Arbitration Committee
Medical and Life Insurance Plan
P. O. Box 270
Jefferson City, MO 65102

- (b) If any participant covered under the Plan, as evidenced by coverage being in force at the time of loss, shall disagree with the adjustment of any claim, the participant shall make written request to the claims administrator for reconsideration and furnish any additional information to substantiate the claim. **(Coventry's complete appeals process is posted on their website at www.modot-mshp-cvty.com.)** The claims administrator will review any new information submitted, reconsider the claim and then supply a written response to the participant to support either a second denial or allow payment of the claim. If benefits are again denied by the claims administrator, the participant may submit a letter of disagreement (along with a copy of the claims administrator's second denial report and supporting information) to the Arbitration Committee. The Arbitration Committee shall meet as soon as possible to evaluate the disputed claim.
- (c) Arbitration Committee decisions will be forwarded to the Board of Trustees for final consideration.
- (d) The Board of Trustees may request further evaluation of a disputed claim by submitting the claim to a professional medical group, which provides retrospective reviews of medical services to plan participants. If a review is to be performed, all documentation will be submitted to the professional medical group for their consideration and recommendation.
- (e) The Arbitration Committee will notify the participant in writing of all final decisions with a copy to the Board of Trustees and the claims administrator.

12.04 Legal Action

No action at law or in equity shall be brought to recover on the Plan prior to the expiration of 60 days after a claim has been filed in accordance with the requirements of the Plan, nor shall such action be brought at all unless brought within three years from expiration of time within which proof of loss is required by the plan.

12.05 Misstatements

- (a) Misstatements made at the time of enrollment or when a claim is made may be grounds for denying enrollment, canceling enrollment or refusing claim payment.
- (b) Any misstatements involving Articles I – XVII of the Plan may be used in canceling enrollment or denying enrollment in the Basic (State Paid) Life Insurance Plan and/or Optional Life Insurance Plan.
- (c) Failure to cooperate with the Board of Trustees (or their designated representatives), the claims administrator or the Arbitration Committee with regard to the investigation of a claim may result in denial of that claim and subsequent claims.

ARTICLE XIII

FUNDING POLICY

13.01 General Information

The State, through a Board of Trustees, will control the funds, establish the premium rates, implement necessary or desired policy revisions and provide general administrative control.

Amounts needed to pay claims and expenses, and to fund the Plan's reserve liabilities, are determined periodically by an independent actuary subject to approval by the Board of Trustees and the Commission.

13.02 State Contributions

(a) Employee Subscriber -

- (i) The state will contribute a certain amount per month for each employee, long-term and work-related disability recipient. The state's contribution for the employee will be that portion of their contribution that is not used for the state life insurance premium.
- (ii) No state contribution will be made for employee subscribers who are on leave of absence without pay. Such subscribers may continue coverage by paying the required contribution without state participation.
- (iii) Active employees on active military leave who continue their medical coverage will receive the state share as long as they are on a paid leave status.
- (iv) Family medical leave recipients in paid or unpaid leave status will receive the state contribution for 12 weeks per calendar year.

(b) Non-Subscriber Employees - If an employee refuses or is not yet eligible for Plan coverage, the state contribution will be added to the funds established to finance the medical and life insurance plans. In no event will a non-subscriber employee receive reimbursement of the state contribution.

(c) Retiree Subscriber - The state will contribute a certain amount per month for each retiree subscriber, provided the retiree has been retained as a special consultant as authorized in Chapter 104 RSMo.

(d) Surviving Spouse Subscriber - The state will contribute a certain amount per month for each surviving spouse subscriber.

(e) Vested and Continuation of Coverage (C.O.B.R.A.) Subscribers - These subscribers will receive no state contribution.

13.03 Subscriber Contribution Amount

The subscriber contribution will vary depending upon the type of subscriber coverage selected, the amount needed to fund the Plan, and the amount of contribution authorized by the Commission. Subscriber contributions are due prior to the first day of each month of coverage. If payment is not received, coverage will end as of the first day of the month for which the subscriber is delinquent.

13.04 Payment of Subscriber Contributions

Subscriber contributions are due in advance of the coverage date.

