LANCASTER GENERAL HEALTH

LG SELECT/LG CONSUMER EMPLOYEE HEALTH BENEFIT PROGRAM

PLAN DOCUMENT

AND

SUMMARY PLAN DESCRIPTION

Effective Date: January 1, 2017
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SUMMARY PLAN DESCRIPTION

Name of Plan:
LG Select/LG Consumer Employee Health Benefit Program (The Plan)

Name, Address and Phone Number of Employer/Plan Sponsor:
Lancaster General Health
555 North Duke Street
P.O. Box 3555
Lancaster, PA  17604-3555
717-544-5511

Employer Identification Number:
23-2250941

Plan Number:
501

Group Number:
800

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

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

Name, Address and Phone Number of Plan Administrator, Fiduciary, and Agent for Service of Legal Process:
Senior Vice President - Human Resources or Vice President – Human Resources
Lancaster General Health
555 North Duke Street
P.O. Box 3555
Lancaster, PA  17604-3555
717-544-5511

Legal process may be served upon the Plan Administrator.

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

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

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

Funding Method:

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

Ending Date of Plan Year:

December 31

Procedures for Filing Claims:

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

The designated claims processor for health benefit (excluding behavioral health) claims is:

CoreSource, Inc.
P. O. Box 2920
Clinton, IA  52733-2920

The designated claims processor for behavioral health claims is:

Quest
P.O. Box 1032
York, PA  17403

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

Express Scripts
One Express Way
St. Louis, MO  63121
www.express-scripts.com

Statement of ERISA Rights:

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

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

2. Obtain, upon written request to the Plan Administrator, copies of documents governing the operation of the Plan, including insurance contracts and collective bargaining agreements and copies of the latest annual report (Form 5500 Series) and updated summary plan description, if applicable. The Plan Administrator may make a reasonable charge for the copies.
3. Receive a summary of the Plan's annual financial report. The Plan Administrator is required by law to furnish each participant with a copy of this summary annual report, if applicable.

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

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

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

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

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

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

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

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

<table>
<thead>
<tr>
<th>LG Select Plan Health Benefits</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Maximum Benefit Per Enrolled Individual While Enrolled In This Plan For:</strong></td>
</tr>
<tr>
<td>Infertility Services</td>
</tr>
<tr>
<td><strong>Maximum Benefit Per Enrolled Individual Per Calendar Year For:</strong></td>
</tr>
<tr>
<td>Extended Care Facility</td>
</tr>
<tr>
<td><strong>Maximum Benefit Per Enrolled Individual Every Five (5) Years For:</strong></td>
</tr>
<tr>
<td>Non-Medically Necessary Foot Orthotics (Employees Only)</td>
</tr>
<tr>
<td><strong>Maximum Benefit Per Transplant:</strong></td>
</tr>
<tr>
<td>Donor Screening Tests</td>
</tr>
<tr>
<td>Travel Expenses</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Deductible Per Calendar Year:</th>
<th>Top Tier</th>
<th>Preferred Provider</th>
<th>Nonpreferred Provider</th>
</tr>
</thead>
<tbody>
<tr>
<td>Individual (Per Person)</td>
<td>$500</td>
<td>$750</td>
<td>$900</td>
</tr>
<tr>
<td>Family (Aggregate)</td>
<td>$1,000</td>
<td>$1,500</td>
<td>$1,800</td>
</tr>
</tbody>
</table>

| Medical/Prescription Drug Out-of-Pocket Expense Limit Per Calendar Year: |
| Individual (Per Person) | $2,500 | $3,750 | $6,400 |
| Family (Aggregate)    | $5,000 | $7,500 | $12,800 |

Refer to Health Benefits, Out-of-Pocket Expense Limit for a listing of charges not applicable to the out-of-pocket expense limit.

Amounts applied toward satisfaction of any deductible or out-of-pocket expense limit may also be applied toward satisfaction of all other deductibles and out-of-pocket expense limits.

**Coinsurance:**

The Plan pays the percentage listed on the following pages for covered expenses incurred by an enrolled individual during a calendar year after the individual or family deductible has been satisfied and until the individual or family out-of-pocket expense limit has been reached. Thereafter, the Plan pays one hundred percent (100%) of covered expenses for the remainder of the calendar year or until the maximum benefit has been reached. Refer to Health Benefits, Out-of-Pocket Expense Limit, for a listing of charges not applicable to the one hundred percent (100%) coinsurance.
<table>
<thead>
<tr>
<th>BENEFIT DESCRIPTION</th>
<th>Top Tier (%)</th>
<th>Preferred Provider (%)</th>
<th>Nonpreferred Provider (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Inpatient Hospital (Facility Expense Only)</td>
<td>100%</td>
<td>*80%</td>
<td>*60%</td>
</tr>
<tr>
<td>Per Admission Copay waived for re-admission within 90 days</td>
<td>(after $200 copay per admission)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Preadmission Testing (Facility Expense Only)</td>
<td>100%</td>
<td>*80%</td>
<td>*60%</td>
</tr>
<tr>
<td>Outpatient Surgery/Ambulatory Surgical Facility</td>
<td>100%</td>
<td>*80%</td>
<td>*60%</td>
</tr>
<tr>
<td>Emergency Room Services</td>
<td>*80%</td>
<td>*80%</td>
<td>*80%</td>
</tr>
<tr>
<td>Emergency Care</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Non-Emergency Care</td>
<td>Not Covered</td>
<td>Not Covered</td>
<td>Not Covered</td>
</tr>
<tr>
<td>Urgent Care Center</td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
</tr>
<tr>
<td>(after $35 copay)</td>
<td>(after $35 copay)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>(after $50 copay)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Retail Health Clinic Visit</td>
<td>100%</td>
<td>100%</td>
<td>*60%</td>
</tr>
<tr>
<td>(after $20 copay)</td>
<td>(after $20 copay)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>e-Visit</td>
<td>100%</td>
<td>100%</td>
<td>*60%</td>
</tr>
<tr>
<td>(after $20 copay)</td>
<td>(after $20 copay)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Telemedicine Benefit – For Employees Only</td>
<td>100%</td>
<td>N/A</td>
<td>N/A</td>
</tr>
<tr>
<td>Limitation: Available only at Employee and Student Health at Duke Street office for certain approved conditions/symptoms</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Ambulance Services</td>
<td>*90%</td>
<td>*80%</td>
<td>*80%</td>
</tr>
<tr>
<td>Physician Services</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Office Visit</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Personal Family Physician</td>
<td>100%</td>
<td>100%</td>
<td>*60%</td>
</tr>
<tr>
<td>(after $20 copay)</td>
<td>(after $20 copay)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Specialist Physician</td>
<td>100%</td>
<td>100%</td>
<td>*60%</td>
</tr>
<tr>
<td>(after $35 copay)</td>
<td>(after $35 copay)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Inpatient Visit</td>
<td>*90%</td>
<td>*80%</td>
<td>*60%</td>
</tr>
<tr>
<td>Surgery</td>
<td>*90%</td>
<td>*80%</td>
<td>*60%</td>
</tr>
</tbody>
</table>

* After Deductible
<table>
<thead>
<tr>
<th>BENEFIT DESCRIPTION</th>
<th>Top Tier</th>
<th>Preferred Provider</th>
<th>Nonpreferred Provider</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>(% of negotiated rate, if applicable, otherwise % of customary and reasonable amount)</td>
<td>(% of negotiated rate, if applicable, otherwise % of customary and reasonable amount)</td>
<td>(% of customary and reasonable amount, if applicable, otherwise % of negotiated rate)</td>
</tr>
<tr>
<td><strong>Physician Services</strong> (continued)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Allergy Injections</td>
<td>*90%</td>
<td>*80%</td>
<td>*60%</td>
</tr>
<tr>
<td>Pathology</td>
<td>100%</td>
<td>*80%</td>
<td>*60%</td>
</tr>
<tr>
<td>Anesthesiology</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Inpatient</td>
<td>*90%</td>
<td>*80%</td>
<td>*60%</td>
</tr>
<tr>
<td>Outpatient</td>
<td>*90%</td>
<td>*80%</td>
<td>*60%</td>
</tr>
<tr>
<td>Nurse Anesthetist</td>
<td>100%</td>
<td>N/A</td>
<td>N/A</td>
</tr>
<tr>
<td>Radiology</td>
<td>100%</td>
<td>*80%</td>
<td>*60%</td>
</tr>
<tr>
<td><strong>Diagnostic Services and Supplies</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Inpatient or Outpatient</td>
<td>100%</td>
<td>*80%</td>
<td>*60%</td>
</tr>
<tr>
<td>Independent Lab</td>
<td>N/A</td>
<td>*80%</td>
<td>*60%</td>
</tr>
<tr>
<td><strong>Second Surgical Opinion</strong></td>
<td>100%</td>
<td>100%</td>
<td>*60%</td>
</tr>
<tr>
<td>(after $35 copay)</td>
<td>(after $35 copay)</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Flu Shot</strong></td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
</tr>
<tr>
<td><strong>Well Child Care</strong></td>
<td>100%</td>
<td>100%</td>
<td>*60%</td>
</tr>
<tr>
<td>Limitation: through age 18</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Routine Preventive Care</strong></td>
<td>100%</td>
<td>100%</td>
<td>*60%</td>
</tr>
<tr>
<td>Limitation: age 19 and over</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Women’s Preventive Services</strong></td>
<td>100%</td>
<td>100%</td>
<td>*60%</td>
</tr>
<tr>
<td><strong>Routine Mammograms</strong></td>
<td>100%</td>
<td>100%</td>
<td>*60%</td>
</tr>
<tr>
<td>Limitation: through age 39 - one (1) mammogram</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><em>maximum benefit</em> while enrolled in this Plan</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>age 40 and over - one (1) mammogram</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><em>maximum benefit</em> per calendar year</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Routine Prostate Examination</strong></td>
<td>100%</td>
<td>100%</td>
<td>*60%</td>
</tr>
<tr>
<td><strong>Routine Sigmoidoscopy</strong></td>
<td>100%</td>
<td>100%</td>
<td>*60%</td>
</tr>
<tr>
<td>Limitation: 1 exam <em>maximum benefit</em> every 5 years</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>age 50 and over</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Routine Colonoscopy</strong></td>
<td>100%</td>
<td>100%</td>
<td>*60%</td>
</tr>
<tr>
<td>Limitation: 1 exam <em>maximum benefit</em> every 10 years</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>age 50 and over</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

* After Deductible
<table>
<thead>
<tr>
<th>BENEFIT DESCRIPTION</th>
<th>Top Tier</th>
<th>Preferred Provider</th>
<th>Nonpreferred Provider</th>
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<tbody>
<tr>
<td></td>
<td>(% of negotiated rate, if applicable, otherwise % of customary and reasonable amount)</td>
<td>(% of negotiated rate, if applicable, otherwise % of customary and reasonable amount)</td>
<td>(% of customary and reasonable amount, if applicable, otherwise % of negotiated rate)</td>
</tr>
<tr>
<td>Extended Care Facility</td>
<td>*90%</td>
<td>*80%</td>
<td>*60%</td>
</tr>
<tr>
<td>Limitation: 180 days maximum benefit per calendar year</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Home Health Care</td>
<td>*90%</td>
<td>*80%</td>
<td>*60%</td>
</tr>
<tr>
<td>Hospice Care</td>
<td>*90%</td>
<td>*80%</td>
<td>*60%</td>
</tr>
<tr>
<td>Durable Medical Equipment</td>
<td>*90%</td>
<td>*80%</td>
<td>*60%</td>
</tr>
<tr>
<td>Durable medical equipment rental or purchase is subject to pre-certification, or a $100 penalty will apply.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Corrective Appliance</td>
<td>*90%</td>
<td>*80%</td>
<td>*60%</td>
</tr>
<tr>
<td>Non-Medically Necessary Foot Orthotics (Employees Only)</td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
</tr>
<tr>
<td>Limitation: 1 pair maximum benefit every 5 years</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Transplant</td>
<td>*90%</td>
<td>*80%</td>
<td>Not Covered</td>
</tr>
<tr>
<td>Limitation: $10,000 maximum benefit per transplant</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>for donor screening tests</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>$10,000 maximum benefit per transplant for travel expenses</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Outpatient Therapy Services</td>
<td>90%</td>
<td>*80%</td>
<td>*60%</td>
</tr>
<tr>
<td>Physical, Occupational and Speech Therapies</td>
<td>90%</td>
<td>*80%</td>
<td>*60%</td>
</tr>
<tr>
<td>Respiratory Therapy</td>
<td>100%</td>
<td>*80%</td>
<td>*60%</td>
</tr>
<tr>
<td>Radiation Therapy and Chemotherapy</td>
<td>*90%</td>
<td>*80%</td>
<td>*60%</td>
</tr>
<tr>
<td>Cardiac/Pulmonary Rehabilitation Therapy</td>
<td>*90%</td>
<td>*80%</td>
<td>*60%</td>
</tr>
<tr>
<td>Dialysis</td>
<td>*90%</td>
<td>*80%</td>
<td>Not Covered</td>
</tr>
<tr>
<td>All Other Eligible Outpatient Therapies</td>
<td>*90%</td>
<td>*80%</td>
<td>*60%</td>
</tr>
<tr>
<td>Birthing Center</td>
<td>100%</td>
<td>*80%</td>
<td>*60%</td>
</tr>
<tr>
<td>Wig</td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
</tr>
<tr>
<td>Podiatry Office Visit</td>
<td>100%</td>
<td>100%</td>
<td>*60%</td>
</tr>
<tr>
<td>*(after $35 copay)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Hyperalimentation or Total Parenteral Nutrition (TPN)</td>
<td>*90%</td>
<td>*80%</td>
<td>*60%</td>
</tr>
<tr>
<td>Outpatient Lactation Counseling</td>
<td>100%</td>
<td>100%</td>
<td>*60%</td>
</tr>
<tr>
<td>Nutritional Counseling</td>
<td>100%</td>
<td>100%</td>
<td>*60%</td>
</tr>
<tr>
<td>Personal Family Physician</td>
<td>100%</td>
<td>100%</td>
<td>*60%</td>
</tr>
<tr>
<td>*(after $20 copay)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Specialist Physician</td>
<td>100%</td>
<td>100%</td>
<td>*60%</td>
</tr>
<tr>
<td>*(after $35 copay)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Other Provider</td>
<td>*90%</td>
<td>*80%</td>
<td>*60%</td>
</tr>
</tbody>
</table>

* After Deductible
<table>
<thead>
<tr>
<th>BENEFIT DESCRIPTION</th>
<th>Top Tier</th>
<th>Preferred Provider</th>
<th>Nonpreferred Provider</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>(% of negotiated rate, if applicable, otherwise % of customary and reasonable amount)</td>
<td>(% of negotiated rate, if applicable, otherwise % of customary and reasonable amount)</td>
<td>(% of customary and reasonable amount, if applicable, otherwise % of negotiated rate)</td>
</tr>
<tr>
<td>Diabetic Care</td>
<td>*90%</td>
<td>*80%</td>
<td>*60%</td>
</tr>
<tr>
<td>Diabetes Outpatient Self-Management Training and Education</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Personal Family Physician</td>
<td>100%</td>
<td>100%</td>
<td>*60%</td>
</tr>
<tr>
<td>(after $20 copay)</td>
<td></td>
<td>(after $20 copay)</td>
<td></td>
</tr>
<tr>
<td>Specialist Physician</td>
<td>100%</td>
<td>100%</td>
<td>*60%</td>
</tr>
<tr>
<td>(after $35 copay)</td>
<td></td>
<td>(after $35 copay)</td>
<td></td>
</tr>
<tr>
<td>Other Provider</td>
<td>100%</td>
<td>100%</td>
<td>*60%</td>
</tr>
<tr>
<td>Group Health Education Courses</td>
<td>100%^</td>
<td>100%^</td>
<td>100%^</td>
</tr>
<tr>
<td>Limitation: For information on the classes offered at Lancaster General Health visit <a href="http://www.LGHealth.org">www.LGHealth.org</a> and click on Classes &amp; Events</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Golden Triangle Specialty Network, LLC. Renal Network</td>
<td>*90%</td>
<td>*80%</td>
<td>Not Covered</td>
</tr>
<tr>
<td>– Note that pre-notification is required or a penalty may apply.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Private Duty Nursing</td>
<td>*90%</td>
<td>*80%</td>
<td>*60%</td>
</tr>
<tr>
<td>All Other Covered Expenses</td>
<td>*90%</td>
<td>*80%</td>
<td>*60%</td>
</tr>
</tbody>
</table>

* After Deductible

^ Applicable only to approved Group Health Education Courses
<table>
<thead>
<tr>
<th>BENEFIT DESCRIPTION</th>
<th>Top Tier (% of negotiated rate, if applicable, otherwise % of customary and reasonable amount)</th>
<th>Quest Network (% of negotiated rate, if applicable, otherwise % of customary and reasonable amount)</th>
<th>Nonpreferred Provider (% of customary and reasonable amount, if applicable)</th>
</tr>
</thead>
</table>
| **Behavioral Health Services – Administered by Quest**  
**Subject to the Health Benefits Deductibles and Out-of-Pocket Maximums**  
*After Deductible*  
$1,500 copay for each inpatient or outpatient service obtained from either Heart of Lancaster and/or Lancaster Regional Medical Center.  
Refer to Health Benefits for complete details. |
| Outpatient | 100% (after $20 copay) | 100% (after $20 copay) | *60% |
| Inpatient (Facility Expense Only)  
Per Admission Copay waived for re-admission within 90 days | 100% (after $20 copay per admission) | *80% | *60% |
| Professional Fees | *90% | *80% | *60% |
| Partial, IOP and ECT (By Exception Only) | 100% | *80% | *60% |
| Emergency Department/Crisis Evaluation | *80% | *80% | *80% |
| Psychological Testing | 100% (after $20 copay) | 100% | *60% |
# LG Consumer Plan Health Benefits

## Maximum Benefit Per Enrolled Individual While Enrolled In This Plan For:

<table>
<thead>
<tr>
<th>Service</th>
<th>Benefit</th>
</tr>
</thead>
<tbody>
<tr>
<td>Infertility Services</td>
<td>$3,000</td>
</tr>
</tbody>
</table>

## Maximum Benefit Per Enrolled Individual Per Calendar Year For:

<table>
<thead>
<tr>
<th>Service</th>
<th>Benefit</th>
</tr>
</thead>
<tbody>
<tr>
<td>Extended Care Facility</td>
<td>180 Days</td>
</tr>
</tbody>
</table>

## Maximum Benefit Per Enrolled Individual Every Five (5) Years For:

<table>
<thead>
<tr>
<th>Service</th>
<th>Benefit</th>
</tr>
</thead>
<tbody>
<tr>
<td>Non-Medically Necessary Foot Orthotics (Employees Only)</td>
<td>1 Pair</td>
</tr>
</tbody>
</table>

## Maximum Benefit Per Transplant:

<table>
<thead>
<tr>
<th>Service</th>
<th>Benefit</th>
</tr>
</thead>
<tbody>
<tr>
<td>Donor Screening Tests</td>
<td>$10,000</td>
</tr>
<tr>
<td>Travel Expenses</td>
<td>$10,000</td>
</tr>
</tbody>
</table>

## Deductible Per Calendar Year:

<table>
<thead>
<tr>
<th>Tier</th>
<th>Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td>Employee Only</td>
<td>$2,000</td>
</tr>
<tr>
<td>Family (Aggregate)</td>
<td>$4,000</td>
</tr>
</tbody>
</table>

## Medical/Prescription Drug Out-of-Pocket Expense Limit Per Calendar Year:

<table>
<thead>
<tr>
<th>Tier</th>
<th>Employee Only</th>
<th>Family (Embedded)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Preferred Provider</td>
<td>$4,000</td>
<td>$8,000</td>
</tr>
<tr>
<td>Nonpreferred Provider</td>
<td>$6,000</td>
<td>$12,000</td>
</tr>
</tbody>
</table>

Refer to *Health Benefits, Out-of-Pocket Expense Limit* for a listing of charges not applicable to the out-of-pocket expense limit.

