



Catholic Healthcare West
CHW

**EPO Plus Plan
Summary Plan Description**

Effective January 1, 2010

OVERVIEW	1
About this Booklet.....	1
Your Coverage is Self-Insured	1
How The EPO Plus Plan Works.....	1
Interpreting the Plan’s Provisions.....	2
Contact Information.....	3
GENERAL INFORMATION	4
Who is Eligible for Coverage.....	4
When Coverage Begins.....	5
Cost of Coverage.....	5
Making Changes After Coverage Begins	6
When Coverage Ends	6
Situations Allowing Continuation of Coverage.....	6
Conversion to Individual Coverage.....	11
HIGHLIGHTS OF CHW EPO PLUS PLAN BENEFITS	12
Out-of-Pocket Expenses.....	12
Coverage for Emergency Care	12
When Prior Authorization is Required.....	12
Summary of Benefits	13
EPO PLUS PLAN COVERED SERVICES & SUPPLIES	15
Medical Coverage	15
Chiropractic Coverage	19
Prescription Drug Coverage.....	19
Medical Exclusions and Limitations	25
Chiropractic Care Exclusions and Limitations.....	26

Prescription Drug Exclusions and Limitations	26
IMPORTANT INFORMATION ABOUT YOUR RIGHTS AND RESPONSIBILITIES UNDER THE PLAN	28
Plan Document Governs	28
Discretionary Authority of Plan Administrator and Plan Fiduciaries	28
Claims and Appeals Procedures for the Plan.....	28
Privacy Rights.....	31
Coordination of Benefits.....	32
Facility of Payment.....	33
Important Information for Medicare-Eligible Individuals.....	34
Right of Reimbursement	34
Right of Recovery	34
Medical Malpractice Disputes	35
No Guarantee of Employment.....	35
Plan Future	35
Your Rights Under Federal Law.....	35
Employer Information.....	37
Administrative Information	37

OVERVIEW

About this Booklet

This booklet describes the CHW Exclusive Provider Option (EPO) Plus Plan, which is available to all eligible CHW Mercy and Memorial Hospital employees. If there is a conflict between what is contained in this brochure and the CHW Exclusive Provider Option (EPO) Plus Plan, the Plan terms will prevail. If you wish, you may review all relevant Plan documents by visiting the Human Resources Department.

Your Coverage is Self-Insured

The EPO Plus Plan is a self-insured plan. This means that CHW pays the actual cost of any eligible medical expenses you and your covered dependents have. Managed Care Systems, LP (MCS), a health care plan administrator, administers the Plan on behalf of CHW and processes the claims that you or your providers file. National Pharmaceutical Services (NPS) administers the prescription drug program, and pays benefits for formulary prescription drugs you purchase at NPS network pharmacies or through the IHMO mail order program. By using your medical plan wisely, you can help control the cost of claims and help keep health care coverage affordable for all employees.

How the EPO Plus Plan Works

The EPO Plus Plan provides benefits for preventive medical services. It also covers the expenses when you or a covered family member is ill or injured. You must receive all of your health care from providers in a network of health care providers especially set up for this Plan. If you receive emergency medical care from a non-network provider, you may submit a claim form to be considered for reimbursement.

Your share of the medical costs is lower when your primary care physician (PCP) manages all of your health care; that is, the PCP provides basic health care services, identifies when it's appropriate to consult with a specialist, and refers you to other network specialists when necessary.

Chiropractic care is available through the MCS Chiropractic network. You don't need a referral from your PCP to take advantage of this benefit. However, the EPO Plus Plan pays chiropractic benefits only for care provided by MCS network chiropractic providers.

Prescription drug benefits are administered through NPS. You can purchase up to a 30-day supply of prescription drugs at NPS participating pharmacies. You may purchase up to a 90-day supply of maintenance prescription drugs through the IHMO mail order prescription drug program. The EPO Plus Plan generally does not pay benefits for any prescription drugs that are prescribed by non-participating providers and/or purchased at non-participating pharmacies. However, if you need a prescription while you are out of the network's area, you may submit a claim form to be considered for reimbursement.

What "Exclusive Provider Organization (EPO)" Means

The Plan is referred to as an *exclusive provider organization* (EPO for short) because you must receive care from a group of specially selected network providers.

The EPO Plus Plan offers the CHW EPO Network. It includes the Golden Empire Managed Care (GEMCare) IPA and Delano Regional Medical Group (DRMG), as well as some independent contracts with various specialty physicians.

CHW EPO. The CHW EPO Network consists of primary care physicians (PCPs) and specialists in two physician groups (the GEMCare and DRMG) that operate in central California. Both groups operate similarly; however, providers in one network may be more convenient to your home or workplace.

Each covered family member must select a PCP to manage his or her care. Family members are not required to be enrolled in the same medical group and may select different PCPs. Family practitioners, general practitioners, internists, and pediatricians are all considered to be PCPs.

If you need to consult with a specialist, your PCP will refer you to one within the network. Specialist referrals will be limited to the physician group you have selected; your PCP will look at all appropriate CHW EPO network specialists.

Emergency Care. This Plan will pay for emergency care when medically necessary – even if a non-network provider performs it. Although you do not need prior referral from your PCP in this situation, it is critical that you contact your PCP as soon as you can after receiving emergency services, regardless of whether the provider is in the network. Your PCP will evaluate your medical situation and make all necessary arrangements to assume responsibility for your continuing care. Once your medical condition is no longer an emergency, you must obtain services from a network provider or your care will not be covered.

What “Plus” Means

The *Plus* in EPO Plus means that you have the option to refer yourself to a network specialist - without a referral from your PCP. In this situation, you may select any specialist who is part of the CHW EPO physician group you selected (GEMCare or DRMG). Your share of the cost for the office visit, however, will be higher if you self-refer (do not get a referral from your PCP).

Please keep in mind that the Plan will not pay benefits for self-referrals to non-network providers.

Interpreting the Plan’s Provisions

In order to equitably administer the provisions of this Plan, Catholic Healthcare West (CHW) reserves the exclusive authority and discretion to determine eligibility for benefits, to interpret and apply the provisions of the Plan or any resolutions, administrative rules and regulations, contracts or writings that CHW might adopt or enter into. In addition, CHW reserves the right to resolve any and all claims and disputes regarding the rights and entitlements of individuals to participate in the Plan and to receive benefits and payments pursuant to the Plan.

Part or all of this authority and discretion might be delegated to others, such as the Plan administrator (MCS) or the Employee Benefits Administration Committee at Catholic Healthcare West as described more fully in the section *Important Information about Your Rights and Responsibilities under the Plan* starting on page 28.

Contact Information

This chart will help you get your questions answered quickly.

For information or action on	Contact	Phone	Web/Email
<ul style="list-style-type: none"> ▪ Approved medical expenses ▪ Plan questions ▪ Pre-authorization of care, when required ▪ Claim filing, disputes and appeals ▪ Retail and mail order pharmacy program information ▪ Mail order pharmacy order form ▪ HIPAA privacy rights and privacy complaints 	Managed Care Systems, LP (MCS), the Plan administrator	1-800-414-5860 1-661-716-7100	www.managedcaresystems.com
<ul style="list-style-type: none"> ▪ Administrative matters ▪ Legally domiciled adults ▪ Qualified Medical Child Support Order (QMCSO) ▪ Addresses of dependents not living with you ▪ Benefit payment arrangement while on FMLA Leave ▪ HIPAA privacy complaint ▪ Mail order pharmacy order form ▪ Plan document review ▪ Participating retail pharmacies ▪ Mail order pharmacy program ▪ Pre-authorization of prescription drugs, when required ▪ Mail order pharmacy order form 	Human Resources Department	Memorial Hospital 1-661-327-4647, ext 1962 Mercy Hospital 1-661-663-6353	
	NPS	1-800-546-5677	www.pti-nps.com

GENERAL INFORMATION

Who is Eligible for Coverage

In general, you are eligible for coverage under the CHW health care program, including this Plan, if you are a regular, full-time or part-time employee who is scheduled to work at least 38.5 hours per pay period.

If you are eligible, you may also enroll your eligible dependents, including:

- Your legal spouse, unless you are legally separated,
- Your unmarried dependent children under the age of 19,
- Your unmarried dependent children between ages 19 and 24 whom you claim as dependents on your federal income tax return,
- Your unmarried dependent children of any age who depend on you for financial support due to a physical or mental disability as described under *Definition of Dependent Children*, and
- A legally domiciled adult, based on information available from Human Resources.

Definition of Dependent Children

Dependent children include your unmarried biological children, adopted children, stepchildren, foster children, and children for whom you have been appointed by a court as legal guardian. To be considered a dependent child, your child must be primarily dependent upon you for financial support, unless there is a Qualified Medical Child Support Order (QMCSO) in effect as described below.

Disabled Dependent Children

If you have a dependent child who is physically or mentally disabled, his or her coverage may continue after age 24 (the maximum age for coverage) as long as you continue to pay the required contributions and provide proof that your child meets all of the following conditions.

To remain eligible for medical coverage, your disabled dependent child:

- Cannot hold a full-time job because of a mental or physical handicap that began before he or she reached age 19,
- Must never have been married, and
- Must have remained continuously dependent on you for at least 50% of financial support since he or she became disabled.

From time to time you may be required to provide proof that your child remains disabled and dependent upon you for support.

Qualified Medical Child Support Order (QMCSO)

Under a federal law effective August 10, 1993, it is possible for a court to issue a judgment or decree that directs the Plan administrator to extend health care coverage to children of a non-custodial parent participating in a health care plan under certain circumstances, usually as the result of divorce or separation. In effect, the court order also mandates that the parent take steps to include the child (or children) under his or her health care coverage. This has important consequences in other areas of benefit determination such as Coordination of Benefits (COB), as described on page 32.

Federal law provides that a Medical Child Support Order must meet certain form and content requirements in order to be a *QMCSO*. When an order is received, each affected participant and each child (or the child's representative) covered by the order will be given notice of the receipt of the order. Coverage under the Plan pursuant to a *QMCSO* won't become effective until the Plan administrator determines that the order is a valid *QMCSO*. Generally, the IRS permits a change to your annual election within 31 days of being notified that a *QMCSO* is qualified.

Notwithstanding anything to the contrary contained herein, CHW intends that the Plan comply with all QMCSO deemed to be qualified. A copy of CHW's policy on Qualified Medical Child Support Orders is available from the Human Resources Department.

Legally Domiciled Adults

You may be eligible to cover a legally domiciled adult under the EPO Plus Plan. Please contact the Human Resources Department for more information.

When Coverage Begins

Enrollment

Before coverage will begin, you must enroll.

- ***New employees:*** If you are a new employee, you must enroll within the time period specified by the Human Resources Department to ensure coverage starts when it is supposed to.
- ***Current employees:*** Each year, during CHW's open enrollment, you have the opportunity to enroll in the CHW EPO Plus Plan or any of the other plans available under the CHW health care program. When you enroll by the open enrollment deadline, coverage will begin on the following January 1.

When you complete your enrollment form, you must select a physician group for yourself and each covered dependent from the CHW EPO Network (either GEMCare or DRMG). From the selected physician group, you must then indicate a primary care physician (PCP) for each enrolled family member. Be sure that the PCP is part of the physician group you have selected.

PCP Selection for Dependent Children Who Don't Live With You

If you have a dependent child who doesn't live with you, you must still select a PCP for that child.

If the child lives outside the CHW EPO service area (e.g., a child who goes to college or a child who lives with another parent), his or her coverage will depend where care is provided:

- ***Outside the CHW EPO service area:*** Your child will only be eligible for urgent care and emergency care outside the GEMCare or DRMG service area.
- ***Within the CHW EPO service area:*** Your child will be eligible for Plan benefits for all medical care provided by the child's PCP or by another network physician.