All contributions will be collected by payroll deduction unless:

- (a) the subscriber is not eligible to receive a payroll or retirement check or one sufficient to cover the required contribution, or
- (b) the employee is on an authorized leave of absence without pay.

If payroll deduction payments are not available, the subscriber will be required to make payments in a manner prescribed by the Board of Trustees.

13.05 Reimbursement of Contributions

- (a) Reimbursement of excess contributions shall not be issued if the subscriber is enrolled in the cafeteria plan and the administrator of the cafeteria plan does not approve a change in status. The subscriber would continue in the same premium category for the remainder of the calendar year.
- (b) Except as outlined in (a) above, a participant may be eligible for reimbursement of excess contribution as follows:
 - (i) Reimbursement shall be issued for excess contributions received by the Plan for the coverage period after the date proper documentation of a plan change or termination of policy is received in the Employee Benefits' office located at the MoDOT Central Office in Jefferson City.

(Ex: A premium has been collected for May's coverage and we receive proper documentation by the last business day in April to cancel coverage effective May 1st.)
 - (ii) Reimbursement of excess contributions shall be issued, as outlined herein, if excess contributions were paid in reliance on misstatements of the Board of Trustees or its' designated representatives (with supporting documentation), but shall be limited to twelve (12) months of reimbursement. However, reimbursement of excess contributions will not be issued if the Plan paid claims for medical services and/or prescription drug costs during the twelve (12) month reimbursement period.
 - (iii) Reimbursement of excess contributions shall not be limited in the event of death of the subscriber or a participant of the Plan. However, premiums are not prorated and reimbursement shall not be issued for the month of death.

Any medical and/or prescription claims paid for the participant, whose Plan coverage was terminated during the refund period, may be recovered by the plan.

ARTICLE XIV

SUBROGATION

14.01 Subrogation for Third Party Liability

Pursuant to Section 104.270, RSMo, and effective January 1, 2003, the commission requires the participant/subscriber to reimburse the Plan for any medical claims paid by the Plan for which there was third-party liability.

The participant/subscriber shall provide information requested by either the Board of Trustees or the third-party administrator regarding the existence of third-party liability. Failure to provide such information may result in the suspension of benefits under the Plan for any and all services including services which are unrelated to the information requested.

Reimbursement to the Plan will be required whenever the participant/subscriber receives payments for physical or mental treatment from individuals, insurance companies, settlements or court verdicts. Any reimbursement shall not exceed the amount actually paid by the Plan.

Reimbursement to the Plan will not be required if the person injured is the policyholder of other liability coverage; however, if the person injured is a dependent of the policyholder of other liability coverage, the Plan can require reimbursement. It is the responsibility of the participant/subscriber to provide to the satisfaction of the Board of Trustees evidence of such insurance.

Failure of any participant/subscriber to provide reimbursement could at the discretion of the Board of Trustees result in the nonpayment of services covered by the Plan including services which are not related to the reimbursement.

ARTICLE XV

ADMINISTRATION

15.01 Plan Administration

The operation of the Plan will be under the supervision of the Board of Trustees. It shall be a principal duty of the Board to ensure that the Plan is carried out in accordance with its terms, and for the exclusive benefit of employees and others entitled to participate in the Plan. The Board of Trustees will have full authority to administer the Plan in all of its details; subject, however, to directives of the Commission and pertinent provisions of the code and other applicable law. The Board's authority includes, but is not limited to, the following:

- (a) to enforce such rules and regulations as the Board deems necessary or proper for the efficient administration of the Plan;
- (b) to interpret the Plan, with the Board's interpretations thereof in good faith to be final and conclusive on all persons claiming or administering benefits under the Plan;
- (c) to decide all questions concerning the Plan and the eligibility of any person to participate in the Plan and to receive benefits provided under the Plan;
- (d) to approve reimbursement requests and to authorize the payment of benefits; and
- (e) to select claims administrators, counsel, accountants, consultants and actuaries as may be required to assist in administering the Plan. Agent/Broker of Record letters will not be provided for any account.