Amounts applied toward satisfaction of any deductible or out-of-pocket expense limit may also be applied toward satisfaction of all other deductibles and out-of-pocket expense limits.

## Coinsurance:

The *Plan* pays the percentage listed on the following pages for *covered expenses incurred* by an *enrolled individual* during a calendar year after the individual or family deductible has been satisfied and until the individual or family out-of-pocket expense limit has been reached. Thereafter, the *Plan* pays one hundred percent (100%) of *covered expenses* for the remainder of the calendar year or until the *maximum benefit* has been reached. Refer to *Health Benefits, Out-of-Pocket Expense Limit*, for a listing of charges not applicable to the one hundred percent (100%) *coinsurance*. 
<table>
<thead>
<tr>
<th>BENEFIT DESCRIPTION</th>
<th>Top Tier (% of negotiated rate, if applicable, otherwise % of customary and reasonable amount)</th>
<th>Preferred Provider (% of negotiated rate, if applicable, otherwise % of customary and reasonable amount)</th>
<th>Nonpreferred Provider (% of customary and reasonable amount, if applicable, otherwise % of negotiated rate)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Inpatient Hospital (Facility Expense Only)</td>
<td>*90%</td>
<td>*90%</td>
<td>*60%</td>
</tr>
<tr>
<td>Preadmission Testing (Facility Expense Only)</td>
<td>*100%</td>
<td>*100%</td>
<td>*60%</td>
</tr>
<tr>
<td>Outpatient Surgery/Ambulatory Surgical Facility</td>
<td>*100%</td>
<td>*100%</td>
<td>*60%</td>
</tr>
<tr>
<td>Emergency Room Services</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Emergency Care</td>
<td>*80%</td>
<td>*80%</td>
<td>*80%</td>
</tr>
<tr>
<td>Non-Emergency Care</td>
<td>Not Covered</td>
<td>Not Covered</td>
<td>Not Covered</td>
</tr>
<tr>
<td>Urgent Care Center</td>
<td>*90%</td>
<td>*90%</td>
<td>*90%</td>
</tr>
<tr>
<td>Retail Health Clinic Visit</td>
<td>*90%</td>
<td>*90%</td>
<td>*90%</td>
</tr>
<tr>
<td>e-Visit</td>
<td>*100% (after $20 copay)</td>
<td>*100% (after $20 copay)</td>
<td>*60%</td>
</tr>
<tr>
<td>Telemmedicine Benefit – For Employees Only</td>
<td>100% (after $20 copay)</td>
<td>N/A</td>
<td>N/A</td>
</tr>
<tr>
<td>Limitation: Available only at Employee and Student Health at Duke Street office for certain approved conditions/symptoms</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Ambulance Services</td>
<td>*90%</td>
<td>*90%</td>
<td>*90%</td>
</tr>
<tr>
<td>Physician Services</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Office Visit</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Personal Family Physician</td>
<td>*100% (after $20 copay)</td>
<td>*100% (after $20 copay)</td>
<td>*60%</td>
</tr>
<tr>
<td>Specialist Physician</td>
<td>*100% (after $35 copay)</td>
<td>*100% (after $35 copay)</td>
<td>*60%</td>
</tr>
<tr>
<td>Inpatient Visit</td>
<td>*90%</td>
<td>*90%</td>
<td>*60%</td>
</tr>
<tr>
<td>Surgery</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Inpatient</td>
<td>*90%</td>
<td>*90%</td>
<td>*60%</td>
</tr>
<tr>
<td>Outpatient at a Facility</td>
<td>*100%</td>
<td>*100%</td>
<td>*60%</td>
</tr>
<tr>
<td>In Physician’s Office</td>
<td>*90%</td>
<td>*90%</td>
<td>*60%</td>
</tr>
<tr>
<td>Allergy Injections</td>
<td>*90%</td>
<td>*90%</td>
<td>*60%</td>
</tr>
<tr>
<td>Pathology</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Inpatient</td>
<td>*90%</td>
<td>*90%</td>
<td>*60%</td>
</tr>
<tr>
<td>Outpatient</td>
<td>*100%</td>
<td>*100%</td>
<td>*60%</td>
</tr>
</tbody>
</table>

* After Deductible
**BENEFIT DESCRIPTION**

<table>
<thead>
<tr>
<th>Physician Services (continued)</th>
<th>Top Tier (if negotiated rate, if applicable, otherwise % of customary and reasonable amount)</th>
<th>Preferred Provider (if negotiated rate, if applicable, otherwise % of customary and reasonable amount)</th>
<th>Nonpreferred Provider (if applicable, otherwise % of negotiated rate)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Anesthesiology</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Inpatient</td>
<td>*90%</td>
<td>*90%</td>
<td>*60%</td>
</tr>
<tr>
<td>Outpatient</td>
<td>*100%</td>
<td>*100%</td>
<td>*60%</td>
</tr>
<tr>
<td>Nurse Anesthetist</td>
<td>*100%</td>
<td>N/A</td>
<td>N/A</td>
</tr>
<tr>
<td><strong>Radiology</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Inpatient</td>
<td>*90%</td>
<td>*90%</td>
<td>*60%</td>
</tr>
<tr>
<td>Outpatient</td>
<td>*100%</td>
<td>*100%</td>
<td>*60%</td>
</tr>
<tr>
<td><strong>Diagnostic Services and Supplies</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Inpatient</td>
<td>*90%</td>
<td>*90%</td>
<td>*60%</td>
</tr>
<tr>
<td>Outpatient</td>
<td>*100%</td>
<td>*90%</td>
<td>*60%</td>
</tr>
<tr>
<td>Independent Lab</td>
<td>N/A</td>
<td>*90%</td>
<td>*60%</td>
</tr>
<tr>
<td><strong>Second Surgical Opinion</strong></td>
<td>*100% (after $35 copay)</td>
<td>*100% (after $35 copay)</td>
<td>*60%</td>
</tr>
<tr>
<td><strong>Flu Shot</strong></td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
</tr>
<tr>
<td><strong>Well Child Care</strong></td>
<td>100%</td>
<td>100%</td>
<td>*60%</td>
</tr>
<tr>
<td>Limitation: through age 18</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Routine Preventive Care</strong></td>
<td>100%</td>
<td>100%</td>
<td>*60%</td>
</tr>
<tr>
<td>Limitation: age 19 and over</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Women’s Preventive Services</strong></td>
<td>100%</td>
<td>100%</td>
<td>*60%</td>
</tr>
<tr>
<td><strong>Routine Mammograms</strong></td>
<td>100%</td>
<td>100%</td>
<td>*60%</td>
</tr>
<tr>
<td>Limitation: through age 39 - one (1) mammogram maximum benefit while enrolled in this Plan age 40 and over - one (1) mammogram maximum benefit per calendar year</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Routine Prostate Examination</strong></td>
<td>100%</td>
<td>100%</td>
<td>*60%</td>
</tr>
<tr>
<td><strong>Routine Sigmoidoscopy</strong></td>
<td>100%</td>
<td>100%</td>
<td>*60%</td>
</tr>
<tr>
<td>Limitation: 1 exam maximum benefit every 5 years age 50 and over</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Routine Colonoscopy</strong></td>
<td>100%</td>
<td>100%</td>
<td>*60%</td>
</tr>
<tr>
<td>Limitation: 1 exam maximum benefit every 10 years age 50 and over</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

* After Deductible
<table>
<thead>
<tr>
<th>BENEFIT DESCRIPTION</th>
<th>Top Tier (% of negotiated rate, if applicable, otherwise % of customary and reasonable amount)</th>
<th>Preferred Provider (% of negotiated rate, if applicable, otherwise % of customary and reasonable amount)</th>
<th>Nonpreferred Provider (% of customary and reasonable amount, if applicable, otherwise % of negotiated rate)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Extended Care Facility</td>
<td>*90%</td>
<td>*90%</td>
<td>*60%</td>
</tr>
<tr>
<td>Limitation: 180 days maximum benefit per calendar year</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Home Health Care</td>
<td>*90%</td>
<td>*90%</td>
<td>*60%</td>
</tr>
<tr>
<td>Hospice Care</td>
<td>*90%</td>
<td>*90%</td>
<td>*60%</td>
</tr>
<tr>
<td>Durable Medical Equipment</td>
<td>Durable medical equipment rental or purchase is subject to pre-certification, or a $100 penalty will apply.</td>
<td>*90%</td>
<td>*60%</td>
</tr>
<tr>
<td>Corrective Appliance</td>
<td>*90%</td>
<td>*90%</td>
<td>*60%</td>
</tr>
<tr>
<td>Non-Medically Necessary Foot Orthotics (Employees Only)</td>
<td>*100%</td>
<td>*100%</td>
<td>*100%</td>
</tr>
<tr>
<td>Limitation: 1 pair maximum benefit every 5 years</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Outpatient Therapy Services</td>
<td>*90%</td>
<td>*90%</td>
<td>*60%</td>
</tr>
<tr>
<td>Dialysis</td>
<td>*90%</td>
<td>*90%</td>
<td>Not Covered</td>
</tr>
<tr>
<td>Birthing Center</td>
<td>*90%</td>
<td>*90%</td>
<td>*60%</td>
</tr>
<tr>
<td>Wig</td>
<td>*100%</td>
<td>*100%</td>
<td>*100%</td>
</tr>
<tr>
<td>Podiatry Office Visit</td>
<td>*100% (after $35 copay)</td>
<td>*100% (after $35 copay)</td>
<td>*60%</td>
</tr>
<tr>
<td>Hyperalimentation or Total Parenteral Nutrition (TPN)</td>
<td>*90%</td>
<td>*90%</td>
<td>*60%</td>
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<td>100%</td>
<td>*60%</td>
</tr>
<tr>
<td>Nutritional Counseling</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Personal Family Physician</td>
<td>*100% (after $20 copay)</td>
<td>*100% (after $20 copay)</td>
<td>*60%</td>
</tr>
<tr>
<td>Specialist Physician</td>
<td>*100% (after $35 copay)</td>
<td>*100% (after $35 copay)</td>
<td>*60%</td>
</tr>
<tr>
<td>Other Provider</td>
<td>*90%</td>
<td>*90%</td>
<td>*60%</td>
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<th>Nonpreferred Provider</th>
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<tr>
<td></td>
<td>(% of negotiated rate, if applicable, otherwise % of customary and reasonable amount)</td>
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<td>(% of customary and reasonable amount, if applicable, otherwise % of negotiated rate)</td>
</tr>
<tr>
<td><strong>Diabetic Care</strong></td>
<td>*90%</td>
<td>*90%</td>
<td>*60%</td>
</tr>
<tr>
<td><strong>Diabetes Outpatient Self-Management Training and Education</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Personal Family Physician</td>
<td>*100% (after $20 copay)</td>
<td>*100% (after $20 copay)</td>
<td>*60%</td>
</tr>
<tr>
<td>Specialist Physician</td>
<td>*100% (after $35 copay)</td>
<td>*100% (after $35 copay)</td>
<td>*60%</td>
</tr>
<tr>
<td>Other Provider</td>
<td>*100%</td>
<td>*100%</td>
<td>*60%</td>
</tr>
<tr>
<td><strong>Group Health Education Courses</strong></td>
<td>100%^</td>
<td>100%^</td>
<td>100%^</td>
</tr>
<tr>
<td>Limitation: For information on the classes offered at Lancaster General Health visit <a href="http://www.LGHealth.org">www.LGHealth.org</a> and click on Classes &amp; Events</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Golden Triangle Specialty Network, LLC. Renal Network</strong> – Note that pre-notification is required or a penalty may apply.</td>
<td>*90%</td>
<td>*90%</td>
<td>Not Covered</td>
</tr>
<tr>
<td><strong>Private Duty Nursing</strong></td>
<td>*90%</td>
<td>*90%</td>
<td>*60%</td>
</tr>
<tr>
<td><strong>All Other Covered Expenses</strong></td>
<td>*90%</td>
<td>*90%</td>
<td>*60%</td>
</tr>
</tbody>
</table>

* After Deductible
^ Applicable only to approved Group Health Education Courses
### Behavior Health Services – Administered by Quest

**Subject to the Health Benefits Deductibles and Out-of-Pocket Maximums**

<table>
<thead>
<tr>
<th>Benefit Description</th>
<th>Top Tier</th>
<th>Quest Network</th>
<th>Nonpreferred Provider</th>
</tr>
</thead>
<tbody>
<tr>
<td>Outpatient</td>
<td>*100% (after $20 copay)</td>
<td>*100% (after $20 copay)</td>
<td>*60%</td>
</tr>
<tr>
<td>Inpatient</td>
<td>*90%</td>
<td>*90%</td>
<td>*60%</td>
</tr>
<tr>
<td>Professional Fees</td>
<td>*90%</td>
<td>*90%</td>
<td>*60%</td>
</tr>
<tr>
<td>Partial, IOP and ECT (By Exception Only)</td>
<td>*90%</td>
<td>*90%</td>
<td>*60%</td>
</tr>
<tr>
<td>Emergency Department/Crisis Evaluation</td>
<td>*80%</td>
<td>*80%</td>
<td>*80%</td>
</tr>
<tr>
<td>Psychological Testing</td>
<td>*100%</td>
<td>*100%</td>
<td>*60%</td>
</tr>
</tbody>
</table>

*After Deductible*

$1,500 copay for each inpatient or outpatient service obtained from either Heart of Lancaster and/or Lancaster Regional Medical Center.

Refer to *Health Benefits* for complete details.
Maximum Benefit Per Enrolled Individual While Enrolled In This Plan For:

<table>
<thead>
<tr>
<th>Service</th>
<th>Benefit</th>
</tr>
</thead>
<tbody>
<tr>
<td>Infertility Services</td>
<td>$3,000</td>
</tr>
</tbody>
</table>

Maximum Benefit Per Enrolled Individual Per Calendar Year For:

<table>
<thead>
<tr>
<th>Service</th>
<th>Benefit</th>
</tr>
</thead>
<tbody>
<tr>
<td>Extended Care Facility</td>
<td>180 Days</td>
</tr>
</tbody>
</table>

Maximum Benefit Per Enrolled Individual Every Five (5) Years For:

<table>
<thead>
<tr>
<th>Service</th>
<th>Benefit</th>
</tr>
</thead>
<tbody>
<tr>
<td>Non-Medically Necessary Foot Orthotics (Employees Only)</td>
<td>1 Pair</td>
</tr>
</tbody>
</table>

Maximum Benefit Per Transplant:

<table>
<thead>
<tr>
<th>Service</th>
<th>Benefit</th>
</tr>
</thead>
<tbody>
<tr>
<td>Donor Screening Tests</td>
<td>$10,000</td>
</tr>
<tr>
<td>Travel Expenses</td>
<td>$10,000</td>
</tr>
</tbody>
</table>

Coinurance:

The Plan pays the percentage listed on the following pages for covered expenses incurred by an enrolled individual during a calendar year after the individual or family deductible has been satisfied and until the individual or family out-of-pocket expense limit has been reached. Thereafter, the Plan pays one hundred percent (100%) of covered expenses for the remainder of the calendar year or until the maximum benefit has been reached. Refer to Health Benefits, Out-of-Pocket Expense Limit, for a listing of charges not applicable to the one hundred percent (100%) coinsurance.
<table>
<thead>
<tr>
<th>BENEFIT DESCRIPTION</th>
<th>Top Tier</th>
<th>Preferred Provider</th>
<th>Nonpreferred Provider</th>
</tr>
</thead>
<tbody>
<tr>
<td>(&lt;% of negotiated rate, if applicable, otherwise % of customary and reasonable amount&gt;)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Inpatient Hospital (Facility Expense Only)</td>
<td>100%</td>
<td>*80%</td>
<td>*60%</td>
</tr>
<tr>
<td>Per Admission Copay waived for re-admission within 90 days</td>
<td>(after $200 copay per admission)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Preadmission Testing (Facility Expense Only)</td>
<td>100%</td>
<td>*80%</td>
<td>*60%</td>
</tr>
<tr>
<td>Outpatient Surgery/Ambulatory Surgical Facility</td>
<td>100%</td>
<td>*80%</td>
<td>*60%</td>
</tr>
<tr>
<td>Emergency Room Services</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Emergency Care</td>
<td>*80%</td>
<td>*80%</td>
<td>*80%</td>
</tr>
<tr>
<td>Deductible waived if admitted</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Non-Emergency Care</td>
<td>Not Covered</td>
<td>Not Covered</td>
<td>Not Covered</td>
</tr>
<tr>
<td>Urgent Care Center</td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
</tr>
<tr>
<td>(after $35 copay)</td>
<td>(after $75 copay)</td>
<td>(after $75 copay)</td>
<td></td>
</tr>
<tr>
<td>Retail Health Clinic Visit</td>
<td>100%</td>
<td>100%</td>
<td>*60%</td>
</tr>
<tr>
<td>(after $15 copay)</td>
<td>(after $50 copay)</td>
<td>(after $50 copay)</td>
<td></td>
</tr>
<tr>
<td>e-Visit</td>
<td>100%</td>
<td>100%</td>
<td>*60%</td>
</tr>
<tr>
<td>(after $20 copay)</td>
<td>(after $20 copay)</td>
<td>(after $20 copay)</td>
<td></td>
</tr>
<tr>
<td>Telemedicine Benefit – For Employees Only</td>
<td>100%</td>
<td>N/A</td>
<td>N/A</td>
</tr>
<tr>
<td>Limitation: Available only at Employee and Student Health at Duke Street office for certain approved conditions/symptoms</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Ambulance Services</td>
<td>*90%</td>
<td>*80%</td>
<td>*80%</td>
</tr>
<tr>
<td>Physician Services</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Office Visit</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Personal Family Physician</td>
<td>100%</td>
<td>100%</td>
<td>*60%</td>
</tr>
<tr>
<td>(after $15 copay)</td>
<td>(after $25 copay)</td>
<td>(after $25 copay)</td>
<td></td>
</tr>
<tr>
<td>Specialist Physician</td>
<td>100%</td>
<td>100%</td>
<td>*60%</td>
</tr>
<tr>
<td>(after $30 copay)</td>
<td>(after $35 copay)</td>
<td>(after $35 copay)</td>
<td></td>
</tr>
<tr>
<td>Inpatient Visit</td>
<td>*90%</td>
<td>*80%</td>
<td>*60%</td>
</tr>
<tr>
<td>Surgery</td>
<td>*90%</td>
<td>*80%</td>
<td>*60%</td>
</tr>
</tbody>
</table>

