Nazareth Area School District

EMPLOYEE HEALTHCARE BENEFIT PLAN
Employee Benefit Trust of Eastern PA

SUMMARY PLAN DESCRIPTION
AND
PLAN DOCUMENT

Claims Processed By:

NCAS® Pennsylvania
An Independent Licensee of the
Blue Cross and Blue Shield Association

Amended, March 2006

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INTRODUCTION

This is the Summary Plan Description (SPD)/Plan Document for the eligible Employees and designated Dependents of Nazareth Area School District. Terms of the Plan are set forth in this document. Interpretation of any specific provisions in the Plan is governed by this document.

For claim forms, enrollment forms and other general information, contact the Nazareth Business Office. For information regarding submission or payment of a claim, contact the Plan Claims Administrator:

NCAS Pennsylvania
Department 778975
Harrisburg, Pennsylvania 17177-8975
1-866-787-9872
www.ncaspa.com

Please read this SPD/Plan Document and keep it in a safe place for reference.

NAZARETH AREA SCHOOL DISTRICT

SCHEDULE OF BENEFITS

BASIC HOSPITAL FACILITY BENEFITS

Inpatient Hospital Room and Board	100% semi-private rate 120 days per period of disability
Inpatient Ancillary Services	100% 120 days per period of disability
Inpatient Mental/Nervous Conditions	100% 30 day maximum per calendar year
Partial Psychiatric Hospitalization	100% 60 days per calendar year
Outpatient Hospital Care	
Diagnostic Services	100% including one routine OBGYN visit and pap smear per calendar year. One routine mammogram per calendar year for Covered Persons age 40 and older. One Prostate Exam and one PSA test per calendar year for Covered Persons age 40 and older.
Surgical Care	100%
Emergency Accident Care	100% treated within 72 hours
Emergency Medical Care	100% treated within 24 hours

Note: The Schedule of Benefits is to be considered a guide for quick reference; it does not include a complete description of the benefit. Please refer to the appropriate benefit section for a complete description of coverage.

Therapy Services, including Radiation Therapy, Cardiac Therapy Chemotherapy, Dialysis, Dialysis Treatment Physical Therapy, Respiration Therapy	100%
Substance Abuse Rehabilitation	100%
Inpatient Hospital Services	30 days per 12-month period
Outpatient Hospital, or Partial Hospitalization Services	100% 30 days per 12-month period
Home Health Care	100% 30 visits per 12-month period
Skilled Nursing Facility	100% 60-day limit per occurrence. Each day counts as one-half day toward inpatient hospital limit per period of disability at the semi-private room rate
Rehabilitation Facility	100% 60-day limit per occurrence.
Hospice Care	100% $7,500 Lifetime maximum

BASIC SURGICAL AND MEDICAL BENEFITS

Inpatient Hospital Visits	100% (UCR)*
Surgery	100% (UCR)*
Maternity	100% (UCR)*

Note: The Schedule of Benefits is to be considered a guide for quick reference; it does not include a complete description of the benefit. Please refer to the appropriate benefit section for a complete description of coverage.

Diagnostic Services	100% including one routine OBGYN visit and pap smear per calendar year. One routine mammogram per calendar year for Covered Persons age 40 and older. One Prostate Exam and one PSA test per calendar year for Covered Persons age 40 and older.
Therapy Services, including Radiation Therapy, Dialysis Treatment, Chemotherapy, Physical Therapy, Shock Therapy	100% (UCR)*
Anesthesia	100% (UCR)*
Second Surgical Opinion	100% (UCR)*
Emergency Accident	100% (UCR)* treated within 72 hours
Emergency Medical	100% (UCR)* treated within 24 hours
Inpatient Mental/Nervous services	100%(UCR)* 30 day maximum per calendar year
Inpatient Drug and Alcohol services	100%(UCR)* 30 day maximum 12 month period

**** Denotes Usual, Customary and Reasonable Charges***

Note: The Schedule of Benefits is to be considered a guide for quick reference; it does not include a complete description of the benefit. Please refer to the appropriate benefit section for a complete description of coverage.

MAJOR MEDICAL BENEFITS

Calendar Year Deductible	$250 Individual, $500 Family Maximum
Coinsurance	
General Covered Medical Services	80%of first $2,000 then 100%
Inpatient Psychiatric Care	80% after basic limitations exceeded (120 day maximum)
Outpatient Psychiatric Treatment	50% UCR, 25 visits per calendar year maximum; 400 visits per lifetime maximum
Lifetime Maximum General Medical	$1,000,000.00

**** Denotes Usual, Customary and Reasonable Charges***

Note: The Schedule of Benefits is to be considered a guide for quick reference; it does not include a complete description of the benefit. Please refer to the appropriate benefit section for a complete description of coverage.

PRESCRIPTION DRUG BENEFITS

Retail – 1 to 30 days supply

Generic Co-pay	Brand Name Co-pay
$5.00	$10.00

Mail Order – 31-90 days supply

Generic Co-pay	Brand Name Co-pay
$10.00	$20.00

Note: The Schedule of Benefits is to be considered a guide for quick reference; it does not include a complete description of the benefit. Please refer to the appropriate benefit section for a complete description of coverage.

DENTAL BENEFITS

Calendar Year Dental Maximum	$1,500 per individual
Deductible (Does not apply to Preventive or Basic Services)	$10 per individual $30 per family
The Dental Program	Percentage Payable
Basic Dental	100%
Oral Surgery	100%
Periodontics	100%
Single Crowns, Inlays, Onlays	100% (one per tooth per 5 year period)

Note: The Schedule of Benefits is to be considered a guide for quick reference; it does not include a complete description of the benefit. Please refer to the appropriate benefit section for a complete description of coverage.

ELIGIBILITY/ENROLLMENT PROVISIONS

ELIGIBILITY

Those eligible to enroll for coverage are Employees and Retirees, in eligible classes as defined by the Employer, the Employee's spouse and unmarried children under twenty-five (25) years of age who are the Employee's children, including step-children, legally adopted children, children legally placed for adoption, foster children and other children who depend upon the employee for more then half of their support as defined by the Internal Revenue Code of the united States and have been reported as dependents on your most recent Federal Income Tax Return and currently qualify for dependency tax status. With respect to unmarried children participating in the Plan prior to attainment of age twenty-five (25) who are incapable of self-sustaining employment by reason of mental retardation or physical handicap, and who became so incapable prior to age twenty-five (25) and remain dependent chiefly upon the Employee for support and maintenance, Plan benefits will not terminate at age twenty-five (25) provided the Employee has, within thirty-one (31) days of the last day of the Plan Year in which the Dependent child's nineteenth birthday occurred, submitted proof of the incapacity in a form satisfactory to the Plan Administrator. The Plan may require proof of such disability from time to time. Children remain eligible for coverage until the end of the calendar year in which age twenty-five (25) is attained.

For a person who becomes a Dependent, other than a newborn, while the Employee is participating under the Plan, coverage shall become effective on the date the Dependent is acquired provided the Employee makes application through the Employer within sixty (60) days from the date the Dependent is acquired. If application is made later than sixty (60) days after the Dependent is acquired, coverage shall become effective on the first of the month following the date the application was submitted.

Newborn children will be considered a Dependent under this program for sixty (60) days immediately following birth. To continue coverage for the newborn beyond that date, application must be made by the Employee within the sixty (60) day period.

EFFECTIVE DATE OF EMPLOYEE COVERAGE

An Employee will be covered for a new benefit or a benefit increase upon hire date of employment and if the Employee satisfies all of the following:

(1) The Eligibility Requirement

(2) The Enrollment Requirements

A decrease in the level of an Employee’s benefits due to a change in class or earnings will take effect as of the date of the change.

WHEN EMPLOYEE COVERAGE TERMINATES

Employee coverage will terminate on the earliest of these dates:

(1) The date the Plan is terminated.

(2) The last day of the calendar month that follows the date the person ceases to be in one (1) of the Eligible Classes as defined by the Employer. (See the COBRA Continuation Option)

CERTIFICATES OF COVERAGE

If a Covered Person loses coverage under this Plan, he has a right to and will be provided with a Certificate of Coverage, which will indicate his beginning and ending dates of coverage. The Covered Person will use the Certificate of Coverage to document periods of creditable coverage when moving from coverage under this Plan to any other type of coverage. If the Covered Person does not receive a Certificate of Coverage, he should contact the Plan Administrator.

DEPENDENT COVERAGE

Eligibility Requirement for Dependent Coverage

A family member of an Employee will become eligible for Dependent Coverage on the first day that the Employee is eligible for Employee Coverage and the family member satisfies the requirements for Dependent Coverage.

At any time, the Plan may require proof that a spouse or a child qualifies or continues to qualify as a Dependent as defined by this Plan.

Requirements for Dependent Coverage

(1) Enrollment Requirements

An Employee may be required to enroll for Dependent Coverage. This enrollment is subject to the same enrollment rules shown under the Employee Coverage Provisions.

This item applies to enrollment of a newborn child for health care benefits after birth. For coverage during and beyond the first thirty-one (31) days after birth, enrollment must be made in that thirty-one (31) day period.

Effective Date of Dependent Coverage

A Dependent's Coverage will take effect on the day that:

(1) The Eligibility Requirement is met;

(2) The Employee is covered under the Plan; and

(3) All Enrollment Requirements are met.

When an Individual Dependent Becomes Covered for Benefits

A Dependent will first be covered for a new benefit on the date that all of these rules are met:

(1) The person is a Dependent and eligible for the new or increased coverage;

(2) The Employee is covered under this Plan;

(3) The Dependent's enrollment requirements of the Plan are met for the benefit.

When Dependent Coverage Terminates

A Dependent's Coverage will terminate on the earliest of:

(1) The date that the Employee's personal coverage under the Plan terminates for any reason (See the COBRA Continuation of Coverage);

(2) The date Dependent Coverage is terminated under the Plan;

(3) The date that the Employee ceases to have a Dependent as defined by the Plan (See the COBRA Continuation Option);

Loss of Dependent Status

Dependent Coverage will cease for a person on the first day of the month that follows the first date that he ceases to be a Dependent as defined by the Plan (See the COBRA Continuation Option.)

IDENTIFICATION CARDS

The Claims Administrator (NCAS) issues identification cards. In case of loss, replacement cards are requested through the Claim Administrator (NCAS) or the Employer.

CHANGE IN ELIGIBILITY TO HEALTH CARE PROGRAM

Promptly notify the Employer of any change in family status such as marriage, birth of child, the marriage of any children, death of spouse, divorces or change of address.

If marriage occurs after joining the Plan the spouse may be added as a Dependent effective on the date of marriage, if notice is given within thirty-one (31) days. If notice is received after thirty-one (31) days, coverage for the spouse will become effective on the first of the month following enrollment.

Coverage for employees, as defined in the fringe benefit packet designated by the Nazereth Area School District, their spouses and unmarried children under the age of twenty-five (25) years are eligible for enrollment. Children remain eligible for coverage under this plan until the end of the calendar year which twenty-five (25) is attained. Coverage will end at the end of the month when the full-time student turns twenty-five (25). Upon application to and acceptance by the Trust through the Administrator, your unmarried children beyond age twenty-five (25) who are permanently disabled and incapable of self-support because of a mental or physical handicap may be continued under the Trust Plan to any Age.

Also, promptly notify the Employer of any change in the Employee or Dependent's eligibility for health care programs, such as, disability insurance, workers' compensation, Medicare, CHAMPUS, etc.

RELEASE OF RECORDS

Through application for benefits, the Employee agrees to the release of medical records for review by the Plan Administrator.

FAMILY AND MEDICAL LEAVE ACT

Regardless of the established leave policies, this Plan shall at all times comply with the Family and Medical Leave Act (FMLA) of 1993 as promulgated in regulations issued by the Department of Labor.

During any leave taken under the Family and Medical Leave Act, the Employer will maintain coverage under this Plan on the same conditions as coverage would have been provided if the covered Employee had been continuously employed during the entire leave period.

If Plan coverage terminates during the FMLA leave, coverage will be reinstated for the Employee and his or her covered Dependents if the Employee returns to work in accordance with the terms of the FMLA leave. Coverage will be reinstated only if the person(s) had coverage under this Plan when the FMLA leave started, and will be reinstated to the same extent that it was in force when that coverage terminated.

QUALIFIED MEDICAL CHILD SUPPORT ORDERS

If an Employee, who is a Covered Person and who has a child or children, becomes divorced, and the child, or children, were not Covered Persons at the time of the divorce, they may become covered under the Plan. However, in order for the child to become covered the Plan Administrator must receive, from the court which has jurisdiction over the divorce, a Qualified Medical Child Support Order (QMCSO). The QMCSO must be in the proper form to be a valid QMCSO.

To be a valid QMCSO the court order must include the following information:

(1) The name and last known mailing address of the Covered Person through whom the child or children will receive benefits.

(2) The name and last known mailing address of each child who will be covered by the Plan.

(3) The name of the Plan the child or children will be covered by.

(4) A reasonable description of the type of coverage to be provided by the Plan or the manner in which such type of coverage is to be determined.

(5) The period to which such order applies, and

(6) The QMCSO must be signed by the Judge, Commissioner or Magistrate who is presiding over the divorce.

The QMCSO may not require the Plan to provide any type or form of benefit, or any benefit option, not otherwise provided under the Plan, except to the extent necessary to meet the requirements of Section 1908 of the Social Security Act.

If the QMCSO does not contain the proper information, benefits will not be extended until a QMCSO which meets the information requirements is presented to the Plan Administrator. However, if a QMCSO is returned to the Covered Person for lack of information or for provision of benefit reasons there will be an opportunity to provide a corrected order. However, a corrected order must be provided within ninety (90) days of the initial order or coverage will be denied. If a corrected order is timely provided coverage will begin on the date of the earliest order.

Under a QMCSO the fact that the child is eligible for, is entitled to, or is provided benefits under Title XIX of the Social Security Act, will not affect the child or children's receipt of benefits under the QMCSO.

ADOPTED CHILDREN

Children who are placed with a Covered Person for adoption are eligible for coverage at the time they are placed. The Plan may not restrict coverage under the Plan of any Dependent child adopted by a Covered Person or beneficiary, or placed with a Covered Person or beneficiary for adoption, if the adoption or placement for adoption occurs while

the Covered Person or beneficiary is eligible for coverage under the plan.

Definitions: For purposes of this section –

a) Child: The term "child" means, in connection with any adoption, or placement for adoption, of the child, an individual who has not attained age eighteen (18) as of the date of such adoption or placement for adoption.
b) Placement for Adoption: The term "placement" or being "placed" for adoption, in connection with any placement for adoption of a child with any person, means the assumption and retention by such person of a legal obligation for total or partial support of such child in anticipation of adoption of such child. The child's placement with such person terminates upon the termination of such legal obligation.

COST MANAGEMENT SERVICES

CLINICAL MANAGEMENT:

To initiate the Preauthorization process a Covered Person must present to the Provider his or her Identification Card, or call : 1-800-471-2242.

PREAUTHORIZATION SERVICES

Preauthorization is a program designed to help ensure that all Covered Persons receive medically necessary and appropriate care while avoiding unnecessary expenses.

When a Covered Person is scheduled to receive services for any of the procedures listed as procedures recommended for Preauthorization, the Clinical Management Department should be contacted in order to review the medical necessity and appropriateness of the procedures being planned. The Preauthorization program is set in motion by a telephone call from the Covered Person or his or her attending Physician. The Clinical Management Department will review the details of the case with the attending physician and will recommend a second or third opinion if subsequent review is warranted. Approval for services should be obtained prior to the service being rendered to the Covered Person. If such prior approval is not obtained or is not followed and the Covered Person undergoes the procedure, then the Plan will pay for those services according to the Schedule of Benefits set forth in the Plan Document.

The following procedures, regardless of whether they are performed as an Inpatient or Outpatient, are recommended for Preauthorization. The Schedule of Benefits set forth in the Plan Document determines final determination of payment.

- All elective and emergency inpatient Facility admissions including Acute Care Hospitals, Skilled Nursing Facilities, Rehabilitation Hospitals and Mental Health and Substance Abuse Partial Hospitalization**.**

- Psychiatric Hospital and Substance Abuse Treatment partial hospitalization.

- Air Ambulance/Air Transport and Non-Emergency Ground Transport between Facilities (expect accident site to facility transport or NICU transport).

- Any reconstructive surgery for the treatment of a medical disease, injury, accident or congenital anomaly.

- Outpatient rehabilitation therapies including physical therapy, occupational therapy, speech therapy and spinal manipulations. Preauthorization is recommended for rehabilitation therapies after the initial six (6) visits in order to ensure that the care being provided is and continues to be medically necessary and appropriate. The completion of a treatment plan may be required for

authorization of Outpatient rehabilitation therapies beyond the initial six (6) visits.

- Home Health Care/Home Infusion Therapy. A treatment plan is recommended for review and preauthorization following the first two (2) visits of home health care or home infusion therapy.

- Durable medical equipment with an estimated cost of greater than three hundred ($300) dollars per item.

- Transplant evaluation and services. Preauthorization will include referral assistance to the Blue Quality Centers for Transplant network if appropriate.

The purpose of the program is to determine what is medically necessary and appropriate and not to determine what is payable under the Plan. The program is not designed to be a substitute for the medical judgment of the attending Physician or other health care provider. The Clinical Management Department will determine the number of days of Medical Care Facility confinement authorized for payment.

Preauthorization of scheduled elective admissions and selected outpatient services should be obtained at least seven (7) days prior to the date of service. If services are provided on an emergency basis, authorization should be obtained within forty-eight (48) hours or within two (2) business days following such services.

Preauthorization recommendations do not apply to services provided by a Hospital Emergency Room Provider. In the event an inpatient admission results for an emergency room visit, the Hospital that is a Participating Provider or the Covered Person or responsible party acting on behalf of the Covered Persons if the Hospital is not a Participating Provider should obtain Preauthorization within forty-eight (48) hours or two (2) business days of the admission.

CONCURRENT REVIEW AND DISCHARGE PLANNING

Concurrent review of a course of treatment and discharge planning from a Medical Care Facility are parts of the Clinical Management program. A Clinical Management Coordinator will monitor the Covered Person's Medical Care Facility stay or use of other medical services and coordinate with the attending Physician, Medical Care Facilities and Covered Person, either the scheduled release or an extension of the Medical Care Facility stay or extension or cessation of the use of other medical services.