15.02 Examination of Records

The Board will make available to each participant records pertaining to the participant for examination at reasonable times during normal business hours.

ARTICLE XVI

AMENDMENT OR TERMINATION OF PLAN

16.01 Amendment

The employer, at any time may amend any or all of the provisions of the Plan without the consent of any employee or participant. However, such amendment will be without prejudice to any valid claim with respect to covered services rendered prior to the effective date of the amendment.

16.02 Termination

The employer reserves the right to terminate the Plan, in whole or in part, at any time. However, such termination will be without prejudice to any valid claim with respect to covered services rendered prior to the effective date of termination.

ARTICLE XVII

MISCELLANEOUS

17.01 Plan Interpretation

The Plan document sets forth the provisions of the Missouri Department of Transportation and Missouri State Highway Patrol Medical and Life Insurance Plan. The Plan shall be read in its entirety and not severed except as provided below.

17.02 Conversion Privilege

There are no conversion privileges under the Plan.

17.03 Non-Alienation of Benefits

No benefit, right or interest of any person hereunder shall be subject to anticipation, alienation, sale, transfer, assignment, pledge, encumbrance or charge, seizure, attachment or legal, equitable or other process or be liable for, or subject to, the debts, liabilities or other obligations of such person, except as otherwise required by law.

17.04 Limitation on Employee Rights

Nothing appearing in or done pursuant to the Plan shall be held or construed:

- (a) to give any person any legal or equitable right against the employer, the Board of Trustees, or the claims administrator, except as expressly provided herein or provided by law;
- (b) to create a contract of employment with any employee, to obligate the employer to continue the service of any employee or to affect or modify the terms of employment of any person in any way; or
- (c) to create any vested rights to benefits or the right to benefits after the termination of coverage.

17.05 Governing Law

To the extent not preempted by federal law, the provisions of the Plan shall be construed, enforced and administered according to the laws of the state of Missouri.

17.06 Severability

If any provision of the Plan is held invalid or unenforceable, its invalidity or unenforceability shall not affect any other provisions of the Plan, and the Plan shall be construed and enforced as if such provision had not been included herein.

17.07 Captions

The captions contained herein are inserted only as a matter of convenience and for reference, and in no way define, limit, enlarge or describe the scope or intent of the Plan, nor in any way will affect the Plan or the construction of any provision thereof.

17.08 Non-Gender Clause

Whenever used in the Plan, the masculine gender will include the feminine and the plural form will include the singular.

**MISSOURI DEPARTMENT OF TRANSPORTATION
AND
MISSOURI STATE HIGHWAY PATROL**

BASIC (STATE PAID) LIFE INSURANCE PLAN

I. ELIGIBLE EMPLOYEES

All employees and individuals on work-related and long-term disability status with the Missouri Department of Transportation and Missouri State Highway Patrol who are members of the MoDOT & Patrol Employees' Retirement System. (The eligibility date for work-related disability recipients was July 1, 2004.)

II. EFFECTIVE DATE OF COVERAGE

The effective date for new employees who enroll in Basic Life Insurance coverage shall be the employee's date of hire.

Application must be made within 31 days after eligibility.

III. AMOUNT OF LIFE INSURANCE

- A. Beginning January 1, 2001, the maximum amount of insurance for which an active employee is eligible shall be one (1) times the annual benefit base rate rounded to the next higher \$1,000. The Missouri Department of Transportation and the Missouri State Highway Patrol provide this benefit at no cost to the employee. The amount of coverage will be effective January 1st of each year based on the employee's July 31st annual benefit base rate of the preceding year.
- B. Long-term disability members approved for benefits prior to January 1, 2002, will continue with the amount they currently have in force. A long-term disability member approved for disability benefits after January 1, 2002, can retain the amount of insurance coverage in force on the date he ceased to be an active full-time, permanent part-time or seasonal employee eligible for benefits.
- C. A work-related disability member approved for disability benefits July 1, 2004, or after, can retain the amount of insurance coverage in force on the date he ceased to be an active full-time, permanent part-time or seasonal employee eligible for benefits.
- D. This coverage shall provide for triple indemnity if death is a result of injury or disease occurring on or after the effective date of insurance and arising out of and in the course of actual performance of duty as an employee.