* After Deductible
<table>
<thead>
<tr>
<th>BENEFIT DESCRIPTION</th>
<th>Top Tier</th>
<th>Preferred Provider</th>
<th>Nonpreferred Provider</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>(% of negotiated rate, if applicable, otherwise % of customary and reasonable amount)</td>
<td>(% of negotiated rate, if applicable, otherwise % of customary and reasonable amount)</td>
<td>(% of customary and reasonable amount, if applicable, otherwise % of negotiated rate)</td>
</tr>
<tr>
<td></td>
<td>Top Tier</td>
<td>Preferred Provider</td>
<td>Nonpreferred Provider</td>
</tr>
<tr>
<td></td>
<td>(% of negotiated rate, if applicable, otherwise % of customary and reasonable amount)</td>
<td>(% of negotiated rate, if applicable, otherwise % of customary and reasonable amount)</td>
<td>(% of customary and reasonable amount, if applicable, otherwise % of negotiated rate)</td>
</tr>
<tr>
<td>Physician Services (continued)</td>
<td>Top Tier</td>
<td>Preferred Provider</td>
<td>Nonpreferred Provider</td>
</tr>
<tr>
<td></td>
<td>(% of negotiated rate, if applicable, otherwise % of customary and reasonable amount)</td>
<td>(% of negotiated rate, if applicable, otherwise % of customary and reasonable amount)</td>
<td>(% of customary and reasonable amount, if applicable, otherwise % of negotiated rate)</td>
</tr>
<tr>
<td>Allergy Injections</td>
<td>*90%</td>
<td>*80%</td>
<td>*60%</td>
</tr>
<tr>
<td>Pathology</td>
<td>100%</td>
<td>*80%</td>
<td>*60%</td>
</tr>
<tr>
<td>Anesthesiology</td>
<td>Top Tier</td>
<td>Preferred Provider</td>
<td>Nonpreferred Provider</td>
</tr>
<tr>
<td></td>
<td>(% of negotiated rate, if applicable, otherwise % of customary and reasonable amount)</td>
<td>(% of negotiated rate, if applicable, otherwise % of customary and reasonable amount)</td>
<td>(% of customary and reasonable amount, if applicable, otherwise % of negotiated rate)</td>
</tr>
<tr>
<td>Inpatient</td>
<td>*90%</td>
<td>*80%</td>
<td>*60%</td>
</tr>
<tr>
<td>Outpatient</td>
<td>*90%</td>
<td>*80%</td>
<td>*60%</td>
</tr>
<tr>
<td>Nurse Anesthetist</td>
<td>100%</td>
<td>N/A</td>
<td>N/A</td>
</tr>
<tr>
<td>Radiology</td>
<td>100%</td>
<td>*80%</td>
<td>*60%</td>
</tr>
<tr>
<td>Diagnostic Services and Supplies</td>
<td>Top Tier</td>
<td>Preferred Provider</td>
<td>Nonpreferred Provider</td>
</tr>
<tr>
<td></td>
<td>(% of negotiated rate, if applicable, otherwise % of customary and reasonable amount)</td>
<td>(% of negotiated rate, if applicable, otherwise % of customary and reasonable amount)</td>
<td>(% of customary and reasonable amount, if applicable, otherwise % of negotiated rate)</td>
</tr>
<tr>
<td>Inpatient or Outpatient</td>
<td>100%</td>
<td>*80%</td>
<td>*60%</td>
</tr>
<tr>
<td>Independent Lab</td>
<td>N/A</td>
<td>*80%</td>
<td>*60%</td>
</tr>
<tr>
<td>Second Surgical Opinion</td>
<td>100%</td>
<td>100%</td>
<td>*60%</td>
</tr>
<tr>
<td></td>
<td>(after $30 copay)</td>
<td>(after $35 copay)</td>
<td></td>
</tr>
<tr>
<td>Flu Shot</td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
</tr>
<tr>
<td>Well Child Care</td>
<td>100%</td>
<td>100%</td>
<td>*60%</td>
</tr>
<tr>
<td>Routine Preventive Care</td>
<td>100%</td>
<td>100%</td>
<td>*60%</td>
</tr>
<tr>
<td></td>
<td>Limitation: through age 18</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Women’s Preventive Services</td>
<td>100%</td>
<td>100%</td>
<td>*60%</td>
</tr>
<tr>
<td>Routine Mammograms</td>
<td>100%</td>
<td>100%</td>
<td>*60%</td>
</tr>
<tr>
<td></td>
<td>Limitation: through age 39 - one (1) mammogram maximum benefit while enrolled in this Plan</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>age 40 and over - one (1) mammogram maximum benefit per calendar year</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Routine Prostate Examination</td>
<td>100%</td>
<td>100%</td>
<td>*60%</td>
</tr>
<tr>
<td>Routine Sigmoidoscopy</td>
<td>100%</td>
<td>100%</td>
<td>*60%</td>
</tr>
<tr>
<td></td>
<td>Limitation: 1 exam maximum benefit every 5 years age 50 and over</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Routine Colonoscopy</td>
<td>100%</td>
<td>100%</td>
<td>*60%</td>
</tr>
<tr>
<td></td>
<td>Limitation: 1 exam maximum benefit every 10 years age 50 and over</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

* After Deductible
<table>
<thead>
<tr>
<th>BENEFIT DESCRIPTION</th>
<th>Top Tier (% of negotiated rate, if applicable, otherwise % of customary and reasonable amount)</th>
<th>Preferred Provider (% of negotiated rate, if applicable, otherwise % of customary and reasonable amount)</th>
<th>Nonpreferred Provider (% of customary and reasonable amount, if applicable, otherwise % of negotiated rate)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Extended Care Facility</td>
<td>*90%</td>
<td>*80%</td>
<td>*60%</td>
</tr>
<tr>
<td>Limitation: 180 days <em>maximum benefit</em> per calendar year</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Home Health Care</td>
<td>*90%</td>
<td>*80%</td>
<td>*60%</td>
</tr>
<tr>
<td>Hospice Care</td>
<td>*90%</td>
<td>*80%</td>
<td>*60%</td>
</tr>
<tr>
<td>Durable Medical Equipment</td>
<td>*90%</td>
<td>*80%</td>
<td>*60%</td>
</tr>
<tr>
<td>Durable medical equipment rental or purchase is subject to pre-certification, or a $100 penalty will apply.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Corrective Appliance</td>
<td>*90%</td>
<td>*80%</td>
<td>*60%</td>
</tr>
<tr>
<td>Non-Medically Necessary Foot Orthotics (Employees Only)</td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
</tr>
<tr>
<td>Limitation: 1 pair <em>maximum benefit</em> every 5 years</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Transplant</td>
<td>*90%</td>
<td>*80%</td>
<td>Not Covered</td>
</tr>
<tr>
<td>Limitation: $10,000 <em>maximum benefit</em> per transplant for donor screening tests</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>$10,000 <em>maximum benefit</em> per transplant for travel expenses</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Outpatient Therapy Services</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Physical, Occupational and Speech Therapies</td>
<td>90%</td>
<td>*80%</td>
<td>*60%</td>
</tr>
<tr>
<td>Respiratory Therapy</td>
<td>90%</td>
<td>*80%</td>
<td>*60%</td>
</tr>
<tr>
<td>Radiation Therapy and Chemotherapy</td>
<td>100%</td>
<td>*80%</td>
<td>*60%</td>
</tr>
<tr>
<td>Cardiac/Pulmonary Rehabilitation Therapy</td>
<td>*90%</td>
<td>*80%</td>
<td>*60%</td>
</tr>
<tr>
<td>Dialysis</td>
<td>*90%</td>
<td>*80%</td>
<td>Not Covered</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>All Other Eligible Outpatient Therapies</td>
<td>*90%</td>
<td>*80%</td>
<td>*60%</td>
</tr>
<tr>
<td>Birthing Center</td>
<td>100%</td>
<td>*80%</td>
<td>*60%</td>
</tr>
<tr>
<td>Wig</td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
</tr>
<tr>
<td>Podiatry Office Visit</td>
<td>100%</td>
<td>100%</td>
<td>*60%</td>
</tr>
<tr>
<td>(after $30 copay)</td>
<td>(after $35 copay)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Hyperalimentation or Total Parenteral Nutrition (TPN)</td>
<td>*90%</td>
<td>*80%</td>
<td>*60%</td>
</tr>
<tr>
<td>Outpatient Lactation Counseling</td>
<td>100%</td>
<td>100%</td>
<td>*60%</td>
</tr>
<tr>
<td>Nutritional Counseling</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Personal Family Physician</td>
<td>100%</td>
<td>100%</td>
<td>*60%</td>
</tr>
<tr>
<td>(after $15 copay)</td>
<td>(after $25 copay)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Specialist Physician</td>
<td>100%</td>
<td>100%</td>
<td>*60%</td>
</tr>
<tr>
<td>(after $30 copay)</td>
<td>(after $35 copay)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Other Provider</td>
<td>*90%</td>
<td>*80%</td>
<td>*60%</td>
</tr>
</tbody>
</table>

*After Deductible*
<table>
<thead>
<tr>
<th>BENEFIT DESCRIPTION</th>
<th>Top Tier</th>
<th>Preferred Provider</th>
<th>Nonpreferred Provider</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>(% of negotiated rate, if applicable, otherwise % of customary and reasonable amount)</td>
<td>(% of negotiated rate, if applicable, otherwise % of customary and reasonable amount)</td>
<td>(% of customary and reasonable amount, if applicable, otherwise % of negotiated rate)</td>
</tr>
<tr>
<td>Diabetic Care</td>
<td>*90%</td>
<td>*80%</td>
<td>*60%</td>
</tr>
<tr>
<td>Diabetes Outpatient Self-Management Training and Education</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Personal Family Physician</td>
<td>100% (after $15 copay)</td>
<td>100% (after $25 copay)</td>
<td>*60%</td>
</tr>
<tr>
<td>Specialist Physician</td>
<td>100% (after $30 copay)</td>
<td>100% (after $35 copay)</td>
<td>*60%</td>
</tr>
<tr>
<td>Other Provider</td>
<td>100%</td>
<td>100%</td>
<td>*60%</td>
</tr>
<tr>
<td><strong>Group Health Education Courses</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Limitation: For information on the classes offered at Lancaster General Health visit <a href="http://www.LGHealth.org">www.LGHealth.org</a> and click on Classes &amp; Events</td>
<td>100%^</td>
<td>100%^</td>
<td>100%^</td>
</tr>
<tr>
<td>Golden Triangle Specialty Network, LLC. Renal Network – Note that pre-notification is required or a penalty may apply.</td>
<td>*90%</td>
<td>*80%</td>
<td>Not Covered</td>
</tr>
<tr>
<td>Private Duty Nursing</td>
<td>*90%</td>
<td>*80%</td>
<td>*60%</td>
</tr>
<tr>
<td>All Other Covered Expenses</td>
<td>*90%</td>
<td>*80%</td>
<td>*60%</td>
</tr>
</tbody>
</table>

* After Deductible
^ Applicable only to approved Group Health Education Courses
### Behavioral Health Services – Administered by Quest

**Subject to the Health Benefits Deductibles and Out-of-Pocket Maximums**

<table>
<thead>
<tr>
<th>BENEFIT DESCRIPTION</th>
<th>Top Tier (%)</th>
<th>Quest Network (%)</th>
<th>Nonpreferred Provider (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Outpatient</td>
<td>100% (after $15 copay)</td>
<td>100% (after $25 copay)</td>
<td>*60%</td>
</tr>
<tr>
<td>Inpatient (Facility Expense Only)</td>
<td>100% (after $200 copay per admission)</td>
<td>*80%</td>
<td>*60%</td>
</tr>
<tr>
<td>Per Admission Copay waived for re-admission within 90 days</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Professional Fees</td>
<td>*90%</td>
<td>*80%</td>
<td>*60%</td>
</tr>
<tr>
<td>Partial, IOP and ECT (By Exception Only)</td>
<td>100%</td>
<td>*80%</td>
<td>*60%</td>
</tr>
<tr>
<td>Emergency Department/Crisis Evaluation</td>
<td>*80%</td>
<td>*80%</td>
<td>*80%</td>
</tr>
<tr>
<td>Psychological Testing</td>
<td>100%</td>
<td>100% (after $25 copay)</td>
<td>*60%</td>
</tr>
</tbody>
</table>

* After Deductible

$1,500 *copay* for each inpatient or outpatient service obtained from either Heart of Lancaster and/or Lancaster Regional Medical Center.

Refer to *Health Benefits* for complete details.
### LGMG/TR Consumer Plan Health Benefits

<table>
<thead>
<tr>
<th>Maximum Benefit Per Enrolled Individual While Enrolled In This Plan For:</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Infertility Services</td>
<td>$3,000</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Maximum Benefit Per Enrolled Individual Per Calendar Year For:</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Extended Care Facility</td>
<td>180 Days</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Maximum Benefit Per Enrolled Individual Every Five (5) Years For:</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Non-Medically Necessary Foot Orthotics (Employees Only)</td>
<td>1 Pair</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Maximum Benefit Per Transplant:</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Donor Screening Tests</td>
<td>$10,000</td>
</tr>
<tr>
<td>Travel Expenses</td>
<td>$10,000</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Deductible Per Calendar Year:</th>
<th>Top Tier</th>
<th>Preferred Provider</th>
<th>Nonpreferred Provider</th>
</tr>
</thead>
<tbody>
<tr>
<td>Employee Only</td>
<td></td>
<td></td>
<td>$2,000</td>
</tr>
<tr>
<td>Family (Aggregate)</td>
<td></td>
<td></td>
<td>$4,000</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Medical/Prescription Drug Out-of-Pocket Expense Limit Per Calendar Year:</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Employee Only</td>
<td>$4,000</td>
</tr>
<tr>
<td>Family (Embedded)</td>
<td>$8,000</td>
</tr>
</tbody>
</table>

Refer to Health Benefits, Out-of-Pocket Expense Limit for a listing of charges not applicable to the out-of-pocket expense limit.

Amounts applied toward satisfaction of any deductible or out-of-pocket expense limit may also be applied toward satisfaction of all other deductibles and out-of-pocket expense limits.

### Coinsurance:

The Plan pays the percentage listed on the following pages for covered expenses incurred by an enrolled individual during a calendar year after the individual or family deductible has been satisfied and until the individual or family out-of-pocket expense limit has been reached. Thereafter, the Plan pays one hundred percent (100%) of covered expenses for the remainder of the calendar year or until the maximum benefit has been reached. Refer to Health Benefits, Out-of-Pocket Expense Limit, for a listing of charges not applicable to the one hundred percent (100%) coinsurance.
<table>
<thead>
<tr>
<th>BENEFIT DESCRIPTION</th>
<th>Top Tier (% of negotiated rate, if applicable, otherwise % of customary and reasonable amount)</th>
<th>Preferred Provider (% of negotiated rate, if applicable, otherwise % of customary and reasonable amount)</th>
<th>Nonpreferred Provider (% of customary and reasonable amount, if applicable, otherwise % of negotiated rate)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Inpatient Hospital (Facility Expense Only)</td>
<td>*90%</td>
<td>*90%</td>
<td>*60%</td>
</tr>
<tr>
<td>Preadmission Testing (Facility Expense Only)</td>
<td>*100%</td>
<td>*100%</td>
<td>*60%</td>
</tr>
<tr>
<td>Outpatient Surgery/Ambulatory Surgical Facility</td>
<td>*100%</td>
<td>*100%</td>
<td>*60%</td>
</tr>
<tr>
<td>Emergency Room Services</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Emergency Care</td>
<td>*80%</td>
<td>*80%</td>
<td>*80%</td>
</tr>
<tr>
<td>Non-Emergency Care</td>
<td>Not Covered</td>
<td>Not Covered</td>
<td>Not Covered</td>
</tr>
<tr>
<td>Urgent Care Center</td>
<td>*90%</td>
<td>*90%</td>
<td>*90%</td>
</tr>
<tr>
<td>Retail Health Clinic Visit</td>
<td>*90%</td>
<td>*90%</td>
<td>*90%</td>
</tr>
<tr>
<td>e-Visit</td>
<td>*100% (after $20 copay)</td>
<td>*100% (after $20 copay)</td>
<td>*60%</td>
</tr>
<tr>
<td>Telemedicine Benefit – For Employees Only</td>
<td>100% (after $20 copay)</td>
<td>N/A</td>
<td>N/A</td>
</tr>
<tr>
<td>Ambulance Services</td>
<td>*90%</td>
<td>*90%</td>
<td>*90%</td>
</tr>
<tr>
<td>Physician Services</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Office Visit</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Personal Family Physician</td>
<td>*100% (after $15 copay)</td>
<td>*100% (after $15 copay)</td>
<td>*60%</td>
</tr>
<tr>
<td>Specialist Physician</td>
<td>*100% (after $30 copay)</td>
<td>*100% (after $30 copay)</td>
<td>*60%</td>
</tr>
<tr>
<td>Inpatient Visit</td>
<td>*90%</td>
<td>*90%</td>
<td>*60%</td>
</tr>
<tr>
<td>Surgery</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Inpatient</td>
<td>*90%</td>
<td>*90%</td>
<td>*60%</td>
</tr>
<tr>
<td>Outpatient at a Facility</td>
<td>*100%</td>
<td>*100%</td>
<td>*60%</td>
</tr>
<tr>
<td>In Physician’s Office</td>
<td>*90%</td>
<td>*90%</td>
<td>*60%</td>
</tr>
<tr>
<td>Allergy Injections</td>
<td>*90%</td>
<td>*90%</td>
<td>*60%</td>
</tr>
<tr>
<td>Pathology</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Inpatient</td>
<td>*90%</td>
<td>*90%</td>
<td>*60%</td>
</tr>
<tr>
<td>Outpatient</td>
<td>*100%</td>
<td>*100%</td>
<td>*60%</td>
</tr>
</tbody>
</table>

* After Deductible
<table>
<thead>
<tr>
<th>BENEFIT DESCRIPTION</th>
<th>Top Tier</th>
<th>Preferred Provider</th>
<th>Nonpreferred Provider</th>
</tr>
</thead>
<tbody>
<tr>
<td>(continued)</td>
<td>(% of negotiated rate, if applicable, otherwise % of customary and reasonable amount)</td>
<td>(% of negotiated rate, if applicable, otherwise % of customary and reasonable amount)</td>
<td>(% of customary and reasonable amount, if applicable, otherwise % of negotiated rate)</td>
</tr>
<tr>
<td><strong>Physician Services</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Anesthesiology</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Inpatient</td>
<td>*90%</td>
<td>*90%</td>
<td>*60%</td>
</tr>
<tr>
<td>Outpatient</td>
<td>*100%</td>
<td>*100%</td>
<td>*60%</td>
</tr>
<tr>
<td>Nurse Anesthetist</td>
<td>*100%</td>
<td>N/A</td>
<td>N/A</td>
</tr>
<tr>
<td>Radiology</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Inpatient</td>
<td>*90%</td>
<td>*90%</td>
<td>*60%</td>
</tr>
<tr>
<td>Outpatient</td>
<td>*100%</td>
<td>*100%</td>
<td>*60%</td>
</tr>
<tr>
<td><strong>Diagnostic Services and Supplies</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Inpatient</td>
<td>*90%</td>
<td>*90%</td>
<td>*60%</td>
</tr>
<tr>
<td>Outpatient</td>
<td>*100%</td>
<td>*90%</td>
<td>*60%</td>
</tr>
<tr>
<td>Independent Lab</td>
<td>N/A</td>
<td>*90%</td>
<td>*60%</td>
</tr>
<tr>
<td><strong>Second Surgical Opinion</strong></td>
<td>*100%</td>
<td>*100%</td>
<td>*60%</td>
</tr>
<tr>
<td>(after $30 copay)</td>
<td>(after $30 copay)</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Flu Shot</strong></td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
</tr>
<tr>
<td><strong>Well Child Care</strong></td>
<td>100%</td>
<td>100%</td>
<td>*60%</td>
</tr>
<tr>
<td>Limitation: through age 18</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Routine Preventive Care</strong></td>
<td>100%</td>
<td>100%</td>
<td>*60%</td>
</tr>
<tr>
<td>Limitation: age 19 and over</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Women’s Preventive Services</strong></td>
<td>100%</td>
<td>100%</td>
<td>*60%</td>
</tr>
<tr>
<td><strong>Routine Mammograms</strong></td>
<td>100%</td>
<td>100%</td>
<td>*60%</td>
</tr>
<tr>
<td>Limitation: through age 39 - one (1) mammogram</td>
<td>maximum benefit</td>
<td>maximum benefit while enrolled in this Plan</td>
<td></td>
</tr>
<tr>
<td>age 40 and over - one (1) mammogram</td>
<td>maximum benefit</td>
<td>per calendar year</td>
<td></td>
</tr>
<tr>
<td><strong>Routine Prostate Examination</strong></td>
<td>100%</td>
<td>100%</td>
<td>*60%</td>
</tr>
<tr>
<td><strong>Routine Sigmoidoscopy</strong></td>
<td>100%</td>
<td>100%</td>
<td>*60%</td>
</tr>
<tr>
<td>Limitation: 1 exam maximum benefit every 5 years</td>
<td>age 50 and over</td>
<td>age 50 and over</td>
<td></td>
</tr>
<tr>
<td><strong>Routine Colonoscopy</strong></td>
<td>100%</td>
<td>100%</td>
<td>*60%</td>
</tr>
<tr>
<td>Limitation: 1 exam maximum benefit every 10 years</td>
<td>age 50 and over</td>
<td>age 50 and over</td>
<td></td>
</tr>
</tbody>
</table>