When Coverage Starts

Coverage under the CHW EPO Plus Plan generally begins on the first day of the month after you complete 30 days of employment. For example, if your first day of employment were mid-May, you would complete 30 days of employment by mid-June and would be eligible for coverage on July 1, the first day of the month after you completed 30 days of employment.

If you enroll for coverage during open enrollment, coverage will start on the following January 1.

Your dependents' coverage will begin when your coverage begins, provided you have enrolled them.

If you acquire a new dependent after coverage begins, the date coverage starts will depend on the situation. Refer to *Adding Newly Acquired Dependents after Coverage Begins* on page 6 for details.

Cost of Coverage

Currently, CHW EPO Plus Plan coverage for you and your eligible dependents is offered at no cost to you. CHW pays the full cost of coverage under this Plan.

Making Changes after Coverage Begins

If you are a new employee, after you enroll in the CHW health care program your elections remain in effect for the remainder of the calendar year.

Once a year during CHW's open enrollment period (usually during the 4th quarter), you will have the opportunity to change your medical elections for the upcoming calendar year.

In general, your medical plan elections remain in effect for the calendar year. However, if you have a qualified family status change during the year, you may be eligible to make changes during the year, as explained below.

Qualified family status changes include:

- Getting married, becoming legally separated, or getting a divorce,
- Birth or adoption of a dependent child,
- Death of a spouse or dependent child,
- A change in your employment status that affects your eligibility for CHW medical coverage (such as moving to part-time status),
- A change in your spouse's employment status that affects your spouse's eligibility for benefit coverage with his or her employer (such as losing a job or becoming employed),
- A child becoming ineligible for coverage.

Any change you make in your medical coverage must be related to your change in family status. For example, if you have a baby, you may add your newborn child to your medical plan, but you may not change medical options at that time. You must make any changes to your coverage within 30 days of your status change.

Adding Newly Acquired Dependents after Coverage Begins

When you enroll a newly acquired dependent within 30 days of the date they become your dependent (or the date of legal guardianship), their coverage will begin as described below:

- For your new spouse and his or her dependents, coverage begins on the first of the month after the marriage date,
- For a newborn, coverage begins on the date of birth,
- For a newly adopted child, coverage begins on the date he or she is placed in your physical custody,
- For a dependent child for whom you are named the legal guardian, coverage will begin on the first day of the month after the administrator receives the enrollment request.

When Coverage Ends

Coverage for you and your dependents under the EPO Plus Plan generally ends the last day of the month:

- Your employment with CHW ends,
- You or your dependents no longer meet the eligibility requirements described on page 4 or any new eligibility requirements that CHW establishes,
- Your benefits are discontinued as a result of the leave policy rules concerning benefit continuation, as described in the following section,
- You stop making any required contributions for coverage, or
- CHW terminates the Plan.

Situations Allowing Continuation of Coverage

You may be able to continue coverage under the CHW EPO Plus Plan when it would otherwise end if:

- You are on a leave of absence under FMLA,
- You are on an approved military leave, or
- You are eligible for COBRA coverage.

Continuation of Coverage During an Approved Leave of Absence under FMLA

If CHW, in accordance with the Family and Medical Leave Act of 1993 (FMLA), grants you an approved family or medical leave of absence (an *approved FMLA leave*), you may continue health care coverage for you and your eligible dependents for up to 12 weeks during the period of approved FMLA leave.

At the time you request the leave, you must agree to make any contributions required by CHW to continue coverage. These contributions, if any, will be at the same level required while you were an active employee. If you fail to make contributions, your action will be considered as giving up (revoking) coverage under the Plan.

If you elect to continue medical coverage during the leave, you may elect to make your contributions to the Plan either:

- Before your leave begins,
- During your leave on the same schedule as if you were not on leave (however, on an after-tax basis), or
- Under another system mutually agreed to by you and the Human Resources Department, as long as the system agreed to is consistent with applicable Department of Labor regulations.

If you elect to continue coverage and make payments on time, the full amount of elected coverage is available to you at all times, including during the period of unpaid leave. If your coverage terminates because of non-payment, you will not be entitled to receive benefits for the period of time during which coverage was canceled.

If you do not make contributions while on leave, your coverage will be terminated on the date your contribution was due and not paid; you will not be entitled to receive benefits for the period of time during which coverage was terminated.

In short, if you are granted continued coverage while on an approved FMLA leave, your coverage will end on the earlier of the following dates:

- The date you are required to make any contribution but fail to do so,
- The date CHW determines your approved FMLA leave is over, or
- The date the program, or a particular coverage within the program, is discontinued (however, coverage for health care expenses may be available to you under another plan sponsored by CHW).

Coverage for a dependent will not be continued beyond the date it would otherwise end.

If you acquire a new dependent while your coverage is continued during an approved FMLA leave, the dependent will be eligible for the continued coverage on the same terms as would be applicable if you were actively at work, described in *Adding Newly Acquired Dependents after Coverage Begins* on page 6.

If you return to work when your approved FMLA leave is over, you will be covered under this Plan as though you had remained an active employee rather than going on an approved FMLA leave.

If you don't return to work after your approved FMLA leave is over, you may, on the date your coverage ends, be eligible for COBRA coverage on the same terms as you would if your employment ended for any reason other than gross misconduct.

Military Leave

If you are eligible to take a leave of absence under the Uniformed Services Employment and Reemployment Rights Act of 1993 (USERRA), you are entitled to continuation of coverage rights similar to those under COBRA (described on page 8). Under USERRA rules, you may elect to continue coverage for up to 24 months. If your military leave is less than 31 days, your contribution for coverage will be the same as if you were an active employee. When you return from military leave, you are entitled to resume your health plan benefits, without exclusions or waiting periods (on the same basis as prior to your military leave). This applies to both employee and dependent coverage, regardless of whether you elected continuation of coverage during your military leave. Any Plan exclusions or waiting periods that would not apply if you were not absent for military service may only be imposed for service-connected illnesses or injuries.

COBRA Continuation Coverage

The Consolidated Omnibus Budget Reconciliation Act of 1985, or COBRA, is a federal law that requires employers to provide employees and their dependents with the opportunity to continue health care coverage at their own expense for a period of time after employer-provided coverage ends.

Note that as part of the American Recovery and Reinvestment Act of 2009 (“ARRA” or the “Stimulus Law”), you might be entitled to a subsidy that covers up to 65% of your COBRA premiums. Persons who were involuntarily terminated between September 1, 2008 and February 28, 2010 are eligible. If this applies to you, the Human Resources Department will notify you.

COBRA coverage is the same as that offered to active employees. If the coverage provided to active employees changes while you or your dependents are receiving coverage through COBRA, your or your dependents’ coverage will change accordingly.

The following is a summary description of the continuation coverage rights and obligations of participants and beneficiaries covered under this Plan. It also contains information concerning qualifying events and qualified beneficiaries, premiums and notice (and election) requirements and procedures, and the duration of the continuation coverage. Should a qualifying event occur in the future, CHW will send you additional information and the appropriate election notice at that time.

It is important that all covered individuals (employee, spouse, and dependent children if able) take the time to read this information carefully and to be familiar with its contents. If there is a covered dependent whose legal residence is not yours, please provide written notification to the Human Resources Department so a notice can be sent to them as well. Please keep in mind that this information is a summary and thus cannot cover every possible situation. Please contact the Human Resources Department for more information if you have specific questions.

Generally

Each individual (employee, spouse, and dependent child) covered under the Plan is considered a *qualified beneficiary* and has independent election rights to continuation coverage. For example, a spouse could elect continuation coverage even if the covered employee does not elect to continue coverage. Or a parent could elect to continue coverage on behalf of their dependent child who is losing coverage as a result of the qualifying event. If elected, continuation coverage is available to qualified beneficiaries subject to their continued eligibility. CHW reserves the right to verify eligibility and terminate continuation coverage back to the original continuation effective date, if it is determined you are ineligible or coverage was obtained through a material misrepresentation of the facts.

In deciding whether to elect COBRA coverage, you should take into account that a failure to continue your health coverage will affect your future rights under federal law. Three considerations should be kept in mind:

- First, if you have more than a 63-day gap in health coverage you can lose the right to avoid having pre-existing condition exclusions applied to you by *other* group health plans. Electing continuation coverage under this Plan may help you avoid such a gap.
- Second, if you do not get continuation coverage for the maximum time available to you, you will lose the guaranteed right to purchase individual health insurance policies that do not impose such pre-existing condition exclusions.
- Finally, you should take into account that you have special enrollment rights under federal law. You have the right to request special enrollment in another group health plan for which you are otherwise eligible (such as a plan sponsored by your spouse’s employer) within 30 days after your group health coverage ends because of the qualifying events discussed in this section. You will also have the same special enrollment right at the end of continuation coverage if you get continuation coverage for the maximum time available to you.

For You

You may continue your medical coverage through COBRA if your coverage ends due to one of the following qualifying events:

- Your employment with CHW ends for any reason except as a result of gross misconduct, or
- You are no longer considered eligible because the number of hours you work is reduced.

For Your Spouse

If you are the covered spouse of an employee, you may have the right to continue your medical coverage through COBRA for yourself if you lose coverage under the Plan due to any of the following reasons:

- Your spouse's employment with CHW ends for any reason except as a result of gross misconduct or there is a reduction in your spouse's hours of employment with CHW,
- Your spouse dies,
- You are divorced or legally separated from your spouse, or
- Your spouse becomes entitled to Medicare.

For Your Dependent Children

If you are the covered dependent child of an employee, you may have the right to continue your medical coverage through COBRA for yourself if you lost coverage under the Plan due to any of the following reasons:

- The employee's employment with CHW ends for any reason except as a result of gross misconduct or there is a reduction in the employee's hours of employment with CHW.
- The employee dies,
- The employee's divorce or legal separation from his or her spouse,
- The employee becomes entitled to Medicare, or
- You cease to be a dependent of the employee, under the terms of the Plan.

Special Note Regarding Previously Uncovered Dependents

At the time your coverage ends, you may not obtain COBRA coverage for previously uncovered dependents; however, if you elect COBRA coverage for yourself, you may add eligible dependents to your COBRA coverage during the next annual open enrollment period. If, while you are covered under COBRA, you have a baby or adopt a child, you may enroll the child. Coverage will be effective immediately with no pre-existing condition limitation as long as you enroll the child within 30 calendar days of the child's birth or adoption placement.

Electing COBRA Coverage

If a qualifying event has occurred for you, your spouse, or your dependent child(ren), that person must elect continuation coverage no later than sixty (60) days from the date of the notification that a qualifying event has occurred. If the qualified beneficiary elects coverage during the 60-day election period, coverage is retroactive to the first day of loss of coverage. A completed election form must be returned to CHW, signed and dated, before the 60-day election period runs out. If premium payment is not submitted with the election form, initial payment for continuation coverage must be received within forty-five (45) days from the date the election was made and it must cover the retroactive monthly coverage period beginning with the date of loss of coverage.

When you enroll in COBRA, you may only elect coverage under the plan in which you are already enrolled. However, if you are still on COBRA coverage during the next open enrollment period, you may change your plan elections. Please note, however, that once you decline COBRA medical coverage, you may not re-enroll in COBRA coverage again.

Notification Requirements for CHW and You

CHW will inform you and any eligible dependent of your rights to continued coverage under COBRA following your termination or one of the qualifying events described previously. This will occur within forty-four (44) days from the date of the qualifying event or the date coverage is lost.

If coverage for a dependent ends as the result of a divorce or a child's losing his or her dependent status, **you or your dependent must notify CHW within 60 days of the qualifying event.** CHW will send you or your dependent a COBRA election form within 14 days after receiving notice of the qualifying event.