IV. COST

There shall be no cost to the employee for the life insurance provided, unless such employee is on an authorized leave of absence without pay for the purpose of military, education, maternity, illness, emergency, family medical leave, etc. In such cases, the employee may continue coverage by paying the required premium normally paid by the state for the amount of coverage provided.

Evidence of insurability will not be required if an employee's insurance was canceled while on an authorized leave of absence and he later returns to work. The employee will qualify for coverage as soon as he is paid on the payroll. Application should be completed at that time for re-enrollment.

Individuals on work-related disability or long-term disability status who desire to continue the life insurance coverage, must pay the required premium normally paid by the state for the amount of coverage provided. The premium payment is to be made through payroll deduction for those disability recipients approved prior to July 1, 2004. After July 1, 2004, the disability recipient will be required to make a manual payment or electronic transfer of funds.

V. BENEFICIARY

The employee, work-related disability recipient, or long-term disability recipient must name the beneficiary(s) on the furnished form. The beneficiary(s) may be changed by completing and filing the required form.

VI. TERMINATION OF COVERAGE

Coverage for terminating or retiring employees terminates at the end of the month in which the employee terminates or retires.

Coverage for individuals on work-related disability or long-term disability status will terminate in the event the individual retires or fails to make the premium payment. If coverage is canceled while on work-related disability or long-term disability, re-enrollment is not allowed until the employee returns to active work status.

VII. PORTABILITY AND CONVERSION PRIVILEGES

If Basic Life Insurance, or any portion thereof, terminates, any individual covered under the Policy may make application for portability or conversion with the current insurance carrier without providing Evidence of Good Health.

To apply for portability or conversion, the individual must, within 31 days of the date group coverage terminates, make written application to the insurance carrier and pay the premium required for his age and class of risk.

**MISSOURI DEPARTMENT OF TRANSPORTATION
AND
MISSOURI STATE HIGHWAY PATROL**

OPTIONAL GROUP LIFE INSURANCE PLAN

I. ELIGIBILITY PROVISIONS

A. Employees, Long-Term and Work-Related Disability Recipients, and Retirees

All Employees and individuals on work-related disability and long-term disability status with the department or the patrol who are members of the MoDOT & Patrol Employees' Retirement System and who are currently Covered under the Basic (State Paid) Life Insurance Plan are eligible.

Employees on an approved military leave of absence may elect to continue their Coverage as long as premiums are paid and they have continued their Basic (State Paid) Life Coverage. If the Employee terminates his Coverage while on an approved military leave of absence, they may reinstate their Coverage upon return to active employment following an honorable discharge (provided the total military leave does not exceed five (5) years). The Coverage can be provided without Evidence of Good Health as long as they are rehired by the Employer and make application for reinstatement of Coverage within thirty-one (31) days from the date of their return to active employment. Coverage cannot go into effect before the person returns to active employment and cannot exceed the amount for which they are eligible.

Retirees may retain insurance Coverage as specified in Article 19.3, "Amount of Life Insurance" C., D., E., and F.

No Retiree or disability recipient may terminate Coverage and later re-enroll, except a Retiree who terminates their Coverage while on active military leave. Upon their return from military leave, they may reinstate their Coverage in the amount they had immediately prior to the leave (provided the leave does not exceed five (5) years). The Retiree must apply for reinstatement within thirty-one (31) days from the date of honorable discharge from the military.

B. Dependents - Spouse and/or Child(ren) of Employees Enrolled in Optional Group Life Insurance

- (1) Spouse means the person to whom you are legally married and is eligible for Coverage if:
- (a) the Employee is enrolled; Work-Related or Long-Term Disability Recipient or Retiree is enrolled;
 - (b) if application is received within thirty-one (31) days of date of Marriage or Employee's date of hire; or Evidence of Good Health is approved by the insurance carrier prior to the Employee's status change to Work-Related or Long-Term Disability Recipient or Retiree.