* After Deductible
<table>
<thead>
<tr>
<th>BENEFIT DESCRIPTION</th>
<th>Top Tier (% of negotiated rate, if applicable, otherwise % of customary and reasonable amount)</th>
<th>Preferred Provider (% of negotiated rate, if applicable, otherwise % of customary and reasonable amount)</th>
<th>Nonpreferred Provider (% of customary and reasonable amount, if applicable, otherwise % of negotiated rate)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Extended Care Facility</td>
<td>*90%</td>
<td>*90%</td>
<td>*60%</td>
</tr>
<tr>
<td>Limitation: 180 days maximum benefit per calendar year</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Home Health Care</td>
<td>*90%</td>
<td>*90%</td>
<td>*60%</td>
</tr>
<tr>
<td>Hospice Care</td>
<td>*90%</td>
<td>*90%</td>
<td>*60%</td>
</tr>
<tr>
<td>Durable Medical Equipment</td>
<td>*90%</td>
<td>*90%</td>
<td>*60%</td>
</tr>
<tr>
<td>Durable medical equipment rental or purchase is subject to pre-certification, or a $100 penalty will apply.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Corrective Appliance</td>
<td>*90%</td>
<td>*90%</td>
<td>*60%</td>
</tr>
<tr>
<td>Non-Medically Necessary Foot Orthotics (Employees Only)</td>
<td>*100%</td>
<td>*100%</td>
<td>*100%</td>
</tr>
<tr>
<td>Limitation: 1 pair maximum benefit every 5 years</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Outpatient Therapy Services</td>
<td>*90%</td>
<td>*90%</td>
<td>*60%</td>
</tr>
<tr>
<td>Dialysis</td>
<td>*90%</td>
<td>*90%</td>
<td>Not Covered</td>
</tr>
<tr>
<td>Birthing Center</td>
<td>*90%</td>
<td>*90%</td>
<td>*60%</td>
</tr>
<tr>
<td>Wig</td>
<td>*100%</td>
<td>*100%</td>
<td>*100%</td>
</tr>
<tr>
<td>Podiatry Office Visit</td>
<td>*100% (after $30 copay)</td>
<td>*100% (after $30 copay)</td>
<td>*60%</td>
</tr>
<tr>
<td>Hyperalimentation or Total Parenteral Nutrition (TPN)</td>
<td>*90%</td>
<td>*90%</td>
<td>*60%</td>
</tr>
<tr>
<td>Outpatient Lactation Counseling</td>
<td>100%</td>
<td>100%</td>
<td>*60%</td>
</tr>
<tr>
<td>Nutritional Counseling</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Personal Family Physician</td>
<td>*100% (after $15 copay)</td>
<td>*100% (after $15 copay)</td>
<td>*60%</td>
</tr>
<tr>
<td>Specialist Physician</td>
<td>*100% (after $30 copay)</td>
<td>*100% (after $30 copay)</td>
<td>*60%</td>
</tr>
<tr>
<td>Other Provider</td>
<td>*90%</td>
<td>*90%</td>
<td>*60%</td>
</tr>
<tr>
<td>* After Deductible</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>BENEFIT DESCRIPTION</td>
<td>Top Tier</td>
<td>Preferred Provider</td>
<td>Nonpreferred Provider</td>
</tr>
<tr>
<td>---------------------------------------------------------</td>
<td>------------------------</td>
<td>--------------------</td>
<td>-----------------------</td>
</tr>
<tr>
<td></td>
<td>(% of negotiated rate, if applicable, otherwise % of customary and reasonable amount)</td>
<td>(% of negotiated rate, if applicable, otherwise % of customary and reasonable amount)</td>
<td>(% of customary and reasonable amount, if applicable, otherwise % of negotiated rate)</td>
</tr>
<tr>
<td>Diabetic Care</td>
<td>*90%</td>
<td>*90%</td>
<td>*60%</td>
</tr>
<tr>
<td>Diabetes Outpatient Self-Management Training and Education</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Personal Family Physician</td>
<td>*100% (after $15 copay)</td>
<td>*100% (after $15 copay)</td>
<td>*60%</td>
</tr>
<tr>
<td>Specialist Physician</td>
<td>*100% (after $30 copay)</td>
<td>*100% (after $30 copay)</td>
<td>*60%</td>
</tr>
<tr>
<td>Other Provider</td>
<td>*100%</td>
<td>*100%</td>
<td>*60%</td>
</tr>
<tr>
<td>Group Health Education Courses</td>
<td>100%^</td>
<td>100%^</td>
<td>100%^</td>
</tr>
<tr>
<td>Limitation: For information on the classes offered at Lancaster General Health visit <a href="https://www.LGHealth.org">www.LGHealth.org</a> and click on Classes &amp; Events</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Golden Triangle Specialty Network, LLC. Renal Network</td>
<td>*90%</td>
<td>*90%</td>
<td>Not Covered</td>
</tr>
<tr>
<td>– Note that pre-notification is required or a penalty may apply</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Private Duty Nursing</td>
<td>*90%</td>
<td>*90%</td>
<td>*60%</td>
</tr>
<tr>
<td>All Other Covered Expenses</td>
<td>*90%</td>
<td>*90%</td>
<td>*60%</td>
</tr>
</tbody>
</table>

* After Deductible

^ Applicable only to approved Group Health Education Courses
<table>
<thead>
<tr>
<th>BENEFIT DESCRIPTION</th>
<th>Top Tier (% of negotiated rate, if applicable, otherwise % of customary and reasonable amount)</th>
<th>Quest Network (% of negotiated rate, if applicable, otherwise % of customary and reasonable amount)</th>
<th>Nonpreferred Provider (% of customary and reasonable amount, if applicable)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Behavioral Health Services – Administered by Quest</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Subject to the Health Benefits Deductibles and Out-of-Pocket Maximums</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Outpatient</td>
<td>*100% (after $15 copay)</td>
<td>*100% (after $15 copay)</td>
<td>*60%</td>
</tr>
<tr>
<td>Inpatient</td>
<td>*90%</td>
<td>*90%</td>
<td>*60%</td>
</tr>
<tr>
<td>Professional Fees</td>
<td>*90%</td>
<td>*90%</td>
<td>*60%</td>
</tr>
<tr>
<td>Partial, IOP and ECT (By Exception Only)</td>
<td>*90%</td>
<td>*90%</td>
<td>*60%</td>
</tr>
<tr>
<td>Emergency Department/Crisis Evaluation</td>
<td>*80%</td>
<td>*80%</td>
<td>*80%</td>
</tr>
<tr>
<td>Psychological Testing</td>
<td>*100%</td>
<td>*100%</td>
<td>*60%</td>
</tr>
</tbody>
</table>

* After Deductible

$1,500 copay for each inpatient or outpatient service obtained from either Heart of Lancaster and/or Lancaster Regional Medical Center.

Refer to Health Benefits for complete details.
Prescription Drug Program

Managed by Express Scripts

<table>
<thead>
<tr>
<th>Select Plans (No Deductible)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Prescription Drug Out-of-Pocket Expense Limit Per Calendar Year</strong></td>
</tr>
<tr>
<td><strong>Prescription Drug Coverage</strong></td>
</tr>
<tr>
<td><strong>LGH Convenience and SOP LifeCare Pharmacies Only</strong></td>
</tr>
<tr>
<td>$6 Generic/$25 Formulary/$60 Non-formulary (30 day supply)</td>
</tr>
<tr>
<td>$15 Generic/$62.50 Formulary/$162.50 Non-formulary (90 day supply)</td>
</tr>
<tr>
<td>Specialty Rx – 10% ($100 maximum) 30 day supply; 10% ($300 maximum) 90 day supply</td>
</tr>
<tr>
<td><strong>Rx Retail Pharmacy (30 day supply)</strong></td>
</tr>
<tr>
<td><strong>Rx Mail Order (90 day supply)</strong></td>
</tr>
<tr>
<td><strong>Specialty Rx</strong></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Consumer Plans (After Deductible)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Prescription Drug Out-of-Pocket Expense Limit Per Calendar Year</strong></td>
</tr>
<tr>
<td><strong>Prescription Drug Coverage ^</strong></td>
</tr>
<tr>
<td><strong>LGH Convenience and SOP LifeCare Pharmacies Only</strong></td>
</tr>
<tr>
<td>$6 Generic/$25 Formulary/$60 Non-formulary (30 day supply)</td>
</tr>
<tr>
<td>$15 Generic/$62.50 Formulary/$162.50 Non-formulary (90 day supply)</td>
</tr>
<tr>
<td>Specialty Rx – 10% ($100 maximum) 30 day supply; 10% ($300 maximum) 90 day supply</td>
</tr>
<tr>
<td><strong>Rx Retail Pharmacy (30 day supply)</strong></td>
</tr>
<tr>
<td><strong>Rx Mail Order (90 day supply)</strong></td>
</tr>
<tr>
<td><strong>Specialty Rx</strong></td>
</tr>
</tbody>
</table>

^ Consumer Plan copays are applicable after annual deductible (individual and/or family, if applicable) has been satisfied.

Enrollees will have $0 copays when purchasing generic contraceptives (oral Rx & devices) and preventive medications with a prescription, such as aspirin and fluoride.

Refer to Prescription Drug Program for complete details.
PHC/AETNA PREFERRED PROVIDER OR NONPREFERRED PROVIDER

Enrolled individuals have the choice of using an LG Health provider, a PHC, Aetna or Quest preferred provider or a nonpreferred provider.

PREFERRED PROVIDER

A preferred provider is a physician, hospital or ancillary service provider which has an agreement in effect with the Preferred Provider Organization (PPO) to accept a reduced rate for services rendered to enrolled individuals. This is known as the negotiated rate. The preferred provider cannot bill the enrolled individual for any amount in excess of the negotiated rate. Enrolled individuals should contact the Human Resources Department for a current listing of preferred providers. Enrolled individuals may contact Quest for a listing of preferred behavioral health providers.

NONPREFERRED PROVIDER

A nonpreferred provider does not have an agreement in effect with the Preferred Provider Organization. This Plan will allow only the customary and reasonable amount as a covered expense. The Plan will pay its percentage of the customary and reasonable amount for the nonpreferred provider services, supplies and treatment. The enrolled individual is responsible for the remaining balance. This results in greater out-of-pocket expenses to the enrolled individual.

REFERRALS

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

EXCEPTIONS

The following listing of exceptions represents services, supplies or treatments rendered by a nonpreferred provider where covered expenses shall be payable at the preferred provider coinsurance level and as regards covered expenses for an emergency, paid at the greatest of the following three amounts: the amount negotiated with preferred providers for such covered expenses, or the amount determined as the customary and reasonable amount, or the amount that would be paid under Medicare for such emergency:

1. Emergency treatment rendered at a nonpreferred provider facility or at a preferred provider facility by a nonpreferred provider. If the enrolled individual is admitted to the hospital on an emergency basis, covered expenses shall be payable at the preferred provider level.
2. Nonpreferred anesthesiologist when the operating surgeon is a preferred provider and/or the facility where such services are rendered is a preferred provider.
3. Nonpreferred assistant surgeon if the operating surgeon is a preferred provider.
4. Radiologist or pathologist services for interpretation of x-rays and diagnostic laboratory and surgical pathology tests rendered by a nonpreferred provider when the facility where such services are rendered is a preferred provider.
5. While the enrolled individual is confined to a preferred provider hospital, the preferred provider physician requests a consultation from a nonpreferred provider, or a newborn visit is performed by a nonpreferred provider.
6. Medically necessary specialty services, supplies or treatments which are not available from a provider within the Preferred Provider Organization.
7. Treatment rendered at a facility of the uniformed services or Indian Health Care facility.
HEALTH BENEFITS

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

COPAY

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

For LG Select Plan only, the copay will not be applied toward the calendar year deductible.

Heart of Lancaster and Lancaster Regional Medical Center have a $1,500 copay for inpatient or outpatient services.

DEDUCTIBLES

Individual Deductible

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

Family Deductible

If, in any calendar year, enrolled members of a family incur covered expenses that are subject to the deductible that are equal to or greater than the dollar amount of the family deductible shown on the Schedule of Benefits, then the family deductible will be considered satisfied for all family members for that calendar year. Any number of family members may help to meet the family deductible amount, but no more than each person’s individual deductible amount may be applied toward satisfaction of the family deductible by any family member.

COINSURANCE

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

OUT-OF-POCKET EXPENSE LIMIT

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

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

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

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

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

MAXIMUM BENEFIT

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

HOSPITAL/AMBULATORY SURGICAL FACILITY

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

Covered expenses shall include:

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

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

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

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

FACILITY PROVIDERS

You are encouraged to contact CoreSource prior to receiving any of the following services.

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

Covered expenses shall include:

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

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

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

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

EMERGENCY ROOM SERVICES

Emergency Care

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

Non-Emergency Care

Emergency room treatment for conditions that do not meet the definition of emergency will be considered non-emergency use of the emergency room. If emergency room services are used for treatment of a non-emergency medical condition, the facility and physician charges for such treatment shall not be considered a covered expense.

URGENT CARE CENTER

Covered expenses shall include charges for treatment in an urgent care center, payable as specified on the Schedule of Benefits.

RETAIL HEALTH CLINIC

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

PHYSICIAN SERVICES AND PROFESSIONAL PROVIDER SERVICES

You are encouraged to contact CoreSource prior to receiving any of the following services.

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

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

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

   For related operations or procedures performed through the same incision or in the same operative field, covered expenses shall include the surgical allowance for the highest paying procedure and fifty percent (50%) of the surgical allowance for each additional procedure.

   When two (2) or more unrelated operations or procedures are performed at the same operative session, covered expenses shall include the surgical allowance for each procedure.
3. Surgical assistance provided by a physician or professional provider if it is determined that the condition of the enrolled individual or the type of surgical procedure requires such assistance. Covered expenses for the services of an assistant surgeon are limited to twenty percent (20%) of the surgical allowance.

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

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

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

7. Radiologist or pathologist services for diagnosis or treatment, including radiation therapy and chemotherapy.

8. Allergy testing consisting of percutaneous, intracutaneous and patch tests and allergy injections.

**E-Visit**

e-visits are available for employees and dependents, over age eighteen (18), enrolled in the LG Select or LG Consumer health insurance plans. To be eligible, patients must be seen in person at a LG Health Physicians family medicine practice within the past two (2) years.

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

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

Participants will answer a series of questions regarding their symptoms and a provider will respond within 5 hours, during normal business hours.

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

**Telemedicine Benefit – For Employees Only**

For employees only, covered expenses shall include charges for telemedicine services provided at Employee and Student Health office on Duke Street, utilizing Lancaster General Health’s Physicians.

Charges for telephone consultations from any other professional providers shall not be a covered expense.

**Second Surgical Opinion**

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

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

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

You are encouraged to contact CoreSource prior to receiving any of the following services.

*Covered expenses* shall include services and supplies for diagnostic laboratory tests, electronic tests, pathology, ultrasound, nuclear medicine, magnetic imaging and x-rays.

**TRANSPLANT**

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

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

1. When the recipient is enrolled under this Plan, the Plan will pay the recipient's *covered expenses* related to the transplant.
2. When the donor is enrolled under this Plan, the Plan will pay the donor's *covered expenses* related to the transplant, provided the recipient is also covered under this Plan. *Covered expenses incurred* by each person will be considered separately for each person.
3. Expenses incurred by the donor who is not ordinarily enrolled under this Plan according to eligibility requirements will be *covered expenses* to the extent that such expenses are not payable by any other form of health coverage, including any government plan or individual policy of health coverage, and provided the recipient is enrolled under this Plan. The donor's expense shall be applied to the recipient's maximum benefit. In no event will benefits be payable in excess of the maximum benefit still available to the recipient.
4. Surgical, storage and transportation costs directly related to procurement of an organ or tissue used in a transplant procedure will be covered for each procedure completed. If an organ or tissue is sold rather than donated, the purchase price of such organ or tissue shall not be considered a *covered expense* under this Plan.
5. Travel expenses for the enrolled recipient and one (1) other person (two (2) other persons if the recipient is an eligible dependent child) to accompany the recipient or donor to and from a facility and for lodging and meals at or near the facility where the recipient or donor is confined, subject to the maximum benefit as specified on the Schedule of Benefits.

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

**Institutes of Excellence Program**

In addition to the above transplant benefits, the *enrolled individual* may be eligible to participate in an Institutes of Excellence Program. *Enrolled individuals* should contact the Health Care Management Organization to discuss this benefit by calling:

1-877-848-9997

An Institute of Excellence is a *facility* within an Institutes of Excellence Network that has been chosen for its proficiency in performing one or more transplant procedures. Usually located throughout the United States, the Institutes of Excellence *facilities* have greater transplant volumes and surgical team experience than other similar *facilities*.

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

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

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

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

The Plan shall cover services, supplies and treatments for medically necessary abortions when the life of the mother would be endangered by continuation of the pregnancy or when the pregnancy is a result of rape or incest.

Complications from an abortion shall be a covered expense, whether or not the abortion is a covered expense.

BIRTHING CENTER

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

INFERTILITY SERVICES

You are encouraged to contact CoreSource prior to receiving the following services.

Covered expenses shall include expenses for infertility testing, infertility counseling, treatment and follow-up and artificial insemination limited to three (3) cycles of insemination attempts after the diagnosis of infertility is established. Covered expenses for infertility services shall be limited to the amount indicated on the Schedule of Benefits.

GENETIC COUNSELING, TESTING AND SCREENING

Genetic counseling, testing and screening are subject to pre-certification.

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

WELL NEWBORN CARE

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

Such care shall include, but is not limited to:

1. Physician services
2. Hospital services
3. Circumcision

FLU SHOT

Covered expenses shall include flu shots, subject to the maximum benefit as specified on the Schedule of Benefits.
WELL CHILD CARE

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

ROUTINE PREVENTIVE CARE

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

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

WOMEN’S PREVENTIVE SERVICES

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

1. Annual well-woman office visits to obtain preventive care;
2. Screening for gestational diabetes in a pregnant woman:
   a. Between twenty-four (24) and twenty-eight (28) weeks of gestation; and
   b. At the first prenatal visit for a pregnant woman identified to be at high risk for diabetes.
3. Human papillomavirus DNA testing no more frequently than every three (3) years for a woman age thirty (30) and above;
4. Annual counseling for sexually transmitted infections for a sexually active woman;
5. Annual counseling and screening for human immune-deficiency virus for a sexually active woman;
6. FDA approved contraceptive methods (unless covered under the Prescription Drug Program), sterilization procedures and patient education and counseling for a woman with reproductive capacity (reversal of surgical sterilization is not a covered expense);
7. Breastfeeding support, supplies and counseling in conjunction with each birth, including the cost of renting breastfeeding equipment; and
8. Annual screening and counseling for interpersonal and domestic violence.