SECOND AND/OR THIRD OPINION PROGRAM

Certain surgical procedures are performed either inappropriately or unnecessarily. In some cases, surgery is only one of several treatment options. In other cases, surgery will not help the condition.

In order to prevent unnecessary or potentially harmful surgical treatments, the second and/or third opinion program fulfills the dual purpose of protecting the health of the Plan's Covered Persons and protecting the financial integrity of the Plan.

Benefits will be provided for a second (and third, if necessary) opinion consultation to determine the Medical Necessity of an elective surgical procedure. An elective surgical procedure is one that can be scheduled in advance; that is, it is not an emergency or of a life-threatening nature.

The patient may choose any board-certified specialist who is not an associate of the attending Physician and who is affiliated in the appropriate specialty.

CASE MANAGEMENT

Case Management is a program whereby a case manager monitors patients and explores, discusses and recommends coordinated and/or alternate types of appropriate Medically Necessary care. The case manager consults with the patient, the family and the attending Physician in order to develop a plan of care for approval by the patient's attending Physician and the patient. This plan of care may include some or all of the following:

-- personal support to the patient;

-- contacting the family to offer assistance and support;

-- monitoring Hospital or Skilled Nursing Facility;

-- determining alternative care options; and

-- assisting in obtaining any necessary equipment and services.

Case Management occurs when this alternate benefit will be beneficial to both the patient and the Plan.

The case manager will coordinate and implement the Case Management program by providing guidance and information on available resources and suggesting the most appropriate treatment plan. The Plan Administrator, attending Physician, patient and patient's family must all agree to the alternate treatment plan. Once agreement has been Reached, the Plan Administrator will direct the Plan to reimburse for Medically Necessary expenses as stated in the treatment plan, even if these expenses normally would not be paid by the Plan.

Note: Case Management is a voluntary service. There are no reductions of benefits or penalties if the patient and family choose not to participate.

Each treatment plan is individually tailored to a specific patient and should not be seen as appropriate or recommended for any other patient, even one with the same diagnosis.

BASIC HOSPITAL BENEFITS

FACILITY PROVIDER

A participating facility provider is a licensed Hospital or other Provider in the Blue Cross Network which is primarily engaged in providing diagnostic and/or therapeutic care for the medical diagnosis and treatment of injured and sick persons. Other eligible facilities include:

Ambulatory Surgical Facility
Birthing Facility
Freestanding Dialysis Facility
Freestanding Outpatient Facility
Home Health Care Agency
Hospice
Psychiatric Hospital
Rehabilitation Hospital
Substance Abuse Treatment Facility

INPATIENT HOSPITAL SERVICES

When a Covered Person is admitted for Medically Necessary treatment as an inpatient to a Hospital, he is eligible for the following benefits:

- Semi-private room and board including special diets. The average semi-private room rate will be allowed toward the charge for a private room, unless a private room is Medically Necessary. If Medically Necessary, the private room will be covered equal to the charge of the lowest priced private accommodations.
- Specialty bed accommodations
- General nursing care
- Use of operating, delivery, recovery, treatment and other specialty service rooms, and equipment/supplies.
- Prescribed drugs
- Dressings, medical and surgical supplies, splints, and casts.

The following services are also covered when the service is provided and billed by the Hospital or Facility Provider:

- Diagnostic services
- Therapy services (including shock therapy).
- Anesthesia, anesthesia supplies and services rendered by an Employee of the Hospital or Facility Provider.

- Oxygen and administration of oxygen.
- Administration of blood and blood plasma (but not the blood or blood plasma).
- Transplant services to a recipient when recipient is enrolled in this Plan (charges for organs or bones are excluded).
- Pre-admission testing required in connection with an inpatient admission when rendered prior to a scheduled admission and not performed to establish a diagnosis.
- Local inter-hospital ambulance service billed by the facility when used to transport a participant between hospitals if the required care is not available at the first hospital.

INPATIENT ADMISSIONS FOR PHYSICAL REHABILITATION

Immediately following an acute care hospitalization is limited to sixty (60) days per occurrence, subject to utilization review.

INPATIENT CARE FOR MENTAL AND NERVOUS DISORDERS

When a Covered Person is admitted for Medically Necessary treatment as an inpatient to a Hospital for treatment of Mental/Nervous disorders including drug addiction or alcoholism, benefits will be eligible as with any other Sickness subject to the benefit limitations as outlined in the Schedule of Benefits.

PARTIAL HOSPITALIZATION FOR PSYCHIATRIC SERVICES

Partial psychiatric hospitalization is a medically-supervised treatment program designed for patients with psychiatric or emotional disorders who do not require 24-hour care, but who require more intensive treatment that is ordinarily offered on an Outpatient basis.

The Plan covers sixty (60) days of care per Calendar Year in an approved program. This benefit is part of and not in addition to the benefit for Inpatient psychiatric care.

BENEFIT PERIOD AND RENEWAL INTERVAL

Inpatient Hospitalization per distinct period of disability is covered for either Medical or Mental/Nervous conditions as set forth in the Schedule of Benefits. In determining when one (1) period of disability ends and a new one begins, all Hospital confinements are considered as having occurred during one (1) continuous period of disability unless evidence acceptable to the Plan Administrator is furnished that;

(1) The latest hospital confinement is due to causes entirely unrelated to the causes of all previous confinements: or

(2) Each participant, including the employee, spouse and unmarried children,

shall be entitled to one hundred twenty (120) inpatient days during each benefit period. The total number of days may be used for one or several hospital or approved facility stays. Whenever ninety (90) days or more have elapsed since the last discharge and his/her next admission, his/her new "benefit period" begins and 120 days are again available.

MATERNITY BENEFITS

Coverage for charges related to the care and treatment of Pregnancy are covered the same as any other Sickness. Maternity benefits are available to eligible Employees, spouses and Dependent daughters. Coverage is provided for birthing centers.

Maternity Hospital services also include concurrent services in Hospital for the newborn child or children who are dependents.

Under Federal law, the Plan cannot restrict benefits for any hospital length of stay in connection with childbirth for the mother or the newborn child(ren) to less than forty-eight (48) hours following a normal vaginal delivery, or less than ninety-six (96) hours following a cesarean section; or require that a provider obtain authorization from the Plan or insurance issuer for prescribing a length of stay not in excess of the above stated periods.

DENTAL CARE

The inpatient hospital services of this Program are covered for dental care when the Participant is hospitalized for dental or oral surgery necessary for the treatment of fractures and/or dislocations of the jaw, and for the extraction of teeth partially or totally covered by bone. Other dental processes are not covered unless inpatient hospital or approved facility services are required to safeguard the health of the Participant from the effect of dentistry because of a specific non-dental organic impairment.

TRANSPLANT SERVICES

Human organ and tissue transplant services, including the Covered Services for the removal of an organ from a donor, are covered for the recipient and for a donor who is not a Covered Person and not covered under another health care plan.

OUTPATIENT HOSPITAL/FACILITY SERVICES

Surgery

Surgical services, including charges for use of the facility and supplies, provided in the outpatient department of an approved facility are covered.

Oral Surgery

Charges for the care of the mouth, teeth, gums and alveolar processes will be covered charges when provided in the outpatient department of an approved facility only if that care is for the following oral surgical procedures:

(1) Excision of tumors and cysts of the jaws (not relating to supporting tooth structures) cheeks, lips, tongue, roof and floor of mouth when a lab exam is required.

(2) Emergency repair due to injury to sound natural teeth. This repair must be made and the accident must have occurred while the person was covered under the Plan.

(3) Surgery needed to correct accidental injuries to the jaws, cheeks, lips, tongue, floor and roof of the mouth when the injuries occurred while the person was covered under the plan.

(4) Excision of benign bony growths of the jaw and hard palate not related to supporting tooth structures excluding procedures performed for the preparation of the mouth for dentures.

(5) External incision and drainage of cellulitis.

(6) Incision of sensory sinuses, salivary glands, or ducts.

(7) Surgical removal of impacted teeth which are partially or totally covered by bone.

Emergency Accident Care

Emergency care for the initial treatment and follow up of traumatic bodily injuries resulting from an accident are covered. Treatment must be rendered within seventy-two (72) hours of the accident. This benefit includes all necessary follow-up care to a Provider.

Emergency Medical Care

If a Covered Person requires emergency medical care, benefits of this Plan are provided for the initial treatment within twenty-four (24) hours of the onset of the medical emergency.

"Medical Emergency" means a sudden onset of a condition with acute symptoms requiring immediate medical care and includes such conditions as heart attacks, cardiovascular accidents, poisonings, loss of consciousness or respiration, convulsions or other such acute medical conditions as determined to be medical emergencies by the Claims Administrator.

Diagnostic Services

Charges for outpatient diagnostic medical services made for the diagnosis of disease or injury, in addition to the laboratory and x-ray expense benefits as described below, are covered.

- One (1) routine screening pap test per calendar year.
- One (1) routine gynecological exam per calendar year.
- One (1) prostrate exam per calendar year for Participants forty (40) and older.
- One (1) routine screening mammogram per calendar year for Participants forty (40) years of age and older.
- One (1) routine PSA test per calendar year for Participants forty (40) and older.

PREADMISSION TESTING (PAT)

Tests and studies required in connection with the Covered Person's admission rendered or accepted by a Hospital on an outpatient basis prior to a scheduled admission are eligible. Preadmission testing does not include tests or studies performed to establish a diagnosis. Benefits apply only if the services are not repeated when the Covered Person is admitted to the Hospital as an inpatient.

Therapy Services

Therapy services are covered following a disease or Injury until the Covered Person reaches a maximum potential improvement.

_ Radiation Therapy
_ Chemotherapy
_ Cardiac Therapy
_ Dialysis Treatment
_ Physical Therapy
_ Shock Therapy
_ Respiration Therapy

SUBSTANCE ABUSE DETOXIFICATION

Detoxification services provided in a Substance Abuse Treatment Facility are covered as part of the inpatient Hospital benefit.

SUBSTANCE ABUSE REHABILITATION

Rehabilitative services in a Substance Abuse Treatment Facility are covered. To be a covered service, the patient must be ambulatory and detoxified, and the admission must be voluntary

Treatment for drug abuse and/or Alcoholism

Benefits are available for thirty (30) days of Inpatient care per twelve (12) month period. Two (2) days care in a Substance Abuse Treatment Facility shall count as one day of Inpatient Hospital Care and will be deducted from the number of Inpatient Hospital days available.

Covered Services

Inpatient services for treatment of substance abuse and/or alcoholism

(1) Bed, board and general nursing services.

(2) Ancillary Services:

- Drug, biologicals, and solutions when dispensed by the Facility;
- Supplies and equipment required for rehabilitation;
- Counseling for the patient and family, psychotherapy, psychological testing or other services provided by qualified employees of the facility when such services are necessary for patient care and treatment;
- Diagnostic services.

(3) Outpatient or partial hospitalization for treatment of drug abuse and/or alcoholism.

- Nursing services provided by an R.N. or L.P.N.;
- Diagnostic services;
- Take-home drugs that under federal law only may be dispensed by written prescription and which are provided for general use by the Food and Drug Administration which are dispensed to an Outpatient on days when psychotherapy is provided;
- Counseling for the patient, psychotherapy, and psychological

testing; and

- Family counseling visits with family members to assist in the patient's diagnosis and treatment.

SKILLED NURSING FACILITY CARE

Benefits will be provided when room and board and skilled nursing services are provided in an approved skilled nursing facility and are combined with other necessary therapeutic services and supplies in accordance with generally accepted medical standards to establish a program of medical treatment subject to Benefit Maximums as outlined in the Schedule of Benefits. Benefits will be payable if and when:

- The patient is confined as a bed patient in the facility:

- The attending physician certifies that the confinement is needed for further care of the condition that caused the hospital confinement.

Custodial care which consist of services and supplies including room and board and other institutional services furnished to an individual primarily to assist him in activities of daily livings, whether or not he/she is disabled is not covered. The need for skilled nursing facility care must be certified by patient's attending physician.

HOME HEALTH CARE SERVICES

Benefits are provided for home health care visits by a Home Health Care Agency as an alternative to inpatient Hospital care as specified in the Schedule of Benefits.

Home health care services include such benefits as: nursing service, dietitian services, physical therapy, occupational therapy, speech therapy, inhalation therapy, Durable Medical Equipment and Prescription Drugs for the condition being treated and dressings and medical supplies.

The following services are not covered:

(1) Homemaker services;

(2) Custodial Care;

(3) Food or home delivered meals.

HOSPICE CARE

For a terminally ill patient, services can be provided in the home by a Hospice Agency up to the maximum benefit shown on the Schedule of Benefits.

The services provided under this Plan include medical care by a Physician affiliated with the Hospice, nursing service, therapy services except for dialysis treatments, medical and

surgical supplies and Durable Medical Equipment, prescribed drugs (drugs and biologicals), oxygen and its administration, medical social service consultations, dietitian services, home health aide services, and family counseling services.

Benefits are not provided for medical care rendered by a private Physician, volunteers who do not regularly charge for services, pastoral services, homemaker services, food or home delivered meals, or Hospice inpatient services except for respite care.

If curative treatment or extraordinary measures are elected to sustain life, eligibility to receive further Hospice benefits cease.

BASIC SURGICAL AND MEDICAL BENEFITS

When a Covered Person is ill or injured, the Plan helps pay for Covered Services by a Professional Provider who is a person or practitioner licensed where required and performing services within the scope of such license. These Professional Providers are:

Audiologist
*Certified Clinical Nurse Specialist
*Certified Community Health Nurse
*Certified Enterostomal Therapy Nurse
*Certified Psychiatric Mental Health Nurse
*Certified Registered Nurse Anesthetist
*Certified Registered Nurse Practitioner
Chiropractor
Clinical Laboratory
Dentist
Doctor of Medicine
Nurse Midwife
Optometrist
Osteopath
Physical Therapist
Podiatrist
Psychologist
LSW/MSW
Speech Language Pathologist
Teacher of the Hearing Impaired

*Excluded from eligibility are registered professional nurses employed by a health care facility or by an anesthesiology group.

CAPITAL BLUE CROSS PHYSICIAN NETWORK

This Plan is a plan which offers a Network Provider Organization.

This Plan has entered into an agreement with certain Hospitals, Physicians and other health care providers, which are called Participating Network Providers. Network Providers have agreed to charge reduced fees to persons covered under the Plan. It is the Covered Person's choice as to which Provider to use.

Payment for Covered Services performed by Participating Professional Providers will be made to the Professional Provider for the negotiated fee for the amount charged, at the rate shown in the Schedule of Benefits. Participating Professional Providers are those providers who have contracted with Capital Blue Cross and Capital Advantage Insurance Company Network in Pennsylvania or who are participating Blue Shield providers in other states.

A Participating Professional Provider must accept the negotiated fee allowance as payment in full for Covered Services. The Covered Person is responsible for any Deductible, Coinsurance, and amounts exceeding the maximum or for any services which are not covered. The sum of the Covered Person's payment and the Plan's payment will be accepted as payment in full provided that the Covered Person's payment is made to the Participating Professional Provider within 60 days of notification by the Plan. If the Covered Person's payment is not made within 60 days, the Participating Provider may bill the Covered Person the difference between the charge and the Usual, Customary and Reasonable (UCR) allowance.

Payment for Covered Services by Non-Participating Professional Providers will be made to the Covered Person at the rate shown in the Schedule of Benefits, of the UCR allowance or the amount charged, whichever is less. Such payment will constitute full discharge of the Plan's liability. Professional Providers are not obligated to accept the UCR allowance as payment in full. The Covered Person is responsible for payment of any remaining charges.

A list of Capital Blue Cross Physicians is available on line at www.capbluecross.com. If you do not have access to the Internet you can call 1-800-962-2242.

PAYMENT OF BENEFITS

Usual, Customary and Reasonable (UCR) Method

Usual, Customary and Reasonable (UCR) means that a fee is determined and payable by the Plan Administrator (using UCR tables developed by Medical Data Research) under the direction of the Plan, for Covered Services as follows:

- The Usual Fee is the fee which an individual Professional Provider most frequently charges the majority of patients for the procedure performed.

- The Customary Fee is the fee determined on charges made by most Professional Providers of the same specialty in comparable geographic/economic areas for the procedure performed.

- The Reasonable Fee (which may differ from the usual or customary charge) is the fee determined by considering unusual clinical circumstances; the degree of professional involvement; or the actual cost of equipment and facilities involved in providing the service.

Payment for Covered Services performed by Participating Professional Providers will be made to the Professional Provider on the basis of 100% of the negotiated fee or the amount charged, whichever is less. Participating Professional Providers are those

providers who have contracted with Capital Blue Cross for the Capital Blue Cross Provider Network in Pennsylvania or who are participating Blue Shield providers in other states.

A Participating Professional Provider must accept the negotiated fee allowance as payment in full for Covered Services. The Covered Person is responsible for any Deductible or amounts exceeding the maximum or for any services which are not covered. The sum of the Covered Person's payment and the Plan's payment will be accepted as payment in full provided that the Covered Person's payment is made to the Participating Professional Provider within sixty (60) days of notification by the Plan. If the Covered Person's payment is not made within sixty (60) days, the Participating Provider may bill the Covered Person the difference between the charge and the UCR allowance.

Payment for Covered Services by Non-Participating Professional Providers will be made to the Covered Person on the basis of 100% of the UCR allowance or the amount charged, whichever is less. Such payment will constitute full discharge of the Plan's liability. Non-Participating Professional Providers are not obligated to accept the UCR allowance as payment in full. The Covered Person is responsible for payment of any remaining charges.

SURGERY

Surgery is covered when rendered for the treatment of disease or Injury. Separate payment will not be made for inpatient pre-operative care or any post-operative care normally provided by the surgeon as part of the surgical procedure.

A. In the same operative field – The Plan shall pay 100% of the UCR level for the highest paying procedure and no allowance will be made for additional procedures except where the Claims Administrator deems that an additional amount is warranted.

B. In separate operative fields and through separate incisions – The total payment for all such procedures shall not exceed the maximum payment for the highest paying procedure, plus 50% of the maximum payment for each of the other operations, unless otherwise specified.