Any person who elects COBRA continuation coverage must notify CHW within 60 days after the later of:

- The date coverage ends as a result of a qualifying event, or
- The date a notice is received from CHW stating that coverage has ended.

If this notification is not completed according to the above timeframe and procedure, the right to continuation coverage is forfeited.

When CHW notifies a spouse of the availability of COBRA coverage, that notice also applies to all other covered dependents living with the spouse. However, each covered dependent has an independent right to elect continued coverage. No *evidence of insurability*, or proof of good health, is required to continue coverage under COBRA.

If you or your dependents do not elect COBRA continuation coverage, coverage will end as described on page 6.

Cost of COBRA Continuation Coverage

Important Note: You May Be Eligible for COBRA Premium Assistance

As part of the American Recovery and Reinvestment Act of 2009 (“ARRA” or the “Stimulus Law”), you might be entitled to a subsidy that covers up to 65% of your COBRA premiums. Only persons who were involuntarily terminated between September 1, 2008 and February 28, 2010 are eligible. If this applies to you, the Human Resources Department will notify you.

You or your covered dependents must pay a premium for COBRA continuation coverage. This premium may include any portion of the premium formerly paid by CHW plus a 2% administration fee. However, the premium will not exceed 102% of the rate that would apply for an active employee with similar coverage on the date this premium was due.

After the initial 18-month period, disabled individuals on extended COBRA continuation coverage, as explained under *Extended COBRA Coverage and Notification Requirements* on page 11, may be charged up to 150% of the current active employee rate.

The premium rate will be determined at the beginning of the calendar year and will apply to anyone who elects to continue coverage during that period. The premium rates will not change during the calendar year unless CHW revises the group health care program for all participants, or continuing dependent coverage is terminated because there are no longer any eligible dependents under COBRA coverage.

As explained above, if you elect COBRA coverage, CHW must receive your initial premiums by the 45th day following the date you elect coverage. Otherwise, you will not be eligible for COBRA coverage. The initial premium payment must include premiums for coverage from the date group coverage ended. You must pay additional premiums in monthly installments; however, you will be allowed a 30-day grace period for subsequent monthly premium payments.

If you do not make premium payments before the grace period ends, CHW will terminate your COBRA coverage.

How Long COBRA Coverage Lasts

An individual’s coverage under COBRA ends on the earliest of the following dates:

- The last day of the 18-month period following the date group coverage ended, or on the date CHW stops providing any group health care coverage, if the qualifying event is your termination or a reduction in work hours,
- Last day of the 36-month period following the date group coverage ended, or on the date CHW stops providing any employee group health care coverage, if the qualifying event is any of the others listed under *For Your Dependents* on page 9 of this description (this provision applies to dependent coverage only),

- Last day of the grace period for non-payment of the premium (as described under *Notification Requirements* above), in which case coverage will end retroactive to the last month for which coverage was paid,
- The date the new coverage begins, if an individual becomes entitled to Medicare or any group health care plan benefits that do not include any pre-existing condition limitations that would apply to that individual (this date may vary for different individuals in the same family), or
- The date an applicable pre-existing condition limitation expires under your new group health plan (until this limitation expires, you can continue COBRA coverage, even if you are already enrolled in the new plan).

Extended COBRA Coverage and Notification Requirements

If you or your covered dependents are disabled (as determined by the Social Security Administration) when your employment ends or your hours are reduced, or if you or your covered dependents become disabled at any time during the first 60 days of COBRA coverage, you will be allowed to continue coverage under COBRA for an additional 11 months. This extension brings your total COBRA eligibility to 29 months. You must pay any increase in the required premium necessary to continue coverage for the additional 11 months.

To be eligible for this additional continued coverage, you must notify CHW within 60 days following the date the Social Security Administration determines you are disabled, but no later than the end of your initial 18-month COBRA coverage period. You must also notify CHW within 60 days of the determination that you are no longer disabled. The additional COBRA continuation coverage will end if you are no longer disabled.

If your spouse or dependent has continued coverage due to your termination or reduction in hours and another qualifying event, such as your death or a divorce, occurs during the 18-month continuation period, your spouse or dependent will be allowed additional COBRA continuation coverage up to a maximum of 36 months from the date the group coverage initially ended.

If you become entitled to Medicare benefits during the continuation period, your dependents may continue coverage for up to an additional 36 months from your Medicare entitlement date.

Conversion to Individual Coverage

There is no conversion privilege under this Plan.

HIGHLIGHTS OF CHW EPO PLUS PLAN BENEFITS

Out-of-Pocket Expenses

This section provides highlights of the main out-of-pocket expenses you will – and will not – have under the EPO Plus Plan.

Deductible

There is no deductible under the EPO Plus Plan.

Copayments

Copayments (or *copays*) are flat dollar amounts you pay for certain covered services. After you pay the required copayment for a particular covered service, the Plan will pay the remainder of the cost for that service.

The EPO Plus Plan covers most services for no copayment, and almost all others for a small copay, as shown in the chart on page 13.

Coinsurance

The term *coinsurance* refers to a percentage of eligible expenses for which you are responsible. At this time, coinsurance is required only for infertility testing; you pay 50% of covered expenses.

Maximum Out-of-Pocket Limit

The term *maximum out-of-pocket limit* refers to the most you will have to pay in copayments for covered medical services during the calendar year. (It does NOT include prescription drug copayments or charges for health care services that are excluded from the Plan.) The maximum out-of-pocket limit is \$1,000 per person. For families of three or more, the family's maximum out-of-pocket limit is \$3,000.

Lifetime Maximum Benefits

Some medical plans limit the amount of benefits the plan will pay over a covered individual's lifetime. The EPO Plus Plan does not have a lifetime maximum.

Coverage for Emergency Care

The Plan generally provides coverage for covered services that are provided in:

- An urgent care facility or
- A licensed hospital's emergency room when there is a *medical emergency*.

A *medical emergency* occurs when a medical condition manifests itself by acute symptoms of sufficient severity (including severe pain) such that the absence of immediate medical attention could reasonably be expected to result in placing the health of an individual (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy. Generally, emergency health care services do not require prior authorization.

When Prior Authorization is Required

If a certain health care service requires prior authorization, your PCP or specialist is responsible for calling MCS to get the authorization.

Summary of Benefits

The following chart highlights, in general, the types of medical services, treatments, and care and prescription drugs covered under the CHW EPO Plus Plan. For more details, refer to *EPO Plus Plan Covered Services and Supplies*, starting on page 15. Remember also to review the *Exclusions and Limitations* section, starting on page 25, since coverage for some medical services, treatments, and care may be limited.

If you are unsure about a particular medical expense, be sure to contact MCS at 1-661-716-7100 or 1-800-414-5860 to verify benefit coverage.

Plan Feature	Summary of Benefits
PRESCRIPTION DRUGS (covered only when prescribed by a participating provider and purchased at a participating pharmacy or through the Plan's mail order program, unless prescription is required while patient is out of the network's area)	
Prescription Drugs (administered through NPS)	The EPO Plus Plan requires mandatory generic substitution unless physician indicates dispense as written (DAW). The Plan pays benefits only for prescription drugs on the formulary and not excluded by Plan design.
Participating Retail Pharmacy (30-day supply)	\$5 copay when filled with a generic equivalent. (Tier 1) \$10 copay when filled with a preferred brand name. (Tier 2) \$25 copay when filled with non-preferred brand name. (Tier 3)
Mail Order Pharmacy (90-day supply)	\$10 copay when filled with a generic equivalent. (Tier 1) \$20 copay when filled with a preferred brand name. (Tier 2) \$50 copay when filled with non-preferred brand name. (Tier 3)
Diabetic Supplies (30-day supply)	\$5 copay for Lancets; \$10 copay for Strips
HOSPITAL INPATIENT	
Semi-Private Room	Plan pays 100%.
Miscellaneous (except take-home prescription drugs)	Plan pays 100%.
HOSPITAL OUTPATIENT	
Surgery (facility)	Plan pays 100%.
Emergency Care	\$50 copay (waived if admitted).
Diagnostic X-Ray and Lab	Plan pays 100%.
Other Covered Outpatient Services	Plan pays 100%.
PHYSICIAN INPATIENT	
Surgery, Surgical Assistant	Plan pays 100%.
Anesthesiologist	Plan pays 100%.
Chemotherapy	Plan pays 100%.
Physician Visits (except mental health & chemical dependency)	Plan pays 100%.
PHYSICIAN OUTPATIENT	
Surgeon, Surgical Assistant	Plan pays 100%.
Anesthesiologist	Plan pays 100%.

Plan Feature	Summary of Benefits
Office Visits (except mental health & chemical dependency)	\$10 copay for visit to PCP. \$10 copay for visit to network specialist when PCP refers you. \$25 copay to self-refer to a network specialist.
Office Visit to OB/GYN for Pregnancy	\$25 copay for initial visit (regardless of PCP referral).
Physician's Visits to Employee's Home (<i>at discretion of physician</i>)	\$10 copay.
WELLNESS AND PREVENTIVE CARE	
Well Baby Care (up to age 2)	Plan pays 100%.
Immunizations (up to age 3)	Plan pays 100%.
Immunizations (age 3 and older)	Plan pays 100%.
Routine Pap Smear (1 per year)	Plan pays 100%.
Periodic Health Evaluation	Plan pays 100%.
Diagnostic X-Ray and Lab (includes mammography)	Plan pays 100%.
Allergy Injections and Services (includes serum)	Plan pays 100%.
Other Covered Services	Plan pays 100%.
SHORT-TERM THERAPY	
Physical, Speech, Respiratory, Occupational, Neuromuscular, and Rehabilitation Therapy	Plan pays 100% (60-day limit, for all therapies combined).
Patient Education	Plan pays 100%.
MENTAL HEALTH/CHEMICAL DEPENDENCY	
Chemical Dependency Therapy (benefit limits are integrated with mental health)	<u>Inpatient</u> : Plan pays 100 <u>Outpatient Counseling</u> : You pay \$20/visit, up to 20 visits per calendar year. <u>Outpatient Psychiatry</u> : \$10 copay/visit
Mental Health (benefit limits are integrated with chemical dependency therapy)	<u>Inpatient</u> : Plan pays 100% <u>Outpatient Counseling</u> : You pay \$20/visit, up to 20 visits per calendar year. <u>Outpatient Psychiatry</u> : \$10 copay/visit
OTHER PROVIDERS/SERVICES	
Chiropractic (self-referral; covered only within MCS chiropractic network)	\$10 copay/visit, up to 20 visits per year.
Urgent Care Facility	\$35 copay/visit outside office hours \$10 copay/visit during normal office hours.
Ambulance (ground or air)	Plan pays 100%.
Ambulatory Surgical Center	Plan pays 100%.
Durable Medical Equipment (including oxygen and prosthetics/orthotics)	Plan pays 100% when medically necessary.
Annual Eye Refraction	\$10 copay.
Hearing Test	\$10 copay.
Home Health Care	1 – 30 visits: Plan pays 100%. 31 st visit and after: \$10 copay/visit.
Hospice Care	Plan pays 100%.
Infertility Testing	Plan pays 50%.
Skilled Nursing Facility	Plan pays 100%, up to 100 days per calendar year.

EPO PLUS PLAN COVERED SERVICES & SUPPLIES

The Plan covers medically necessary services and supplies described below when authorized by your PCP. This section lists covered services and supplies in alphabetical order.

Any covered service or supply may require a copayment or have a benefit maximum. Please refer to the *Summary of Benefits* chart starting on page 13 for details.

Certain limitations may apply. Be sure to read the *Exclusions and Limitations* section beginning on page 25 before obtaining care.

Medical Coverage

Ambulance Services

Air and ground ambulance services are covered.