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

ROUTINE MAMMOGRAMS

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

ROUTINE PROSTATE EXAMINATION

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

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

ROUTINE COLONOSCOPY

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

OUTPATIENT THERAPY SERVICES

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

Covered expenses shall include:

1. Services of a professional provider for physical therapy, occupational therapy or speech therapy.
2. Respiratory therapy.
3. Radiation therapy.
4. Chemotherapy.
5. Dialysis therapy or treatment.
6. Home administered infusion therapy, subject to pre-certification.

EXTENDED CARE FACILITY

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

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

Covered expenses shall include:

1. Room and board (including regular daily services, supplies and treatments furnished by the extended care facility) limited to the facility's average semiprivate room rate; and
2. Other services, supplies and treatment ordered by a physician and furnished by the extended care facility for inpatient medical care.

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

HOME HEALTH CARE

Home health care is subject to pre-certification.

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

1. Part-time or intermittent nursing care by a nurse;
2. Physical, respiratory, occupational or speech therapy;
3. Part-time or intermittent home health aide services (under the supervision of a registered nurse) for an enrolled individual who is receiving covered nursing or therapy services.
Covered expenses shall be subject to the maximum benefit specified on the Schedule of Benefits.

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

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

**HOSPICE CARE**

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

Hospice care is a health care program providing a coordinated set of services rendered at home, in outpatient settings, or in facility settings for an enrolled individual suffering from a condition that has a terminal prognosis. Hospice care will be covered only if the enrolled individual’s attending physician certifies that:

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

Covered expenses shall include:

1. Confinement in a hospice to include ancillary charges and room and board.
2. Services, supplies and treatment provided by a hospice to an enrolled individual in a home setting.
3. Physician services and/or nursing care by a nurse.
4. Counseling services provided through the hospice.
5. Bereavement counseling as a supportive service to enrolled individuals in the terminally ill enrolled individual's immediate family. Benefits will be payable for services within three (3) months after the terminally ill person's death.

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

**DURABLE MEDICAL EQUIPMENT**

Durable medical equipment rental or purchase is subject to pre-certification. Failure to obtain pre-certification may result in a reduction of benefits as specified in the Health Benefit Claim Filing Procedure section of this document.

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

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

You are encouraged to contact CoreSource prior to receiving the following services.

Prosthetic Appliances

The initial purchase of a prosthetic appliance (other than dental) shall be a covered expense. A charge for the purchase of a prosthesis is considered incurred on the date the prosthesis is received/delivered. A prosthesis that is received/delivered after the termination date of an enrolled individual's coverage under this Plan is not covered. Repair or replacement of a prosthesis which is medically necessary due to a physiological change in the patient's condition will be considered a covered expense, not more often than once every two (2) years. Enrolled individuals under the age of nineteen (19) who outgrow the prosthetic appliance may receive a replacement more frequently than every two (2) years.

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

Orthotic Appliances

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

DENTAL SERVICES

You are encouraged to contact CoreSource prior to receiving any of the following services.

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

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

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

TEMPOROMANDIBULAR JOINT DYSFUNCTION

You are encouraged to contact CoreSource prior to receiving the following services.

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

SPECIAL EQUIPMENT AND SUPPLIES

Covered expenses shall include medically necessary special equipment and supplies including, but not limited to: casts; splints; braces; trusses; surgical and orthopedic appliances; colostomy and ileostomy bags and supplies required for their use; catheters; allergy serums; crutches; electronic pacemakers; oxygen and the administration thereof; the initial pair of eyeglasses or contact lenses due to cataract surgery; soft lenses or sclera shells intended for use in the treatment of illness or injury of the eye; anti-embolic stockings with a pressure gradient of 20 MM HG or more; a
wig or hairpiece when required due to chemotherapy, surgery or burns; surgical dressings and other medical supplies ordered by a professional provider in connection with medical treatment, but not common first aid supplies.

**COSMETIC/RECONSTRUCTIVE SURGERY**

You are encouraged to contact CoreSource prior to receiving any of the following services.

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

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

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

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

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

Covered expenses will include eligible charges related to medically necessary mastectomy.

For an enrolled individual who elects breast reconstruction in connection with such mastectomy, covered expenses will include:

1. reconstruction of a surgically removed breast; and
2. surgery and reconstruction of the other breast to produce a symmetrical appearance.

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

**PODIATRY SERVICES**

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

**HYPERALIMENTATION OR TOTAL PARENTERAL NUTRITION (TPN)**

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

**OUTPATIENT LACTATION COUNSELING**

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

**NUTRITIONAL COUNSELING**

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

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

2. Orthotics and shoes related to the treatment of diabetes.
3. Monitoring supplies.
4. Insulin and insulin infusion devices.
5. Syringes and injection aids.
6. Pharmacological agents for controlling blood sugar.

**DIABETES OUTPATIENT SELF-MANAGEMENT TRAINING AND EDUCATION**

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

1. upon diagnosis of diabetes;
2. to treat a significant change in the *enrolled individual’s* symptoms/conditions that requires changes in the *enrolled individual’s* self-management; or
3. for a new medication or therapeutic process to treat/manage the *enrolled individual’s* diabetes.

**OUTPATIENT CARDIAC/PULMONARY REHABILITATION PROGRAMS**

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

**SURGICAL TREATMENT OF MORBID OBESITY**

You are encouraged to contact CoreSource prior to receiving the following services.

*Morbid obesity* is defined as a BMI greater than 40 kilos per meter squared, or as a BMI greater than 35 kilos per meter squared and when two (2) or more co-morbidities exist. This definition does not apply to those under the age of 18.

*Covered expenses* shall include charges for surgical treatment of *morbid obesity* for *enrolled individuals* with health problems that are aggravated by or related to the *morbid obesity*, including, but not limited to Gastric Bypass, Sleeve Gastrectomy, and Adjustable Banding. Services must be performed at Lancaster General Health, by Bariatric Physician Specialists, or performed at a Center of Excellence facility for bariatric surgery.

*Inpatient* facility services performed at Lancaster General Health, by Bariatric Physician Specialists, will be payable at 100% after a $200 copay per admission (no deductible) for LG Select Plan, and will be payable at 90% after deductible for LG Consumer Plan. *Outpatient* facility services performed at Lancaster General Health, by Bariatric Physician Specialists, will be payable at 100% (no deductible) for LG Select Plan, and will be payable at 100% after deductible for LG Consumer Plan. Surgery services performed at Lancaster General Health, by Bariatric Physician Specialists, will be payable at 100% (no deductible) for LG Select Plan, and will be payable at 100% after deductible for LG Consumer Plan. The employee is required to successfully complete a twelve-week pre-operative program that includes monitoring by a dietician, exercise physiologist, psychologist, and the bariatric surgeon who will be performing the surgical treatment. The successful completion of this program is demonstrated through a patient’s behavior modification, indicative of post-operative change.
Services not performed at Lancaster General Health, but performed at a Center of Excellence facility for bariatric surgery, will be subject to $2,500 additional copay and payable at 80% after the deductible has been met for LG Select Plan, and 90% after the deductible has been met for LG Consumer Plan. The employee is required to successfully complete a twelve-week pre-operative program that includes monitoring by a dietician, exercise physiologist, psychologist, and the bariatric surgeon who will be performing the surgical treatment. The successful completion of this program is demonstrated through a patient’s behavior modification, indicative of post-operative change.

**PEDIATRIC OBESITY**

Office visits and/or consultations and lab studies that are ordered for the purpose of diagnosis and/or on-going management of obesity and associated co-morbid condition in pediatric patients are allowable under the Plan.

Bariatric surgical treatment of pediatric patients will require precertification with peer review to determine medical necessity.

**Covered expenses** shall include charges for surgical treatment of pediatric obesity for enrolled individuals with health problems that are aggravated by or related to the obesity, including, but not limited to Gastric Bypass, Sleeve Gastrectomy, and Adjustable Banding. Services must be performed at Lancaster General Health by Bariatric Physician Specialists, or performed at a Center of Excellence facility for bariatric surgery. Inpatient facility services performed at Lancaster General Health, by Bariatric Physician Specialists, will be payable at 100% after a $200 copay per admission (no deductible) for LG Select Plan, and will be payable at 90% after deductible for LG Consumer Plan. Outpatient facility services performed at Lancaster General Health, by Bariatric Physician Specialists, will be payable at 100% (no deductible) for LG Select Plan, and will be payable at 100% after deductible for LG Consumer Plan. Surgery services performed at Lancaster General Health, by Bariatric Physician Specialists, will be payable at 100% (no deductible) for LG Select Plan, and will be payable at 100% after deductible for LG Consumer Plan. Services not performed at Lancaster General Health, but performed at a Center of Excellence facility for bariatric surgery, will be subject to $2,500 additional copay and payable at 80% after the deductible has been met for LG Select Plan, and 90% after the deductible has been met for LG Consumer Plan.

**GROUP HEALTH EDUCATION COURSES**

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

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

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

**Reimbursement**

Reimbursement request should be submitted to CoreSource (the reimbursement form is available at www.LGHealth.org). To be reimbursed by CoreSource, participants must provide signed reimbursement request form and proof of payment.

**ROUTINE PATIENT COSTS FOR APPROVED CLINICAL TRIALS**

**Covered expenses** shall include charges for “routine patient costs” incurred by a “qualified individual” participating in an approved clinical trial. “Routine patient costs” do not include:

1. An investigational item, device or service;
2. An item or service provided solely to satisfy data collection and analysis needs, which are not used in the
direct clinical management of the patient; or,
3. A service that is clearly inconsistent with widely accepted and established standards of care for a particular
diagnosis.

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

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

1. The referring health care professional has concluded that the covered person’s participation in such trial
would be appropriate; or,
2. The covered person provides medical and scientific information establishing that the covered person’s
participation in such trial would be appropriate.

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

PRIVATE DUTY NURSING

Private duty nursing services are subject to pre-certification.

Medically necessary services of a private duty nurse shall be a covered expense.

SURCHARGES

Any excise tax, sales tax, surcharge, (by whatever name called) imposed by a governmental entity for services,
supplies and/or treatments rendered by a professional provider; physician; hospital; facility or any other health care
provider; shall be a covered expense under the terms of the Plan.

MENTAL HEALTH, ALCOHOL AND DRUG ABUSE SERVICES

Prior authorization is required for Mental Health and Substance Abuse treatment and must be obtained
through Quest. Quest may be contacted by calling:

1-800-364-6352

Claims for Mental Health and Substance Abuse are to be submitted to the following address:

Quest
P.O. Box 1032
York, PA 17405-1032

Quest will coordinate, determine medical necessity of, and prior authorize, the payment of benefits for all mental
illnesses, psychiatric conditions and substance abuse treatment (“Mental Health and Substance Abuse”). Quest contact
information may be accessed via your ID card.

If you have any questions about your Mental Health and Substance Abuse coverage or how to access coverage, please
contact Quest.
The following are benefits:

Alcoholism, Drug Abuse and Drug Dependency

Rehabilitation, therapy and counseling, family counseling and intervention. Inpatient rehabilitation treatment also includes lodging, dietary services and drugs/medicines. Services provided by halfway houses, boot camps and wilderness programs are not covered expenses.

Mental Illness Services


b. Outpatient Mental Illness Services – See Schedule of Benefits.

c. Psychological Testing – Psychological testing for therapeutic purposes only; as determined to be medically necessary, and for which prior authorization has been received.
HEALTH BENEFITS EXCLUSIONS

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

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

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

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

4. Charges for hospital admission on Friday, Saturday or Sunday unless the admission is an emergency situation, or surgery is scheduled within twenty-four (24) hours. If neither situation applies, hospital expenses will be payable commencing on the date of actual surgery.

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

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

7. Charges for marriage or relationship counseling.

8. Except as specifically stated in Health Benefits, Dental Services, charges for or in connection with: treatment of injury or disease of the teeth; oral surgery; treatment of gums or structures directly supporting or attached to the teeth; or dental implants.

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

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

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

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

13. Charges for nonprescription drugs, such as vitamins, cosmetic dietary aids, and nutritional supplements.

15. Charges for clothing or shoes of any type, including but not limited to orthopedic shoes, children’s corrective shoes, shoes used in conjunction with leg braces and shoe inserts except for inserts and shoes for enrolled individuals with diabetes or peripheral vascular disease.

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

17. Charges incurred as a result of, or in connection with, any procedure or treatment excluded by this Plan which has resulted in medical complications either directly or indirectly, except for complications from a non-covered abortion, as specified herein.

18. Charges for services provided to an enrolled individual for an elective abortion (See Health Benefits, Pregnancy for specifics regarding the coverage of abortions). However, complications from such procedure shall be a covered expense.

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

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

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

22. Charges for examination to determine hearing loss or the fitting, purchase, repair or replacement of a hearing aid; or for a cochlear implant.

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

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


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

27. Charges for oral surgery that encompasses orthognathic, prosthodontics or prognathic surgical procedures, except for Temporomandibular Joint Dysfunction.

28. Charges for custodial care, residential care, domiciliary care or rest cures.

29. Charges for travel or accommodations, whether or not recommended by a physician, except as specifically provided herein.

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

31. Charges for expenses related to hypnosis.

32. Charges for the expenses of the donor of an organ or tissue for transplant to a recipient who is not an enrolled individual under this Plan.
33. Charges for professional services billed by a professional provider who is an employee of a hospital or any other facility and who is paid by the hospital or other facility for the service provided.

34. Charges for environmental change including hospital or physician charges connected with prescribing an environmental change.

35. Charges for room and board in a facility for days on which the enrolled individual is permitted to leave (a weekend pass, for example).

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

37. Charges for massage therapy, sex therapy, diversional therapy or recreational therapy.

38. Charges for holistic medicines or providers of naturopathy.

39. Charges for or related to the following types of treatment:
   a. primal therapy;
   b. rolfing;
   c. psychodrama;
   d. megavitamin therapy;
   e. visual perceptual training.

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

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

42. Charges for immunizations required for travel or employment.

43. Charges for any services performed by a professional provider enrolled in an education or training program when such services are related to the education or training program.

44. Charges for blood clotting factors for chronic prophylactic or maintenance therapy.

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

46. Charges for corrective appliances used primarily for cosmetic purposes, including but not limited to, cranial prostheses and molding helmets.

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

48. Charges for newborn home deliveries.

49. Charges for surgery performed solely to address psychological or emotional factors.

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

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

52. Charges for any services, supplies or treatment not specifically provided herein.
PRESCRIPTION DRUG PROGRAM

PRESCRIPTION DRUG PROGRAM

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

The Lancaster General Hospital Convenience Pharmacy (Convenience Pharmacy) provides medications at discounted prices and chooses to pass those savings onto our enrolled individuals. When you fill your prescriptions at the Convenience Pharmacy, both enrolled individuals and LG Health save considerable dollars. You may also purchase eligible 90-day prescriptions at the Convenience Pharmacy for much lower copays than those offered at retail pharmacies. The LG Health Convenience Pharmacy is located in the Lancaster General Hospital and provides daily and weekly delivery service to LG Health enrolled individuals employed at off-site facilities.

RETAIL PHARMACY OPTION COPAY

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

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

MAIL ORDER PROGRAM

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

MAIL ORDER OPTION COPAY

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

SPECIALTY MEDICATIONS OPTION

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

BENEFIT LIMITATIONS

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

1. Refills only up to the number of times specified by a physician.
2. Refills up to one year from the date of order by a physician.
**AFFORDABLE CARE ACT MEDICATIONS**

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

13. Charges for services, supplies or treatment rendered by any individual who is a close relative of the enrolled individual or who resides in the same household as the enrolled individual.
14. Charges for services, supplies or treatment rendered by physicians or professional providers beyond the scope of their license; for any treatment, confinement or service which is not recommended by or performed by an appropriate professional provider.

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

16. Claims not submitted within the Plan's filing limit deadlines as specified in the section, Medical/Dental Claim Filing Procedure.

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

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

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

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

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

21. Charges for injuries sustained while an active participant in a professional sporting event (engaged in on an individual or group basis for wage or profit) or professional hazardous avocations.
ELIGIBILITY, ENROLLMENT AND EFFECTIVE DATE

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

EMPLOYEE ELIGIBILITY

An employee's premium contribution rate will vary depending upon whether he or she is regularly employed for more or less than thirty (30) hours of service per week. In the event an employee’s weekly work schedule will vary and the employer cannot reasonably predict his or her eligibility status at the time of hire, he or she will be deemed a "variable hour employee." The employer shall determine the eligibility status of newly hired variable hour employees using a "lookback method" and a twelve (12) month initial measurement period ("IMP"). Coverage shall be offered for the corresponding twelve (12) month initial stability period ("ISP") to newly hired variable hour employees who are deemed eligible based on average weekly "hours of service" during their IMP. The IMP shall commence on the first pay period of the first full month following the date of hire. For purposes of this provision, hours of service include any hours for which an employee is entitled to compensation (including PTO) as well as unpaid FMLA leave, military leave under USERRA and jury duty leave.

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

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

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

EMPLOYEE ENROLLMENT

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

EMPLOYEE(S) EFFECTIVE DATE

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

- Assistant Dean College
- Associate Vice President College
- Chair
- Chief
- Chief Executive Officer
- Dean College
- Director
- Director/Physician
- Director AIP
- Director College

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Executive Vice President
Manager College
Managing Physician
President College
Senior Director
Senior Vice President
Staff Physician
Staff Resident
Supervising Physician
Vice President
Vice President College
Vice President Physician
The following Advanced Practice Providers
  o Clinical Nurse Specialist
  o CRNA
  o Nurse Practitioner
  o Nurse Practitioner-Specialty

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

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

**DEPENDENT(S) ELIGIBILITY**

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

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

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

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

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

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

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

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

DEPENDENT ENROLLMENT

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

DEPENDENT(S) EFFECTIVE DATE

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

1. The date the employee's coverage becomes effective.
2. The date the dependent is acquired, provided the employee has applied for dependent coverage within one (1) month of the date acquired.
3. Newborn children born with no complications will be considered a dependent under this Plan for up to two (2) days immediately following normal vaginal birth and for up to four (4) days immediately following caesarean section birth. For coverage under the Plan for the newborn beyond that date, the employee must submit an application for enrollment within one (1) month of birth.
4. Newborn children born with complications shall be enrolled from birth, provided the employee has applied for dependent coverage within one (1) month of birth.
5. Coverage for a newly adopted or to be adopted child shall be effective on the date the child is placed for adoption, provided the employee has applied for dependent coverage within one (1) month of the date the child is placed for adoption.

SPECIAL ENROLLMENT PERIOD (OTHER COVERAGE)

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

1. Termination of the other coverage (including exhaustion of COBRA benefits).
2. Cessation of employer contributions toward the other coverage.
3. Divorce.
4. Termination of other employment or reduction in number of hours of other employment.
5. Death of dependent or spouse.
6. Cessation of other coverage because employee or dependent no longer resides or works in the service area and no other benefit package is available to the individual.

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

8. An incurred claim that would exceed the other coverage’s maximum benefit limit. The maximum benefit limit is all-inclusive and means that no further benefits are payable under the other coverage because the specific total benefit pay out maximum has been reached under the other coverage. The right for special enrollment continues for thirty (30) days after the date the claim is denied under the other coverage.

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

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

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

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

**SPECIAL ENROLLMENT PERIOD (NEW DEPENDENT)**

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

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

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

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

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

1. in the case of marriage, the date of such marriage;
2. in the case of a dependent’s birth, the date of such birth;
3. in the case of adoption or placement for adoption, the date of such adoption or placement for adoption.