C. Bilateral surgical procedures performed in separate operative fields – The total payment for both procedures shall not exceed 150% of the maximum UCR allowance for the single procedure, unless an additional amount is deemed warranted by the Claims Administrator.

Operations for cosmetic purposes are not covered except those performed to correct a condition resulting from a birth defect or an accident which occurs while the person is covered by the Plan. The person must be enrolled without interruption from the date of the accident to the date of the operation in order for cosmetic surgery to be eligible under the Plan. Also covered are elective sterilization, but not reversals, and routine neonatal circumcision, occurring on or after the effective date of this coverage.

ORAL SURGERY

Charges for the care of the mouth, teeth, gums and alveolar processes will be covered charges under Surgical/Medical Benefits only if that care is for the following oral surgical procedures:

(1) Excision of tumors and cysts of the jaws (not relating to supporting tooth structures) cheeks, lips, tongue, roof and floor of mouth when a lab exam is required.

(2) Emergency repair due to injury to sound natural teeth. This repair must be made and the accident must have occurred while the person was covered under the Plan.

(3) Surgery needed to correct accidental injuries to the jaws, cheeks, lips, tongue, floor and roof of the mouth when the injuries occurred while the person was covered under the plan.

(4) Excision of benign bony growths of the jaw and hard palate not related to supporting tooth structures excluding procedures performed for the preparation of the mouth for dentures.

(5) External incision and drainage of cellulitis.

(6) Incision of sensory sinuses, salivary glands, or ducts.

(7) Surgical removal of impacted teeth which are partially or totally covered by bone.

ASSISTANT SURGERY

Services of an assistant surgeon who actively assists the operating surgeon are covered when the condition of the patient or the type of surgery performed requires assistance, as determined by the Plan Administrator. Such services will be provided only when the Hospital does not employ interns, residents, or house staff.

Surgical assistance is not covered when performed by a provider who himself performs and bills for another surgical procedure during the same operative session.

ANESTHESIA

Benefits are provided for the administration of anesthesia in connection with Covered Services. The anesthesia must be administered by a physician or certified nurse anesthetisit (or performed in the presence of an and under the supervision of a physician) and billed for by a the physician or his assistant.

Anesthesia services consist of the administration of an anesthetic agent or anesthetic drug by injection or inhalation. Administration of local infiltration anesthetic is not covered.

MATERNITY

Maternity services, including pre-natal and post-natal care, performed by a licensed physician or licensed nurse midwife is covered for all females. Pregnancy will be treated as any other condition, illness or disease.

ROUTINE NEWBORN CARE

Professional visits of a Professional Provider to examine the newborn while the mother is an inpatient in a Hospital or Birthing Center are covered.

INPATIENT MEDICAL CARE

This benefit applies when a medical charge is incurred for the care of a Covered Person's Injury or Sickness during a hospital confinement that starts while the person is covered under the Plan.

A medical charge is the Usual, Customary and Reasonable Charge of a Physician for medical care performed while the Covered Person is hospital confined.

INPATIENT PSYCHIATRIC CARE

Treatment of Mental Illness including visits for drug addiction or Alcoholism rendered by a Professional Provider in charge of the case to a Covered Person who is an inpatient in a Hospital. Such care is available for thirty (30) days in a calendar year. All psychiatric visits are applied toward the benefit period of one-hundred twenty (120) days available for inpatient care.

SKILLED NURSING CARE VISITS

Inpatient skilled nursing care benefits are covered subject to a limit of two (2) visits the first week of confinement and one visit a week for each consecutive week of confinement thereafter. Coverage is available for the period of confinement covered under the basic skilled nursing facility benefit.

A. The Covered Person's illness or Injury requires at least three (3) days of Hospitalization;

B. The Covered Person's condition requires skilled nursing care for continued treatment; and

C. The Covered Person is admitted to the Skilled Nursing Facility within fourteen (14) days following discharge from an accredited Hospital.

INPATIENT CONSULTATIONS

Inpatient consultations are covered if the condition requires it and the Professional Provider in charge of the case requests the consultation. There is a limit of one (1) consultation per consultant during any one (1) inpatient stay.

SECOND SURGICAL OPINION

A second opinion consultation is covered to determine the medical necessity of an elective surgical procedure. Elective surgery is that surgery which is not of an emergency or life threatening nature.

Such services must be performed and billed for by a Professional Provider other than the consultant who provided the patient with the initial surgical consultation. One (1) additional consultation, as a third opinion, is eligible in cases where the second opinion disagrees with the first recommendation.

CONCURRENT CARE

Inpatient medical care rendered by a Professional Provider who is not in charge of the case but whose particular skills are required for the treatment of complicated conditions is covered. This does not include observation or reassurance of the patient, standby services, routine pre-operative physical examinations or medical care routinely performed in the pre-operative or post-operative or pre-natal or post-natal periods.

DIAGNOSTIC SERVICES

The following diagnostic services required to determine a definite condition or illness are covered:

- **A.** Diagnostic radiology, consisting of X-ray, ultrasound and nuclear medicine.
- **B.** Diagnostic medical, consisting of ECG, EEG, and other diagnostic medical procedures approved to diagnose a condition or disease.
- **C.** Diagnostic laboratory, consisting of pathology tests performed, billed for, or ordered by a Professional Provider. This includes one routine pap smear per calendar year. There is no limit on pap smears that are medically necessary.
- **D.** Allergy testing.

CONVULSIVE THERAPY

Convulsive therapy including anesthesia for electroshock therapy is covered.

EMERGENCY ACCIDENT CARE

Benefits provided following an accidental injury, if emergency treatment is rendered within seventy-two (72) hours. This includes all medically necessary follow-up care.

These benefits will not be provided if any other benefit of this program is payable. For

example: If the accident services are classified as Surgery (suturing, fracture care, etc.) payment will be made as a surgical benefit.

EMERGENCY MEDICAL CARE

Coverage is provided for the initial treatment of emergency medical services performed within twenty-four (24) hours.

Medical emergency is a sudden onset of a medical condition with acute symptoms of severity that the absence of immediate medical attention could result in;

A. Permanently placing the patient's health in jeopardy,
B. Causing other serious medical consequences,
C. Causing serious impairment to bodily functions,
D. Causing serious and permanent dysfunction of any body part.

TRANSPLANT SERVICES

Coverage is provided for human organ or tissue transplants incurred by the Participant as a recipient as long as the transplant is not considered Experimental or Investigational. Covered expenses incurred by the donor of an organ or tissue transplant are covered the same way as any other sickness when the donor is a Participant under this Plan.

Covered expenses incurred by the donor of an organ or tissue transplant when the donor is not a Participant under this Plan are covered to the extent of any benefits remaining after payment of the Participants expenses as a recipient, when the donors expenses are not covered under any group or individual medical policy or benefit plan are charged to the recipient.

Covered expenses include organ or tissue procurement from a cadaver consisting of removal and transporting the donated part; services and supplies furnished by a Facility Provider; treatment and surgery by a Professional Provider and drug therapy treatment to prevent rejection of the transplanted organ or tissue.

If an organ or tissue is sold rather then donated, no benefit will be available for the purchase price of such organ or tissue.

THERAPY SERVICES

A. Radiation Therapy - The cost of radioactive material and therapy is covered.

B. Chemotherapy - For a Covered Person who is an inpatient or outpatient is covered, including the cost of the drugs approved by the Food and Drug Administration (FDA) as anti-neoplastic agents.

C. Physical Therapy – Benefits are provided for physical therapy services when performed and billed for by a doctor. Physical therapy is the

diagnosis and treatment of injury or illness with the aid of physical agents such as light, heat, cold, water and electricity or with mechanical apparatus. Physical therapy is subject to utilization review. Occupational therapy would not be covered.

D. Dialysis Treatment is covered.

PREVENTIVE SERVICES

Preventive services are covered when performed and billed for by a Professional Provider. "Preventive Services" generally describe health care services performed to detect the early warning signs or avoid certain health problems. These services are performed when the Covered Person has no symptoms of Illness or evidence of disease. Refer to Schedule of Benefits for payment levels.

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Routine Mammography

Benefits are provided for one (1) screening mammography per Calendar Year for females forty (40) years of age and older. For females under age forty (40), all Physician-recommended mammograms are covered.

Benefits for mammography screening are payable only if performed by a mammography service Provider which is properly certified by the Department of Health in accordance with the Mammography Quality Assurance Act of 1992.

Routine Papanicolaou Test and Gynecological Examination

Benefits are provided for one (1) routine Papanicolaou Test and one (1) routine gynecological examination including a pelvic examination and clinical breast examination, per Calendar Year for all females.

Benefits for one (1) routine Papanicolaou Test and one (1) routine gynecological examination are not subject to Deductible, Coinsurance and maximum amounts.

PSA Test

Benefits are provided for one (1) routine PSA Test per Calendar year for member's age 40 and older.

Prostate Exam

Benefits are provided for one (1) routine Prostate exam per Calendar year for member's age 40 and older.

MAJOR MEDICAL BENEFITS

Major Medical Benefits apply when covered charges are incurred by a Covered Person for care of an Injury or Sickness and while the person is covered for these benefits under the Plan.

BENEFIT PERIOD

The Major Medical Benefit Period is a Calendar Year.

DEDUCTIBLE

Deductible Amount

This is an amount of covered charges for which no benefits will be paid. Before benefits can be paid in a Calendar Year a Covered Person must meet the Deductible shown in the Schedule of Benefits.

Deductible Three Month Carry Over

Covered Expenses applied toward the Deductible in October, November, and December will be applied toward the Deductible in the next Calendar Year.

Family Unit Limit

When the dollar amount shown in the Schedule of Benefits has been earned by members of a Family Unit toward their Calendar Year deductibles, the deductibles of all members of that Family Unit will be considered satisfied for that year.

Deductible For A Common Accident

This provision applies when two (2) or more Covered Persons in a Family Unit are injured in the same accident. These persons need not meet separate Deductibles for the treatment of injuries incurred in this accident; instead, only one (1) Deductible will be required for them as a unit.

BENEFIT PAYMENT

Each Calendar Year, benefits will be paid for covered charges of a Covered Person that are in excess of the deductible amounts paid under Basic Benefits for the same services. Payment will be made at the rate of 80% of the usual, customary and reasonable medical expenses covered under the Plan.

For covered psychiatric care expenses, the plan pays 50% for Outpatient Care. The Covered Person is responsible for the remaining balance.

MAXIMUM BENEFIT AMOUNT

The Maximum Benefit Amount for Major Medical Benefits is shown in the Schedule of Benefits. It is the total amount of benefits that will be paid under the Major Medical Benefits for all covered charges incurred by a Covered Person.

COVERED SERVICES

When a Covered Person requires health care services, the services must be performed by one (1) of the following Facility Providers listed below in order to be covered under the Major Medical Benefits:

Ambulatory Surgical Facility
Birthing Facility
Freestanding Dialysis Facility
Home Health Care Agency
Hospital
Psychiatric Hospital
Rehabilitation Hospital
Skilled Nursing Facility

Professional Providers eligible to perform services are:

Certified Clinical Nurse Specialist, Certified Community Health Nurse, Certified Enterostomal Therapy Nurse, Certified Psychiatric Mental Health Nurse, Certified Registered Nurse Anesthetist, Certified Registered Nurse Practitioner.
(Excluded from eligibility are registered professional nurses employed by a health care facility or by an anesthesiology group)
Chiropractor
Clinical Laboratory
Dentist
Doctor of Medicine
Doctor of Osteopathy
Licensed Practical Nurse
LSW/MSW
Nurse Midwife
Optometrist
Physical Therapist
Podiatrist
Psychologist
Registered Nurse

Covered Services are:

(1) Bed, board and general nursing service in a Hospital or other Facility Provider when a Covered Person occupies:

A. The full cost of a semi- private room;

B. The full cost of a private room if it is Medically Necessary. If it is not Medically Necessary, then the participant is entitled to the Provider's average semi-private room charge;

C. A bed in a special care unit - a designated unit which has concentrated all facilities, equipment, and supportive services for the provision of an intensive level of care for critically ill patients.

(2) Drugs and medicines provided to a Covered Person who is an inpatient in a Facility Provider.

(3) Use of operating or treatment rooms and equipment.

(4) Whole blood, administration of blood, blood processing and blood derivatives.

(5) Oxygen and the administration of oxygen.

(6) Medical and surgical dressings, casts and splints.

(7) Surgery

A. The performance of generally accepted operative and cutting procedures including specialized instrumentation's, endoscopic examinations and other procedures;

B. The correction of fractures and dislocations; and

C. The treatment of burns.

Services, supplies or charges for surgery and related services are not covered when intended solely to improve appearance. This does not apply to services to restore bodily function or correct deformity resulting from disease, trauma, congenital or developmental anomalies or previous therapeutic processes.

(8) Services of an assistant surgeon who actively assists the operating surgeon in the performance of covered surgery.

(9) Anesthesia, anesthesia supplies and services rendered in a Facility Provider by an Employee of the Facility Provider. Benefits will be provided for administration of anesthesia ordered by the attending Professional Provider and rendered by a Professional Provider.

(10) Medical care and consultations of a Professional Provider for the diagnosis and treatment of an Injury or illness. Maximums for chiropractic care are specified in the Schedule of Benefits.

(11) Maternity care services are covered. Maternity care includes normal delivery, complications of Pregnancy and nursery care of the newborn infant.

(12) Diagnostic services ordered by a Professional Provider because of specific symptoms to determine a definite condition or disease, including all medically accepted diagnostic services.

(13) Therapy services or supplies ordered by a Professional Provider used for the treatment of an illness or Injury, including:

- Radiation Therapy
- Chemotherapy
- Dialysis Treatment
- Physical Therapy
- Speech Therapy
- Respiration Therapy

(14) Home Health Care services rendered by a Home Health Care Agency for which benefits would be available under the terms of this benefit section if the Participant were an Inpatient of a Hospital.

(15) Dental services rendered by a Physician or a Dentist which are required as a result of accidental Injury to the jaw, sound natural teeth, mouth, or face occurring on or after the Covered Person's Effective Date. Injury as a result of chewing or biting shall not be considered an accidental Injury.

(16) Private duty nursing services of a Registered Nurse (R.N.) or a Licensed Practical Nurse (L.P.N.) when rendered to an Inpatient in a Hospital and when ordered by a Physician providing that such nurse does not ordinarily reside in the Covered Person's home or is not a member of the Covered Person's immediate family and that the Plan concurs with the Physician's certification that the care is Medically Necessary.

Only the services of a Registered Nurse (R.N.) are available on an Outpatient basis.

(17) Ambulance service providing local transportation by means of a specially designed and equipped vehicle used only for transporting the sick and injured.

A. From a Covered Person's home or the scene of an accident or medical emergency to a Hospital;

B. Between Hospitals;

C. Between a Hospital and Skilled Nursing Facility.

When such facility is the closest institution that can provide Covered Services appropriate to the Covered Person's condition. If there is no facility in the local area that can provide Covered Services appropriate to the Covered Person's condition, "Ambulance Service" means transportation to the closest facility outside the local area that can provide the necessary service.

In addition, benefits are available for emergency services actually provided by an Advanced Life Support Unit even though the unit does not provide transportation.

(18) Psychiatric care services for individual and group psychotherapy, psychological testing, family counseling and convulsive therapy treatments for the treatment of Mental Illness.

Benefits for psychiatric care services will not exceed the Benefit Maximum on the Schedule of Benefits per Covered Person for combined Inpatient and Outpatient psychiatric services.

For the Outpatient psychiatric care services of a Professional Provider, the Plan will not recognize expenses in excess of the amount specified in the Schedule of Benefits per visit. Payment is made at 50% of eligible expense.

(19) The rental of Durable Medical Equipment (but not to exceed the total cost of purchase) or, at the option of the Plan, the purchase of Durable Medical Equipment when prescribed by a Professional Provider within the scope of license and required for therapeutic use.

(20) Purchase, fitting, necessary adjustment, repairs and replacements of prosthetic devices and supplies which replace all or part of a body organ (including contiguous tissue) or replace all or part of the function of a permanently inoperative or malfunctioning body part (excluding dental appliances and the replacement of cataract lenses except when new cataract lenses are needed because of prescription change)

Replacements for prosthetic appliances are covered only for Dependent children.

(21) Purchase, fitting, necessary adjustment, repairs and replacements of orthotic devices. An orthotic device is a rigid or semi-rigid supportive device which restricts or eliminates motion of a weak or diseased body part.

Replacements for orthotic devices are covered only for Dependent children.

(22) Insulin and supplies requiring a Professional Provider's prescription and dispensed by a licensed pharmacist or Physician. Benefits are also provided for non-reusable medical devices used to administer such drugs.

(23) Routine immunizations administered to an eligible dependent child when determined medically necessary to provide full protection against vaccine preventable diseases are covered and are not subject to deductible. Childhood immunizations are defined as any immunization, including recommended vaccines, booster doses and vaccines recommended for special circumstances. Immunizations for activities or travel are not covered under the Plan.

(24) Participants may donate blood for their future surgery.

GENERAL PLAN EXCLUSIONS AND LIMITATIONS

These exclusions and limitations apply to all medical services under Basic Hospital/Facility, Basic Surgical/Medical or Major Medical coverage, except where otherwise noted.

FOR ALL BASIC HOSPITAL, BASIC SURGICAL/MEDICAL AND MAJOR MEDICAL BENEFITS SHOWN IN THE SCHEDULE OF BENEFITS, A CHARGE FOR THE FOLLOWING IS NOT COVERED:

(1) Care, treatment or supplies for which a charge was incurred before a person was covered under this Plan.

(2) Charges excluded or limited by the Plan design as mentioned in this document, or charges for services except as provided in this document.

(3) Charges incurred which the Plan has no legal obligation to pay**.**

(4) Charges for any illness or bodily Injury which occurs in the course of employment if benefits or compensation are available, in whole or in part, under the Workers' Compensation laws.

(5) Care and treatment for which a Covered Person would have no legal obligation to pay in the absence of this or any similar coverage.

(6) Care and treatment rendered after the date of termination of the Covered Person's coverage except that an inpatient stay that began prior to the date of termination will continue to be covered until benefits are exhausted, the Covered Person is discharged, or whichever occurs first.