Blood and Blood Products

Blood transfusions, including blood processing, the cost of blood, unreplaced blood, and blood products, are covered. Self-donated (autologous) blood transfusions, however, are covered only for surgery.

Dental Services and Supplies

The Plan covers dental services and supplies only when provided by a physician in these specific circumstances:

- Emergency dental care to sound teeth following an accidental injury,
- Hospitalization and professional services for non-covered dental treatment that is deemed medically necessary by your PCP,
- Dental examination and treatment of gingival tissue (gums) performed for the diagnosis or treatment of a tumor.

Diabetic Medical Equipment

Diabetic supplies are covered and may include blood glucose monitors, insulin pumps and related supplies, pen delivery systems, and podiatric devices. Additional supplies may be covered. Refer to *Prescription Drug Coverage* starting on page 19.

Self-management training and education will be covered also.

Disorders of the Jaw

The Plan covers the following treatment of jaw disorders:

- Services to correct abnormally positioned or improperly developed bones of the upper or lower jaw, provided services are medically necessary due to a recent injury, the existence of cysts, tumors, or neoplasma, or a functional disorder, and
- Medical services to correct disorders of the temporomandibular jaw joint (also known as TMJ disorders) are covered if they are medically necessary. However, dental services such as crowns, inlays, onlays, bridgework, or other dental appliances are never covered under any circumstances.

Durable Medical Equipment

Durable medical equipment is covered and will be repaired or replaced when necessary. However, repair or replacement of equipment that has been misused or lost will not be covered.

Health Evaluation

For preventive health purposes, a periodic health evaluation and diagnostic preventive procedures are covered, based on recommendations published by the U.S. Preventive Services Task Force.

Home Health Care

The Plan covers services provided by a home health agency. These services are provided in a member's home and are limited part-time intermittent skilled nursing care and home health aide services, physical therapy, occupational therapy, speech-language therapy, medical social services, and other services as authorized.

The PCP is responsible for setting up a treatment plan describing the length, type, and frequency of the services to be provided. MCS may require authorization before home health care is initiated.

Home Visits

Visits by a network physician to a participant's home are covered if the physician concludes that the visit is medically and otherwise reasonably warranted.

Hospice Care

Hospice care is available for covered individuals who have been diagnosed as terminally ill. To be considered terminally ill, the person must have a prognosis of six months or less to live. MCS must pre-authorize hospice care before it is initiated.

Hospice care includes physician services, counseling, medications, other necessary services and supplies, and homemaker services.

Immunizations and Injections

Immunizations and injections, professional services to inject the medication, and the medications that are injected (including any serum) are covered, except when provided for travel-related purposes.

Inpatient Hospital Confinement

Care in a semi-private room or in a licensed special treatment unit is covered. Benefits for a private room are limited to the hospital's most common charge for a semi-private room, unless a private room is determined to be medically necessary.

Laboratory and X-ray Services

Laboratory and X-ray services and materials are covered on an inpatient and outpatient basis.

Mental Health/Chemical Dependency Treatment

Outpatient: The Plan covers outpatient treatment for crisis intervention, short-term evaluation, and substance abuse rehabilitation. Visits may include mental health consultations, medication management, and psychological testing. Some benefits may be subject to annual limitations.

Inpatient: The Plan covers inpatient treatment in a hospital setting or a partial inpatient program in a mental health or substance abuse care facility.

Office Visits

Office visits for services provided by your primary care physician (PCP) and other network health care professionals are covered.

Organ, Tissue, and Bone Marrow Transplants

All inpatient services associated with organ, tissue, and bone marrow transplants that are not considered *experimental or investigational* are covered only if the transplant is authorized by MCS and is performed in a MCS-designated transplant center. Travel and other expenses are covered as noted below.

Transplant travel expenses		
Recipient & Companion	Transportation	Limited to 6 trips/episode and \$250/person/roundtrip
	Hotel	Limited to 1 room double occupancy/\$100/day for 21 days/trip
	Other expenses	Limited to \$25/day/person for 21 days/trip
Donor	Transportation	Limited to 1 trip/episode and \$250/roundtrip
	Hotel	Limited to \$100/day for 7 days
	Other expenses	Limited to \$25/day for 7 days

Benefits for the donor will be reduced by any benefits the donor receives from his or her own medical plan. Donor costs for a member are only covered when the recipient also is a CHW EPO member.

Outpatient Hospital Services

The Plan covers outpatient hospital facility services in the same manner as if they were performed at the physician's office. Examples of outpatient hospital services include outpatient surgery, rehabilitative therapy, laboratory tests, X-rays, and radiation therapy.

Pregnancy

Hospital and professional services for conditions of pregnancy are covered, including prenatal and postnatal care, delivery, and newborn care. However, when the covered female is a child-dependent, the dependent's newborn will not be covered. In cases of identified high-risk pregnancy, prenatal diagnostic procedures and genetic testing of the fetus are also covered.

The Newborns' and Mothers' Health Protection Act of 1996 (the Newborns' Act), requires plans that offer maternity coverage to pay for at least a 48-hour hospital stay following childbirth and 96-hour stay in the case of a cesarean section. Therefore, under this Plan, when you give birth to a child in a hospital, you are entitled to at least 48 hours of inpatient care following a vaginal delivery and at least 96 hours of inpatient care following a cesarean section delivery. A fact sheet is available from the Plan administrator concerning various matters such as when the 48 or 96 hours begins. Longer stays in the hospital will require concurrent review.

You may be discharged earlier only if you and your physician agree to it. If you are discharged earlier, your physician may decide that you should be seen at home or in the office, within 48 hours of the discharge, by a licensed health care provider who specializes in postpartum care and newborn care.

Prosthetics/Corrective Appliances/Orthotics

Internal and external prosthetic devices, including orthotics, required to replace a body part are covered. Examples are artificial legs, surgically implanted hip joints, visual aids (excluding eyewear) to assist the visually impaired with proper dosing of insulin, and internally implanted devices such as pacemakers.

Prosthetic devices designed to restore symmetry after a medically necessary mastectomy is also covered, as described on page 18.

Prosthetic devices will be replaced when they are no longer functional. However, the repair or replacement of a device that has been lost or misused is not covered.

Reconstructive Surgery

Reconstructive surgery is covered if its purpose is to correct, repair, or improve function of an abnormal structure of the body caused by congenital defects, developmental abnormalities, trauma, infection, tumors, or disease.

Reconstructive Surgery: Mastectomy

The Plan covers reconstructive surgery to restore and achieve symmetry following a mastectomy, in accordance with the Women's Health and Cancer Rights Act of 1998 (WHCRA). For those individuals receiving mastectomy-related benefits, coverage is provided for:

- All stages of reconstruction of the breast on which the mastectomy was performed,
- Surgery and reconstruction of the other breast to produce a symmetrical appearance,
- Prostheses, and
- Treatment of physical complications of the mastectomy, including lymphedema.

These benefits are subject to the same copayments applicable to other medical and surgical services and supplies provided under this Plan.

Rehabilitation Therapy

Rehabilitation therapy services (physical, speech, occupational, and respiratory therapy) are covered when continuous functional improvement in response to the treatment plan is demonstrated. This is subject to a maximum of 60 visits/incidents per year for all therapies combined.

Second Opinion

You have the right to request a second opinion when:

- Your PCP or the referred specialist gives a diagnosis or recommends a treatment plan that you are not satisfied with, or
- You are not satisfied with the result of treatment you have received, or
- You are diagnosed with, or a treatment plan is recommended for, a condition that threatens loss of life, limb, or bodily function, or a substantial impairment, including a chronic condition, or
- Your PCP and the referred specialist are unable to diagnose your condition, or test results are conflicting.

To request an authorization for a second opinion, call MCS Customer Service at 1-800-414-5860.

A physician who specializes in the illness, disease, or condition must provide the second opinion associated with the request.

Skilled Nursing Facility

Care in a semi-private room is covered. The benefit for a private room is limited to the facility's most common semi-private room rate, unless a private room is medically necessary. Benefits are limited to 100 days per year.

Hospitalization prior to admittance to a skilled nursing facility is not required.

Surgical Services

Services by a surgeon, assistant surgeon, and anesthesiologist or anesthesiologist are covered for both inpatient and outpatient surgeries.

Terminations of Pregnancy

Termination of pregnancy that is medically necessary is covered.

Vision and Hearing Examinations

Eye and ear examinations to determine the need for correction of vision and hearing are covered.

Chiropractic Coverage

The EPO Plus Plan offers:

- Self-referral to any chiropractic provider in the MCS chiropractic network
- \$10 per visit copay for up to 20 visits per year for each Plan participant.

How to Obtain Chiropractic Care

You may call an MCS chiropractic provider's office directly to schedule an appointment. For a current list of participating chiropractic providers, contact MCS Customer Service at 1-800-414-5860 or log onto www.managedcaresystems.com.

Care that Requires Authorization

If the provider determines that your care requires more than five (5) visits, he or she will request authorization from MCS. If an MCS medical director determines that the additional visits are medically necessary, MCS will authorize the care.

Filing a Claim

Typically, there are no claims to be filed for chiropractic coverage. However, if you are ever told to file a claim for benefits, you may follow the process described starting on page 28.

Prescription Drug Coverage

National Pharmaceutical Services (NPS) administers prescription drug benefits. The Plan only covers formulary prescription drugs purchased at retail pharmacies that participate in the NPS pharmacy network or through IHMO's mail order pharmacy. For a current list of participating retail pharmacies, contact MCS Customer Service at 1-800-414-5860, log onto www.managedcaresystems.com or contact the NPS Customer Service Center at 800-546-5677 or log on to www.pti-nps.com.

Special Note to Medicare-Eligible Employees

Medicare prescription drug coverage became available in 2006 to everyone with Medicare. You are entitled to elect this coverage, but CHW has determined that the prescription drug coverage offered by this Plan is on average expected to pay out as much or more than what a standard Medicare Prescription Drug Plan pays. For more information, please contact the Human Resources Department at CHW.

Where to Purchase Prescription Drugs

Participating Retail Pharmacy

You may purchase up to a 30-day supply of prescription drugs at an NPS participating retail pharmacy for one copayment. All you need to do is present your prescription and your ID card to the pharmacist and pay the appropriate copayment.

IHMO Mail Order Program

If you or a covered dependent takes long-term or ongoing medication, you can purchase up to a 90-day supply through IHMO, the EPO Plus Plan's mail order prescription program. To order, send in a completed mail order form (available from NPS, Human Resources, or MCS), along with the prescription and payment, to the address on the form. For more information on the mail order pharmacy, contact MCS Customer Service at 1-800-414-5860, log onto www.managedcaresystems.com or contact NPS at 800-546-5677.

How Prescription Drug Benefits Work

Your prescription drug benefits do not have an annual deductible before coverage starts. Eligibility is from date of enrollment. In order to be covered, your prescription drug must:

- Be prescribed by a participating provider, and
- Purchased at a participating retail pharmacy or through the IHMO mail order program.

The CHW EPO Plus Plan generally will not cover any prescription drugs that are prescribed by a non-participating provider or purchased at a non-participating pharmacy. However, if you need a prescription while you are out of the network's area, you may submit a claim form to be considered for reimbursement, as described starting on page 23.

NPS Formulary

The Plan covers prescription drugs that are included in the NPS formulary. A formulary is a plan's approved list of prescription drugs. The NPS formulary includes generic drugs, preferred brand name drugs, and non-preferred brand name drugs, all of which are paid at different levels (described under *Three-Tier Prescription Drug Benefits*, below).

The NPS formulary is created and maintained by NPS. Before deciding whether to include a drug on the formulary, NPS reviews medical literature and consults with specialists to assess the drug for its:

- Safety,
- Effectiveness,
- Cost-effectiveness (when there is a choice between two drugs having the same result, the less costly drug will be listed on the formulary),
- Side effect profile, and
- Therapeutic outcome.