**SPECIAL ENROLLMENT PERIOD (CHILDREN’S HEALTH INSURANCE PROGRAM (CHIP) REAUTHORIZED ACT OF 2009)**

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

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

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

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

**ANNUAL BENEFIT ENROLLMENT**

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

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

The effective date of coverage as the result of an annual benefit enrollment period will be the following January 1st.

Except for a status change listed below, the annual benefit enrollment period is the only time an employee may change benefit options or modify enrollment. Status changes include:

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

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

3. Cessation of required employee contributions.

4. Taking or returning from a leave of absence under the Family and Medical Leave Act of 1993 (FMLA).

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

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

7. A court order, judgment or decree.

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

9. A COBRA qualifying event.
TERMINATION OF COVERAGE

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

**TERMINATION OF EMPLOYEE COVERAGE**

1. The date the employer terminates the Plan and offers no other group health benefits program.
2. The date the employee is no longer eligible for benefits.
3. The last day worked by the employee.
4. Twenty-four (24) months following the date the employee becomes a full-time, active member of the armed forces of any country.
5. The date the employee ceases to make any required contributions.

**TERMINATION OF DEPENDENT(S) COVERAGE**

1. The date the employer terminates the Plan and offers no other group health benefits program.
2. The date the employee is no longer eligible for benefits.
3. The last day worked by the employee.
4. The date such person ceases to meet the eligibility requirements of the Plan, except that for a dependent child who reaches age 26, termination shall be the last day of the month in which the dependent child reaches age 26.
5. The date the employee ceases to make any required contributions on the dependent's behalf.
6. The date the employee's spouse becomes a full-time, active member of the armed forces of any country.
7. The date the Plan discontinues dependent coverage for any and all dependents.

**LEAVE OF ABSENCE**

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

**FAMILY AND MEDICAL LEAVE ACT (FMLA)**

*Eligible Leave*

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

1. Birth of a child of the employee and in order to care for such child;
2. Placement of a child with the employee for adoption or foster care;
3. To care for the spouse, child, or parent of the employee, if such spouse, child, or parent has a serious health condition;
4. Because of a serious health condition that makes the employee unable to perform the functions of the position of such employee;
5. Because of any qualifying exigency (as determined by regulation) arising out of the fact that the spouse, child, or parent of the employee is on active duty (or has been notified of an impending call or order to active duty) in the Armed Forces in support of a contingency operation; or

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

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

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

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

**Outpatient Status**

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

**Serious Injury or Illness**

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

**Contributions**

During this leave, the employer will continue to pay the same portion of the employee's contribution for the Plan. The employee's portion of the contribution will go to arrears. Upon return to work, the amount in arrears will be collected evenly from the next four (4) paychecks for the employee to be up to date.

**Reinstatement**

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

**Repayment Requirement**

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

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

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

2. Rehire or return to active service must occur within thirty (30) days of the last pay date.

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

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

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

An employee who returns to work more than thirty (30) days after the termination date, following an approved leave of absence or termination of employment will be considered a new employee for purposes of eligibility and will be subject to all eligibility requirements, including all requirements relating to the effective date of coverage.
CONTINUATION OF COVERAGE

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

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

QUALIFYING EVENTS

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

1. Death of the employee.
2. The employee's termination of employment (other than termination for gross misconduct), or reduction in work hours to less than the minimum required for coverage under the Plan. This event is referred to below as an "18-Month Qualifying Event."
3. Divorce or legal separation from the employee.
4. The employee's entitlement to Medicare benefits under Title XVIII of the Social Security Act, if it results in the loss of coverage under this Plan.
5. A dependent child no longer meets the eligibility requirements of the Plan.
6. The last day of leave under the Family and Medical Leave Act of 1993, or an earlier date on which the employee informs the employer that he or she will not be returning to work.
7. The call-up of an employee reservist to active duty.

NOTIFICATION REQUIREMENTS

1. When eligibility for continuation of coverage results from a spouse being divorced or legally separated from an enrolled employee, or a child's loss of dependent status, the employee or dependent must submit a completed Qualifying Event Notification form to the Plan Administrator (or its designee) within sixty (60) days of the latest of:
   a. The date of the event;
   b. The date on which coverage under this Plan is or would be lost as a result of that event; or
   c. The date on which the employee or dependent is furnished with a copy of this Plan Document and Summary Plan Description.

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

Within fourteen (14) days of the receipt of a properly completed Qualifying Event Notification, the Plan Administrator (or its designee) will notify the employee or dependent of his rights to continuation of coverage, and what process is required to elect continuation of coverage. This notice is referred to below as "Election Notice."
2. When eligibility for continuation of coverage results from any qualifying event under this Plan other than the ones described in Paragraph 1 above, the employer must notify the Plan Administrator (or its designee) not later than thirty (30) days after the date on which the employee or dependent loses coverage under the Plan due to the qualifying event. Within fourteen (14) days of the receipt of the notice of the qualifying event, the Plan Administrator (or its designee) will furnish the Election Notice to the employee or dependent.

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

4. In the event an Election Notice is furnished, the eligible employee or dependent has sixty (60) days to decide whether to elect continued coverage. Each person who is described in the Election Notice and was enrolled under the Plan, on the day before the qualifying event, has the right to elect continuation coverage. He must advise the Plan Administrator (or its designee) of this choice by returning to the Plan Administrator (or its designee) a properly completed Election Notice not later than the last day of the sixty (60) day period. If the Election Notice is mailed to the Plan Administrator (or its designee), it must be postmarked on or before the last day of the sixty (60) day period. This sixty (60) day period begins on the later of the following:
   a. The date coverage under the Plan would otherwise end; or
   b. The date the person receives the Election Notice from the Plan Administrator (or its designee).

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

COST OF COVERAGE

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

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

WHEN CONTINUATION COVERAGE BEGINS

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

FAMILY MEMBERS ACQUIRED DURING CONTINUATION

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

1. In the event any of the following events occur during the period of continuation coverage resulting from an 18-Month Qualifying Event, it is possible for a dependent's continuation coverage to be extended:
   a. Death of the employee.
   b. Divorce or legal separation from the employee.
   c. The child's loss of dependent status.

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

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

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

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

2. A person who loses coverage on account of an 18-Month Qualifying Event may extend the maximum period of continuation coverage from eighteen (18) months to up to twenty-nine (29) months in the event both of the following occur:
   a. That person (or another person who is entitled to continuation coverage on account of the same 18-Month Qualifying Event) is determined by the Social Security Administration, under Title II or Title XVI of the Social Security Act, to have been disabled before the sixtieth (60th) day of continuation coverage; and
   b. The disability status, as determined by the Social Security Administration, lasts at least until the end of the initial eighteen (18) month period of continuation coverage.

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

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

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

**END OF CONTINUATION**

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

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

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

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

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

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

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

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

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

**SPECIAL RULES REGARDING NOTICES**

1. Any notice required in connection with continuation coverage under this Plan must, at minimum, contain sufficient information so that the Plan Administrator (or its designee) is able to determine from such notice the employee and dependent(s) (if any), the qualifying event or disability, and the date on which the qualifying event occurred.

2. In connection with continuation coverage under this Plan, any notice required to be provided by any individual who is either the employee or a dependent with respect to the qualifying event may be provided by a representative acting on behalf of the employee or the dependent, and the provision of the notice by one individual shall satisfy any responsibility to provide notice on behalf of all related eligible individuals with respect to the qualifying event.
3. As to an Election Notice, Non-Eligibility Notice or Early Termination Notice:
   a. A single notice addressed to both the employee and the spouse will be sufficient as to both individuals if, on the basis of the most recent information available to the Plan, the spouse resides at the same location as the employee; and
   b. A single notice addressed to the employee or the spouse will be sufficient as to each dependent child of the employee if, on the basis of the most recent information available to the Plan, the dependent child resides at the same location as the individual to whom such notice is provided.

PRE-EXISTING CONDITIONS

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

MILITARY MOBILIZATION

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

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

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

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

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

PLAN CONTACT INFORMATION

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

ADDRESS CHANGES

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

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

POST-SERVICE CLAIM PROCEDURE

FILING A CLAIM

1. Claims should be submitted to the claims processor at the address noted below:

   CoreSource, Inc.
   P.O. Box 898
   Arnold, MD  21012

   The date of receipt will be the date the claim is received by the claims processor.

2. All claims submitted for benefits must contain all of the following:
   a. Name of patient.
   b. Patient’s date of birth.
   c. Name of employee.
   d. Address of employee.
   e. Name of employer and group number.
   f. Name, address and tax identification number of provider.
   g. Employee CoreSource Member Identification Number.
   h. Date of service.
   i. Diagnosis.
   j. Description of service and procedure number.
   k. Charge for service.
   l. The nature of the accident, injury or illness being treated.

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

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

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

NOTICE OF AUTHORIZED REPRESENTATIVE

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

NOTICE OF CLAIM

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

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

TIME FRAME FOR BENEFIT DETERMINATION

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

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

NOTICE OF BENEFIT DENIAL

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

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

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

APPEALING A DENIED POST-SERVICE CLAIM

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

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

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

**NOTICE OF BENEFIT DETERMINATION ON APPEAL**

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

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

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

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

RIGHT TO EXTERNAL APPEAL

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

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

NOTICE OF RIGHT TO EXTERNAL APPEAL

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

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

1. The reason for ineligibility and the availability of the Employee Benefits Security Administration at 866-444-3272, if the request is complete but not eligible for external review.
2. If the request is incomplete, the information or materials necessary to make the request complete and the opportunity for the covered person to perfect the external review request by the later of the following:
   a. The four (4) month filing period; or
   b. Within the forty-eight (48) hour time period following the covered person’s receipt of notification.

INDEPENDENT REVIEW ORGANIZATION

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

NOTICE OF EXTERNAL REVIEW DETERMINATION

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

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

The plan administrator (or its designee) shall provide the covered person (or authorized representative) the right to request an expedited external review upon the covered person’s receipt of either of the following:

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

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

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

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

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

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

FOREIGN CLAIMS

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

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

You are encouraged to contact CareChampion (available 24/7), if you have any questions regarding the requirements of this section.

HEALTH CARE MANAGEMENT

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

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

FILING A PRE-CERTIFICATION CLAIM

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

All inpatient admissions, home health care (excluding supplies), hospice care, transplant procedures, genetic counseling, testing and screening, durable medical equipment, private duty nursing, PET scans, MRI scans (brain/spine only), esophagastroduodenoscopy, nuclear stress test and colonoscopy under age 50 only (for a medical diagnosis) are to be certified by the Health Care Management Organization. For non-urgent care, the enrolled individual (or their authorized representative) must contact the Health Care Management Organization at least fifteen (15) calendar days prior to initiation of services. If the Health Care Management Organization is not contacted at least fifteen (15) calendar days prior to initiation of services for non-urgent care, benefits may be reduced.

For urgent care, the enrolled individual (or their authorized representative) must contact the Health Care Management Organization within forty-eight (48) hours or the next business day, whichever is later, after the initiation of services. Please note that if the enrolled individual needs medical care that would be considered as urgent care, then there is no requirement that the Plan be contacted for prior approval.

Enrolled individuals are encouraged to contact the Health Care Management Organization by calling:

1-877-848-9997

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

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

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

However, hospital maternity stays in excess of forty-eight (48) or ninety-six (96) hours as specified above must be pre-certified.
If the enrolled individual (or authorized representative) fails to contact the Health Care Management Organization prior to the hospitalization and within the timelines detailed above, the amount of benefits payable for nonpreferred provider covered expenses incurred shall be reduced by $500. If the Health Care Management Organization declines to grant the full pre-certification requested, benefits for days not certified as medically necessary by the Health Care Management Organization shall be denied. (Refer to Post-Service Claim Procedure discussion above.)

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

**FILING A PRE-NOTIFICATION**

Pre-Notification is required for all renal dialysis. The enrolled individual (or their authorized representative) must call the Health Care Management Organization prior to initiation of services. If the Health Care Management Organization is not called at prior to initiation of services, benefits may be reduced. Please note that if the enrolled individual needs medical care that would be considered as urgent care, then there is no requirement that the Plan be contacted for prior approval. For urgent care, the enrolled individual (or their authorized representative) must call the Health Care Management Organization within forty-eight (48) hours or the next business day, whichever is later, after the initiation of services.

Enrolled individuals are encouraged to contact the Health Care Management Organization by calling:

1-877-848-9997

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

1. **Employee’s** name, address, phone number and **Employee CoreSource Member Identification Number**.
2. **Employer’s** name.
3. If not the **employee**, the patient’s name, address, phone number.
4. Treating **physician’s** name and phone number.
5. Name of **facility** or dialysis center.
6. Proposed date of when services are to begin.

If the enrolled individual (or authorized representative) fails to contact the Health Care Management Organization prior to obtaining renal dialysis prior to initiation of service, the amount of benefits payable for covered expenses incurred shall be reduced by $500.

**NOTICE OF AUTHORIZED REPRESENTATIVE**

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

**TIME FRAME FOR PRE-SERVICE CLAIM DETERMINATION**

1. In the event the Plan receives from the enrolled individual (or authorized representative) a communication that fails to follow the pre-certification procedure as described above but communicates at least the name of the enrolled individual, a specific medical condition or symptom, and a specific treatment, service or product for which prior approval is requested, the enrolled individual on (or the authorized representative) will be orally notified (and in writing if requested), within five (5) calendar days of the failure of the proper procedure to be followed.
2. After a completed pre-certification request for non-urgent care has been submitted to the Plan, and if no additional information is required, the Plan will generally complete its determination of the claim within a reasonable period of time, but no later than fifteen (15) calendar days from receipt of the request.

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

CONCURRENT CARE CLAIMS

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

1. If an enrolled individual (or authorized representative) requests to extend a previously approved hospitalization or an ongoing course of treatment, and;
   a. The request involves non-urgent care, then the extension request must be processed within fifteen (15) calendar days after the request was received.
   b. The inpatient admission or ongoing course of treatment involves urgent care, and
      (i.) The request is received at least twenty-four (24) hours before the scheduled end of a hospitalization or course of treatment, then the request must be ruled upon and the enrolled individual (or authorized representative) notified as soon as possible taking into consideration medical exigencies but no later than twenty-four (24) hours after the request was received; or
      (ii.) The request is received less than twenty-four (24) hours before the scheduled end of the hospitalization or course of treatment, then the request must be ruled upon and the enrolled individual (or authorized representative) notified as soon as possible but no later than seventy-two (72) hours after the request was received; or
      (iii.) The request is received less than twenty-four (24) hours before the scheduled end of the hospitalization or course of treatment and additional information is required, the enrolled individual (or authorized representative) will be notified within twenty-four (24) hours of the additional information required. The enrolled individual (or authorized representative) has forty-eight (48) hours to provide such information (may be oral unless written is requested). Upon timely response, the enrolled individual (or authorized representative) will be notified as soon as possible but no later than forty-eight (48) hours after receipt of additional information. Failure to submit requested information timely will result in a denial of such request.

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

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

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

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

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

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

APPELLING A DENIED PRE-SERVICE CLAIM

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

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

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

1. The covered person has the right to submit documents, information and comments and to present testimony.
2. The covered person has the right to access, free of charge, relevant information to the claim for benefits.
3. Before a final determination on appeal is rendered, the covered person will be provided, free of charge, with any new or additional rationale or evidence considered, relied upon, or generated by the plan in connection with the claim. Such information will be provided as soon as possible and sufficiently in advance of the notice of final internal determination to give the covered person a reasonable opportunity to respond prior to that date.
4. The review takes into account all information submitted by the covered person, even if it was not considered in the initial benefit determination.
5. The review by the named fiduciary will not afford deference to the original denial.
6. The named fiduciary will not be:
   a. The individual who originally denied the claim, nor
   b. Subordinate to the individual who originally denied the claim.
7. If original denial was, in whole or in part, based on medical judgment:
a. The named fiduciary will consult with a professional provider who has appropriate training and experience in the field involving the medical judgment.

b. The professional provider utilized by the named fiduciary will be neither:
   (i.) An individual who was consulted in connection with the original denial of the claim, nor
   (ii.) A subordinate of any other professional provider who was consulted in connection with the original denial.

8. If requested, the named fiduciary will identify the medical or vocational expert(s) who gave advice in connection with the original denial, whether or not the advice was relied upon.

**NOTICE OF PRE-SERVICE DETERMINATION ON APPEAL**

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

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

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

**CASE MANAGEMENT**

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

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

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

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

“Special Delivery” is a voluntary program for expectant mothers offering prenatal information, pre-screening for pregnancy related risks and information or preparation for childbirth. This program is designed to identify potential high-risk mothers, as well as help ensure a safer pregnancy for both mother and baby.

Expectant mothers who decide to participate in the “Special Delivery” Program will have access to a twenty-four (24) hour toll-free “babyline” which is staffed by obstetrical nurses and will also have a series of four (4) books called “Trimester.”

An expectant mother may participate in this program by calling the number shown on her identification card and asking for a “Special Delivery” nurse. If possible, she should call during the first three (3) months of her pregnancy in order to receive the full benefits of this program.
COORDINATION OF BENEFITS

The Coordination of Benefits provision is intended to prevent duplication of benefits. It applies when the enrolled individual is also enrolled in any Other Plan(s). When more than one coverage exists, one plan normally pays its benefits in full, referred to as the primary plan. The Other Plan(s), referred to as secondary plan, pays a reduced benefit. When coordination of benefits occurs, the total benefit payable by all plans will not exceed one hundred percent (100%) of "allowable expenses." Only the amount paid by this Plan will be charged against the maximum benefit.

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

DEFINITIONS APPLICABLE TO THIS PROVISION

"Allowable Expenses" means any reasonable, necessary, and customary expenses incurred while enrolled under this Plan. Allowable Expenses do not include expenses contained in the "Exclusions" sections of this Plan. When this Plan is secondary, "Allowable Expense" will include any deductible or coinsurance amounts not paid by the Other Plan(s).

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

When this Plan is secondary, "Allowable Expense" shall not include any amount that is not payable under the primary plan as a result of a contract between the primary plan and a provider of service in which such provider agrees to accept a reduced payment and not to bill the enrolled individual for the difference between the provider's contracted amount and the provider's regular billed charge.

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

1. Group insurance or any other arrangement for coverage for enrolled individuals in a group, whether on an insured or uninsured basis, including, but not limited to, hospital indemnity benefits and hospital reimbursement-type plans;
2. Hospital or medical service organization on a group basis, group practice, and other group prepayment plans or on an individual basis having a provision similar in effect to this provision;
3. A licensed Health Maintenance Organization (HMO);
4. Any coverage for students which is sponsored by, or provided through, a school or other educational institution;
5. Any coverage under a government program and any coverage required or provided by any statute;
6. Group automobile insurance;
7. Individual automobile insurance coverage;
8. Individual automobile insurance coverage based upon the principles of "No-fault" coverage;
9. Any plan or policies funded in whole or in part by an employer, or deductions made by an employer from a person's compensation or retirement benefits;
10. Labor/management trust, union welfare, employer organization, or employee benefit organization plans.
"This Plan" shall mean that portion of the employer's Plan which provides benefits that are subject to this provision.

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

**EFFECT ON BENEFITS**

This provision shall apply in determining the benefits for an enrolled individual for each claim determination period for the Allowable Expenses. If this Plan is secondary, the benefits paid under this Plan may be reduced so that the sum of benefits paid by all plans does not exceed 100% of total Allowable Expenses.