- (2) Unmarried Dependent children (including natural born child(ren), legally adopted child(ren), stepchild(ren), or any other child(ren) related to you by blood or Marriage and who lives with you in a regular parent-child relationship), as follows:
 - (a) If the Subscriber is enrolled in Dependent child life insurance Coverage, the Dependent child(ren) will be Covered from live birth or at the time of physical placement for an adopted child, up to the date the child turns twenty-six (26) years of age and continues to meet the eligibility requirements of the Plan.
 - (b) If you do not otherwise have Dependent life insurance Coverage in place for your child(ren), you must apply in writing within thirty-one (31) days from the date Dependent life insurance under this provision is effective.
 - (c) Unmarried Dependent children twenty-six (26) years of age or older if the child is disabled, primarily dependent upon you for financial support, and satisfactory proof of the dependent upon you for financial support, and satisfactory proof of the Dependent child's disability is submitted within thirty-one (31) days of the date the Dependent child reaches such age. The insurance carrier will have the right to require satisfactory proof that the child continues to meet the required conditions as often as necessary during the first two (2) years of continuation, but not more than once a year after that.

Any Dependent who is full-time military, naval or air force service cannot be a Dependent.

II. EFFECTIVE DATE OF COVERAGE

A. Employees, Long-Term and Work-Related Disability Recipients, and Retirees

The effective date of Coverage of a new Employee will be on the first day of the calendar month following date of employment. For insurance Coverage to become effective:

- (a) the Employee must enroll for Coverage within thirty-one (31) days of date of hire;
- (b) pay the required premiums; and
- (c) meet the active work provisions of the current policy. Employees who do not meet the active work provisions on the effective date will be eligible for Coverage when they return to their assigned duties as specified in the policy.

All Employees enrolled in Optional Group Life Insurance shall become insured on the effective date of their retirement or disability in accordance with III, "Amount of Life Insurance", if they apply for Retiree Coverage and continue to pay their premiums.

B. Dependents - Spouse and/or Child(ren)

- (1) Spouse and/or eligible Dependent child(ren) Coverage, as stated in Article 19.3, G., H. and I., may become effective on the first day of the next calendar month following the Employee's date of hire. For insurance Coverage to become effective the Employee must:

- (a) enroll in Optional Group Life Insurance;
 - (b) enroll for Dependent Coverage;
 - (c) pay the required premiums; and
 - (d) meet the active work provisions of the current policy. Coverage on Dependents of Employees, who do not meet the active work provisions will become effective on the date the Employee returns to their assigned duties as specified in current policy.
- (2) Spouse is eligible for Coverage, as stated in Article 19.3, G and H, on the date of Marriage if:
- (a) the Employee is enrolled in Optional Life Insurance on that date;
 - (b) application is made within thirty-one (31) days of date of Marriage; and
 - (c) premiums are paid.
- (3) Refer to Article 19.7, “Evidence of Insurability”, for additional Spouse Coverage and/or late enrollment requirements.
- (4) Dependent children born after the Employee hire date can enroll as follows:
- (a) effective on the date of birth if application is received within thirty-one (31) days of date of birth; or
 - (b) at any time as long as he/she continues to be an eligible Dependent, application is received, and payroll deduction is authorized to cover any additional premium, with an effective date the first of the month following receipt of application. Evidence of Insurability is not required.

III. AMOUNT OF LIFE INSURANCE

A. Employees

The maximum amount of insurance for which an Employee is eligible shall be six (6) times the annual Benefit base rate rounded to the next higher one thousand dollars (\$1,000) and not to exceed eight hundred thousand dollars (\$800,000).

New Employees can choose from the following elections when enrolling for Coverage:

- (1) Minimum of fifteen thousand dollars (\$15,000).
- (2) A multiple of one (1) times to six (6) times their annual Benefit base rate with automatic annual increases effective January 1 of the year following an increase in their annual Benefit base rate reflected on July 31st of the preceding year.

- (3) A flat amount in a one thousand dollars (\$1,000) increment equal to or greater than fifteen thousand dollars (\$15,000) not to exceed six (6) times their annual Benefit base rate; with no automatic annual increase without evidence of insurability.