NPS updates its formulary as new information becomes available and medications are approved.

Three-Tier Prescription Drug Benefits

Under the EPO Plus Plan your copayment for a prescription is determined by which of the Plan's three tiers applies to the drug. No matter which tier your prescription is under, your copayment represents a significant savings to you compared to the medication's full retail cost.

Tier 1 includes all generic medications, which are the Plan's preferred agents or first line therapy choice. Generic drugs are chemically identical to brand name drugs but are priced at a fraction of the cost of the corresponding brand name drug. The U.S. Food and Drug Administration (FDA) requires that generic drugs provide the same effectiveness and safety as their brand name counterparts. The FDA requires drug manufacturers to show that the generic version enters the bloodstream the same way, contains the same amount of active ingredient, comes in the same dosage form and is taken the same way as the brand name drug. You pay the lowest copayment for generic medications.

Tier 2 includes preferred brand name medications that are still patent protected and do not have generic alternatives available. The NPS Pharmacy and Therapeutics (P&T) Committee has reviewed these medications and found that they are therapeutically superior, offer a better outcome, have a better safety profile, or provide the same therapeutic effect as comparable drugs in Tier 3, but Tier 2 drugs will save the Plan money. You pay the middle copayment for preferred brand name medications.

Tier 3 includes non-preferred brand name medications, drugs that have either equally effective and less costly generic equivalents or one or more alternative preferred brand name medications available in Tier 2 that provide the same therapeutic effect. You or your doctor may decide that a medication in this category is best for you. If you choose a Tier 3 drug, your contribution to the cost of the medication may be the highest copayment.

Remember: The fact that your physician prescribes a particular drug or medication does not automatically mean that it will be covered under the Plan. If the prescribed drug or medication does not have a generic form or is not on the NPS formulary, the network pharmacist will consult with your doctor to determine the best equivalent for you; the Plan may, on review, provide payment for non-formulary drugs if pre-authorized by your PCP, NPS or MCS.

Drugs that Require Prior Authorization

To promote appropriate utilization, selected high-risk or high-cost medications may require prior authorization to be eligible for coverage under the EPO Plus Plan. Prior authorizations are only issued in cases of:

- Medical necessity, defined as a prescription medication which is appropriate and consistent with the diagnosis and which, in accordance with generally accepted medical standards, the current Preferred or Formulary alternatives are not acceptable to current peer-reviewed medical literature, and which meets the following

conditions: a) it is recognized throughout the medical profession as safe and effective; b) it is employed appropriately in a manner and setting consistent with generally accepted United States medical standards; and c) it is not experimental in nature.

- Off-label use of medication - Prior authorizations for unlabeled uses of medications may be granted if: a) the medication is approved by the FDA; and b) two or more peer-reviewed professional medical journals have recognized, based on scientific medical criteria, the safety and effectiveness of the medication or combination of medications, for treatment of the indication for which the medication has been prescribed unless two articles from major peer-reviewed professional medical journals have concluded, based on scientific or medical criteria, that the drug or combination of drugs is unsafe or ineffective or the safety and ineffectiveness of the drug or combination of drugs cannot be determined for the treatment of the indication for which the drug or combination of drugs has been prescribed.
- Over-ride an existing quantity limitation provided a specific dosing and tapering schedule is presented.

In most cases, prior authorization requests will be approved for one year from the date the request is received in the NPS office, however certain exceptions and exclusions apply. Your health care provider should prescribe medications which he/she feels best treats your disease state or medical condition. Prior authorization forms may be obtained from MCS or by calling NPS at 1-800-546-5677. Prior authorization request forms must be completed in full prior to evaluation of your request.

Dispensing Limitations

The control and utilization of medication is an important formulary measure. Quantity limits on medications that are dispensed are intended to safeguard your health, to ensure that you or a member of your family does not receive a prescription for a quantity that exceeds the recommended limits. Limits are set because some medications have the potential to be abused, misused, shared, or have a manufacturer's limit on the maximum dose. The quantity limits are based on FDA-approved dosing schedules and medical literature related to that particular drug.

Prescription Drug*	Dispensing Limit**
Accutane	30 days supply per prescription
Accutane	150 days per calendar year
Actiq	120 lozenges per 30 days
Advair Diskus	1 inhaler (60 blisters) per 30 days
Aerochamber	1 per calendar year
Ambien CR	30 tablets per 30 days
Ambien tablets	30 tablets per 30 days
Amerge 1mg tablets	18 tablets (2 boxes) per 30 days
Amerge 2.5mg tablets	9 tablets (1 box) per 30 days
Anzemet tablets	10 tablets per prescription
Asmanex	.24 gm per 30 days
Axert 6.25mg tablets	18 tablets (3 boxes) per 30 days
Axert 12.5mg tablets	12 tablets (2 boxes) per 30 days
Byetta	2.4 ml per 30 days
Celebrex	60 capsules per 30 days
Clarinet	30 tablets per 30 days
Copaxone	3 per 3 months
Crestor	30 tablets per 30 days
Depo Provera	1 inj per 90 days
Diabetic: Test strips	800 per 3 months
Lancets, and Syringes	800 per 3 months
Edex	6 injections per 30 days
Elidel Cream	30 grams per prescription
Emend	5 per prescription
Erectile Dysfunction (oral) Combined	6 tablets per 30 days
Erectile Dysfunction (non-oral) Combined	6 per 30 days
Estring	1 per 30 days
Femring	1 per 90 days
Fragmin Inj 2500/0.2 ML	12 per 30 days (60 syringes)
Fragmin Inj 5000/0.2 ML	18 per 30 days (60 syringes)
Fragmin Inj 7500/0.3 ML	18 per 30 days (60 syringes)
Fragmin Inj 10000/ML	60 per 30 days (60 syringes)
Fragmin Inj 25000/ML	60 per 30 days (60 syringes)
Foradil	1 inhaler (60 capsules) per 30 days
Frova 2.5mg	18 tablets (2 boxes) per 30 days
Halflytely Kit Bwl-Prep	1 per prescription
Imitrex 25mg tablets	18 tablets (2 boxes) per 30 days
Imitrex 50mg tablets	18 tablets (2 boxes) per 30 days
Imitrex 100mg tablets	9 tablets (1 box) per 30 days
Imitrex injection	3 kits (6 injections) per 30 days
Imitrex Nasal Spray	12 sprays (2 boxes) per 30 days
Iressa	30 tablets per 30 days
Ketek	20 tablets per prescription
Kytril tablets	10 tablets per prescription
Lamisil	90 days supply per calendar year
Lipitor	30 tablets per 30 days
Lovenox Inj 30/0.3 ML	18 per 30 days (60 syringes)
Lovenox Inj 40/0.4 ML	24 per 30 days (60 syringes)
Lovenox Inj 60/0.6 ML	36 per 30 days (60 syringes)
Lovenox Inj 80/0.8 ML	48 per 30 days (60 syringes)
Lovenox Inj 100/1 ML	60 per 30 days (60 syringes)
Lovenox Inj 230/0.8 ML	48 per 30 days (60 syringes)

Prescription Drug*	Dispensing Limit**
Lovenox Inj 150/1 ML	60 per 30 days (60 syringes)
Lovenox Inj 300 MG/3 M	180 per 30 days (60 syringes)
Lunesta	30 tablets per 30 days
Maxalt 5mg tablets	24 tablets (4 boxes) per 30 days
Maxalt 10mg tablets	12 tablets (2 boxes) per 30 days
Migranal Nasal Spray	16 sprays (2 boxes) per 30 days
Muse	6 inserts per 30 days
Namenda	60 tablets per 30 days
Nexium	30 caps per 30 days
Ortho Evra	3 patches per 28 days
Oxycontin	120 tablets per 30 days
Pravachol	30 tablets per 30 days
Provigil 100mg	120 tablets per 30 days
Provigil 200mg	60 tablets per 30 days
Pulmicort	2 Inhalers per 30 days
Pulmozyme	75ml per 30 days
Ranexa	120 tablets per 30 days
Rebif	6ml (12 injections) per 30 days
Regranex	1 tube (15 gm) per prescription
Relpax 20 mg	12 tablets per 30 days
Relpax 40 mg	6 tablets per 30 days
Rozerem	30 tablets per 30 days
Seasonale	91 tablets per 90 days
Seasonique	91 tablets per 90 days
Serevent Diskus	1 inhaler (60 blisters) per 30 days
Sonata tablets	30 tablets per 30 days
Soriatane 10 mg	5 kits per 30 days
Soriatane 25mg	2 kits per 30 days
Sotret	30 days per prescription
Spiriva	1 inhaler (30 capsules) per 30 days
Sporanox	90 days supply per calendar year
Stadol NS	2 bottles (2.5ml each) per 30 days
Strattera	60 caps per 30 days
Sulfamylon Pak 5%	5 per prescription
Tekturna	30 tablets per 30 days
Terazol 3	1 tube per 30 days
Terazol 7	1 tube per 30 days
Toradol/Ketorolac	20 tablets per calendar year
Ultracet	240 tablets per 30 days
Ultram/Tramadol	240 tablets per 30 days
Viagra	6 tablets per 30 days
Vytorin	30 tablets per 30 days
Zetia	30 tablets per 30 days
Zmax	2gm per prescription
Zocor	30 tablets per 30 days
Zofran ODT tablets	10 tablets per prescription
Zofran tablets	10 tablets per prescription
Zofran Sol	100ml per prescription
Zomig Nasal Spray	12 sprays (2 boxes) per 30 days
Zomig 2.5 mg tablets	12 tablets (2 boxes) per 30 days
Zomig 5 mg tablets	6 tablets (2 boxes) per 30 days
Zovirax ointment	30g (2x15gm tubes) per 30 days

*A listed product does not imply that it is a covered benefit. Please review the Plan's limitations and exclusions starting on page 26. If you're not sure a specific drug is covered, contact NPS or MCS.

** These limits are mandated by the Federal Food and Drug Administration.

Any member with a request exceeding the current quantity limits should have a letter from their health care provider. The letter should include diagnosis, reason for exceeding the quantity limit per month, and what the therapy plan will be for the member (i.e., tapering schedule). In most cases the quantity limits selected are set at maximum dosages and should not be exceeded according to the current manufacturer's recommendations. Prior authorizations for quantity limits exceeding the guidelines will be issued for six-month intervals and will require a new letter from your health care provider at the end of the six-month period.

Inclusions

Your prescription drug benefits include coverage of prescriptions for:

- State legend prescription drugs,
- Compound medications of which at least one ingredient is a prescription legend drug,
- Insulin and insulin syringes on prescription,
- Prescription drugs for the treatment of diabetes,
- Diabetic supplies, including insulin needles, syringes, blood glucose monitor strips, lancets and ketone strips,
- Oral contraceptives. (Vaginal contraceptive devices are not covered.)

Special Program for Over-the-counter Products

The Plan provides benefits for certain, specific over-the-counter products, such as Prilosec and Claritin. For a complete list of products and a description of the coverage, contact NPS or MCS.

How to Submit a Manual Claim

If the pharmacy did not submit your request for prescription(s) payment to the NPS system at the time the prescription was filled and less than two weeks have passed, you should return to the pharmacy with your receipt and ask that they attempt to submit the prescription(s) claim to NPS for payment. Once the prescription(s) have been submitted, you should receive your refund from this pharmacy. The pharmacy may call NPS for assistance to get you set up in their computer. If your request that the pharmacy file a claim has gone longer than two weeks, you must submit the claim by following the instructions below.

