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 of coverage on an individual basis, regardless of family enrollment. If the ***employee*** or ***dependent*** chooses to have 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 (60^{th}) 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 address shown on the ID card.

   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*** Trustmark Health Benefits 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 *Care*Champion (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), esophagogastroduodenoscopy, 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 Trustmark Health Benefits 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*** Trustmark Health Benefits 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.

APPEALING 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 allowable expenses ***incurred*** while enrolled under this ***Plan***, part or all of which would be covered 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 plan year or that portion of a plan year during which the ***enrolled individual*** for whom a claim is made has been covered under this ***Plan***.