(7) To the extent payment has been made under Medicare or would have been made for charges if the Covered Person had applied for Medicare and claimed Medicare benefits; however, this exclusion shall not apply when the Plan is obligated by law to offer the Covered Person all the benefits of this Plan and the Covered Person so elects this coverage as primary.

(8) Treatment or services for injuries resulting from the maintenance or use of a motor vehicle if such treatment or service is paid or payable under a plan or policy of motor vehicle insurance, including a certified self-insured plan, or payable under the Catastrophic Loss Trust Fund established under the Pennsylvania Motor Vehicle Financial Responsibility Laws.

(9) Care and treatment performed by a Professional Provider enrolled in an education or training program when such services are related to the education or training program.

(10) Care, treatment or supplies furnished by a program or agency funded by any government. This does not apply to Medicaid or when otherwise prohibited by law.

(11) Care and treatment that is either Experimental/Investigational in nature or not Medically Necessary.

(12) The part of an expense for care and treatment of an injury or sickness that is in excess of the Usual, Customary and Reasonable Charge, unless specified in the Schedule of Benefits.

(13) For injuries sustained while committing an assault or felony.

(14) For any illness or injury suffered after the Covered Person's Effective Date of coverage as a result of an act of war, whether declared or undeclared.

(15) Care and treatment of temporomandibular joint syndrome with intra-oral devices, or any other method to alter vertical dimension.

(16) Professional services performed by a person who ordinarily resides in the Covered Person's home or is related to the Covered Person as a spouse, parent, child, brother or sister, whether the relationship is by blood or exists in law.

(17) Care and treatment provided for cosmetic reasons. This exclusion will not apply if care and treatment is for the repair of damage from and accident that occurred while the person was covered under the Plan.

(18) Correction of myopia or hyperopia by means of corneal microsurgery, such as keratomileusis, keratophakia, and radial keratotomy and all related services.

(19) Charges for eyeglasses or contact lenses and the vision examination for prescribing or fitting eyeglasses or contact lenses. (except for aphakic patients and soft lenses or sclera shells intended for use as corneal bandages)

(20) For hearing aids, tinnitus maskers, or examinations for the prescription or fitting of hearing aids, and all related services.

(21) Routine or periodic physical exams, unless otherwise noted in this plan document**.** Also services will not be available in connection with routine care of teeth, research studies, screenings, or premarital examinations.

(22) Services or supplies provided mainly as a rest cure, maintenance or Custodial Care.

(23) The following care, treatment or supplies for the feet: orthopedic shoes; orthopedic prescription devices to be attached to or placed in shoes; treatment of weak,

strained, flat, unstable or unbalanced feet, metatarsalgai or bunions, except open cutting operations; and treatment of corns, calluses or toenails (except surgery for ingrown nails)*,* unless needed in treatment of a metabolic or peripheral vascular disease.

(24) Spare braces of the leg, arm, back or neck; artificial arms, legs or eyes; or lenses for the eyes.

(25) Services that are of the nature of educational or vocational testing or training.

(26) Professional services billed by a Physician, Dentist or nurse who is an employee of a Hospital or Skilled Nursing Facility and paid by the Hospital or facility for the service.

(27) Air conditioners, air-purification units, humidifiers, allergy-free pillows, blanket or mattress covers, electric heating units, swimming pools, spas, whirlpools, orthopedic mattresses, exercising equipment, vibratory equipment, elevators or stair lifts, stethoscopes, clinical thermometers, scales, elastic bandages or stockings, devices for simulating natural female body contours, except bandages for postmastechtomy surgery, nonprescription drugs and medicines, and first aid supplies and non-hospital adjustable beds.

(28) Care and treatment of obesity, weight loss, or dietary control.

(29) Any treatment leading to or connected with transsexual surgery and sexual impotency.

(30) Charges incurred for failure to keep a scheduled appointment.

(31) Charges for the completion of any insurance forms.

(32) Care and treatment for reversal of surgical sterilization.

(33) The Plan will not provide benefits, under hospital, medical-surgical, major medical or prescription drug benefits or services, supplies or charges to <u>treat</u> infertility. Some tests or procedures that are used for diagnosis of infertility are also used for treatment of infertility. The Plan does provide benefits for services, supplies or charges for tests or procedures to diagnose infertility, but if the same tests or procedures are used for treatment of infertility, the Plan will not provide benefits for them. This exclusion applies to, but is not limited to, any treatment, test, service, supply, drug or procedure for any assisted fertilization technique such as, but not limited to, hormone therapy, embryo transfer, artificial insemination, intra-uterine insemination, in-vitro fertilization (IVF), gamete intra-fallopian transfer (GIFT), and zygote intra-fallopian transfer (ZIFT) or any charge to, for or on behalf of a surrogate mother.

(34) Care and treatment for hair loss including but not limited to: wigs, hair transplants, or any drug that promises hair growth, whether or not prescribed by a Physician. (Durable medical equipment, such as wigs, may be eligible under the Major Medical portion of the Plan).

(35) Exercise programs for treatment of any condition.

(36) Acupuncture or hypnosis.

(37) Abortion, unless to save the life of the mother.

BASIC HOSPITAL BENEFITS EXCLUSIONS

In addition to the General Plan Exclusions and Limitations, the following specific exclusions apply to Basic Hospital Benefits:

(1) Rental or purchase of durable medical equipment or appliances. (Durable medical equipment is eligible under the Major Medical portion of the Plan).

(2) Services of a physician, surgeon, or private duty nurse, or technicians not employed by the hospital. (These services may be eligible under the Basic Surgical or Major medical portion of the Plan)

(3) Personal service such as television and telephone charges, guest meals, barber services, and personal comfort items.

BASIC SURGICAL/MEDICAL BENEFITS EXCLUSIONS

In addition to the General Plan Exclusions and Limitations, the following specific exclusions apply to Basic Surgical/Medical Benefits:

(1) Service provided by or billed by a licensed Chiropractor are covered under the provisions and limitations specified in Major Medical Benefits. These services are not covered under Basic Surgical/Medical Benefits.

(2) Charges for dental and oral surgical procedures involving orthodontic care of teeth, periodontal disease and preparing the mouth for fitting of or continued use of dentures.

(3) Care, treatment or x-ray exams for mouth conditions that are due to periodontal or periapical disease, involve any of the teeth or surrounding tissue or structure or involve the alveolar process or gingival tissues.

MAJOR MEDICAL BENEFITS EXCLUSIONS

In addition to the General Plan Exclusions and Limitations, the following specific exclusions apply to Major Medical Benefits:

(1) Copayment amounts payable by the participant under the Drug Program or the Basic Surgical/Medical Benefits are not eligible for payment under Major

Medical Benefits.

(2) Amounts in excess of the Usual, Customary and Reasonable Charge are not eligible for payment.

PRESCRIPTION DRUG BENEFITS

Formulary Drugs

The prescription drug plan includes a list of drugs that are preferred by the Plan because they help control rising prescription drug cost. This list, sometimes called a formulary, has a wide selection of generic and brand name medications.

A list of formulary drugs is available at www.medco.com or by calling 1-800-711-0917.

Retail Pharmacy

Under the prescription drug program, there are Participating and Non-Participating pharmacies. Participating pharmacies will accept a Member prescription drug card and charge the appropriate co-payment. If a Non-Participating retail pharmacy is used, the Member will be charged the entire cost of the drug and will have to submit a claim form to Medco for reimbursement. The Plan may not reimburse the Member the entire cost of the drug. To find a list of Participating pharmacies, visit www.medco.com (click on "locate a pharmacy"). Retail pharmacies are useful for shot-term prescriptions of 31 days or less.

Mail Order Pharmacy

The mail order program offers convenience and savings by having long-term medications delivered to your home. Medications are dispensed by "Medco by Mail" pharmacist. A 90-day supply or less of medication is available through mail order. Refills can be ordered online, by mail, or by phone anytime, day or night. To order online, register at www.medco.com.

For assistance in using the mail order system, contact the EBTEP office, Monday through Friday (8:00 a.m.- 4:00 p.m.) at 610-515-6510.

EXPENSES NOT COVERED

The benefit will not cover a charge for any of the following:

(1) A charge excluded under the Plan Exclusions.

(2) A drug or medicine that can legally be bought without written prescription. This does not apply to injectible insulin.

(3) Devices of any type, even though such devices may require a prescription. These include (but are not limited to) therapeutic devices, hypodermic needles, syringes, artificial appliances, braces, support garments, or any similar device.

(4) Immunization agents; biological sera; blood or blood plasma; or oxygen, including its administration.

(5) A drug or medicine labeled: "Caution – limited by Federal law to investigative use".

(6) Experimental drugs and medicines, even though a charge is made to the Covered Person.

(7) Any charge for the administration of a covered Prescription Drug.

(8) Any drug or medicine that is consumed or administered at the place where it is dispensed.

(9) Any drug or medicine that is to be taken by the Covered Person, in whole or in part while hospital confined. This includes being confined in any other institution that has a facility for the dispensing of drugs and medicines on its premises.

(10) A charge to a Participant who is entitled to receive reimbursement under Worker's Compensation Laws.

(11) A charge for Prescription Drugs which may be properly received without charge under local, state or Federal programs.

(12) A charge for fertility medication when used to treat infertility.

(13) A charge for drugs used for cosmetic purposes (i.e. for which there is no diagnosed illness, injury or deformity) or as a weight loss supplement (except morbid obesity).

(14) Contraceptive medications.

(15) A charge for Prescription Drugs for smoking cessation (i.e., nicotine gum, nicoderm)

DENTAL BENEFITS

PAYMENT OF BENEFITS

USUAL, CUSTOMARY AND REASONABLE (UCR) METHOD

Usual, Customary and Reasonable (UCR means that fee determined and payable by the Plan Administrator for services in accordance with):

The usual fee which an individual dentist most frequently charges to the majority of his patients for the procedure performed.

The customary fee established by the Plan Administrator based on the charges made by most dentists of similar training and experience in a given geographical area for the procedure performed.

The reasonable fees charged by dentists in unusual circumstances involving complications requiring additional time, skill and experience.

Benefits will be provided for eligible dental services when billed by the licensed dentist in charge of the case. Payment under the Plan is limited to a calendar year individual maximum specified in the schedule of benefits.

THE BASIC PROGRAM

(1) Routine oral examinations and prophylaxis (including cleaning, scaling and polishing of teeth), but not more than once each in any period of six (6) consecutive months. Services must be rendered at least six months from the day they were previously rendered.

(2) Periapical as required and bitewing x-rays one every six months.

(3) Full mouth x-rays, but not more than once in any period of thirty-six (36) consecutive months, unless special need is shown.

(4) Repair of broken partial or full removable dentures.

(5) Palliative emergency treatment for dental plan.

(6) Amalgam, silicate, acrylic, synthetic porcelain, and composite filling restorations to restore diseased or accidentally broken teeth. Gold foil restorations are not eligible.

(7) Simple extraction.

(8) Endodontics, including pulpotomy, direct pulp capping and root canal treatment.

(9) Anesthetic services performed by (or under the direct personal supervision of) and billed for by a dentist other than the operating dentist or his assistant in connection with the performance of covered services. Anesthetic services consist of the administration of an anesthetic agent or anesthetic drug by injection or inhalation, the purpose of which is to render the patient unconscious. The administration of local infiltration or block anesthetic is not covered. IV sedation is covered.

(10) Consultations, limited to one consultation per consultant during any one period of hospitalization, when the participant is an inpatient and his dental condition requires such consultation.

(11) Topical application of fluoride but not more then once in any period of six (6) consecutive months. Services must be rendered at least six months from the day they were previously rendered for dependent children under the age of nineteen (19).

(12) Space maintainers (not made of precious metals) that replace prematurely lost teeth for dependent children under age nineteen (19). No payment will be made for duplicate space maintainers.

SUPPLEMENTAL BASIC SERVICES

Crown, Inlay and Onlay Restoration.

(1) Single unconnected crowns, inlays and onlays (none of which is part of a bridge or are splinted together). Payment will be made for crowns, inlay and onlay restorations only if the tooth cannot be restored with another material, payment for the applicable percentage of the UCR Allowance for that procedure will be made toward the charge for the restoration selected by the Covered Person and the dentist. The balance of the treatment charge remains the responsibility of the Participant.

(2) Replacement of crowns, inlays and onlays, but only if satisfactory evidence is presented that at least five (5) years have elapsed since the date of the insertion of the existing crown, inlay or onlay and only if the existing crown, inlay or onlay is not serviceable and cannot be made serviceable.

(3) Repair of broken crowns, inlays, or onlays or bridges.

Exclusions and Limitations on Crowns, Inlay and Onlay Restorations:

(1) If the Covered Person and dentist decide on personalized crown, inlay and onlay restorations or specialized techniques as opposed to standard procedures, payment of the applicable percentage of the UCR allowance for the standard services will be made toward such treatment and the balance of the cost remains the responsibility of the participant.

(2) No payment will be made for any crown, inlay or onlay restoration or for any denture or bridge and the fitting thereof which was prescribed while the Covered Person was not covered under this Plan or for which the restorative treatment was initiated or the denture or bridge prescribed while the Covered Person was covered under this Plan and which is finally inserted more than thirty (30) days after termination of coverage.

(3) No payment will be made for any duplicate or temporary denture or bridge or any other duplicate or temporary device.

(4) No payment will be made for veneers or similar properties of crown restorations or of bridges placed on or replacing teeth other than the ten (10) upper and ten (10) lower anterior teeth.

(5) No payment will be made until services are completed. Crowns, inlays, onlays, bridges and dentures shall be considered completed on the date they are finally inserted.

ORAL SURGERY

1. Surgical removal of teeth excluding partial or complete bony impactions.
2. Surgical removal of maxillary or mandibular intrabony cysts.
3. Procedures performed for the preparation of the mouth for dentures.
4. Apicoectomy (dental root resection).

PERIODONTICS

1. Periodontal examinations.
2. Gingival curetttage.
3. Gingivectomy and gingivoplasty.
4. Osseous (bone) surgery, in connection with periodontal disease, including flap entry and closure.
5. Mucogingivoplastic surgery.

PREDETERMINATION

Predetermination is used by the Claim Administrator to determine eligibility of the Covered Person and to review the treatment plan to determine the extent of coverage. This assures both the Covered Person and the dentist that the particular service that will be performed is a covered service. However, approval by the Claim Administrator of the treatment plan during the predetermination process does not necessarily constitute acceptance by the Claim Administrator of liability for the services involved in the treatment plan. If the patient's coverage terminated before the planned treatment is completed, the Claim Administrator will not be liable for any service provided after the date of such termination.

Predetermination is required for:

All treatment plans of $200 or more;

The extraction of six (6) or more teeth;

Periodontal services;

Prosthetic, Crowns, Inlay and Onlay Restorations.

Payment for services to participants are limited as follows:

(1) In the event a participant transfers from the care of one dentist during the course of treatment, or if more that one dentist performs services for one dental procedure, the Administrator shall be liable for not more then the amount it would have been liable for had but one dentist performed the service.

(2) In all cases involving covered services in which the dentist and participant select more expensive course of treatment than is customarily provided by the dental practice for the dental condition concerned, payment under this Plan will be based on the charge allowed for the lesser procedure.

(3) A contract between Participant and dentist prior to the effective date of coverage under the Plan, is not invalidated by a subsequent contract made between the Trust and/or Participant and /or dentist. The Participant will be liable for any difference due to the dentist under such a contract after the Trust Liability has been satisfied.

(4) Any additional treatment that is necessitated by lack of Participant cooperation with the dentist or non-compliance with prescribed dental care that results in additional liability with the responsibility of the Participant.

GENERAL EXCLUSIONS AND LIMITATIONS

A. Payment will not be made for:

1. Treatment by other than a dentist (any licensed doctor of dental surgery, doctor of dental medicines, doctor of medicine or doctor of osteopathy acting within the authority of his license), unless the treatment is rendered under the direct supervision of the dentist.

2. Services or supplies that are cosmetic in nature, including, but not limited to, charges for personalization or characterization of dentures.

3. Charges incurred by the Covered Person for failure to keep a scheduled visit with the dentist.

4. Services rendered through a medical department, clinic or similar facility provided or maintained by or on behalf of an employer, mutual benefit association, labor union, trustee or similar persons or groups.

5. Services or supplies which are not necessary, according to accepted standards of dental practice, or which are not recommended or approved by the attending dentist.

6. Services or supplies which do not meet accepted standards of dental practice, including charges for services or supplies which are experimental in nature.

7. Services provided without cost by any governmental agency or services provided under any governmental program (such as Medicare, Title XIX, etc.) for which any periodic payment of rate is made for the Covered Person.

8. Charges for the completion of any insurance forms.

9. Charges for plaque control programs and for oral hygienic and dietary instructions.

10. Implantology.

11. Unusual procedures and techniques.

12. Services for which the Covered Person incurs no charge.

13. Services for any condition covered by Worker's Compensation or similar legislation.

14. Services, the cost of which has been or is later recovered in any action at law or in compromise or settlement of any claim.

15. Services in a hospital performed by a dentist who in any case is compensated by the hospital for similar services performed for patients.

16. Services performed prior to the effective date of the Plan.

17. Procedures, appliances or restorations necessary to alter vertical dimension and/or restore or maintain the occlusion. Such procedures include, but are not limited to, equilibration, periodontal splinting, full mouth rehabilitation, restoration

of tooth structure lost from attrition and restoration or misalignment of the teeth.

18. Services of Assistant Surgeons except that the Covered Person, when an inpatient, will be entitled to the services of a dentist who actively assists the dentist in charge of the case in the performance of covered surgical services when the dental condition of the Covered Person or the type of surgical service requires the assistant and when the hospital does not employ surgical interns, residents or house staff who are utilized for such assistance. The Assistant Surgeon will be paid at the co-insurance level of the covered surgical procedures.
19. Local anesthesia when billed for separately by a dentist.
20. Services related to the care and treatment of TMJ.
21. Services other than those specifically provided herein.
22. Duplicate and temporary devices and appliances.
23. Services performed by a spouse, parent or child participant.
24. Orthodontia
25. Sealants.
26. Prosthetics.