As a member with NPS, you are able to access a paperless claims network of pharmacy providers. In the rare event that you are required to file a paper claim for a covered service from a non-participating pharmacy, you may request a paper claim form which you must fill out completely, provide all listed information, then forward to NPS at:

National Pharmaceutical Services

PO BOX 407
Boys Town, NE 68010

Reimbursements are based on the established network agreements with our preferred providers. This agreement, in part, states that you, as a cardholder in the NPS network, will receive the *lesser of* usual and customary (U&C) charge of this pharmacy provider, or the contracted price of the prescription drug product. Your actual reimbursement amount may be lower than the amount submitted on your original pharmacy receipts by your pharmacy provider. NPS may process your claim for payment of reimbursement minus your copayment in cases where you paid for the prescription(s). *Requests must be submitted for review within 90 days of the date services were rendered.* This request must include the original pharmacy receipts, and the claim form must be completed in its entirety to avoid delays in processing your request. NO PHOTOCOPIES of the pharmacy receipts are accepted. Do not send cancelled checks or cash register receipts. The NPS network consists of pharmacies located in the United States; therefore no international claims will be processed. The form must be completed each time a claim is submitted to NPS.

If you are responsible for a deductible (through primary or secondary insurance coverage), the claim will count toward the date/year in which the claim was received, not the date and/or year the product was purchased. NPS network pharmacies are contracted to provide services for your employer group on a fixed reimbursement schedule and this reimbursement reflects these rates. Reimbursement may also be less than the amount submitted, if a non-participating pharmacy is used. NPS network pharmacy providers are terrific allies in building cost-containment programs for our employer groups, and we encourage you to use NPS network pharmacies as your preferred pharmacy provider.

If you have a question or concern regarding the dispensing of a medication such as whether it is included in the NPS formulary, please contact NPS at 1-800-546-5677. Note that this does not constitute a claim or appeal on your behalf if you dispute whether a medication is or should be covered. If you have a dispute concerning the dispensing of a medication (e.g., your prescription was rejected), you must follow the claims procedures starting on page 28, under the subheading *Post-Service Claims*.

If you have a dispute concerning the pre-authorization of a medication, such as described on page 20, you should follow the claims procedures starting on page 29, under the subheading *Pre-Service Claims*.

The process to appeal the denial of a claim is described starting on page 30.

EXCLUSIONS AND LIMITATIONS

Medical Exclusions and Limitations

The CHW EPO Plus Plan does not cover the following medical services, treatments, and supplies:

- Acupuncture.
- Adoption expenses.
- Artificial insemination.
- Biofeedback.
- Care for conditions or illnesses experienced while the participant is under arrest, detained, imprisoned, incarcerated or confined pursuant to federal, state, or local law. However, the Plan will reimburse out-of-pocket expenses for services required while the participant is confined in a city or county jail or if a juvenile, while detained in any facility, as long as the services are obtained in accordance with this Plan's coverage requirements, including emergency or urgently needed services.
- Conception by artificial means (IVF, GIFT, and ZIFT). Also, costs for the collection, storage, or purchase of sperm or ova are not covered.
- Contraceptive devices other than what is listed under prescription drugs on page 19.
- Cosmetic surgery, services, or supplies.
- Custodial or domiciliary care, meaning services and supplies that are provided to primarily assist with the activities of daily living.
- Dental services except as outlined on page 15.
- Disorders of the jaw, except as outlined on page 15.
- Disposable supplies for home use.
- Durable medical equipment and supplies. The following durable medical equipment and supplies are not covered:
 - Exercise equipment.
 - Hygienic equipment and supplies.
 - Stockings, corrective shoes, and arch supports.
 - Surgical dressing.
 - Jacuzzis and whirlpools.
 - Generic orthotics (i.e., supports or braces for weak or ineffective joints or muscles) that are not custom-made to fit the person's body.
 - Foot orthotics that are not incorporated into a cast, splint, brace, or strapping of the foot.
- Experimental or investigational procedures. (However, the Plan will cover services and supplies to treat medical complications caused by experimental or investigational services or supplies.)
- Eyeglasses and contact lenses, except after cataract surgery.
- Food supplements.
- Routine foot care, orthotics/orthotic devices, or matatarsalgia. Routine foot care includes, but is not limited to, removal or reduction of corns, clipping of toenails, flat feet, fallen arches, and chronic foot strain.
- Services or supplies for which you do not have to pay or for which no charge was made.
- Genetic testing and diagnostic procedures, except for prenatal diagnosis of fetal genetic disorders in cases of high-risk pregnancy.
- Hearing aids.
- Hypnosis.
- Mental health care is covered only as outlined on page 16. The Plan does not cover care for mental retardation, mental health care as a condition or parole or probation, or court-ordered testing for mental disorders.
- Missed appointments, telephone calls, preparation of medical reports, and itemized bills or the completion of forms.
- Services or supplies provided by any institution that is not a legally-operated hospital, a Medicare-approved skilled nursing facility, or other properly licensed facility specified as covered in the Plan documents. Any institution that primarily a place for the aged, a nursing home, or similar institution is not an eligible institution.
- Nonprescription (over-the-counter) drugs, equipment and supplies even if the physician writes a prescription for it. (Exception: supplies and equipment for the management and treatment of diabetes).

- Physical examinations not associated with preventive care, such as physical exams for insurance, licensing, employment, school, camp, or other non-preventive care purposes.
- Personal or comfort items.
- Pregnancy under a surrogate arrangement.
- Private rooms when hospitalized, unless medically necessary.
- Private-duty nursing for hospital patients.
- Any eye surgery performed to correct refractive defects of the eye, such as near-sightedness (myopia), far-sightedness (hyperopia), or astigmatism.
- Rehabilitation therapy (physical, speech, occupational and respiratory therapy) when services are the result of the following conditions:
 - Psychosocial speech delay (including delayed language development).
 - Mental retardation, infantile autism or dyslexia.
 - Syndromes associated with diagnosed disorders attributed to perceptual and conceptual dysfunctions.
 - Attention deficit disorders and associated behavior problems.
 - Developmental articulation and language disorders.
- Reversal of surgical sterilization.
- Services and supplies not authorized according to procedures the Plan and physician groups have established.
- Services performed by an immediate relative.
- Services received before effective date or after termination of coverage, except as specifically provided in the *Extension of Benefits* section of the Plan document.
- Sex change procedures or treatment.
- Termination of pregnancy unless determined medically necessary.
- Treatment or surgery for obesity, weight reduction, or weight management.
- Expenses associated with a work-related illness or injury. (If you suffer a work-related illness or injury, you may be eligible for medical benefits under the CHW Workers' Compensation Insurance program.)

Chiropractic Care Exclusions and Limitations

In addition to the medical exclusions and limitations listed above, the following list of exclusions and limitations pertains to the CHW EPO Plus Plan's chiropractic care coverage:

- Any treatment or service not authorized and delivered by a MCS chiropractic provider.
- Services not documented as necessary and appropriate or classified as experimental or investigational chiropractic care.
- Diagnostic scanning, including MRI, CAT scan, and/or other types of diagnostic scanning.
- Disk decompression therapy, Laser treatment and massage therapy
- Thermography.
- Treatment or services for pre-employment physicals, school physicals, sports physicals, DOT exams or vocational rehabilitation.
- Any treatment or services caused by or arising out of the course of employment or covered under any public liability or auto insurance.
- Hypnotherapy, behavioral training, sleep therapy and weight programs, educational programs, non-medical self-care or self-help, or any self-help physical exercise training, exercise equipment, or any related diagnostic testing.
- Air conditioners, air purifiers, therapeutic beds, mattress supplies or any similar devices and appliances.
- Vitamins, minerals, nutritional supplements, weight loss supplements, analgesic creams or similar products.
- Anesthesia, manipulation under anesthesia, hospitalization or any related services.

Prescription Drug Exclusions and Limitations

In addition to the general exclusions and limitations listed above, the following list of exclusions and limitations pertains to the CHW EPO Plus Plan's prescription drug coverage:

- Allergy serum, products to lessen or end allergic reactions. (Serum is covered under medical benefits.)
- Appetite suppressants, diet aids, or drugs for body weight management.
- Blood and blood products, such as sera, blood derivatives, and blood plasma.

- Dietary or nutritional supplements.
- Drugs covered by another part of the Plan (i.e., prescription drugs administered while an inpatient).
- Drugs prescribed for cosmetic reasons.
- Drug supplies in excess of Food and Drug Administration's (FDA) usage recommendations.
- Hypodermic syringes and needles (exception: insulin needles and syringes).
- All self-injectable drugs (exception: Bee Sting Kit).
- Medical devices.
- Drugs not approved by the Food and Drug Administration (FDA).
- Lost, stolen, or damaged drugs. The Plan does not cover replacement prescriptions for lost, stolen, or damaged drugs.
- Prescriptions purchased at a non-participating pharmacy that are not pre-authorized, unless medical necessity requires purchase while the participant is out of the network's area.
- Nonprescription (over-the-counter) drugs or supplies (except certain diabetic supplies or when covered under the program described on page 23).
- Oxygen. (Oxygen is covered under durable medical equipment on page 15).
- Sexual dysfunction drugs.
- Smoking deterrents.

Additional Exclusions

- Diabetic supplies, Post coitals, Surgery supplies, Allergy and self admin syringes, Other syringes, Enteral and parenteral supplies, Durable home medical equipment, GI & GU ostomy supplies, Asthma and respiratory supplies, Surgery supplies injectables, Blood components and products, Blood components injectables, Diagnostic agents, Diagnostic agents injectables, Anesthetic agents, Anesthetic agents injectables, Fertility agents, Fertility agents injectables, Multi-vitamins, Multi-vitamins injectables, Home injectables, Other home injectables, Vaccines, serums, toxoids and allergens, Other injectables, Hematinic vitamins, Antiretrovirals injectables, Bulk chemicals, Cosmetic alteration, Accutane, Cosmetic hair products, Retin-A products, Anti-depressants injectables, Dialysis supplies, Growth hormones, Growth hormones injectables, Hypnotic/sedative agents injectables, Contraceptives other, Immunosuppressants injectables, OTC equivalents, Anti-psychotic injectables, Anti-anxiety agents injectables, Cognitive services.
- Drugs which are entirely consumed at the time and place of prescribing.
- Prescriptions which are covered under Workers' Compensation law or which are covered without charge under any government program.
- Experimental drugs or drugs labeled *Caution – limited by federal law to investigational use*.
- Medication which is to be taken by or administered to a beneficiary while a patient is in a licensed hospital, nursing home, or similar institution, which operates or allows to be operated on its premises, a facility for dispensing pharmaceuticals.
- Refills in excess of the number specified or authorized by the prescriber or any refill dispensed after one year from the prescriber's original order.
- Mailing and delivery charges (standard delivery services are included).
- Drugs which were distributed by the manufacturer as samples.
- Unapproved uses of drugs, i.e., uses that are not approved by the United States Food and Drug Administration or peer-reviewed medical journals.
- Prescription medications determined to be *less than effective* by the Drug Efficacy Study Implementation Program (DESI).

IMPORTANT INFORMATION ABOUT YOUR RIGHTS AND RESPONSIBILITIES UNDER THE PLAN

This section provides you with important information about the CHW EPO Plus Plan. In this section, you will find information regarding the claims review process, the rights guaranteed to you under federal law and additional administrative information. If you need more information or assistance on benefits matters, contact your Human Resources Department or MCS at 1-800-414-5860.

Plan Document Governs

The benefit plan description contained in this document is a summary of the official Plan document. In all cases, the Plan document controls the administration and operation of the Plan. If a conflict exists between a statement in this description and the Plan document, the Plan document will govern.

Discretionary Authority of Plan Administrator and Plan Fiduciaries

In carrying out their responsibilities, CHW, the Plan administrator, and the Plan fiduciaries have the discretionary authority to interpret the terms of the Plan and to determine the eligibility for benefit payment. Any interpretation or determination made by such discretionary authority shall be given full force and effect, unless it can be shown that the interpretation was arbitrary and capricious.