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

**ORDER OF BENEFIT DETERMINATION**

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

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

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

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

4. **Dependent Children of Separated or Divorced Parents**
   When parents are separated or divorced, the birthday rule does not apply, instead:
   a. If a court decree has given one parent financial responsibility for the child's health care, the plan of that parent pays first. The plan of the stepparent married to that parent, if any, pays second. The plan of the other natural parent pays third. The plan of the spouse of the other natural parent, if any, pays fourth.
   b. In the absence of such a court decree, the plan of the parent with custody pays first. The plan of the stepparent married to the parent with custody, if any, pays second. The plan of the parent without custody pays third. The plan of the spouse of the parent without custody, if any, pays fourth.

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

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

**ELIGIBLE SPOUSE RULE**

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

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

1. The employee’s spouse is not employed.
2. The employee’s spouse’s employer does not provide a group health plan.
3. The employee’s spouse is self-employed.
4. The employee’s spouse’s employer subsidizes less than 50% of the group health coverage for its employees.

**COORDINATION WITH MEDICARE**

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

1. When an employee becomes entitled to Medicare coverage (due to age or disability) and is still actively at work, the employee may continue health coverage under this Plan at the same level of benefits and contribution rate that applied before reaching Medicare entitlement.
2. When a dependent becomes entitled to Medicare coverage (due to age or disability) and the employee is still actively at work, the dependent may continue health coverage under this Plan at the same level of benefits and contribution rate that applied before reaching Medicare entitlement.
3. If the employee and/or dependent are also enrolled in Medicare (due to age or disability), this Plan shall pay as the primary plan. If, however, the Medicare enrollment is due to end stage renal disease, the Plan’s primary payment obligation will end at the end of the thirty (30) month “coordination period” as provided in Medicare law and regulations.
4. If the employee and/or dependent elect to discontinue health coverage under this Plan and enroll under the Medicare program, no benefits will be paid under this Plan. Medicare will be the only payor.

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

**LIMITATIONS ON PAYMENTS**

In no event shall the enrolled individual recover under this Plan and all Other Plan(s) combined more than the total Allowable Expenses offered by this Plan and the Other Plan(s). Nothing contained in this section shall entitle the enrolled individual to benefits in excess of the total maximum benefits of this Plan during the claim determination period. The enrolled individual shall refund to the employer any excess payments.

**RIGHT TO RECEIVE AND RELEASE NECESSARY INFORMATION**

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

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

AUTOMOBILE ACCIDENT BENEFITS

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

1. No-fault automobile insurance laws
2. Financial responsibility laws
3. Other automobile liability insurance laws

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

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

2. For the purposes of this section the following people are deemed “covered by an automobile insurance policy.”
   
   a. An owner or principal named insured individual under such policy.
   b. A family member of an insured person for whom coverage is provided under the terms and conditions of the automobile insurance policy.
   c. Any other person who, except for the existence of the Plan, would be eligible for medical expense benefits under an automobile insurance policy.

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

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

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

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

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

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

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

3. Assisting in Plan’s Reimbursement Activities. The enrolled individual has an obligation to assist the Plan to obtain reimbursement of the Reimbursable Payments that it has made on behalf of the enrolled individual, and to provide the Plan with any information concerning the enrolled individual’s other insurance coverage (whether through automobile insurance, other group health program, or otherwise) and any other person or entity (including their insurer(s)) that may be obligated to provide payments or benefits to or for the benefit of the enrolled individual. The enrolled individual is required to (a) cooperate fully in the Plan’s (or any Plan fiduciary’s) enforcement of the terms of the Plan, including the exercise of the Plan’s rights to subrogation and reimbursement, whether against the enrolled individual or any third party, (b) not do anything to prejudice those enforcement efforts or rights (such as settling a claim against another party without including the Plan as a co-payee for the amount of the Reimbursable Payments and notifying the Plan), (c) sign any document deemed by the Plan Administrator to be relevant to protecting the Plan’s subrogation, reimbursement or other rights, and (d) provide relevant information when requested. The term “information” includes any documents, insurance policies, police reports, or any reasonable request by the Plan Administrator or claims processor to enforce the Plan’s rights.

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

ADMINISTRATION OF THE PLAN

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

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

APPLICABLE LAW

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

ASSIGNMENT

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

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

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

BENEFITS NOT TRANSFERABLE

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

CLERICAL ERROR

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

CONFORMITY WITH STATUTE(S)

Any provision of the Plan which is in conflict with statutes which are applicable to this Plan is hereby amended to conform to the minimum requirements of said statute(s).
EFFECTIVE DATE OF THE PLAN

The effective date of this Plan is January 1, 2017.

FRAUD OR INTENTIONAL MISREPRESENTATION

If the enrolled individual or anyone acting on behalf of an enrolled individual makes a false statement on the application for enrollment, or withholds information with intent to deceive or affect the acceptance of the enrollment application or the risks assumed by the Plan, or otherwise misleads the Plan, the Plan shall be entitled to recover its damages, including legal fees, from the enrolled individual, or from any other person responsible for misleading the Plan, and from the person for whom the benefits were provided. Any fraud or intentional misrepresentation of a material fact on the part of the enrolled individual or an individual seeking coverage on behalf of the individual in making application for coverage, or any application for reclassification thereof, or for service thereunder is prohibited and shall render the coverage under this Plan null and void.

INCAPACITY

If, in the opinion of the employer, an enrolled individual for whom a claim has been made is incapable of furnishing a valid receipt of payment due him and in the absence of written evidence to the Plan of the qualification of a guardian or personal representative for his estate, the employer may on behalf of the Plan, at his discretion, make any and all such payments to the provider of services or other person providing for the care and support of such person. Any payment so made will constitute a complete discharge of the Plan's obligation to the extent of such payment.

INCONTESTABILITY

All statements made by the employer or by the employee covered under this Plan shall be deemed representations and not warranties. Such statements shall not void or reduce the benefits under this Plan or be used in defense to a claim unless they are contained in writing and signed by the employer or by the enrolled individual, as the case may be. A statement made shall not be used in any legal contest unless a copy of the instrument containing the statement is or has been furnished to the other party to such a contest.

LEGAL ACTIONS

The decision by the plan administrator/claims processor on review will be final, binding, and conclusive, and will be afforded the maximum deference permitted by law. All claim review procedures provided for in the plan document must be exhausted before any legal or equitable action is brought. Notwithstanding any other state or federal law, any and all legal actions to recover benefits, whether against the Plan, plan administrator, claims processor, employer, any other fiduciary, or their employees, must be filed within two years from the date the expense was incurred or one year from the date the completed claim was filed, whichever occurred first.

LIMITS ON LIABILITY

Liability hereunder is limited to the services and benefits specified, and the employer shall not be liable for any obligation of the enrolled individual incurred in excess thereof. The employer shall not be liable for the negligence, wrongful act, or omission of any physician, professional provider, hospital, or other institution, or their employees, or any other person. The liability of the Plan shall be limited to the reasonable cost of covered expenses and shall not include any liability for suffering or general damages.

LOST DISTRIBUTEES

Any benefit payable hereunder shall be deemed forfeited if the Plan Administrator is unable to locate the enrolled individual to whom payment is due, provided, however, that such benefits shall be reinstated if a claim is made by the enrolled individual for the forfeited benefits within the time prescribed in the applicable Claim Filing Procedure section of this document.
MEDICAID ELIGIBILITY AND ASSIGNMENT OF RIGHTS

The Plan will not take into account whether an individual is eligible for, or is currently receiving, medical assistance under a state plan for medical assistance as provided under Title XIX of the Social Security Act ("State Medicaid Plan") either in enrolling that individual as an enrolled individual or in determining or making any payment of benefits to that individual. The Plan will pay benefits with respect to such individual in accordance with any assignment of rights made by or on behalf of such individual as required under a state Medicaid plan pursuant to § 1912(a)(1)(A) of the Social Security Act. To the extent payment has been made to such individual under a state Medicaid Plan and this Plan has a legal liability to make payments for the same services, supplies or treatment, payment under the Plan will be made in accordance with any state law which provides that the state has acquired the rights with respect to such individual to payment for such services, supplies or treatment under the Plan.

PLAN IS NOT A CONTRACT

The Plan shall not be deemed to constitute a contract between the employer and any employee or to be a consideration for, or an inducement or condition of, the employment of any employee. Nothing in the Plan shall be deemed to give any employee the right to be retained in the service of the employer or to interfere with the right of the employer to terminate the employment of any employee at any time.

PLAN MODIFICATION AND AMENDMENT

The employer may modify or amend the Plan from time to time at its sole discretion, and such amendments or modifications which affect enrolled individuals will be communicated to the enrolled individuals. Any such amendments shall be in writing, setting forth the modified provisions of the Plan, the effective date of the modifications, and shall be signed by the employer's designee.

Such modification or amendment shall be duly incorporated in writing into the master copy of the Plan on file with the employer, or a written copy thereof shall be deposited with such master copy of the Plan. Appropriate filing and reporting of any such modification or amendment with governmental authorities and to enrolled individuals shall be timely made by the employer.

PLAN TERMINATION

The employer reserves the right to terminate the Plan at any time. Upon termination, the rights of the enrolled individuals to benefits are limited to claims incurred up to the date of termination. Any termination of the Plan will be communicated to the enrolled individuals.

Upon termination of this Plan, all claims incurred prior to termination, but not submitted to either the employer or claims processor within twelve (12) months of the effective date of termination of this Plan, will be excluded from any benefit consideration.

PRONOUNS

All personal pronouns used in this Plan shall include either gender unless the context clearly indicates to the contrary.

RECOVERY FOR OVERPAYMENT

Whenever payments have been made from the Plan in excess of the maximum amount of payment necessary, the Plan will have the right to recover these excess payments. If the Plan makes any payment that, according to the terms of the Plan, should not have been made, the Plan may recover that incorrect payment, whether or not it was made due to the Plan's or the Plan designee's own error, from the person or entity to whom it was made or from any other appropriate party.
STATUS CHANGE

If an employee or dependent has a status change while enrolled in the Plan (i.e., dependent to employee, COBRA to active) and no interruption in coverage has occurred, the Plan will provide continuous coverage with respect to any deductible(s), coinsurance and maximum benefit.

TIME EFFECTIVE

The effective time with respect to any dates used in the Plan shall be 12:01 a.m. as may be legally in effect at the address of the Plan Administrator.

WORKERS' COMPENSATION NOT AFFECTED

This Plan is not in lieu of, and does not affect any requirement for, coverage by Workers' Compensation Insurance.
HIPAA PRIVACY

The following provisions are intended to comply with applicable Plan amendment requirements under Federal regulation implementing Section 264 of the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

DISCLOSURE BY PLAN TO PLAN SPONSOR

The Plan may take the following actions only upon receipt of a Plan amendment certification:

1. Disclose protected health information to the plan sponsor.

2. Provide for or permit the disclosure of protected health information to the plan sponsor by a health insurance issuer or HMO with respect to the Plan.

USE AND DISCLOSURE BY PLAN SPONSOR

The plan sponsor may use or disclose protected health information received from the Plan to the extent not inconsistent with the provisions of this HIPAA Privacy section or the privacy rule.

OBLIGATIONS OF PLAN SPONSOR

The plan sponsor shall have the following obligations:

1. Ensure that:
   a. Any agents (including a subcontractor) to whom it provides protected health information received from the Plan agree to the same restrictions and conditions that apply to the plan sponsor with respect to such information; and
   b. Adequate separation between the Plan and the plan sponsor is established in compliance with the requirement in 45 C.F.R. 164.504(f)(2)(iii).

2. Not use or further disclose protected health information received from the Plan, other than as permitted or required by the Plan documents or as required by law.

3. Not use or disclose protected health information received from the Plan:
   a. For employment-related actions and decisions; or
   b. In connection with any other benefit or employee benefit plan of the plan sponsor.

4. Report to the Plan any use or disclosure of the protected health information received from the Plan that is inconsistent with the use or disclosure provided for of which it becomes aware.

5. Make available protected health information received from the Plan, as and to the extent required by the privacy rule:
   a. For access to the individual;
   b. For amendment and incorporate any amendments to protected health information received from the Plan; and
   c. To provide an accounting of disclosures.

6. Make its internal practices, books, and records relating to the use and disclosure of protected health information received from the Plan available to the Secretary of the U.S. Department of Health and Human Services for purposes of determining compliance by the Plan with the privacy rule.
7. Return or destroy all protected health information received from the Plan that the plan sponsor still maintains in any form and retain no copies when no longer needed for the purpose for which the disclosure by the Plan was made, but if such return or destruction is not feasible, limit further uses and disclosures to those purposes that make the return or destruction of the information infeasible.

8. Provide protected health information only to those individuals, under the control of the plan sponsor who perform administrative functions for the Plan; (i.e., eligibility, enrollment, payroll deduction, benefit determination, claim reconciliation assistance), and to make clear to such individuals that they are not to use protected health information for any reason other than for Plan administrative functions nor to release protected health information to an unauthorized individual.

9. Provide protected health information only to those entities required to receive the information in order to maintain the Plan (i.e., claim administrator, case management vendor, pharmacy benefit manager, claim subrogation, vendor, claim auditor, network manager, stop-loss insurance carrier, insurance broker/consultant, and any other entity subcontracted to assist in administering the Plan).

10. Provide an effective mechanism for resolving issues of noncompliance with regard to the items mentioned in this provision.

11. Reasonably and appropriately safeguard electronic protected health information created, received, maintained, or transmitted to or by the plan sponsor on behalf of the Plan. Specifically, such safeguarding entails an obligation to:
   a. Implement administrative, physical, and technical safeguards that reasonably and appropriately protect the confidentiality, integrity, and availability of the electronic protected health information that the plan sponsor creates, receives, maintains, or transmits on behalf of the Plan;
   b. Ensure that the adequate separation as required by 45 C.F.R. 164.504(f)(2)(iii) is supported by reasonable and appropriate security measures;
   c. Ensure that any agent, including a subcontractor, to whom it provides this information agrees to implement reasonable and appropriate security measures to protect the information; and
   d. Report to the Plan any security incident of which it becomes aware.

**EXCEPTIONS**

Notwithstanding any other provision of this HIPAA Privacy section, the Plan may:

1. Disclose summary health information to the plan sponsor:
   a. If the plan sponsor requests it for the purpose of:
      (i.) Obtaining premium bids from health plans for providing health insurance coverage under the Plan; or
      (ii.) Modifying, amending, or terminating the Plan;

2. Disclose to the plan sponsor information on whether the individual is participating in the Plan;

3. Use or disclose protected health information:
   a. With (and consistent with) a valid authorization obtained in accordance with the privacy rule;
   b. To carry out treatment, payment, or health care operations in accordance with the privacy rule; or
   c. As otherwise permitted or required by the privacy rule.
DEFINITIONS

Certain words and terms used herein shall be defined as follows and are shown in bold and italics throughout the document:

Accident

An unforeseen event resulting in injury.

Alcoholism, Drug Abuse and Drug Dependency

The physiological and psychological addiction to a controlled drug or substance, or to alcohol. Dependence upon tobacco, nicotine and caffeine are not included in this definition.

Alcohol and Drug Dependency Facility

A state or licensed institution, which specializes in treatment of chemical dependency or its medical complications.

Alternate Recipient

Any child of an employee or their spouse who is recognized in a Qualified Medical Child Support Order (QMCSO) or National Medical Support Notice (NMSN) which has been issued by any court judgment, decree, or order as being entitled to enrollment for coverage under this Plan.

Ambulatory Surgical Facility

A facility provider with an organized staff of physicians which has been approved by the Joint Commission on the Accreditation of Healthcare Organizations, or by the Accreditation Association for Ambulatory Health, Inc., or by Medicare; or that has a contract with the Preferred Provider Organization as a preferred provider. An ambulatory surgical facility is a facility that:

1. Has permanent facilities and equipment for the purpose of performing surgical procedures on an outpatient basis;
2. Provides treatment by or under the supervision of physicians and nursing services whenever the enrolled individual is in the ambulatory surgical facility;
3. Does not provide inpatient accommodations; and
4. Is not, other than incidentally, a facility used as an office or clinic for the private practice of a physician.

Approved Clinical Trial

A Phase I, Phase II, Phase III, or Phase IV clinical trial that is conducted in relation to the prevention, detection, or treatment of cancer or other “life-threatening disease or condition” and is further described in accordance with federal law and applicable federal regulations.

Birthing Center

A facility that meets professionally recognized standards and complies with all licensing and other legal requirements that apply.

Chemotherapy

The treatment of disease by means of chemical substances or drugs used in reference to neoplastic disease (cancer).
Claims Processor

Refer to the *Summary Plan Description* (SPD) section of this document.

Close Relative

The employee's spouse, children, brothers, sisters, or parents; or the children, brothers, sisters or parents of the employee's spouse.

Coinsurance

The benefit percentage of covered expenses payable by the Plan for benefits that are provided under the Plan. The coinsurance is applied to covered expenses after the deductible(s) have been met, if applicable.

Concurrent Care

A request by an enrolled individual (or their authorized representative) to the Health Care Management Organization prior to the expiration of an enrolled individual's current course of treatment to extend such treatment OR a determination by the Health Care Management Organization to reduce or terminate an ongoing course of treatment.

Confinement

A continuous stay in a hospital, extended care facility, hospice, or birthing center due to an illness or injury diagnosed by a physician.

Congenital Condition

An abnormal condition that developed in utero and was noted and documented by a physician within the first two (2) years of the affected person’s life.

Copay

A cost sharing arrangement whereby an enrolled individual pays a set amount to a provider for a specific service at the time the service is provided.

Corrective Appliance

*Medically necessary* prosthetic appliances and orthotic appliances. All corrective appliances must be prescribed by a physician and used primarily for medical purposes and not primarily for recreational sports or to improve physical appearance (except as related to reconstructive surgery following mastectomy).

Prosthetic appliances must also: (i) replace all or part of a missing body organ and its adjoining tissue or all or part of the function of a permanently useless or malfunctioning body organ, and (ii) be an implantable prosthetic appliance or equivalent external device.

Orthotic devices must also: (i) be a device added to the body to stabilize or immobilize a body part, prevent deformity, protect against injury or assist with function; and (ii) be rigid or semi-rigid and correct a diagnosed musculoskeletal mal-alignment of a weakened or diseased body part; or (iii) be rigid or semi-rigid and stop or limit motion of a weak or diseased body part.

Cosmetic Surgery

Surgery for the restoration, repair, or reconstruction of body structures directed toward altering appearance.
Covered Expenses

Medically necessary services, supplies or treatments that are recommended or provided by a physician, professional provider or covered facility for the treatment of an illness or injury and that are not specifically excluded from coverage herein. Covered expenses shall include specified preventive care services.

Custodial Care

Care provided primarily for maintenance of the enrolled individual or which is designed essentially to assist the enrolled individual in meeting his activities of daily living and which is not primarily provided for its therapeutic value in the treatment of an illness or injury. Custodial care includes, but is not limited to: help in walking, bathing, dressing, feeding, preparation of special diets and supervision over self-administration of medications. Such services shall be considered custodial care without regard to the provider by whom or by which they are prescribed, recommended or performed.

Room and board and skilled nursing services are not, however, considered custodial care (1) if provided during confinement in an institution for which coverage is available under this Plan, and (2) if combined with other medically necessary therapeutic services, under accepted medical standards, which can reasonably be expected to substantially improve the enrolled individual’s medical condition.

Customary and Reasonable Amount

Any negotiated fee (where the provider has contracted to accept such fee as payment in full for covered expenses of the Plan) assessed for services, supplies or treatment by a nonpreferred provider, or a fee assessed by a provider of service for services, supplies or treatment which shall not exceed the general level of charges made by others rendering or furnishing such services, supplies or treatment within the area where the charge is incurred and is comparable in severity and nature to the illness or injury. Due consideration shall be given to any medical complications or unusual circumstances which require additional time, skill or experience. Except as to negotiated fees, the customary and reasonable amount is determined from a statistical review and analysis of the charges for a given procedure in a given area. The percentage applicable to this Plan is 90% and is applied to CPT codes or HIAA Code Analysis using Fair Health benchmarking tables.