COORDINATION OF BENEFITS

COORDINATION OF THE BENEFIT PLANS

Coordination of benefits set out rules for the order of payment of Covered Services when two (2) or more plans -- including Medicare -- are paying. When a Covered Person is covered by this Plan and another plan, or the Covered Person's spouse is covered by another plan or the couple's covered children are covered under two (2) or more plans, the plans will coordinate benefits when a claim is received.

The plan that pays first (Primary Plan) according to the rules will pay as if there were no other plan involved. The secondary and subsequent plans will pay the balance due up to 100% of the total amount charged.

BENEFIT PLAN

This provision will coordinate the medical benefits of a benefit plan. The term benefit plan means this Plan or any one (1) of the following plans:

(1) Group or blanket benefit plans.

(2) Blue Cross and Blue Shield group plans.

(3) Group practice and other group prepayment plans.

(4) Federal government plans or programs. This includes Medicare.

(5) Other plans required or provided by law. This does not include Medicaid or any benefit plan like it that, by its terms, does not allow coordination.

(6) No Fault Auto Insurance, by whatever name it is called, when not prohibited by law.

AMOUNT CHARGED

For a charge to be eligible it must be a covered expense under the plan.

In the case of HMO (Health Maintenance Organization) plans:

If the Covered Person is referred to a Provider outside the HMO system by the HMO, the HMO is responsible for the cost of such services.

When the HMO is primary for a Covered Person and the Covered Person does not seek HMO services, the Plan will not pay for those services unless the service provided is not covered by (not available through) the HMO, and this is so stated (i.e. as an exclusion) in

the HMO schedule of benefits**.** Additionally, for the Plan to pay, the service must be a Plan-covered benefit.

The Claims Administrator reserves the right to have the Covered Person provide a denial of claim from the HMO before coordinating a claim. In a medical emergency or for accident claims, where the HMO services were not used, the criteria used by the HMO to evaluate its payment shall be conclusive. If the HMO denies payment for such a claim, the Plan will also not provide payment. A Covered Person will be required to furnish documentation that they have utilized the services of the HMO Primary care physician when requesting payment for services provided outside the HMO.

AUTOMOBILE LIMITATIONS

The medical benefits available to any participant under any motor vehicle insurance policy under which the participant is an insured shall be determined before the benefits available under this plan.

BENEFIT PLAN PAYMENT ORDER

When two (2) or more plans provide benefits for the same allowable charge, benefit payment will follow these rules:

(1) Plans that do not have a coordination provision, or one like it, will pay first. Plans with such a provision will be considered after those without one.

(2) Plans with a coordination provision will pay their benefits by these rules up to the allowable charge.

(a) The benefit plan that covers the person as an Employee or member will be considered before a benefit plan that covers the person as a Dependent.

(b) The benefits of a benefit plan which covers a person as an Employee who is neither laid off nor retired are determined before those of a benefit plan which covers that person as a laid off or Retired Employee. The benefits of a benefit plan which covers a person as a Dependent of an Employee who is neither laid off nor retired are determined before those of a benefit plan which covers a person as a Dependent of a laid off or Retired Employee. If the other benefit plan does not have this rule, and if, as a result, the plans do not agree on the order of benefits this rule does not apply.

(c) When a child is covered as the Dependent of both parents the plan of the parent whose birthday falls earlier in the year will be considered before that of the plan of the parent whose birthday falls later in the year. If both parents have the same birthday, the benefits of a plan which covered the parent for a longer period of time are determined first. The year of birth of the parent does not affect this provision. However, if the other plan does not have the Birthday Rule, but instead has a rule based on the gender of the parent, and if, as a result, the plans do not agree on the order of benefits, the rule in the other plan (the Gender Rule) will determine the

order of benefits. However, when a child's parents are divorced or separated, these rules will apply:

(i) This rule applies when the parent with custody of the child has not remarried. The benefit plan of the parent with custody will be considered before the benefit plan of the parent without custody.

(ii) This rule applies when the parent with custody of the child has remarried. The benefit plan of the parent with custody will be considered first. The benefit plan of the stepparent that covers the child as a Dependent will be considered next. The benefit plan of the parent without custody will be considered last.

(iii) This rule will be in place of items (i) and (ii) above when it applies. A court decree may state which parent is financially responsible for medical benefits of the child. In this case, the benefit plan of that parent will be considered before other plans that cover the child as a Dependent.

(iv) If the specific terms of the court decree state that the parents shall share joint custody, without stating that one (1) of the parents is responsible for the health care expenses of the child, the plans covering the child shall follow the order of benefit determination rules outlined above when a child is covered as a Dependent and the parents are not separated or divorced.

(d) If there is still a conflict after these rules have been applied, the benefit plan which has covered the person longer will be considered first.

(3) Medicare will pay last to the extent stated in federal law. When Medicare pays first, this Plan will base its payment upon benefits that would have been paid by Medicare under Part A and B, regardless or whether or not the person was enrolled under both of these parts.

CLAIMS DETERMINATION PERIOD

Benefits will be coordinated on a Calendar Year basis. This is called the claims determination period.

RIGHT TO RECEIVE OR RELEASE NECESSARY INFORMATION

To make this provision work, this Plan may give or obtain needed information from an insurer or any other organization or person. This information may be given or obtained without the consent of or notice to any other person. A Covered Person will give this Plan the information it asks for about other plans and their payment of allowable charges.

FACILITY OF PAYMENT

This Plan may repay other plans for benefits paid that the Plan Administrator determines it should have paid. The repayment will count as a valid payment under this Plan.

RIGHT OF RECOVERY

This Plan may pay benefits that should be paid by another benefit plan. In this case this Plan may recover the amount paid from the other benefit plan or the Covered Person. That repayment will count as a valid payment under the other benefit plan.

Further, this Plan may pay benefits that are later found to be greater than the allowable charge. In this case, this Plan may recover the amount of the overpayment from the source to which it was paid.

SUBROGATION

To the extent that benefits for Covered Services are provided or paid under this program, the Plan shall be subrogated and succeed to any rights of recovery of a Subscriber for expenses incurred against any person or organization except insurers on policies of health insurance issued to and in the name of the Subscriber.

The Subscriber shall pay the Plan the amount recovered by suit, settlement, or otherwise from any third party or his insurer to the extent of the benefits provided or paid under this program to the extent permitted by law.

The Subscriber shall take such action, furnish such information and assistance, and execute such papers as the Plan may request to facilitate enforcement of its rights, and shall take no action prejudicing the rights and interest of the Plan under this Program.

The provisions shall not apply where subrogation is specifically prohibited by law.

HOW MEDICARE AFFECTS PLAN PAYMENTS

There are times when federal law determines whether this Plan or Medicare will pay its benefits first.

Benefit Payment Order

The following explains which benefits of the Plan or Medicare will be paid first for the same charges:

(1) The Plan pays first when an Active Employee or Covered Spouse is age sixty-five (65) and over.

(2) The Plan pays first when an Active Employee or Dependent is both disabled and covered by Medicare.

(3) The Plan will pay first during the time period designated by Medicare of a Covered Person's treatment for end-stage renal failure. After this initial time period has been met, Medicare will pay first.

Determining Benefit Payment

After the benefit payment order is determined, the Coordination of Benefits provision will apply.

COBRA CONTINUATION OPTIONS

A federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA), requires that most employers sponsoring a group health plan ("Plan") offer Employees and their families covered under their health plan the opportunity for a temporary extension of health coverage (called "COBRA continuation coverage") in certain instances where coverage under the Plan would otherwise end. This notice is intended to inform Plan Participants and beneficiaries, in summary fashion, of the rights and obligations under the continuation coverage provisions of COBRA, as amended and reflected in final and proposed regulations published by the Department of the Treasury. This notice is intended to reflect the law and does not grant or take away any rights under the law. Complete instructions on COBRA, as well as election forms and other information, will be provided by the Plan Administrator to Plan Participants who become Qualified Beneficiaries under COBRA.

Note: Special COBRA rights apply to employees who have been terminated or experienced a reduction of hours and who qualify for a trade readjustment allowance or alternative trade adjustment assistance under a federal law called the Trade Act of 1974. These employees must have made petitions for certification to apply for TAA on or after November 4, 2002.

The employees, if they do not already have COBRA coverage, are entitled to a second opportunity to elect COBRA coverage for themselves and certain family members, but only within a limited period of 60 days or less and only during the six months immediately after their group health plan coverage ended.

Any employee who qualifies or may qualify for assistance under this special provision should contact his or her Plan Administrator for further information.

What is COBRA continuation coverage? COBRA continuation coverage is group health plan coverage that an employer must offer to certain Plan Participants and their eligible family members (called "Qualified Beneficiaries") at group rates for up to a statutory-mandated maximum period of time or until they become ineligible for COBRA continuation coverage, whichever occurs first. The right to COBRA continuation coverage is triggered by the occurrence of one of certain enumerated events that result in the loss of coverage under the terms of the employer's Plan (the "Qualifying Event"). The coverage must be identical to the Plan coverage that the Qualified Beneficiary had immediately before the Qualifying Event, or if the coverage has been changed, the coverage must be identical to the coverage provided to similarly situated active employees who have not experienced a Qualifying Event (in other words, similarly situated non-COBRA beneficiaries).

Who is a Qualified Beneficiary? In general, a Qualified Beneficiary is:

(i) Any individual who, on the day before a Qualifying Event, is covered under a Plan by virtue of being on that day either a covered Employee, the Spouse of a covered Employee, or a Dependent child of a covered Employee. If, however,

an individual is denied or not offered coverage under the Plan under circumstances in which the denial or failure to offer constitutes a violation of applicable law, then the individual will be considered to have had the Plan coverage and will be considered a Qualified Beneficiary if that individual experiences a Qualifying Event.

(ii) Any child who is born to or placed for adoption with a covered Employee during a period of COBRA continuation coverage. If, however, an individual is denied or not offered coverage under the Plan under circumstances in which the denial or failure to offer constitutes a violation of applicable law, then the individual will be considered to have had the Plan coverage and will be considered a Qualified Beneficiary if that individual experiences a Qualifying Event.

(iii) A covered Employee who retired on or before the date of substantial elimination of Plan coverage which is the result of a bankruptcy proceeding under Title 11 of the U.S. Code with respect to the Employer, as is the Spouse, surviving Spouse or Dependent child of such a covered Employee if, on the day before the bankruptcy Qualifying Event, the Spouse, surviving Spouse or Dependent child was a beneficiary under the Plan.

The term "covered Employee" includes not only common-law employees (whether part-time or full-time) but also any individual who is provided coverage under the Plan due to his or her performance of services for the employer sponsoring the Plan (e.g., self-employed individuals, independent contractor, or corporate director).

An individual is not a Qualified Beneficiary if the individual's status as a covered Employee is attributable to a period in which the individual was a nonresident alien who received from the individual's Employer no earned income that constituted income from sources within the United States. If, on account of the preceding reason, an individual is not a qualified beneficiary, then a Spouse or Dependent child of the individual is not considered a Qualified Beneficiary by virtue of the relationship to the individual. A domestic partner is not a Qualified Beneficiary.

Each Qualified Beneficiary (including a child who is born to or placed for adoption with a covered Employee during a period of COBRA continuation coverage) must be offered the opportunity to make an independent election to receive COBRA continuation coverage.

What is a Qualifying Event? A Qualifying Event is any of the following if the Plan provided that the Plan participant would lose coverage (i.e., cease to be covered under the same terms and conditions as in effect immediately before the Qualifying Event) in the absence of COBRA continuation coverage:

(i) The death of a covered Employee.

(ii) The termination (other than by reason of the Employee's gross misconduct), or reduction of hours, of a covered Employee's employment.

(iii) The divorce or legal separation of a covered Employee from the Employee's Spouse.

(iv) A covered Employee's enrollment in the Medicare program.

(v) A Dependent child's ceasing to satisfy the Plan's requirements for a Dependent child (e.g., attainment of the maximum age for dependency under the Plan).

(vi) A proceeding in bankruptcy under Title 11 of the U.S. Code with respect to an Employer from whose employment a covered Employee retired at any time.

If the Qualifying Event causes the covered Employee, or the Spouse or a Dependent child of the covered Employee, to cease to be covered under the Plan under the same terms and conditions as in effect immediately before the Qualifying Event (or in the case of the bankruptcy of the Employer, any substantial elimination of coverage under the Plan occurring within 12 months before or after the date the bankruptcy proceeding commences), the persons losing such coverage become Qualified Beneficiaries under COBRA if all the other conditions of the COBRA law are also met. Any increase in contribution that must be paid by a covered Employee, or the Spouse, or a Dependent child of the covered Employee, for coverage under the Plan that results from the occurrence of one of the events listed above is a loss of coverage.

The taking of leave under the Family and Medical Leave Act of 1993 ("FMLA") does not constitute a Qualifying Event. A Qualifying Event occurs, however, if an Employee does not return to employment at the end of the FMLA leave and all other COBRA continuation coverage conditions are present. If a Qualifying Event occurs, it occurs on the last day of FMLA leave and the applicable maximum coverage period is measured from this date (unless coverage is lost at a later date and the Plan provides for the extension of the required periods, in which case the maximum coverage date is measured from the date when the coverage is lost.) Note that the covered Employee and family members will be entitled to COBRA continuation coverage even if they failed to pay the employee portion of premiums for coverage under the Plan during the FMLA leave.

What is the election period and how long must it last? An election period is the time period within which the Qualified Beneficiary can elect COBRA continuation coverage under the Employer's Plan. A Plan can condition availability of COBRA continuation coverage upon the timely election of such coverage. An election of COBRA continuation coverage is a timely election if it is made during the election period. The election period must begin not later than the date the Qualified Beneficiary would lose coverage on account of the Qualifying Event and must not end before the date that is 60 days after the later of the date the Qualified Beneficiary would lose coverage on account of the Qualifying Event or the date notice is provided to the Qualified Beneficiary of her or his right to elect COBRA continuation coverage.

Is a covered Employee or Qualified Beneficiary responsible for informing the Plan Administrator of the occurrence of a Qualifying Event? In general, the Employer or Plan Administrator must determine when a Qualifying Event has occurred. However,

each covered Employee or Qualified Beneficiary is responsible for notifying the Plan Administrator of the occurrence of a Qualifying Event that is:

(i) A Dependent child's ceasing to be a Dependent child under the generally applicable requirements of the Plan.

(ii) The divorce or legal separation of the covered Employee.

The Plan is not required to offer the Qualified Beneficiary an opportunity to elect COBRA continuation coverage if the notice is not provided to the Plan Administrator within 60 days after the later of: the date of the Qualifying Event, or the date the Qualified Beneficiary would lose coverage on account of the Qualifying Event.

Is a waiver before the end of the election period effective to end a Qualified Beneficiary's election rights? If, during the election period, a Qualified Beneficiary waives COBRA continuation coverage, the waiver can be revoked at any time before the end of the election period. Revocation of the waiver is an election of COBRA continuation coverage. However, if a waiver is later revoked, coverage need not be provided retroactively (that is, from the date of the loss of coverage until the waiver is revoked). Waivers and revocations of waivers are considered made on the date they are sent to the Employer or Plan Administrator, as applicable.

When may a Qualified Beneficiary's COBRA continuation coverage be terminated? During the election period, a Qualified Beneficiary may waive COBRA continuation coverage. Except for an interruption of coverage in connection with a waiver, COBRA continuation coverage that has been elected for a Qualified Beneficiary must extend for at least the period beginning on the date of the Qualifying Event and ending not before the earliest of the following dates:

(i) The last day of the applicable maximum coverage period.

(ii) The first day for which Timely Payment is not made to the Plan with respect to the Qualified Beneficiary.

(iii) The date upon which the Employer ceases to provide any group health plan (including successor plans) to any Employee.

(iv) The date, after the date of the election, that the Qualified Beneficiary first becomes covered under any other Plan that does not contain any exclusion or limitation with respect to any pre-existing condition, other than such an exclusion or limitation that does not apply to, or is satisfied by, the Qualified Beneficiary.

(v) The date, after the date of the election, that the Qualified Beneficiary first enrolls in the Medicare program (either part A or part B, whichever occurs earlier).

(vi) In the case of a Qualified Beneficiary entitled to a disability extension, the later of:

(a) (i) 29 months after the date of the Qualifying Event, or (ii) the first day of the month that is more than 30 days after the date of a final determination under Title II or XVI of the Social Security Act that the disabled Qualified Beneficiary whose disability resulted in the Qualified Beneficiary's entitlement to the disability extension is no longer disabled, whichever is earlier; or

(b) the end of the maximum coverage period that applies to the Qualified Beneficiary without regard to the disability extension.

The Plan can terminate for cause the coverage of a Qualified Beneficiary on the same basis that the Plan terminates for cause the coverage of similarly situated non-COBRA beneficiaries, for example, for the submission of a fraudulent claim.

In the case of an individual who is not a Qualified Beneficiary and who is receiving coverage under the Plan solely because of the individual's relationship to a Qualified Beneficiary, if the Plan's obligation to make COBRA continuation coverage available to the Qualified Beneficiary ceases, the Plan is not obligated to make coverage available to the individual who is not a Qualified Beneficiary.

What are the maximum coverage periods for COBRA continuation coverage? The maximum coverage periods are based on the type of the Qualifying Event and the status of the Qualified Beneficiary, as shown below.

(i) In the case of a Qualifying Event that is a termination of employment or reduction of hours of employment, the maximum coverage period ends 18 months after the Qualifying Event if there is not a disability extension and 29 months after the Qualifying Event if there is a disability extension.

(ii) In the case of a covered Employee's enrollment in the Medicare program before experiencing a Qualifying Event that is a termination of employment or reduction of hours of employment, the maximum coverage period for Qualified Beneficiaries other than the covered Employee ends on the later of:

(a) 36 months after the date the covered Employee becomes enrolled in the Medicare program; or

(b) 18 months (or 29 months, if there is a disability extension) after the date of the covered Employee's termination of employment or reduction of hours of employment.

(iii) In the case of a bankruptcy Qualifying Event, the maximum coverage period for a Qualified Beneficiary who is the retired covered Employee ends on the date of the retired covered Employee's death. The maximum coverage period for a Qualified Beneficiary who is the Spouse, surviving Spouse or Dependent child

of the retired covered Employee ends on the earlier of the date of the Qualified Beneficiary's death or the date that is 36 months after the death of the retired covered Employee.