B. Work-Related and Long-Term Disability Recipients

Long-term disability Participants approved for Benefits prior to January 1, 2002, will continue with the amount they currently have in force. A long-term disability Participant approved for disability Benefits after January 1, 2002, can retain the amount of insurance Coverage in force on the date he ceased to be an active full-time, permanent part-time or seasonal Employee eligible for Benefits.

Work-Related Disability Recipients approved for Benefits prior to July 1, 2004, will continue with the amount of Coverage they currently have in force. A work-related disability Participant approved for disability Benefits after July 1, 2004, can retain the amount of insurance Coverage in force on the date he ceased to be an active full-time, permanent part-time or seasonal Employee eligible for Benefits.

Work-Related and Long-Term Disability Recipients can continue with the amount of Coverage (as stated above) they have in force at the time they are approved for disability. When they become eligible to retire, they can continue all or a portion of their optional life insurance in accordance with the Plan guidelines stated in Article 19.3, C., D., E. and F.

C. Retirees (Retirement date prior to September 1, 1998.)

- (1) Employees retired prior to May 1, 1982 are not eligible for Coverage.
- (2) Employees retired between May 1, 1982 and May 1, 1984 may retain an amount no greater than two thousand five hundred dollars (\$2,500) in multiples of five hundred dollars (\$500).
- (3) Employees retired on or after May 1, 1984, may retain an amount no greater than five thousand dollars (\$5,000) in multiples of five hundred dollars (\$500).
- (4) Employees retired on or after September 1, 1988, may retain an amount no greater than ten thousand dollars (\$10,000) in multiples of five hundred dollars (\$500).
- (5) Employees retired on or after May 1, 1996, may retain an amount no greater than sixty thousand dollars (\$60,000) in multiples of five hundred dollars (\$500).

D. Retirees under the "Closed Plan" (Retirement date September 1, 1998 or thereafter) may retain Optional Group Life Insurance into retirement as follows:

- (1) Maximum Coverage of sixty thousand dollars (\$60,000)
- (2) Minimum Coverage of fifteen thousand dollars (\$15,000)
- (3) Employees who carry Optional Group Life Insurance in an amount less than sixty thousand dollars (\$60,000) may retain the amount of optional Coverage they carried as an Employee, plus the amount of their Basic (State Paid) Life Insurance Coverage, not to exceed sixty thousand dollars (\$60,000).

- (4) Any Employee with less than sixty thousand dollars (\$60,000) Coverage (Optional plus Basic (State Paid)) as an active Employee must provide evidence of insurability to increase their Coverage (maximum sixty thousand dollars (\$60,000)). Application for increased Coverage must be submitted and approved made prior to retirement.

Example: An Employee carries fifteen thousand dollars (\$15,000) Optional Group Life Insurance, plus thirty thousand dollars (\$30,000) Basic (State Paid) Life Insurance, for a total of forty-five thousand dollars (\$45,000) in Coverage. The maximum amount of Optional Group Life Insurance this Employee may carry into retirement (without evidence of insurability) is forty-five thousand dollars (\$45,000).

- (5) Employees who carry only the Basic (State Paid) Life Insurance may elect Optional Group Life Insurance in an amount equal to their Basic (State Paid) Life, not to exceed sixty thousand dollars (\$60,000), without evidence of insurability. If Basic (State Paid) Life Coverage is less than sixty thousand dollars (\$60,000), they must provide evidence of insurability to increase their Coverage (maximum sixty thousand dollars (\$60,000)). Application for increased Coverage must be made prior to retirement.
- (6) Employees who did not carry the Basic (State Paid) Life Insurance at the time of their retirement **are ineligible** to enroll in Optional Group Life Insurance.

E. Retirees (Retirement date July 1, 2000 or thereafter) retiring under the “Year 2000 Plan” and receiving the temporary annuity of eight-tenths of a percentage point (.8%) may retain Optional Group Life Insurance as follows:

- (1) Minimum of fifteen thousand dollars (\$15,000)
- (2) Employees who carry Optional Group Life insurance can retain the amount of Coverage in effect the month prior to retirement (Basic (State Paid) Coverage cannot be included in this amount).
- (3) Coverage will be reduced at age sixty-two (62) to the maximum allowed of sixty thousand dollars (\$60,000).