Dentist

A Doctor of Dental Medicine (D.M.D.), a Doctor of Dental Surgery (D.D.S.), a Doctor of Medicine (M.D.), or a Doctor of Osteopathy (D.O.), other than a close relative of the enrolled individual, who is practicing within the scope of his license.

Dependent

For information regarding eligibility for dependents, refer to the Eligibility, Enrollment and Effective Date, Dependent(s) Eligibility section of this document.

Durable Medical Equipment

Medical equipment which:

1. Can withstand repeated use;
2. Is primarily and customarily used to serve a medical purpose;
3. Is generally not used in the absence of an illness or injury;
4. Is appropriate for use in the home.

All provisions of this definition must be met before an item can be considered durable medical equipment. Durable medical equipment includes, but is not limited to: crutches, wheel chairs, hospital beds, etc.
Effective Date

The date of this Plan or the date on which the enrolled individual's coverage commences, whichever occurs later.

Eligible Spouse Rule

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

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

1. The employee’s spouse is not employed.
2. The employee’s spouse’s employer does not provide a group health plan.
3. The employee’s spouse is self-employed.
4. The employee’s spouse’s employer subsidizes less than 50% of the group health coverage for its employees.

Embedded Deductible

Any number of family members may help to meet the family deductible amount, but no more than each person's individual deductible amount may be applied toward satisfaction of the family deductible by any family member.

Emergency

An accidental injury, or the sudden onset of an illness where the acute symptoms of sufficient severity (including severe pain) so that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonable expect the absence of immediate medical attention to result in:

1. Placing the enrolled individual’s health, or with respect to a pregnant woman, the health of the mother or her unborn child, in serious jeopardy, or
2. Causing other serious medical consequences, or
3. Causing serious impairment to bodily functions, or
4. Causing serious dysfunction of any bodily organ or part.

Employee

A person directly involved in the regular business of and compensated for services, as reported on the individual’s annual W-2 form by the employer, who meets the employer’s eligibility service requirements.

Employer

The employer is Lancaster General Health.
**E-visit**

We offer a secure online tool that allows you to receive care for minor health conditions without a trip to the doctor’s office.

**Enrolled Individual**

A person who is eligible for coverage under this *Plan*, or becomes eligible at a later date, and for whom the coverage provided by this *Plan* is in effect.

**Experimental/Investigational**

Services, supplies, drugs and treatment which do not constitute accepted medical practice properly within the range of appropriate medical practice under the standards of the case and by the standards of a reasonably substantial, qualified, responsible, relevant segment of the medical community or government oversight agencies at the time services were rendered.

The claims processor, named fiduciary for post-service claim appeals, named fiduciary for pre-service claim appeals, employer/Plan Administrator, or their designee must make an independent evaluation of the experimental/non-experimental standings of specific technologies. The claims processor, named fiduciary for post-service claim appeals, named fiduciary for pre-service claim appeals, employer/Plan Administrator or their designee shall be guided by a reasonable interpretation of Plan provisions and information provided by qualified independent vendors who have also reviewed the information provided. The decisions shall be made in good faith and rendered following a factual background investigation of the claim and the proposed treatment. The claims processor, named fiduciary for post-service claim appeals, named fiduciary for pre-service claim appeals, employer/Plan Administrator or their designee will be guided by the following examples of experimental services and supplies:

1. If the drug or device cannot be lawfully marketed without approval of the U.S. Food and Drug Administration and approval for marketing has not been given at the time the drug or device is furnished; or
2. If the drug, device, medical treatment or procedure, was not reviewed and approved by the treating facility’s institutional review board or other body serving a similar function, or if federal law requires such review or approval; or
3. If “reliable evidence” shows that the drug, device, medical treatment or procedure is the subject of on-going Phase I or Phase II clinical trials, is in the research, experimental, study or investigational arm of on-going Phase III clinical trials, or is otherwise under study to determine its maximum tolerated dose, its toxicity, its safety, or its efficacy as compared with a standard means of treatment or diagnosis; or
4. If “reliable evidence” shows that prevailing opinion among experts regarding the drug, device, medical treatment or procedure is that further studies or clinical trials are necessary to determine its maximum tolerated dose, its toxicity, its safety, or its efficacy as compared with standard means of treatment or diagnosis.

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

**Extended Care Facility**

An institution, or distinct part thereof, operated pursuant to law and one which meets all of the following conditions:

1. It is licensed to provide, and is engaged in providing, on an inpatient basis, for persons convalescing from illness or injury, professional nursing services, and physical restoration services to assist enrolled individuals to reach a degree of body functioning to permit self-care in essential daily living activities. Such services must be rendered by a Registered Nurse or by a Licensed Practical Nurse under the direction of a Registered Nurse.
2. Its services are provided for compensation from its enrolled individuals and under the full-time supervision of a physician or Registered Nurse.
3. It provides twenty-four (24) hour-a-day nursing services.
4. It maintains a complete medical record on each enrolled individual.
5. It is not, other than incidentally, a place for rest, a place for the aged, a place for drug addicts, a place for alcoholics, a place for custodial or educational care, or a place for the care of mental and nervous disorders.
6. It is approved and licensed by Medicare.

This term shall also apply to expenses incurred in an institution referring to itself as a skilled nursing facility, convalescent nursing facility, or any such other similar designation.

Facility

A healthcare institution, which meets all applicable state or local licensure requirements.

Generic Drug

A prescription drug that is generally equivalent to a higher-priced brand name drug with the same use and metabolic disintegration. The drug must meet all Federal Drug Administration (FDA) bioavailability standards and be dispensed according to the professional standards of a licensed pharmacist or physician and must be clearly designated by the pharmacist or physician as generic.

Health Care Management

A process of evaluating if services, supplies or treatment are medically necessary and appropriate to help ensure cost-effective care.

Health Care Management Organization

The individual or organization designated by the employer for the process of evaluating whether the service, supply, or treatment is medically necessary. The Health Care Management Organization is CoreSource, Inc.

Home Health Aide Services

Services which may be provided by a person, other than a Registered Nurse, which are medically necessary for the proper care and treatment of a person.

Home Health Care

Includes: skilled nursing visits and IV Infusion therapy for the purposes of pre-service claims only.

Home Health Care Agency

An agency or organization which meets fully every one of the following requirements:

1. Is primarily engaged in and duly licensed, if licensing is required, by the appropriate licensing authority, to provide skilled nursing and other therapeutic services.
2. Has a policy established by a professional group associated with the agency or organization to govern the services provided. This professional group must include at least one physician and at least one Registered Nurse. It must provide for full-time supervision of such services by a physician or Registered Nurse.
3. Maintains a complete medical record on each enrolled individual.
4. Has a full-time administrator.
5. Qualifies as a reimbursable service under Medicare.
**Hospice**

An agency that provides counseling and medical services and may provide *room and board* to a terminally ill *enrolled individual* and which meets all of the following tests:

1. Has obtained any required state or governmental Certificate of Need approval.
2. Provides service twenty-four (24) hours-per-day, seven (7) days a week.
3. Is under the direct supervision of a *physician*.
4. Has a Nurse coordinator who is a Registered Nurse.
5. Has a social service coordinator who is licensed.
6. Is an agency that has as its primary purpose the provision of *hospice* services.
7. Has a full-time administrator.
8. Maintains written records of services provided to the *enrolled individual*.
9. Is licensed, if licensing is required.

**Hospital**

An institution which meets the following conditions:

1. Is licensed and operated in accordance with the laws of the jurisdiction in which it is located which pertain to *hospitals*.
2. Is engaged primarily in providing medical care and treatment to *ill and injured* persons on an *inpatient* basis at the *enrolled individual's* expense.
3. Maintains on its premises all the facilities necessary to provide for the diagnosis and medical and surgical treatment of an *illness* or *injury*; and such treatment is provided by or under the supervision of a *physician* with continuous twenty-four (24) hour nursing services by or under the supervision of Registered Nurses.
4. Qualifies as a *hospital* and is accredited by the Joint Commission on the Accreditation of Healthcare Organizations. This condition may be waived in the case of *emergency* treatment in a *hospital* outside of the United States.
5. Must be approved by *Medicare*. This condition may be waived in the case of *emergency* treatment in a *hospital* outside of the United States.

Under no circumstances will a *hospital*, other than incidentally, be a place for rest, a place for the aged, or a nursing home.

*Hospital* shall include a facility designed exclusively for physical rehabilitative services where the *enrolled individual* received treatment as a result of an *illness* or *injury*.

**Illness**

A bodily disorder, disease, physical sickness, or *pregnancy* of an *enrolled individual*.

**Infertility**

A condition diagnosed by a *physician* resulting in the inability of a woman to conceive a pregnancy or carry a pregnancy to a live birth after unprotected sexual intercourse for at least twelve (12) months prior to the diagnosis.
**Incurred or Incurred Date**

With respect to a *covered expense*, the date the services, supplies or treatment are provided.

**Injury**

A physical harm or disability which is the result of a specific incident caused by external means. The physical harm or disability must have occurred at an identifiable time and place. *Injury* does not include *illness* or infection of a cut or wound.

**Inpatient**

A *confinement* of an *enrolled individual* in a *hospital*, *hospice*, or *extended care facility* as a registered bed patient, for twenty-three (23) or more consecutive hours and for whom charges are made for *room and board*.

**Intensive Care**

A service which is reserved for critically and seriously ill *enrolled individuals* requiring constant audio-visual surveillance which is prescribed by the attending *physician*.

**Intensive Care Unit**

A separate, clearly designated service area which is maintained within a *hospital* solely for the provision of *intensive care*. It must meet the following conditions:

1. Facilities for special nursing care not available in regular rooms and wards of the *hospital*;
2. Special life saving equipment which is immediately available at all times;
3. At least two beds for the accommodation of the critically ill; and
4. At least one Registered Nurse in continuous and constant attendance twenty-four (24) hours-per-day.

This term does not include care in a surgical recovery room, but does include cardiac care unit or any such other similar designation.

**Leave of Absence**

A period of time during which the *employee* does not work, but which is of a stated duration after which time the *employee* is expected to return to active work.

**Maximum Benefit**

Any one of the following, or any combination of the following:

1. The maximum amount paid by this *Plan* for any one *enrolled individual* for a particular *covered expense*. The maximum amount can be for:
   
   a. The entire time the *enrolled individual* is participating in this *Plan*, or
   b. A specified period of time, such as a calendar year.

2. The maximum number as outlined in the *Plan* as a *covered expense*. The maximum number relates to the number of:

   a. Treatments during a specified period of time, or
   b. Days of *confinement*, or
   c. Visits by a *home health care agency*.
**Medically Necessary (or Medical Necessity)**

Service, supply or treatment which is determined by the claims processor, named fiduciary for post-service claim appeals, named fiduciary for pre-service claim appeals, employer/Plan Administrator or their designee to be:

1. Appropriate and consistent with the symptoms and provided for the diagnosis or treatment of the enrolled individual’s illness or injury and which could not have been omitted without adversely affecting the enrolled individual’s condition or the quality of the care rendered; and

2. Supplied or performed in accordance with current standards of medical practice within the United States; and

3. Not primarily for the convenience of the enrolled individual or the enrolled individual’s family or professional provider; and

4. Is an appropriate supply or level of service that safely can be provided; and

5. Is recommended or approved by the attending professional provider.

The fact that a professional provider may prescribe, order, recommend, perform or approve a service, supply or treatment does not, in and of itself, make the service, supply or treatment medically necessary and the claims processor, named fiduciary for post-service claim appeals, named fiduciary for pre-service claim appeals, employer/Plan Administrator or their designee, may request and rely upon the opinion of a physician or physicians. The determination of the claims processor, named fiduciary for post-service claim appeals, named fiduciary for pre-service claim appeals, employer/Plan Administrator or their designee shall be final and binding.

**Medicare**

The programs established by Title XVIII known as the Health Insurance for the Aged Act, which includes: Part A, Hospital Benefits For The Aged; Part B, Supplementary Medical Insurance Benefits For The Aged; Part C, Miscellaneous provisions regarding both programs; and Part D, Medicare Prescription Drug Benefit, including any subsequent changes or additions to those programs.

**Mental Illness**

Includes, but is not limited to: schizophrenia, bipolar disorder, obsessive-compulsive disorder, major depressive disorder, panic disorder, panic disorder, anorexia nervosa, bulimia nervosa, schizo-affective disorder or delusional disorder.

**Morbid Obesity**

A diagnosed condition, defined as having a body mass index (BMI) that is greater than or equal to forty (40) kilos per meter squared, or as having a BMI greater than 35 kilos per meter squared and when two (2) or more co-morbidities exist. This definition does not apply to those under the age of 18.

**Named Fiduciary for Post-Service Claim Appeals**

*Health Benefit (excluding behavioral health) Claims:*
CoreSource

*Behavioral Health Claims:*
Quest

*Prescription Drug Claims:*
Express Scripts

**Named Fiduciary for Pre-Service Claim Appeals**

*Health Benefit (excluding behavioral health) Claims:*
CoreSource
Behavioral Health Claims:  
Quest

Prescription Drug Claims:  
Express Scripts

Negotiated Rate

The rate the preferred providers have contracted to accept as payment in full for covered expenses of the Plan.

Nonparticipating Pharmacy

Any pharmacy, including a hospital pharmacy, physician or other organization, licensed to dispense prescription drugs, which does not fall within the definition of a participating pharmacy.

Nonpreferred Provider

A physician, hospital, or other health care provider who does not have an agreement in effect with the Preferred Provider Organization at the time services are rendered.

Nurse

A licensed person holding the degree Registered Nurse (R.N.), Licensed Practical Nurse (L.P.N.), Licensed Vocational Nurse (L.V.N.) or Doctorate of Nursing Practice (D.N.P.) who is practicing within the scope of their license.

Outpatient

An enrolled individual shall be considered to be an outpatient if he is treated at:

1. A hospital as other than an inpatient;
2. A physician’s office, laboratory or x-ray facility; or
3. An ambulatory surgical facility; and

The stay is less than twenty-three (23) consecutive hours.

Partial Hospitalization

The provision of medically necessary psychological/psychiatric services in a structured therapeutic program which is provided on a planned and regularly scheduled basis for a minimum of three (3) hours, but less than twenty-four (24) hours in any one calendar day. Such programs provide intense therapeutic services for patients leaving an inpatient facility or in lieu of twenty-four (24) hour care. Partial hospitalization does not include: half-way houses, custodial care facilities, transitional living facilities or structured day programs for the treatment of chronic mental health conditions.

Participating Pharmacy

Any pharmacy licensed to dispense prescription drugs, which is contracted with the pharmacy benefit manager.

Personal Family Physician

A licensed Doctor of Medicine (M.D.) or Doctor of Osteopathy (D.O.) who is a family practitioner, pediatrician or general internist.

Pharmacy Benefit Manager

The pharmacy benefit manager is Express Scripts.
Physician

A Doctor of Medicine (M.D.) or a Doctor of Osteopathy (D.O.), other than a close relative of the enrolled individual, who is practicing within the scope of his license.

Placed For Adoption

The date the employee assumes legal obligation for the total or partial financial support of a child during the adoption process.

Plan

"Plan" refers to the benefits and provisions for payment of same as described herein. The Plan is the LG Select/LG Consumer Employee Health Benefit Program (The Plan).

Plan Administrator

The Plan Administrator is responsible for the day-to-day functions and management of the Plan. The Plan Administrator is the employer.

Plan Sponsor

The Plan Sponsor is Lancaster General Health.

Plan Year End

The Plan Year End is December 31.

Preferred Provider

A physician, hospital or other health care provider who has an agreement in effect with the Preferred Provider Organization at the time services are rendered.

Preferred Provider Organization

An organization who selects and contracts with certain hospitals, physicians, and other health care providers to provide services, supplies and treatment to enrolled individuals at a negotiated rate.

Pregnancy

The physical state which results in childbirth or miscarriage.

Privacy Rule


Professional Provider

A person or other entity licensed where required and performing services within the scope of such license.

Qualified Prescriber

A physician, dentist or other health care practitioner who may, in the legal scope of their license, prescribe drugs or medicines.
Reconstructive Surgery

Surgical repair of abnormal structures of the body, caused by congenital defects, developmental abnormalities, trauma, infection, tumors or disease.

Relevant Information

Relevant information, when used in connection with a claim for benefits or a claim appeal, means any document, record or other information:

1. Relied on in making the benefit determination; or
2. That was submitted, considered or generated in the course of making a benefit determination, whether or not relied upon; or
3. That demonstrates compliance with the duties to make benefit decisions in accordance with Plan documents and to make consistent decisions; or
4. That constitutes a statement of policy or guidance for the Plan concerning the denied treatment or benefit for the enrolled individual’s diagnosis, even if not relied upon.

Retail Health Clinic

A medical clinic located within a larger retail operation that offers convenient, general medical services to the public, that meets professionally recognized standards and complies with all licensing and other legal requirements that apply.

Retail health clinics are generally staffed by non-physician providers such as physician assistants or nurse practitioners who are able to provide basic treatment and write prescriptions. Retail health clinics shall not include specialty clinics, such as providers of eye care, or clinics offering care on a one-time or seasonal basis, such as clinics offering only flu vaccinations.

Room and Board

Room and linen service, dietary service, including meals, special diets and nourishments, and general nursing service. Room and board does not include personal items.

Semiprivate

The daily room and board charge which a facility applies to the greatest number of beds in its semiprivate rooms containing two (2) or more beds.

Specialist Physician

A licensed Doctor of Medicine (M.D.) or Doctor of Osteopathy (D.O.) who is other than a personal family physician.

Speech Therapy

Therapy intended to:

1. develop or improve speech after surgery to correct a congenital condition, which surgery was performed within the first five (5) years of life to correct a condition that would have impaired the ability to speak;
2. restore speech after a loss or impairment of a demonstrated, previous ability to speak; or
3. restore or develop speech that is diminished due to accident or episodic illness.
Telemedicine

Allows Lancaster General Health’s Physicians to evaluate, diagnose and treat patients from our Employee and Student Health Office on Duke Street using telecommunication technology.

Urgent Care

An emergency or an onset of severe pain that cannot be managed without immediate treatment.

Urgent Care Center

A facility which is engaged primarily in providing minor emergency and episodic medical care and which has:

1. a board-certified physician, a Registered Nurse (RN) and a registered x-ray technician in attendance at all times;
2. has x-ray and laboratory equipment and life support systems.

An urgent care center may include a clinic located at, operated in conjunction with, or which is part of a regular hospital.
NOTICE OF NON-DISCRIMINATION

Lancaster General Health complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. Lancaster General Health does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

Lancaster General Health:

Provides free aids and services to people with disabilities to communicate effectively with us, such as: Qualified sign language interpreters

Written information in other formats (large print, audio, accessible electronic formats, other formats)

Provides free language services to people whose primary language is not English, such as: Qualified interpreters

Information written in other languages

If you need these services, contact Jennifer Zeiders at 717-544-4578.

If you believe that Lancaster General Health has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with:

Jennifer Zeiders, Manager – Benefits
555 N Duke Street, PO Box 3555
Lancaster, PA 17604
717-544-4578, Fax 717-544-1351
Or email at jzeiders2@lghealth.org

You can file a grievance in person or by mail, fax, or email. If you need help filing a grievance, Jennifer Zeiders is available to help you.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or by mail or phone at:

U.S. Department of Health and Human Services
200 Independence Avenue, SW
Room 509F, HHH Building
Washington, D.C. 20201
1-800-368-1019, 800-537-7697 (TDD)