(iv) In the case of a Qualified Beneficiary who is a child born to or placed for adoption with a covered Employee during a period of COBRA continuation coverage, the maximum coverage period is the maximum coverage period applicable to the Qualifying Event giving rise to the period of COBRA continuation coverage during which the child was born or placed for adoption.

(v) In the case of any other Qualifying Event than that described above, the maximum coverage period ends 36 months after the Qualifying Event.

Under what circumstances can the maximum coverage period be expanded? If a Qualifying Event that gives rise to an 18-month or 29-month maximum coverage period is followed, within that 18- or 29-month period, by a second Qualifying Event that gives rise to a 36-months maximum coverage period, the original period is expanded to 36 months, but only for individuals who are Qualified Beneficiaries at the time of both Qualifying Events. In no circumstance can the COBRA maximum coverage period be expanded to more than 36 months after the date of the first Qualifying Event.

How does a Qualified Beneficiary become entitled to a disability extension? A disability extension will be granted if an individual (whether or not the covered Employee) who is a Qualified Beneficiary in connection with the Qualifying Event that is a termination or reduction of hours of a covered Employee's employment, is determined under Title II or XVI of the Social Security Act to have been disabled at any time during the first 60 days of COBRA continuation coverage. To qualify for the disability extension, the Qualified Beneficiary must also provide the Plan Administrator with notice of the disability determination on a date that is both within 60 days after the date of the determination and before the end of the original 18-month maximum coverage.

Can a Plan require payment for COBRA continuation coverage? Yes. For any period of COBRA continuation coverage, a Plan can require the payment of an amount that does not exceed 102% of the applicable premium except the Plan may require the payment of an amount that does not exceed 150% of the applicable premium for any period of COBRA continuation coverage covering a disabled qualified beneficiary that would not be required to be made available in the absence of a disability extension. A group health plan can terminate a qualified beneficiary's COBRA continuation coverage as of the first day of any period for which timely payment is not made to the Plan with respect to that qualified beneficiary.

Must the Plan allow payment for COBRA continuation coverage to be made in monthly installments? Yes. The Plan is also permitted to allow for payment at other intervals.

What is Timely Payment for payment for COBRA continuation coverage? Timely Payment means payment that is made to the Plan by the date that is 30 days after the first day of that period. Payment that is made to the Plan by a later date is also

considered Timely Payment if either under the terms of the Plan, covered Employees or Qualified Beneficiaries are allowed until that later date to pay for their coverage for the period or under the terms of an arrangement between the Employer and the entity that provides Plan benefits on the Employer's behalf, the Employer is allowed until that later date to pay for coverage of similarly situated non-COBRA beneficiaries for the period.

Notwithstanding the above paragraph, a Plan cannot require payment for any period of COBRA continuation coverage for a Qualified Beneficiary earlier than 45 days after the date on which the election of COBRA continuation coverage is made for that Qualified Beneficiary. Payment is considered made on the date on which it is sent to the Plan.

If Timely Payment is made to the Plan in an amount that is not significantly less than the amount the Plan requires to be paid for a period of coverage, then the amount paid will be deemed to satisfy the Plan's requirement for the amount to be paid, unless the Plan notifies the Qualified Beneficiary of the amount of the deficiency and grants a reasonable period of time for payment of the deficiency to be made. A "reasonable period of time" is 30 days after the notice is provided. A shortfall in a Timely Payment is not significant if it is no greater than the lesser of $50 or 10% of the required amount.

Must a qualified beneficiary be given the right to enroll in a conversion health plan at the end of the maximum coverage period for COBRA continuation coverage? If a Qualified Beneficiary's COBRA continuation coverage under a group health plan ends as a result of the expiration of the applicable maximum coverage period, the Plan must, during the 180- day period that ends on that expiration date, provide the Qualified Beneficiary with the option of enrolling under a conversion health plan if such an option is otherwise generally available to similarly situated non-COBRA beneficiaries under the Plan. If such a conversion option is not otherwise generally available, it need not be made available to Qualified Beneficiaries.

HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT (HIPAA)

The privacy provisions of the Health Insurance Portability and Accountability Act of 1996 (HIPAA), apply to health information created or maintained by health care providers who engage in certain electronic transactions, health plans, and health care clearinghouses. The primary purpose of the Privacy Rules is to require health plans and providers to maintain administrative and physical safeguards to protect the confidentiality of health information and protect against unauthorized access.

It is necessary for certain members of the Employee Benefit Trust of Eastern Pennsylvania (the "Trust") that perform services in connection with administration of the Nazareth Area School District Employee Benefit Plan (the "Plan") to have access to Protected Health Information of its covered persons. Under the HIPAA Standards for Privacy of Individually Identifiable Health Information (45 CFR Part 164, the "Privacy Standards") these members are permitted to have such access only if the Plan is in accordance with the following Privacy Standards:

General
The Plan shall not disclose Protected Health Information to any member of the Trust unless each of the conditions set out in this section are met. "Protected Health Information" shall have the same definition as set out in the HIPAA Privacy Standards but generally shall mean individually identifiable information about the past, present or future physical or mental health or condition of an individual, including information about treatment or payment for treatment.

Permitted Uses and Disclosures. Protected Health Information disclosed to members of the Trust shall be used or disclosed by them only for purposes of Plan administrative functions. The Plan's administrative functions shall include all Plan payment functions and health care operations. The terms "payment" and "health care operations" shall have the same definitions as set out in the HIPAA Privacy Standards, but the term "payment" generally shall mean activities taken with respect to payment of premiums or contributions, or to determine or fulfill Plan responsibilities with respect to coverage, provision of benefits, or reimbursement for health care. "Health care operations" generally shall mean activities on behalf of the Plan that are related to quality assessment; evaluation, training or accreditation of health care providers; underwriting, premium rating and other functions related to obtaining or renewing an insurance contract, including stop loss insurance; medical review; legal services or auditing functions; or business planning, management and general administrative activities.

Authorized Employees. The Plan shall disclose Protected Health Information

only to members of the Trust who are designated and are authorized to receive such Protected Health Information, and only to the extent and in the minimum amount necessary for that person to perform his or her duties with respect to the Plan. For purposes of this section, "members of the Trust" shall refer to all employees and other persons under the control of the Trust.

a. Updates Required. The Trust shall amend internal documentation promptly with respect to any changes in the members of the Trust who are authorized to receive Protected Health Information.

b. Use And Disclosure Restricted. An authorized member of the Trust who receives Protected Health Information shall use or disclose the Protected Health Information only to the extent necessary to perform his or her duties with respect to the Plan.

c. Resolution of issues of noncompliance. In the event that any member of the Trust uses or discloses Protected Health Information other than as permitted by this document and the HIPAA Privacy Standards, the incident shall be reported to the Plan's privacy officer. The privacy officer shall take appropriate action, including:

    (1) Investigation of the incident to determine whether the breach occurred inadvertently, through negligence or deliberately; whether there is a pattern of breaches; and the degree of harm caused by the breach;

    (2) Appropriate sanctions against the persons causing the breach which, depending upon the nature of the breach, may include oral or written reprimand, additional training, or termination of employment;

    (3) Mitigation of any harm caused by the breach, to the extent practicable; and

    (4) Documentation of the incident and all actions taken to resolve the issue and mitigate any damages.

Certification of Trust. The Trust must provide certification that it agrees to:

a. *Not use or further disclose the information other than as permitted or required by the Plan documents or as required by law;*

b. Ensure that any agent or subcontractor, to whom it provides Protected Health Information received from the Plan, agrees to the same restrictions and conditions that apply to the Trust with respect to such information;

c. Not use or disclose Protected Health Information for employment-related actions and decisions or in connection with any other benefit or employee benefit plan of the Trust;

d. Report to the Plan any use or disclosure of the Protected Health Information of which it becomes aware that is inconsistent with the uses or disclosures permitted by this section of the Plan Document , or required by law;

e. Make available Protected Health Information to individual Plan members in accordance with § 164.524 of the HIPAA Privacy Standards, (through the Claims Administrator);

f. Make available Protected Health Information for amendment by individual Plan members and incorporate any amendments to Protected Health Information in accordance with § 164.526 of the HIPAA Privacy Standards (through the Claims Administrator);

g. Make available the Protected Health Information required to provide an accounting of disclosures to individual Plan members in accordance with § 164.528 of the Privacy Standards (through the Claims Administrator);

h. Make its internal practices, books and records relating to the use and disclosure of Protected Health Information received from the Plan available to the Department of Health and Human Services for purposes of determining compliance by the Plan with the HIPAA Privacy Standards;

i. If feasible, return or destroy all Protected Health Information received from the Plan that the Trust still maintains in any form, and retain no copies of such information when no longer needed for the purpose for which disclosure was made, except that, if such return or destruction is not feasible, limit further uses and disclosures to those purposes that make the return or destruction of the information infeasible; and

j. Ensure the adequate separation between the Plan and Employer members of the Trust, as required by § 164.504(f)(2)(iii) of the HIPAA Privacy Standards.

COMPLIANCE WITH HIPAA ELECTRONIC SECURITY STANDARDS

Under the Security Standards for the Protection of Electronic Protected Health Information (45 CFR Part 164.300 et. seq., the "Security Standards"), the Employer agrees to implement reasonable and appropriate administrative, physical and technical safeguards to protect the confidentiality, integrity and availability of Electronic Protected Health Information that the Employer creates, maintains or transmits on behalf of the Plan. "Electronic Protected Health Information" shall have the same definition as set out in the Security Standards, but generally shall mean Protected Health Information that is transmitted by or maintained in electronic media. The Employer shall ensure that any agent or subcontractor to whom it provides Electronic Protected Health Information shall agree, in writing, to implement reasonable and appropriate security measures to protect the Electronic Protected Health Information.

The Employer shall ensure that reasonable and appropriate security measures are implemented to comply with the conditions and requirements set forth in Compliance With HIPAA Privacy Standards provisions (3) Authorized Employees and (4) Certification of Employers.

NOTICE OF BENEFIT UNDER THE WOMEN'S HEALTH AND CANCER RIGHTS ACT OF 1988

Your health insurance program through the Employee Benefit Trust of Eastern PA provides coverage for mastectomies. In addition to this coverage, and in compliance with the federal Women's Health and Cancer Rights Act, mastectomy patients who elect to have reconstructive surgery also have these benefits:

- Reconstructive surgery for the breast on which the mastectomy was performed;
- Reconstructive surgery for the other breast to provide a symmetrical appearance;
- Prostheses; and
- Treatment of physical complications at all stages of the mastectomy, including lymphedemas.

Some of these benefits may have time restrictions, and you may have other benefits available to you relating to mastectomy services. These services are subject to the same deductibles, copays and/or coinsurance that are applicable to your benefits program. The extent to which any of these items is appropriate following a mastectomy is a matter to be determined in consultation with the physician and the patient.

HEALTH INSURANCE FOR RETIREES

In accordance with Act 43 of 1989 of the Pennsylvania Legislature, certain retirees are entitled to purchase continuation coverage in a group health plan. According to the statute, retirees are eligible if they are "a member of the Public School Employees' Retirement System who has taken super-annuation retirement, has retired within thirty (30) or more years of credited service, or has taken disability retirement."

The employee should contact the Payroll Department for the applicability of the law and the rates currently in effect.

MILITARY MOBILIZATION

If an Employee or an Employee's Dependent 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 or the Employee's Dependent may continue their health coverage's, pursuant to the Uniformed Services Employment and Reemployment Rights Act (USERRA).

When the leave is less than thirty-one (31) days, the Employee or 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 more than thirty-one (31) days, then the Employer may require the Employee or Employee's Dependent to pay no more than 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. Eighteen (18) 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 Employee or the Employee's Dependent coverage will be reinstated without exclusions or a waiting period.

DEFINED TERMS

Active Employee is an Employee who performs all of the duties of his job with the Employer on a regular full-time basis.

Alcoholism is the condition caused by regular excessive compulsive drinking of alcohol that results in a chronic disorder affecting physical health and/or personal or social functioning.

Ambulatory Surgical Center is a licensed facility that is used mainly for performing outpatient surgery, has a staff of Physicians, has continuous Physician and nursing care by registered nurses (R.N.s) and does not provide for overnight stays. A Facility Provider, with an organized staff of Physicians, which has been licensed and approved by the appropriate governmental agency and which has been approved by the Joint Commission on the Accreditation of Health Care Organizations, or by the Accreditation Association for Ambulatory Health Care, Inc., and which:

A. Has permanent facilities and equipment for the primary purpose of performing surgical procedures on an Outpatient basis;
B. Provides treatment by or under the supervision of Physicians and nursing services whenever the patient is in the facility;
C. Does not provide Inpatient accommodations; and
D. Is not, other than incidentally, a facility used as an office or clinic for the private practice of a Physician.

Assignment of benefits is the payment of benefits to someone other than the member or physician.

Benefit Period is the specified period of time during which charges for Covered Services must be incurred in order to be eligible for payment by the Plan. A charge shall be considered incurred on the date the service or supply was provided to a Covered Person.

Birthing Center means a freestanding health facility, place, professional office or institution which is not a Hospital or in a Hospital, where births occur in a home-like atmosphere. The facility must be licensed and operated in accordance with the laws pertaining to Birthing Centers in the jurisdiction where the facility is located.

Calendar Year means January 1st through December 31st of the same year.

Certified Registered Nurse is a certified registered nurse anesthetist, certified registered nurse practitioner, certified enterostomal therapy nurse, certified community health nurse, certified psychiatric mental health nurse, or certified clinical nurse specialist, certified by the State Board of Nursing or a national nursing organization recognized by the State Board of Nursing. This excludes any registered professional nurses employed by a health care facility, as defined in the Health Care Facilities Act, or by an anesthesiology group.

Claims Administrator is NCAS Pennsylvania.

COBRA means the Consolidated Omnibus Budget Reconciliation Act of 1985, as amended.

Coinsurance is a specific percentage of the amount of the Provider's Reasonable Charge for Covered Services which the Covered Person is required to pay and which will be deducted from the Provider's Reasonable Charge. Coinsurance is calculated based upon the amount of the Provider's Reasonable Charge or the Provider's actual charge, whichever is less, after the Deductible and applicable Copayment have been applied.

Cosmetic Surgery means medically unnecessary surgical procedures, usually, but not limited to, plastic surgery directed toward preserving beauty or correcting scars, burns or disfigurements.

Covered Employer is the Nazareth Area School District.

Covered Person is an Employee or Dependent who is covered under this Plan.

Covered Service is a service or supply specified in this document for which benefits will be provided when rendered by a Provider.

Custodial Care is care primarily for the maintenance of the Covered Person, or which is designed essentially to assist the Covered Person in meeting activities of daily living and which is not primarily provided for its therapeutic value in the treatment of an illness, disease, bodily injury, or condition. Custodial care includes, but is not limited to, help in walking, bathing, dressing, feeding preparation of special diets and supervision over self-administration of medications, which do not require the technical skills or professional training of medical or nursing personnel in order to be performed safely and effectively.

Deductible is a specified dollar amount of Covered Services that must be incurred and paid by a Covered Person before the Plan will assume any liability for all or part of the remaining Covered Services.

Dentist is a person who is properly trained and licensed to practice Dentistry and who is practicing within the scope of such license.

Dependent is the spouse and unmarried children who meet the eligibility requirements outlined in the "Eligibility Provisions" section of the Plan.

Durable Medical Equipment is equipment which:

(1) Can withstand repeated use;

(2) Is primarily and customarily used to serve a medical purpose;

(3) Generally is not useful to a person in the absence of an illness or Injury.

Drug Abuse is physical, habitual dependence on drugs. This includes (but is not limited to) dependence on drugs that are medically prescribed. This does not include dependence on alcohol, tobacco and ordinary caffeine-containing drinks.

Effective Date is the date on which coverage begins in accordance with the eligibility provisions.

Employee means a person who is a regular Employee of the Employer, regularly scheduled to work for the Employer in an Employee/Employer relationship.

Experimental and/or Investigational means care and treatment which does not constitute accepted medical practice, properly within the range of appropriate medical treatment, under standards of the case and by the standards of a reasonably substantial, qualified, responsible, relevant segment of the medical community.

The Plan Administrator must make an independent evaluation of the experimental/ non-experimental standings of specific technologies. The Plan Administrator shall be guided by a reasonable interpretation of Plan provisions. The decisions shall be made in good faith and rendered following a detailed factual background investigation of the claim and the proposed treatment. The Plan Administrator will be guided by the following principles:

(1) The medical condition must be life-threatening, desperate, life-shortening or one that leads to paralysis or severe loss of bodily or motor functions.

(2) Conventional therapy does not exist or has failed.

(3) The risk-benefit ratio of patient outcome must be as favorable as that of established therapies or no treatment at all.

(4) The technology must be appropriate, in level of service and intensity, to the nature of the disease or condition being treated.

(5) Public policy would support the procedure(s) as a valid and ethical course of treatment.

(6) The technology is judged to be reasonably clinically effective according to reported peer reviewed scientific literature and/or preponderant expert medical opinion.

If a technology does not meet the above criteria, in whole or in significant part, it will be deemed Experimental and/or Investigational. The decisions of the Plan Administrator can be appealed to the Plan Trustees whose decision will be final and binding on the Plan.

Drugs are considered Experimental if they are not commercially available for purchase and/or they are not approved by the Food and Drug Administration for general use.

Facility Provider is a Hospital or other Provider approved by the Plan. The Facility Provider must be primarily engaged in providing diagnostic and/or therapeutic care for the medical diagnosis and treatment of injured and sick persons and be licensed to do so.

Family Unit is the Covered Employee and his family members who are covered as Dependents under the Plan.

Freestanding Dialysis Facility is a Facility Provider, licensed and approved by the appropriate governmental agency, which is primarily engaged in providing dialysis treatment, maintenance or training to Covered Person on an Outpatient or home care basis.

Freestanding Outpatient Facility is a Provider, licensed and approved by the appropriate governmental agency, which is primarily engaged in providing Outpatient diagnostic and/or therapeutic services by or under the supervision of Physicians.