Claims and Appeals Procedures for the Plan

The following claims procedures apply to claims made under this Plan. It is the intent of CHW and the Plan Sponsor, Managed Care Systems, LP, that the claims procedures described below comply with Department of Labor Regulations found at Section 2560.503-1. These procedures are superseded to the extent that they are inconsistent with policies, contracts or written notices to you that report on modifications mandated by law or regulation.

Filing a Claim

When you receive care from a network PCP or specialist, they will file a claim on your behalf; you need not contact anyone. Claims are reviewed and paid by MCS in accordance with the rules and provisions contained in the Plan document. If the claim submitted by your PCP or specialist is denied for any reason, you and your health care provider will be notified of the denial as described below in more detail.

If you are required to request pre-authorization for health care federal law considers your request for pre-authorization technically as a **claim**, and thus you are entitled to appeal if authorization is denied. Different types of claims include: Post-Service (the most common), Pre-Service, and Concurrent Care.

Post-Service Claims

When your network PCP or specialist files a claim on your behalf, such a claim is considered a ***Post-Service Claim***. If your Post-Service Claim is denied, you will receive a written notice from MCS, the Plan administrator, within 30 days of MCS receiving the claim. The letter or notice will explain the reason for denial and refer to the provision(s) of the Plan on which the denial is based. In addition, MCS will tell you whether the denial was based on an internal rule, guideline, protocol or similar criterion and offer to provide you with a copy of such guidelines, free of charge. If the denial was based on account of questionable medical necessity or the experimental nature of the requested service, MCS will offer to send you a written explanation of the scientific or clinical basis for the denial, also free of charge. You will receive a Claim Appeals form and a copy of the appeals procedures. As in all other appeals under this Plan, you have 180 days after receiving notice of denial in which to file an appeal.

Pre-Service Claims

If you are required to notify MCS or receive approval from MCS prior to obtaining a benefit under the Plan, such a request is considered a ***Pre-Service Claim***. If your Pre-Service Claim was submitted properly with all the necessary information, you will receive a written notice of MCS's decision within fifteen (15) days after it receives the submission. If MCS needs more time to respond, it will notify you before the 15 days have passed and tell you when it expects to respond, but this will never be more than 30 days from the time you made your first request.

If your request is filed improperly (for example, it is missing required information), MCS will notify you within fifteen (15) days on how to correct it. Once you are notified of this request for additional information, you have forty-five (45) days to provide the information. If you fail to respond and the 45 days lapse, your Pre-Service Claim will be denied. If all the information is received within the 45-day timeframe, MCS will notify you in writing of its determination within fifteen (15) days after it receives the needed information. If MCS determines that your Pre-Service Claim is denied, the notice will explain the reason for the denial and refer to the provision(s) of the Plan on which the denial is based. In addition, MCS will tell you whether the denial was based on an internal rule, guideline, protocol or similar criterion and offer to provide you with a copy of such guidelines, free of charge. If the denial was based on account of questionable medical necessity or the experimental nature of the requested service, MCS will offer to send you a written explanation of the scientific or clinical basis for the denial, also free of charge. You will receive a Claim Appeals form and a copy of the appeals procedures.

As in all other appeals under this Plan, you have 180 days after receiving notice of denial in which to file an appeal.

Concurrent Care Claims

Generally there are two instances in which this type of claim is made:

1) MCS approves an ongoing course of treatment to be provided over a certain period of time or for a specific number of treatments and MCS reduces or ends treatment before the end of the time period or number of treatments. Under this situation, the discontinuance or reduction is considered a denial of services and if you wish to appeal the denial, you must follow the procedures noted on page 30.

2) MCS approves an ongoing course of treatment to be provided over a certain period of time or for a specific number of treatments, and you request MCS to extend the treatment. Under this situation, your request will be decided within 24 hours by MCS, provided that your request is made at least 24 hours prior to the end of the approved treatment. **Note that if your request for extended treatment is not made at least 24 hours prior to the end of the approved treatment, your request will be answered within 72 hours by MCS.**

If MCS denies your request for ongoing treatment, such notice will be given to you as soon as possible but no later than 24 hours (72 hours if your request is made after the 24-hour period as described above) following your request so that you have sufficient time to appeal (see page 30) and obtain a determination before the health benefit is reduced or terminated.

You will receive a written confirmation of the determination, which will explain the reason for denial and will refer to the provision(s) of the Plan on which the denial is based. In addition, MCS will tell you whether the denial was based on an internal rule, guideline, protocol or similar criterion and offer to provide you with a copy of such guidelines, free of charge. If the denial was based on account of questionable medical necessity or the experimental nature of the requested service, MCS will offer to send you a written explanation of the scientific or clinical basis for the denial, also free of charge.

You will receive a Claim Appeals form and a copy of the appeals procedures. As with all other appeals under this Plan, you have 180 days after receiving notice of denial in which to file an appeal.

Note that if an ongoing course of treatment was previously approved for a specific period of time or number of treatments, and you request to extend treatment in a non-urgent circumstance, your request will be considered a new claim and decided according to post-service or pre-service timeframes, whichever applies.

Appealing a Denied Claim

Federal law considers the phrase *Denied Claim* to include a denial, reduction, termination of or a failure to provide or make payment for a benefit requested. It also includes a denial, reduction, termination or failure to provide for a benefit determined to be experimental or investigational.

The first step to resolving a dispute is to contact MCS by telephone, at 1-800-414-5860. Ask to speak to a customer service representative. Under federal law and regulations, your telephone inquiry is NOT considered a formal appeal. Rather, it is considered an informal way of attempting to resolve a dispute prior to filing a written appeal. After receiving the initial denial, you have 180 days to appeal the decision. **Contacting MCS by phone does not begin the formal appeals process.** The formal process is described below.

The Appeals Process

If you disagree with a claim determination and you wish to appeal, you must contact MCS in writing within 180 days of receiving the denial in order to formally request an appeal, using the appeal form provided to you. Be sure that your request includes the following:

- The patient's name and the identification number from the ID card,
- The date(s) of health care service(s),
- The provider's name,
- The reason(s) you believe the claim should be paid,
- Any documentation or other written information to support your request for claim payment.

A qualified individual who was not involved in the original decision being appealed will be appointed to decide your appeal. MCS may consult with, or seek the participation of, medical experts as part of the appeal resolution process. By filing an appeal, you consent to this referral and the sharing of pertinent health claim information. Upon request and free of charge you have the right to reasonable access to and copies of all documents, records, and other information relevant to your claim for benefits.

Response to your Appeal

You will be provided with written or electronic notification of the decision on your appeal as follows:

- For appeals of ***Pre-Service Claims***, the first level appeal will be conducted and you will be notified by MCS of its decision within **15** days from receipt of a request for appeal of a denied claim.
- For appeals of ***Post-Service Claims***, the first level appeal will be conducted and you will be notified by MCS of its decision within **30** days from receipt of a request for appeal of a denied claim.
- For appeals of ***Concurrent Care Claims***, you or your doctor can appeal at any time as long as it is before 180 days from the date of the denial. The time frames for MCS to respond to your appeal depend on the situation. For example, if the claim is for continuing urgent care, MCS will respond to your appeal as soon as possible, not later than 72 hours.

Making A Final Appeal

If you are not satisfied with the resolution of your concern, you may request a final appeal in writing to the Employee Benefits Administration Committee at Catholic Healthcare West. The Employee Benefits Administration Committee will confirm in writing that your final appeal has been received. Within 30 days of receiving your written appeal, you will be notified of the final decision rendered by the Committee.

If you are still not satisfied the resolution, you may file a suit in a court of law as is provided under ERISA. See *Your Rights Under Federal Law* on page 35 for more details.

Summary Chart for Claims and Appeals

Type of claim	Initial decision to you within	Appeal decision to you within
Post-service	30 days	30 days
Pre-service	15 days	15 days
Concurrent care	As soon as possible, no later than 24 hours or 72 hours, if applicable	Depends on whether claim is pre-service, post-service or urgent care

Privacy Rights

A federal law, the Health Insurance Portability and Accountability Act of 1996 (HIPAA) requires that health plans protect the confidentiality of your *protected health information*, also known by its acronym *PHI*. A complete description of your rights under HIPAA can be found in the Plan's privacy notice, which was distributed to you upon enrollment and is available from the Human Resources Department or MCS at 1-800-414-5860.

In the course of providing benefits to you under this Plan, the Plan administrator and others may acquire PHI. Accordingly, the Plan has developed procedures to restrict access to such protected health information to persons who need to know it in order to process, complete, or administer the Plan benefits. The Plan and CHW will not use or further disclose PHI except as necessary for treatment, payment, health plan operations and plan administration or as permitted or required by law. In accordance with HIPAA rules and regulations, the Plan has required all of its business associates to also observe HIPAA's privacy rules by certifying that they have privacy procedures in place and maintain a code strict confidentiality in conformance with HIPAA. The Plan will not (unless you authorize it to do so) use or disclose PHI for employment-related actions and decisions or in connection with any other benefit or employee benefit plan sponsored by CHW.

Under HIPAA, you have certain rights with respect to your PHI, including rights to see and copy information, receive an accounting of certain disclosures of the information and, under certain circumstances, change the information. You also have the right to file a complaint with the Plan or with the Secretary of the U.S. Department of Health and Human Services if you believe your rights under HIPAA have been violated. Further information is detailed below.

Finally, you should know that this Plan maintains a detailed privacy policy, which provides a complete description of your rights under HIPAA's privacy rules. For a copy of the policy, if you have questions about the privacy of your health information, or if you wish to file a complaint under HIPAA, please contact the Human Resources Department or MCS at 1-800-414-5860.

Filing a Complaint

If you wish to file a privacy complaint under HIPAA, you must contact either the Human Resources Department or MCS at 1-800-414-5860 who will direct your complaint to the Plan's Privacy Officer. Your complaint will be recorded and reviewed by the Privacy Officer, and you will receive a written notice within 90 days of receiving your complaint of what action was taken, if any, or if any changes have been made to the Plan's privacy policies or procedures. Any individual found to have failed to comply with the Plan's privacy policies and procedures will be subject to disciplinary action by the Plan Sponsor, which disciplinary action may include, among other appropriate or lesser sanctions, demotion, removal to another function not involving compliance with privacy rules, and/or termination of employment as appropriate. If you wish to do so, you may file a written appeal with the Privacy Officer within 60 days after the date on which you receive a written notice regarding your complaint. The Privacy Officer will review your appeal and notify you of its decision regarding any additional action taken within 60 days of receiving your appeal.

Note that you may at any time file a privacy complaint if you believe that the Plan is not complying with HIPAA. Complaints may be filed with the Secretary of the Department of Health and Human Services, Hubert Humphrey Building, 200 Independence Avenue S.W., Washington, D.C. 20201. Complaints must be filed in writing and describe the acts or omissions about which you are complaining. A complaint to the Secretary must name the entity

that is the subject of the complaint and be filed within 180 days of when you learned or should have learned about the act or omission complained of, unless this time limit is waived by the Secretary for good cause shown.

No intimidation, discrimination, or retaliation shall be permitted against you for the exercise of your rights under the Privacy Rule or our privacy policies, including the right to file a privacy complaint.

Coordination of Benefits

Coordination of benefits (COB) is a process regulated by law that determines financial responsibility for payment of covered expenses when an individual is covered by two or more group health plans. The objective of COB is to ensure that the group health plans—combined—will not pay more than 100% of covered expenses.

CHW's COB activities will not interfere with your medical care.

Coordination of benefits is a bookkeeping activity that occurs between two medical plans or HMOs. However, you may occasionally be asked to provide information about your other coverage.