F. Employees retiring January 1, 2007, will be eligible for the above Coverage amounts listed in Article 19.3, D. and E., and Spouse Coverage listed in Article 19.3 H. The Coverage amounts must be in one thousand dollars (\$1,000) increments.

G. Spouse (Effective May 1, 2006)

H. Spouse insurance Coverage is as follows:

- (1) Guaranteed issue of fifteen thousand dollars (\$15,000), if enrolled within thirty-one (31) days of Employee’s date of hire or within thirty-one (31) days of date of Marriage.
- (2) Coverage greater than fifteen thousand dollars (\$15,000) requires an approved application, and may be purchased in multiples of five thousand dollars (\$5,000) up to one hundred thousand dollars (\$100,000), not to exceed the amount of insurance carried by the Employee, Work-Related Disability Recipient or Long-Term Disability Recipient.
- (3) Minimum of fifteen thousand dollars (\$15,000)

- (4) Spouse Coverage can continue into retirement in five thousand dollars (\$5,000) increments not to exceed Retiree's Coverage amount; however, upon the Retiree's death, Spouse Coverage terminates.

- I. Child(ren)

Child(ren) insurance is issued for a fixed amount of fifteen thousand dollars (\$15,000) of Coverage per child.

IV. ADJUSTMENTS AMOUNT OF COVERAGE OR PREMIUM

- A. Employees, Long-Term and Work-Related Disability Recipients, and Retirees

If an Employee, Long-Term or Work-Related Disability Recipient, or Retiree's birthday causes him to be placed into an age bracket requiring a higher premium, the payroll deduction premium will be automatically increased the month following his date of birth.

If the annual Benefit base rate of an Employee decreases and reduces the maximum amount of Coverage the Employee is entitled to, such reduction will automatically take effect on the first day of the month following the reduction in eligibility.

Retirees may reduce the amount of their Coverage in five hundred dollars (\$500) increments at any time but may not increase the amount of their Coverage.

Work-Related Disability Recipients and Long-Term Disability Recipients may reduce the amount of their Coverage in one thousand dollars (\$1,000) increments at any time but may not increase the amount of their Coverage. They also cannot discontinue Coverage and later re-enroll. When the Disability Recipients become eligible to retire, they can continue all or a portion of their optional life insurance as set out in Article 19.3, C., D., E., and F, offered to Retirees. If a Work-Related Disability Recipient or Long-Term Disability Recipient had canceled his Optional Group Life Insurance and returns to active work status he can re-enroll with approved evidence of insurability.

Coverage for Employees participating in the Optional Group Life Insurance, who are enrolled in a multiple of one (1) times to six (6) times their annual Benefit base rate, will automatically increase on January 1, the year following any increase in the Employee's annual Benefit base rate reflected on July 31st of the preceding year.

- B. Spouse

The premium for Spouse Coverage will automatically increase the month following the birthday of the Employee, Work-Related or Long-Term Disability Recipient, or Retiree, which causes the Spouse to be placed into an age bracket requiring a higher premium. The premium for Spouse Coverage is based on the Employee's Work-Related or Long-Term Disability Recipient's, or Retiree's age.

If the annual Benefit base rate of an Employee decreases and reduces the amount of Optional Group Life Insurance for that Employee, the amount of Spouse insurance may be reduced. If the amount of Spouse insurance reduces, the reduction will automatically take effect on the first day of the month following the reductions in wage or Benefit.

If the annual Benefit base rate of an Employee increases, the amount of Spouse insurance may be allowed to increase, subject to the limitations of the Plan with evidence of insurability. This increase must be initiated by the Employee.

V. COST

The cost of the insurance is based upon the amount of Coverage times the rate for their appropriate age bracket.

The cost of insurance for a Spouse is based upon the amount of Coverage times the rate for the Employee's, Work-Related or Long-Term Disability Recipient's, or Retiree's appropriate age bracket.

Rates are based on a contract bid by an insurance carrier and may change. Participants will be notified in advance of any such changes.