Home Health Care Agency is a Facility Provider, licensed and approved by the appropriate governmental agency which:

A. Provides skilled nursing and other services on an intermittent basis in the Covered Person's home; and
B. Is responsible for supervising the delivery of such services under a plan prescribed by the attending Physician.

Hospice Agency is a Facility Provider, licensed and approved by the appropriate governmental agency which is primarily engaged in providing palliative care to terminally ill Covered Person and their families with such services being centrally coordinated through an interdisciplinary team directed by a Physician.

Hospital is an institution which is engaged primarily in providing medical care and treatment of sick and injured persons on an inpatient basis at the patient's expense and which fully meets these tests: it is accredited as a Hospital by the Joint Commission on Accreditation of Healthcare Organizations; it is approved by Medicare as a Hospital; it maintains diagnostic and therapeutic facilities on the premises for surgical and medical diagnosis and treatment of sick and injured persons by or under the supervision of a staff of Physicians; it continuously provides on the premises twenty-four (24) hour-a-day nursing services by or under the supervision of registered nurses (R.N.s); and it is operated continuously with organized facilities for operative surgery on the premises.

The definition of Hospital shall be expanded to include the following:

(1) A facility operating legally as a Psychiatric Hospital and licensed as such by the state in which the facility operates.

(2) A facility operating primarily for the treatment of Substance Abuse if it meets these tests: maintains permanent and full-time facilities for bed care and full-time confinement of at least fifteen (15) resident patients; has a Physician in regular attendance; continuously provides twenty-four (24) hour a day nursing service by a registered nurse (R.N.); has a full-time psychiatrist or psychologist on the staff; and is primarily engaged in providing diagnostic and therapeutic services and facilities for treatment of Substance Abuse.

(3) A facility which is primarily engaged in providing rehabilitation care services on an inpatient basis. Rehabilitation care services consist of the combined use of medical, social, educational, and vocational services to enable

patients, disabled by disease or Injury to achieve the highest possible level of functional ability. Services are provided by or under the supervision of an organized staff of Physicians. Continuous nursing services are provided by or under the supervision of a Registered Nurse.

Injury means an accidental physical Injury to the body caused by unexpected external means.

Inpatient is a Covered Person who is a registered overnight bed patient in a Facility Provider, and for whom a room and board charge is made.

Intensive Care Unit is defined as a separate, clearly designated service area which is maintained within a Hospital solely for the care and treatment of patients who are critically ill. This also includes what is referred to as a "coronary care unit" or an "acute care unit". It has: facilities for special nursing care not available in regular rooms and wards of the Hospital; special life saving equipment which is immediately available at all times; at least two (2) beds for the accommodation of the critically ill; and at least one (1) registered nurse (R.N.) in continuous and constant attendance twenty-four (24) hours a day.

Lifetime is a word that appears in this Plan in reference to benefit maximums and limitations. Lifetime is understood to mean while covered under this Plan. Under no circumstances does Lifetime mean during the Lifetime of the Covered Person.

Medical Care is the professional services rendered by a Professional Provider for the treatment of an illness or injury.

Medically Necessary are Services or supplies provided by a Provider that the Plan determines are:

- **A.** Appropriate for the symptoms and diagnosis or treatment of the Covered Person's condition, illness, disease, or injury; and
- **B.** Provided for the diagnosis, or the direct care and treatment of the Covered Person's condition, illness, disease, or injury; and
- **C.** In accordance with standards of good medical practice; and
- **D.** Not primarily for the convenience of a Covered Person or the Provider; and
- **E.** The most appropriate supply or level of service that can safely be provided to the Covered Person. When applied to hospitalization, this further means that the Covered Person requires acute care as a bed patient due to the nature of the services provided or the Covered Person's condition, and the Covered Person cannot receive safe or adequate care as an Outpatient or in another less costly setting.

Medicare is the Health Insurance for the Aged and Disabled program under Title XVIII of the Social Security Act, as amended.

Mental Illness is an emotional or mental disorder characterized by an abnormal functioning of the mind or emotions and in which psychological, cognitive, emotional or

behavioral disturbances are the dominating feature.

Mental Disorder is neurosis, psychoneurosis, psychopathy, psychosis, or mental or emotional disease or disorder of any kind.

Morbid Obesity is a diagnosed condition in which the body weight exceeds the medically recommended weight by either 100 pounds or is twice the medically recommended weight in the most recent Metropolitan Life Insurance Co. tables for a person of the same height, age and mobility as the Covered person.

Outpatient Care is treatment including services, supplies and medicines provided and used at a Hospital under the direction of a Physician to a person not admitted as a registered bed patient; or services rendered in a Physician's office, laboratory or X-ray facility, an Ambulatory Surgical Center, or the patient's home.

Pharmacy means any establishment which is registered and licensed as a Pharmacy with the appropriate governmental agency and in which Prescription Drugs are regularly compounded and dispensed to the public by a Pharmacist. An institutionally based pharmacy that does not dispense to the general public is not a Pharmacy for purposes of this program.

Physician means a person who is a doctor of medicine (M.D.) or a doctor of osteopathy (D.O.), licensed, and legally entitled to practice medicine in all its branches, perform surgery and dispense drugs.

Plan means Nazareth Area School District Employee Healthcare Benefit Plan, which is a benefits plan for certain employees of Nazareth Area School District and eligible dependents as described in this document.

Plan Year is the twelve (12)-month period beginning on either the Effective Date of the Plan or on the day following the end of the first Plan Year which is a short Plan Year.

Pregnancy is childbirth and conditions associated with Pregnancy, including complications.

Prescription Drugs are (a) any medication which by federal or state law may not be dispensed without a prescription, (b) insulin, (c) non-reusable devices used to administer such drugs and (d) diabetic supplies.

Professional Provider means a licensed doctor of medicine, Dentist, podiatrist, osteopath, optometrist, chiropractor, audiologist, physical therapist, psychologist, nurse midwife, speech-language pathologist, teacher of the hearing impaired, clinical laboratory, certified clinical nurse specialist, certified community health nurse, certified enterostomal therapy nurse, certified psychiatric mental health nurse, certified registered nurse anesthetist, certified registered nurse practitioner, acting within the authority of such licensure.

Provider means a person or entity licensed or approved to provide Covered Services and performing services within the authority of such licensure.

A. Participating Provider is a Provider that has an agreement with Capital Blue Cross pertaining to payment for Covered Services rendered to a Covered Person.

B. Non-participating Provider is a Provider that does not meet the definition of a Participating Provider.

C. Reciprocating Provider is a Facility Provider that has an agreement with a Blue Cross Plan other then Capital Blue Cross pertaining to payment for Covered Services to a Covered Person.

Psychiatric Hospital is a Facility Provider approved by the Joint Commission on the Accreditation of Health Care Organizations or by the American Osteopathic Hospital Association and by the Plan which is primarily engaged in providing diagnostic and therapeutic services for the Inpatient treatment of Mental Illness. Such services are provided by or under the supervision of an organized staff of Physicians. Continuous nursing services are provided by or under the supervision of a Registered Nurse.

Recovery means moneys paid to the Covered Person by way of judgment, settlement, or otherwise to compensate for all losses caused by the Injuries or Sickness whether or not said losses reflect medical or dental charges covered by the Plan.

Rehabilitation Hospital is a Facility Provider approved by the Joint Commission on the Accreditation of Health Care organizations, or by the Commission on Accreditation of Rehabilitation Facilities which is primarily engaged in providing skilled rehabilitation services on an Inpatient basis. Skilled rehabilitation services consist of the combined use of medical, social, educational, and vocational services to enable Covered Persons disabled by disease or injury to achieve the highest possible level of functional ability. Skilled rehabilitation services are provided by or under the supervision of an organized staff of Physicians. Continuous nursing services are provided by or under the supervision of a Registered Nurse.

Retired Employee is a former Active Employee of a Covered Employer who was retired while employed by a Covered Employer under the formal written plan of the Covered Employer and elects to contribute to the Plan the contribution required from the Retired Employee.

Sickness is a Covered Person's illness, disease or Pregnancy (including complications). For a newborn child after birth, but before release from a medical facility, Sickness also includes a congenital defect, a birth abnormality or a premature birth.

Skilled Nursing Facility is a facility that fully meets all of these tests:

(1) It is licensed to provide for persons convalescing from Injury or Sickness, professional nursing services on an inpatient basis. The service must be rendered by a registered nurse (R.N.) or by a licensed practical nurse (L.P.N.) under the direction of a registered nurse. Physical restoration services to assist patients to reach a degree of body functioning to permit self-care in essential daily living activities must be provided.

(2) Its services are provided for compensation from its patients and under the full-time supervision of a Physician or a registered nurse.

(3) It provides twenty-four (24) hour per day nursing services by licensed nurses, under the direction of a full-time registered nurse.

(4) It maintains a complete medical record on each patient.

(5) It has an effective utilization review plan.

(6) It is not, other than incidentally, a place for: rest, the aged, drug addicts, alcoholics, mental retardates, Custodial or educational care or care of Mental Disorders.

(7) It is approved and licensed by Medicare.

This term also applies to charges incurred in a facility referring to itself as an extended care facility, convalescent nursing home, or any other similar nomenclature.

Spouse means the legally recognized marital partner of an Employee.

Substance Abuse Treatment Facility is a Provider licensed by the state, approved by the Joint Commission on the Accreditation of Health Care Organization, which primarily provides detoxification and/or rehabilitation treatment for substance abuse. This facility must also meet the minimum standards set by the Pennsylvania Department of Health, the Pennsylvania Office of Drug and Alcohol Programs, or other appropriate governmental agency.

Subrogation is the Plan's right to pursue the Covered Person's claims for medical or dental charges against the other party.

Surgery

A. The performance of generally accepted operative and cutting procedures including specialized instrumentation's, endoscopic examinations and other procedures;

B. The correction of fractures and dislocations; and

C. Usual and related pre-operative and post-operative care.

Total Disability (Totally Disabled) means: in the case of an Active Employee, the inability to perform the substantial duties of his or her occupation or of a similar occupation for which the person is reasonably capable due to education and training, as a result of Injury or Sickness.

In the case of a Dependent or Retired Employee, it means substantially unable to perform the normal activities of a person of like age and sex in good health.

Usual, Customary and Reasonable Charge is the fee determined and payable by Claims Administrator (using UCR tables developed by Medical Data Research at no less then the 90th percentile) in accordance with:

A. the USUAL fee which an individual Professional Provider most frequently charges to the majority of patients for the procedure performed***;***

B. the CUSTOMARY fee determined by the Plan based on charges made by Professional Providers of similar training and experience in a given geographic area for the procedure performed; or

C. the REASONABLE fee (which may differ from the usual or customary charge) determined by the Plan by considering unusual clinical circumstances; the degree of professional involvement; or the actual cost of equipment and facilities involved in providing the service

CLAIM FILING AND APPEAL PROCEDURES
HOW TO SUBMIT A CLAIM

Claim filing instructions are included on the back of the Plan identification card. The three digit alpha prefix (YWT) that appears before the Employee's ID number on the card must be included when claims are submitted to local Blue Cross and Blue Shield Plans. If the alpha prefix is not used, the claims may be routed incorrectly and payment could be delayed. Participating providers should submit claims to their local Plan following current filing procedures.

Hospital/Facility Claims

Show the identification card at the time services are rendered. Facilities bill Blue Cross directly. If there are questions regarding a physician claim, contact NCAS Pennsylvania for information.

Physician Claims

Show the identification card at the time services are rendered. Participating physicians will bill Capital Blue Cross directly. All physician claims can be submitted directly through Capital Blue Cross, whether participating or non-participating with the Capital Blue Cross Network to facilitate claim filing. If there are questions regarding a physician claim, contact NCAS Pennsylvania for information.

Other Medical Claims

(1) Obtain a claim form from the Nazareth Area School District office, any individual building offices or the Plan Administrator.

(2) Complete the Employee portion of the form. ALL QUESTIONS MUST BE ANSWERED.

(3) Have the Physician complete the provider's portion of the form.

(4) For Plan reimbursements, attach bills for services rendered. ALL BILLS MUST SHOW:

- Name of Plan
- Employee's name
- Name of patient
- Name, address, telephone number of the provider of care
- Diagnosis
- Type of services rendered, with diagnosis and/or procedure codes
- Date of services
- Charges

(5) Send the above to the Claims Administrator at this address:

NCAS Pennsylvania
P O Box 778975
Harrisburg, Pennsylvania 17177-8975
1-866-787-9872

WHEN CLAIMS SHOULD BE FILED

Claims should be filed with the Claims Administrator no later then the end of the calendar year following the year in which the claims are incurred. Claims filed later than that date may be declined or reduced unless:

(a) it's not reasonably possible to submit the claim in that time; and

(b) the claim is submitted within one year from the date incurred. This one year period will not apply when the person is not legally capable of submitting the claim.

The Claims Administrator will determine if enough information has been submitted to enable proper consideration of the claim. If not, more information may be requested from the claimant. The Plan reserves the right to have a Plan Participant seek a second medical opinion.

CLAIMS PROCEDURE

Following is a description of how the Plan processes Claims for benefits. A Claim is defined as any request for a Plan benefit, made by a claimant or by a representative of a claimant, that complies with the Plan's reasonable procedure for making benefit Claims. The times listed are maximum times only. A period of time begins at the time the Claim is filed. Decisions will be made within a reasonable period of time appropriate to the circumstances. "Days" means calendar days.

There are different kinds of Claims and each one has a specific timetable for either approval, payment, request for further information, or denial of the Claim. If you have any questions regarding this procedure, please contact the Plan Administrator.

The definitions of the types of Claims are:

Urgent Care Claim

A Claim involving Urgent Care is any Claim for medical care or treatment where using the timetable for a non-urgent care determination could seriously jeopardize the life or health of the claimant; or the ability of the claimant to regain maximum function; or in the opinion of the attending or consulting Physician, would subject the claimant to severe pain that

could not be adequately managed without the care or treatment that is the subject of the Claim.

A Physician with knowledge of the claimant's medical condition may determine if a Claim is one involving Urgent Care. If there is no such Physician, an individual acting on behalf of the Plan applying the judgment of a prudent layperson who possesses an average knowledge of health and medicine may make the determination.

In the case of a Claim involving Urgent Care, the following timetable applies:

Notification to claimant of benefit determination ..... 72 hours

Insufficient information on the Claims, or failure to follow the Plan's procedure for filing a Claim:

Notification to claimant, orally or in writing..... 24 hours

Response by claimant, orally or in writing..... 48 hours

Benefit determination, orally or in writing..... 48 hours

Ongoing courses of treatment, notification of:

Reduction or termination before the end of treatment . 72 hours

Determination as to extending course of treatment .... 24 hours

If there is an adverse benefit determination on a Claim involving Urgent Care, a request for an expedited appeal may be submitted orally or in writing by the claimant. All necessary information, including the Plan's benefit determination on review, may be transmitted between the Plan and the claimant by telephone, facsimile, or other similarly expeditious method. It is important to understand that these procedures only apply to a Plan that applies Preauthorization or Predetermination requirements to medical care or treatment of claims involving Urgent Care.

Post-Service Claim

A Post-Service Claim means any Claim for a Plan benefit that is not a Claim involving Urgent Care; in other words, a Claim that is a request for payment under the Plan for covered medical services already received by the claimant.

In the case of a Post-Service Claim, the following timetable applies:

Notification to claimant of benefit determination ..... 30 days

Extension due to matters beyond the control of the Plan..... 15 days

Insufficient information on the Claim:

Notification of ..... 15 days

Response by claimant ..... 45 days

Review of adverse benefit determination ..... 30 days per benefit appeal

Notice to claimant of adverse benefit determinations

Except with Urgent Care Claims, when the notification may be orally followed by written or electronic notification within three days of the oral notification, the Plan Administrator shall provide written or electronic notification of any adverse benefit determination. The notice will state, in a manner calculated to be understood by the claimant:

(1) The specific reason or reasons for the adverse determination.

(2) Reference to the specific Plan provisions on which the determination was based.

(3) A description of any additional material or information necessary for the claimant to perfect the Claim and an explanation of why such material or information is necessary.

(4) A description of the Plan's review procedures, incorporating any voluntary appeal procedures offered by the Plan, and the time limits applicable to such procedures. This will include a statement of the claimant's right to bring a civil action under section 502 of ERISA following an adverse benefit determination on review.

(5) A statement that the claimant is entitled to receive, upon request and free of charge, reasonable access to, and copies of, all document, records, and other information relevant to the Claim. "You and your Plan may have other voluntary alternative dispute resolution option, such as mediation. One way to find out what may be available is to contact your local U.S. Department of Labor Office."

(6) If the adverse benefit determination was based on an internal rule, guideline, protocol, or other similar criterion, the specific rule, guideline, protocol, or criterion will be provided free of charge. If this is not practical, a statement will be included that such a rule, guideline, protocol, or criterion was relied upon in making the adverse benefit determination and a copy will be provided free of charge to the claimant upon request.

(7) If the adverse benefit determination is based on the Medical Necessity or Experimental or Investigational treatment or similar exclusion or limit, an explanation of the scientific or clinical judgment for the determination, applying the terms of the Plan to the claimant's medical circumstances, will be provided, If this is not practical, a statement will be included that such explanation will be provided free of charge, upon request.

Appeals

When a claimant receives an adverse benefit determination, the claimant has 180 days following receipt of the notification in which to appeal the decision. A claimant may submit written comments, documents, records, and other information relating to the Claim. If the claimant so requests, he or she will be provided, free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the claim.

Appeals should be directed to the Claim Administrator at the following address:

NCAS Pennsylvania
Appeals Unit
P. O. Box 69700
Harrisburg, Pennsylvania 17106-9700

The period of time within which a benefit determination on review is required to be made shall begin at the time an appeal is filed in accordance with the procedures of the Plan. This timing is without regard to whether all the necessary information accompanies the filing.

A document, record, or other information shall be considered relevant to a Claim if it:

(1) was relied upon in making the benefit determination;

(2) was submitted, considered, or generated in the course of making the benefit determination, without regard to whether it was relied upon in making the benefit determination;

(3) demonstrated compliance with the administrative processes and safeguards designed to ensure and to verify that benefit determinations are made in accordance with Plan documents and Plan provisions have been applied consistently with respect to all claimants; or

(4) constituted a statement of policy or guidance with respect to the Plan concerning the denied treatment option or benefit.