The primary plan pays benefits first without regard to other coverage that may exist. A secondary plan pays after the primary plan. It typically takes into account what the primary plan paid so that payment from all applicable plans do not exceed 100% of the total covered expense.

The following rules describe which plan is primary and which plan is secondary:

1. **Subscriber vs. Dependent.** The plan covering the person as a subscriber (for example an employee or retiree) is primary, and the plan that covers the person as a dependent is secondary.
2. **Plan Without COB Provision.** A plan that does not contain a coordination of benefits provision is always primary.
3. **Child Covered By More Than One Plan.** The order of payment when a child is covered by more than one plan is:
 - a. **Birthday Rule:** The primary plan is the plan of the parent whose birthday is earlier in the year if:
 - The parents are married;
 - The parents are not separated (whether or not they have ever been married); or
 - A court decree awards joint custody without specifying that one party has the responsibility to provide health care coverage.

If both parents have the same birthday, the plan that covered either of the parents longer is primary.

- b. **Court-Ordered Responsible Parent:** If a court decree states that one of the parents is responsible for the child's health care expenses or health care coverage and the plan administrator of that parent has actual knowledge of those terms, that plan is primary. This rule applies to claim determination periods or plan years starting after the plan administrator is given notice of the court decree.
- c. **Parents Not Married, Divorced, or Separated:** If there is no court order specifying responsibility for the child's health care coverage and the parents are not married, separated (whether or not they ever have been married), or divorced, the order of benefits is:
 - The plan of the custodial parent.
 - The plan of the spouse of the custodial parent.
 - The plan of the noncustodial parent.
 - The plan of the spouse of the noncustodial parent.

4. **Active vs. Inactive Employee.** The plan that covers a person as an active employee is primary in relation to a plan that covers the person as a laid-off or retired employee. When the person has the same status under both plans, the plan provided by active employment is first to pay.
5. **Length of Coverage.** If the preceding rules do not determine the order of payment, the plan that covers the individual longer is primary.
6. **Equal Sharing.** If none of the preceding rules determines the primary plan, covered expenses will be shared equally between the plans.

Effect on the Benefits of This Plan

When the EPO Plus Plan is secondary, it may reduce its benefits so that the total benefits paid are not more than 100% of total covered expenses. If you are an individual eligible for Medicare, please see the special note below concerning the coordination of your benefits.

Coverage by Two Closed Panel Plans

The EPO Plus Plan is considered a closed panel plan because the Plan pays benefits only when health care services are provided by a network provider. If a covered person is enrolled in two or more closed panel plans and expenses are not covered by one closed panel plan, COB rules will not apply. But if services received from a non-network provider are due to an emergency and would be covered by both plans, then both plans will provide coverage according to COB rules.

Right to Receive and Release Information

Certain facts about health care coverage and services are needed to apply these COB rules and to determine benefits payable under this Plan and other plans.

CHW may obtain the facts it needs from or give them to other organizations or persons for the purpose of applying these rules and determining benefits payable under this Plan and other plans covering the person claiming benefits.

CHW need not tell or obtain the consent of any person to do this. Each person claiming benefits under this Plan must give CHW any facts it needs to apply those rules and determine benefits payable.

CHW California's Right to Pay Others

A *payment made* under another plan may include an amount that should have been paid under this Plan. If this happens, CHW may pay that amount to the organization that made the payment. That amount will then be treated as though it were a benefit paid under this Plan. CHW will not have to pay that amount again.

Recovery of Excessive Payments by CHW

If the payment amount made by CHW is more than it should have paid under this COB provision, CHW may recover the excess from one or more of the persons it has paid, or for whom it has paid, or for any other person or organization that may be responsible for the benefits or services provided for the covered person.

Facility of Payment

A payment made under another plan may include an amount that should have been paid under this Plan. If it does, the claims administrator may pay that amount to the organization that made the payment. That amount will then be treated as a benefit payable under this Plan, and the claims administrator will not have to pay that amount again. The term *payment made* can mean the reasonable cash value of the health care service provided.

Important Information for Medicare-Eligible Individuals

If you (or your spouse) are eligible for coverage under Medicare while you are a participant in the EPO Plus Plan, your benefits payable under the Plan might be affected. An individual is considered eligible for Medicare if he or she is:

- Covered under Medicare, or
- Not covered under Medicare because he or she refused, dropped or failed to make proper request for Medicare coverage.

In general, Medicare is the primary payer only for *retirees* age 65 and older. However, if you reach age 65 and are still an active employee covered under a CHW health care program and are eligible for Medicare, Medicare will be considered the secondary payer of benefits while the EPO Plus Plan will be primary. (See the section *Coordination of Benefits* on page 32 for details on primary and secondary plans.) Note that the EPO Plus Plan will determine benefits payable to a Medicare-eligible individual based on the assumption that such an individual has enrolled in Part B of Medicare. For more information, please contact the Human Resources Department at CHW.

Medicare is also the secondary payer for an:

- Active employee's spouse who is over the age of 65,
- Active employee's covered dependent who is eligible for Medicare due to a disability (regardless of age), or
- Individual receiving treatment for end-stage renal disease (during the first 30 months of such treatment).

Right of Reimbursement

This provision applies when you or your covered dependents receive or are eligible to receive reimbursement from a third party as the result of an illness or injury. This provision will apply whether or not the third party admits liability for payment. The purpose of this provision is to ensure that no benefit payments are duplicated under the CHW EPO Plus Plan.

The term *third party reimbursement* includes any source of health care reimbursement. Examples: settlement, judgment, or uninsured/underinsured/no-fault motorist insurance coverage.

If third party reimbursement is or may be due to you or your covered dependents, but is not yet paid, the claims administrator may advance benefit payment to the individual. The individual must agree to:

- Promptly notify the claims administrator of any payment received from the third party, and
- Reimburse the claims administrator the benefits advanced under the EPO Plus Plan, up to the amount of any reimbursement received from the third party.

Any benefit paid will be subject to all provisions that apply under the CHW EPO Plus Plan.

In the event a covered individual refuses to reimburse the claims administrator in accordance with the terms of this provision, the claims administrator has the right to deduct the amount of benefits paid from any future benefits payable to the covered individual or to any other covered family employee. The claims administrator has the right to bring legal action against the covered individual to recover any balance owed under the terms of this provision.

Right of Recovery

Whenever an overpayment is made, the Plan has the right to recover the excess payment from the recipient (including you, an insurance company or any other organization receiving excess payments). If necessary, the Plan administrator may withhold payment on future benefits until the overpayment is recovered.

Further, whenever payments have been made based on fraudulent information provided by you, the Plan will exercise the right to withhold payment on future benefits until the overpayment is recovered.

Medical Malpractice Disputes

Any dispute alleging the medical malpractice, negligence and/or wrongful act of any health care provider shall not include CHW or MCS and shall include only the provider subject to the allegation.

No Guarantee of Employment

By adopting and maintaining this Plan, CHW has not entered into an employment contract with any employee. Nothing contained in the Plan document or in the description gives any employee the right to be employed by CHW or to interfere with CHW's right to discharge any employee at any time.

Plan Future

CHW intends to continue this Plan but reserves the right through its Board of Directors (or the Board's designees) to terminate, suspend, withdraw, amend or modify the Plan at any time.

Your Rights Under Federal Law

The Employee Retirement Income Security Act of 1974 (ERISA) was enacted to protect the interest of participants and beneficiaries in certain employee benefit plans.

As a participant in the CHW benefit plans described in this Plan description, you have certain rights and protections under ERISA, as outlined in the following statement adapted from the U.S. Department of Labor regulations.

ERISA Rights Statement

Participants and beneficiaries under this Plan are entitled to certain rights and protection under ERISA. Specifically, ERISA provides that all Plan participants are entitled to:

- Examine without charge at the Plan administrator's office (MCS) and at other specified locations, such as the Human Resources Department, all documents governing this Plan, including all Plan documentation, insurance contracts and a copy of the latest annual report filed by the Plan with the U.S. Department of Labor, and available at the Public Disclosure Room of the Employee Benefits Security Administration.
- Obtain upon written request to the Plan administrator (MCS), copies of documents governing the operation of this Plan, including insurance contracts, collective bargaining agreements, a copy of the latest annual report, and an updated Summary Plan Description. The Plan administrator may make a reasonable charge for the copies.
- Receive a summary of the Plan's annual financial report. MCS is required by law to furnish each enrollee with a copy of this summary annual report.

If there is a cessation of contributions to the Plan as a result of a COBRA qualifying event, you, your covered spouse or your dependents may have to continue such contributions by self-payment. Please check pages 8 to 11 of this booklet for information and the rules governing your COBRA continuation coverage rights.

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

Prudent Actions by Plan Fiduciaries

In addition to creating rights for Plan participants and beneficiaries, ERISA imposes obligations upon the persons who are responsible for the operation of the CHW EPO Plus Plan. These persons who operate your Plan are called *fiduciaries* in the law. Fiduciaries must act solely in the interest of the Plan beneficiaries and they must exercise reasonable prudence in the performance of their Plan duties. Fiduciaries who violate ERISA may be removed and

required to make good any losses they have caused the Plan. No one, including an employer, may fire or otherwise discriminate against employees, participants or beneficiaries in order to prevent them from obtaining a benefit or exercising their rights under ERISA.

Enforce Your Rights

If a claim for a welfare benefit is denied or ignored, in whole or in part, beneficiaries have a right to know why this was done, obtain copies of documents relating to the decision without charge, and to appeal any denial, all within certain time schedules. The process of making a claim or filing an appeal is described on pages 28 to 31.

You should know that under ERISA there are steps that can be taken to enforce the above rights. For instance, if you request a copy of Plan documents or the latest annual report from the Plan and do not receive them within thirty (30) days, you may file suit in a federal court. In such a case, the court may require the Plan administrator to provide the materials and pay you up to \$110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the Plan administrator. If you have a claim for benefits, which is denied or ignored, in whole or in part, you may file suit in a state or federal court after exhausting the Plan's administrative procedures (pages 28 to 31). If a Plan fiduciary misuses the Plan's money or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor or you may file suit in a federal court.

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

Assistance with Your Questions

If you have any questions about the Plan, you should contact the Plan administrator, MCS. If you have any questions about this statement or about your rights under ERISA or if you need assistance in obtaining documents from the Plan administrator, you should contact the nearest office of the Employee Benefits Security Administration, U.S. Department of Labor, listed in your telephone directory, or the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue N.W., Washington, D.C., 20210. You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefits Security Administration.

Privacy Rights

As noted on page 31 in this booklet, the federal Health Insurance Portability and Accountability Act of 1996 (HIPAA) requires special precautions of health benefit plans to protect the privacy of *protected health information*. In the course of providing benefits to you under this Plan, MCS or the Human Resources Department may acquire protected health information. Accordingly, the Plan has developed procedures to restrict access to protected health information to persons who need to know it in order to process, complete, or administer the Plan benefits. If you would like more details about your privacy rights, please contact MCS, as noted on page 3.

Employer Information

Catholic Healthcare West
420 34th Street
Bakersfield, California 93301

Employer Identification Number:

- Mercy Healthcare Bakersfield #95-1660858
- Bakersfield Memorial Hospital #95-1802779

Administrative Information

Plan Sponsor: Catholic Healthcare West
2215 Truxtun Avenue
Bakersfield, California 93301

Plan Administrator: Managed Care Systems, LP
4550 California Avenue, Suite 500
Bakersfield, California 93309
Customer Service Department: 1-800-414-5860

Agent for Service of Legal Process: Benefits Manager
Catholic Healthcare West
420 34th Street
Bakersfield, California 93301

Name of Plan: CHW Exclusive Provider Organization (EPO) Plus Plan

Type of Plan: Welfare plan

Plan Number: 501

Plan Year: January 1 – December 31

Funding Arrangement: Self-funded