VI. BENEFICIARY

A. Employees, Long-Term and Work-Related Disability Recipients, and Retirees

The Employee, Long-Term or Work-Related Disability Recipient or Retiree must designate a beneficiary or beneficiaries before insurance becomes effective. Such a designation must be indicated on the furnished form. The beneficiary or beneficiaries may be changed by completing and filing the required form.

B. Dependents - Spouse and/or Child(ren)

The Employee, Retiree, Work-Related Disability Recipient or Long-Term Disability Recipient is the beneficiary of Dependents Optional Group Life Insurance.

VII. EVIDENCE OF INSURABILITY

A. General Requirements

If evidence of insurability (EOI) is required based on one (1) of the conditions listed below, you must complete and submit a Medical History Statement along with the enrollment form to your insurance representative. Any proposed insured may also be asked to have a health examination. If the insurance company approves Coverage, the insurance will become effective on the first day of the month following the date of approval if the Employee meets the active work provisions of the current policy.

(1) Employees – EOI required if:

- (a)** enrollment is not made within thirty-one (31) days from the date of employment.
- (b)** Employee elects to increase his Coverage for any reason other than an annual Benefit base rate increase.
- (c)** Employees, Work-Related and Long-Term Disability Recipients planning to retire and wishing to retain their current level of Coverage after retirement will not be required to show evidence of insurability, except as set forth in Article 19.3

- (2) Spouse – EOI required if:
 - (a) enrollment for Spouse Optional Group Life Insurance is not made within thirty-one (31) days of the date of eligibility.
 - (b) at any time when the desired amount of Spouse insurance exceeds fifteen thousand dollars (\$15,000).
 - (c) at any time after the initial eligibility period if you request an increase in the amount of Spouse insurance.
- (3) Dependent – Children

Evidence of Insurability will not be required for child(ren) Coverage at any time as long as they meet the eligibility guidelines for a Dependent.

VIII. TERMINATION OF COVERAGE

- A. Employees, Long-Term and Work-Related Disability Recipients, and Retirees terminates as follows:
 - (1) termination of this policy;
 - (2) terminating Employees at the end of the last month of employment;
 - (3) retiring Employees at the end of the last month of employment unless the Employee enrolls under the Retiree provisions;
 - (4) change of status from long-term or work-related disability to Retiree, unless the disability Participant enrolls under the Retiree provisions; or
 - (5) failure to make required premium payment;
 - (6) termination is requested by the Participant, with cancellation to be effective the first day of the month following receipt of the cancellation form in the Employee Benefits Office located in Jefferson City, MO.
- B. Dependents - Spouse and/or Child(ren)

Spouse Coverage will terminate as follows:

- (1) the date Coverage of the Employee, Long-Term and Work-Related Disability Recipient, or Retiree terminates;
- (2) in the event of a divorce; or
- (3) the Employee, Long-Term and Work-Related Disability Recipient, or Retiree elects to terminate Spouse Coverage, with cancellation to be effective the first day of the month following receipt of the cancellation form in the Employee Benefits Office located in Jefferson City, MO.

Child Coverage will terminate as follows:

- (1) child's Marriage;
- (2) child attains twenty-six (26) years of age;
- (3) on the child's twenty-sixth (26th) birthday unless the child qualifies for continued Coverage as a disabled child and the Employee reapplies for Coverage within thirty-one (31) days of the normal termination date of the child;
- (4) the date Coverage of the Employee, Long-Term and Work-Related Disability Recipient terminates;
- (5) the Employee, Long-Term or Work-Related Disability Recipient elects to terminate child Coverage, with cancellation to be effective the first day of the month following receipt of the cancellation form in the Employee Benefits Office located in Jefferson City, MO; or
- (6) Employee's, Long-Term or Work-Related Disability Recipient's retirement.

IX. PORTABILITY AND CONVERSION PRIVILEGES

If Optional Life Insurance or any portion thereof, terminates, then any individual Covered under the Policy may make application with the insurance carrier for portability or without providing Evidence of Good Health.

To apply for portability or conversion of life insurance, the individual must, within thirty-one (31) days of the date group Coverage terminates, make written application to the insurance carrier and pay the premium required for his age and class of risk.