The review shall take into account all comments, documents, records, and other information submitted by the claimant relating to the Claim, without regard to whether such information was submitted or considered in the initial benefit determination. The review will not afford deference to the initial adverse benefit determination and will be conducted by a fiduciary of the Plan who is neither the individual who made the adverse determination nor a subordinate of that individual.

If the determination was based on a medical judgment, including determinations with regard to whether a particular treatment, drug, or other item is Experimental,

Investigational, or not Medically Necessary or appropriate, the fiduciary shall consult with a health care professional who was not involved in the original benefit determination. This health care professional will have appropriate training and experience in the field of medicine involved in the medical judgment. Additionally, medical or vocational experts whose advice was obtained on behalf of the Plan in connection with the initial determination will be identified.

If after exhausting Step #1 of the Review Procedure, an Employee may request an Appeal to Plan Trustees for a full and fair review. Such request must be made to the Claims Administrator in writing and received by the Claims Administrator within 60 days of receipt of the response to Step #1. The Claims Administrator must submit such request for appeal to the Employee Benefit Trust of Eastern Pennsylvania Trust Manager for placement on the agenda of the next regularly scheduled meeting of the Board of Trustees, which will in no case be more than 120 days after the request for appeal is received by the Trust Manager. The appeal will be submitted to the Plan Trustees on the basis of the records and will be heard by the Plan Trustees on an anonymous basis. The written decision of the Plan Trustees will be made by the Claims Administrator to the Employee within 30 days of the Plan Trustees meeting where action was taken on such appeal and will include specific reasons for the decision and specific reference to the Plan provisions on which the decision is based. The decision by the Plan Trustees will be final action by the Employee Benefit Trust of Eastern Pennsylvania Benefit Trust Plan Trustees on such appeal.

Voluntary appeals, including voluntary arbitration

During voluntary dispute resolution, any statue of limitations or other defense based on timeliness is tolled during the time any voluntary appeal is pending.

The Plan waives any right to assert that a claimant has failed to exhaust administrative remedies because he or she did not elect to submit a benefit dispute to the voluntary appeal provided by the Plan. A claimant may elect a voluntary appeal after exhaustion of appeals of an adverse benefit determination as explained in the section above entitled, “Appeals”. However, this voluntary appeal may be conducted as one of the two appeals available to the claimant.

The Plan will provide to the claimant, at no cost and upon request, sufficient information about the voluntary appeal to enable the claimant to make an informed judgment about whether to submit a benefit dispute to the voluntary rights to any other benefits under the Plan; will list the rules of the appeal; state the claimant’s right to representation; enumerate the process for selecting the decision maker; and give circumstances, if any, that may affect the impartiality of the decision maker.

No fees or costs will be imposed on the claimant as part of the voluntary level of appeal, and the claimant will be told this.

RESPONSIBILITIES FOR PLAN ADMINISTRATOR

Funding of the Plan and Payment of Benefits

The cost of the Plan is funded as follows:

For Employee and /or Dependent Coverage - Funding is derived from funds of the Covered Employer and Contributions made by the Covered Employees.

The level of any Employee contributions will be set by the Covered Employer. These Employee Contributions will be used in funding the cost of the Plan as soon as practicable after they have been received from the Employee or withheld from the Employee's pay through payroll deduction. Contributions through payroll deduction are exempt from federal, social security and state income taxes.

Facility of Payment

If, in the opinion of the Employer, a valid release cannot be rendered for the payment of any benefit payable under this Plan, the Employer may, at its option, make such payment to the individuals as have, in the Employer's opinion, assumed the care and principal support of the Covered Person and are therefore equitably entitled thereto. In the event of the death of the Covered Person prior to such time as all benefit payments due him have been made, the Employer may, at its sole discretion and option, honor benefit assignments, if any, prior to the death of such Covered Person.

Fiduciary Operation

Each Fiduciary shall discharge his duties with respect to the Plan solely in the interest of the Covered Persons and beneficiaries and (i) for the exclusive purposes of providing benefits to Covered Persons and their beneficiaries and defraying reasonable expenses of administering the Plan, (ii) with care, skill, prudence and diligence under the circumstances then prevailing that a prudent man acting in a like capacity and familiar with such matters would use in the conduct of an enterprise of a like character and with like aims, and (iii) in accordance with the documents and instruments governing the Plan to the extent that they are consistent with the provisions of The Employee Retirement Income Security Act of 1974, except as otherwise possible under such Act and the Plan Documents.

Plan Administrator

The Administrator shall be responsible for compliance by the Plan with all requirements of Part I of Subtitle B of Title I of the Employee Retirement Income Security Act of 1974. In addition, the Administrator shall have full charge of the operation and management of the Plan.

The Claims Administrator, if any, shall provide claims paying and related services to the

Employer and the Administrator in connection with the operation of the Plan. The Claims Administrator shall be entitled to reasonable compensation for its services.

The Employer, Administrator, and Claims Administrator may designate any person or persons to carry out their respective responsibilities. Any person or group of persons may serve in more than one (1) fiduciary capacity with respect to the Plan.

A Named Fiduciary or a fiduciary designated by a Named Fiduciary may employ one (1) or more persons to render advice with regard to any responsibility such fiduciary has under the Plan.

Any fiduciary, Employee, agent, representative or other person performing services to or for the Plan or Employer shall be entitled to reasonable compensation for services rendered, unless such person is the Employer or already receives full-time pay from the Employer, and for reimbursement of expenses properly and actually incurred.

Plan Modification and Amendment of Plan (Subject to Approval of the Employee Benefit Trust of Eastern Pennsylvania)

The Plan and any provision thereof may be modified or amended by mutual agreement between the Employer and the Association. The modification or amendment will be effective at the date of approval or at such later date as Employer may determine in connection therewith. Such modification or amendment shall be duly incorporated in writing into the master copy of the Plan on file with the Employer or written copy thereof shall be deposited with such master copy of the Plan. The process for amending the Plan will be for the Plan Administrator to produce a proposed amendment. After approval by the Employer the Plan Administrator will sign the amendment. The amendment will be effective as of the effective date shown on the amendment. Appropriate filing and reporting of any such modification or amendment with governmental authorities and to Employee Covered Persons shall be timely made by the Administrator in accordance with Title I of the Employee Retirement Income Security Act of 1974.

Plan Termination

The Plan is created as a permanent Plan, however, may be terminated at any time by the Employer upon due authorization of such termination effective as of the date of such authorization, or at such later date as the Employer may provide. In the event of such termination, the Employer shall have no obligation under the Plan beyond paying the difference between the claims incurred (even though later filed) and expenses of the Plan due up to the date of termination plus extended benefits, if any, as provided herein. Such claims and expenses shall be paid from the Plan funds as normal expenses of the Plan.

Assignment of Benefits

The Covered Person's benefits may not be assigned except by consent of the Administrator.

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 discharge any Employee at any time; provided, however, that the foregoing shall not be deemed to modify the provisions of any collective bargaining agreements which may be made by the Employer with the bargaining representatives of any Employee.

Clerical Error or Omission

Clerical error or clerical omission as relates to any insurance or administrative responsibility of any party providing services or protection to any plan Covered Person or other party to the Plan will not void coverage which would otherwise have been in force nor continue coverage which would have terminated. If a clerical error or clerical omission occurs, the Plan Administrator and the Claims Administrator may equitably adjust any Employee contributions, administrative fee charges, claims payment or recovery, or premium payment with respect to which a clerical error or clerical omission has occurred. The adjustment will be such that the parties occupy the position(s) they would have occupied had the error or omission not occurred. However, if more than six (6) months has elapsed prior to discovery of any error, adjustment of premiums or fees is waived. No party shall be liable for the failure of any other party to perform.

Plan Administrator's Authority to Interpret the Plan

The Plan Administrator retains discretionary authority to interpret the Plan document and Summary Plan description in matters involving payment or nonpayment or exclusion of claims, definition of Plan terms, determination of medical necessity for treatment, determination of whether a disputed procedure is experimental, determination of gross misconduct for continuation of benefits purposes, determination of hazardous activity and any other decision which involves discretion on the part of the Plan. In the event that a dispute arises regarding the Plan Administrator's exercise of discretionary authority**,** the decisions can be appealed to the Plan Trustees whose decision will be final and binding on the Plan. The Trustees decision is subject to member appeal through the grievance /arbitration process.

Less Expensive Alternate Medical Treatment

The Plan Administrator reserves the right to approve a medical treatment which is not routinely covered but is a less expensive appropriate medical treatment that what is recommended by a Physician. Approval of the less expensive alternate medical treatment shall require approval of the Plan Administrator.

Definition and Construction

This Plan shall be construed, enforced and administered in accordance with the *Employee Retirement Income Security Act of 1974 and the Amendments thereto.*

Administrator

The Employer shall be the Administrator of the Plan; provided, however, the Chief Executive Officer of the Employer or his designee may from time to time designate a person, committee or organization to perform the duties of the Employer or Administrator of the Plan. Except as otherwise specifically provided in the Plan or in any insurance contract, the Administrator shall have the authority to control and manage the operation and administration of the Plan and shall be the Named Fiduciary of the Plan. The Administrator shall have all power necessary or convenient to enable it to exercise such authority. In connection therewith, the Administrator may provide rules and regulations not inconsistent with the provisions hereof, for the operation and management of the Plan, and may, from time to time, amend or rescind such rules and regulations. The Administrator shall serve until removed by the Employer, which removal may be with or without cause and without advance notice. The Administrator shall have the discretionary authority to make decisions relative to payment of claims, determination of benefits and eligibility for benefits, determination of Covered Person contributions and determination of the basis for calculation of said benefit contributions. The Administrator's decisions in these matters are subject to member appeal to the Trustees.

Non-alienation

No benefit under the Plan shall be liable for any debt, liability, contract, engagement or tort of any individual covered by the Plan, nor subject to anticipation, sale, assignment, transfer, encumbrance, pledge, charge, attachment, garnishment, execution, alienation or any other voluntarily or involuntarily alienation or other legal or equitable process, nor transferable by operation of law, except as may be provided in the Schedules.

Allocation of Fiduciary Responsibilities

Each fiduciary under the Plan shall be responsible only for the specific duties assigned under the Plan and shall not be directly or indirectly responsible for the duties assigned to another fiduciary, except as may otherwise be provided in the Employee Retirement Income Security Act of 1974 (ERISA).

Limitation of Rights and Obligations

Neither the establishment nor maintenance of the Plan nor any amendment thereof, nor the purchase of any insurance contract, nor any act or omission under the Plan or resulting from the operation of the Plan shall be construed:

a) As conferring upon any Covered Person, Employee, Dependent, or any other

person any right or claim against the Employer or the Administrator, except to the extent that such right or claim shall be specifically expressed and provided in the Plan or provided under the Employee Retirement Income Security Act of 1974 (ERISA); or

b) As an agreement, consideration or inducement of employment or as affecting in any manner or to an extent whatsoever the rights or obligations of the Employer or any Covered Person or Employee to continue or terminate the employment relationship at any time.

Nondiscrimination

The Plan shall not discriminate as to coverage or benefits in favor of highly compensated Employees of the Employer in violation of Code Sections 501(c)(9) or 505.

Audit

If an audit of the Plan is required under the Act for any Plan Year, Administrator shall engage an independent qualified public accountant. Such audit shall be conducted in accordance with the requirements of Section 103 of the Employee Retirement Income Security Act of 1974 (ERISA).

Termination of the Plan

In the event the Plan is terminated and the Plan holds assets at the time of termination, the Plan's assets shall be used in the following priority:

a) For payment of any Plan expense including outstanding claims, taxes, administrative, legal, accounting or auditing fees.
b) For payment of any premiums which were incurred prior to the termination of the Plan, subject to satisfaction of c).
c) For a final accounting to be made, including filing of tax documents with the Internal Revenue Service.

If, after all of the above have been satisfied and reserves established for c) above, and there are remaining assets, then the remaining assets will be distributed in equal amounts to the individuals who were Covered Persons in the Plan during the twelve (12) Months immediately prior to the termination of the Plan.

GENERAL PLAN INFORMATION

CERTAIN EMPLOYEE RIGHTS UNDER ERISA

Covered Employees in this Plan are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA). ERISA specifies that all Plan Covered Persons (Covered Employees under this Plan) shall be entitled to:

(1) Examine, without charge, at the Plan Administrator's office, all Plan documents including insurance contracts and copies of all documents filed by the Plan with the U.S. Department of Labor, such as detailed annual reports and plan descriptions.

(2) Obtain copies of all Plan documents and other Plan information upon written request to the Plan Administrator. The Plan Administrator may make a reasonable charge for the copies.

(3) Receive a summary of the Plan's annual financial report.

(4) File suit in a federal court, if any materials requested are not received within thirty (30) days of the Covered Person's request, unless the materials were not sent because of matters beyond the control of the Plan Administrator. The court may require the Plan Administrator to pay up to $110 for each day's delay until the materials are received.

In addition to creating rights for Covered Employees, ERISA imposes obligations upon the individuals who are responsible for the operation of the Plan. The individuals who operate the Plan, called "fiduciaries" of the Plan, have a duty to do so prudently and in the interest of the Employees and their beneficiaries. No one, including the Employer or any other person, may fire a Covered Employee in any way to prevent the Employee from obtaining benefits under the Plan or from exercising his rights under ERISA.

If an Employee's claim for a benefit is denied, in whole or in part, the Employee must receive a written explanation of the reason for the denial. The Employee has the right to have the Plan reviewed and consider the claim. Under ERISA there are steps that the Employee can take to enforce the above rights. For instance, if the Employee requests materials from the Plan and does not receive them within thirty (30) days, that person may file suit in federal court. In such a case, the court may require the Plan Administrator to provide the materials and to pay the Employee up to $110 a day until he receives the materials, unless the materials were not sent because of reasons beyond the control of the Plan Administrator. If the Employee has a claim for benefits which is denied or ignored, in whole or in part, that Covered Person may file suit in state or federal court.

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

If the Employee has any questions about the Plan, he should contact the Plan Administrator. If the Covered Employee has any questions about this statement or his rights under ERISA, that Employee should contact the nearest area office of the Pension and Welfare Benefits Administration, U.S. Department of Labor, 200 Constitution Avenue, N.W., Washington, D.C. 20210. The nearest regional office is the Philadelphia Regional Office, Gateway Bldg., 3535 Market Street, Room M300, Philadelphia, PA 19104, Phone: 215/596-1134**.**

IMPORTANT NOTICE REGARDING EXPERIMENTAL OR INVESTIGATIONAL TREATMENTS

The Plan does not cover services which it determines are Experimental or Investigational in nature because those services are not accepted by the broad medical community as effective treatments. However, the Plan acknowledges that situations exist when a patient and his Provider agree to pursue an Experimental treatment. If your Provider performs an Experimental or Investigational procedure, you are responsible for the charges. You or your Provider may contact the Claims Administrator to determine whether a service is considered Experimental Investigations.

The terms “Experimental or Investigational” and “Provider” are defined in this booklet.

Relationship to Blue Cross and Blue Shield Association

This program is between Nazareth Area School District, NCAS Pennsylvania, and Capital Blue Cross only. Capital Blue Cross and NCAS Pennsylvania are independent corporations operating under a license from the Blue Cross and Blue Shield Association (“the Association”), which is a national association of independent Blue Cross and Blue Shield Plans throughout the United States. Although all of these independent Blue Cross and Blue Shield Plans operate from a license with the Association, each of them is a separate and distinct corporation. The Association allows Capital Blue Cross and NCAS Pennsylvania to use the familiar Blue Cross and Blue Shield words and symbols. Capital Blue Cross and NCAS Pennsylvania are not contracting agents of the national Association. Only Capital Blue Cross and NCAS Pennsylvania shall be liable to Nazareth Area School District for any of the Plan obligations under this program.

Out-of-Area Claims

When a Covered Person receives Medical Care through the BlueCard Program outside the Capital Blue Cross service area, the amount paid for Covered Services is typically calculated on the **lesser** of:

(1) The Provider's **billed charges** for your Covered Services, or

(2) The **negotiated price** for Covered Services the local Blue Cross or Blue Shield Plan passes on to Capital Blue Cross.

Often this "negotiated price" is simply a discount. But sometimes it is an estimated final price that factors in expected settlements or other non-claims transactions with the health care Facility Providers or with a specified group of Facility Providers. The negotiated price may also be a discount from billed charges that reflects an average expected savings. The estimated or average price may be prospectively adjusted to correct for over-or underestimation of past prices.

In addition, a few Blue Cross and Blue Shield Plans are governed by state laws that do not allow the Covered Person liability calculations (the amount the Covered Person pays for Covered Services) based on the lesser of billed charges or the negotiated price. When covered health care services are received in one of these states, the amount paid for Covered Services will be calculated using the state's methods.

TYPE OF ADMINISTRATION

The Plan is a self-funded welfare plan and the administration is provided through a third party Claims Administrator.

PLAN NAME
Nazareth Area School District Employee Benefit Plan

PLAN NUMBER*:* 501

TAX ID NUMBER*:* 23-2251070 Employee Benefit Trust of Eastern Pennsylvania

PLAN EFFECTIVE DATE*:* July 1, 1997

PLAN YEAR ENDS: JUNE 30TH

EMPLOYER INFORMATION: Nazareth Area School District

One Education Plaza
Nazareth, PA 18064
(610) 759-1170

PLAN ADMINISTRATOR*:*

Employee Benefit Trust of Eastern Pennsylvania

6 Danforth Drive
Easton, PA 18045-7899
(610) 515-6510

AGENT FOR SERVICE OF LEGAL PROCESS*:*

Trust Manager
Employee Benefit Trust of Eastern Pennsylvania

6 Danforth Drive
Easton, PA 18045-7899
(610) 515-6415

CLAIMS ADMINISTRATOR*:*

NCAS Pennsylvania
Department 778974
Harrisburg, Pennsylvania 17177-8975
(866) 787-9872

PLAN FIDUCIARY:

Employee Benefit Trust of Eastern Pennsylvania.

6 Danforth Drive
Easton, PA 18045-7899
(610) 515-6510