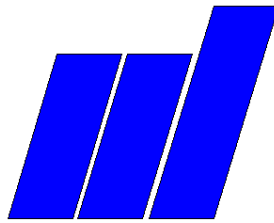

EMPLOYEE

BENEFIT

PLAN



City of McAllen

Amended and Restated Effective October 1, 2010

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INTRODUCTION

WHEREAS, the City of McAllen, the City of McAllen Public Utilities and the Board of Trustees of the City of McAllen, hereinafter referred to as the "City," hereby establishes the benefits, rights and privileges which shall pertain to Covered Participants, as defined herein, and which benefits are provided through a fund established by the City and hereinafter referred to as the "Plan".

The City of McAllen has prepared this Plan document to help you understand the medical benefits. The Medical Plan described in this Plan provides coverage for a wide range of medical care, services and supplies. However, your benefits are affected by certain limitations and conditions that require you to be an informed consumer of health services and to only use those services you need. The medical benefits are not provided for certain kinds of Treatment or services, even if recommended by your physician. Please review the General Plan Exclusions and Limitations section and the Cost Containment section. We urge you to familiarize yourself with the provisions in this Plan in order to understand your benefits.

This is to certify that the City of McAllen has selected a plan of medical benefits and as Plan Administrator, has the responsibility for compliance with state and federal law applicable to employee benefits. The Plan covers City employees, dependents of employees, elected officials, dependents of elected officials, retirees, dependents of retirees, retiree city officials, dependents of retiree city officials, city agency Affiliates, dependents of city agency Affiliates, continuation of coverage ("COC") participants, dependents of COC participants who are eligible for coverage, become covered and continued to be covered according to terms of the Plan. The terms of the Plan are described in the following pages. The City hereby reserves the right to amend this Plan if circumstances warrant and have given the Plan Administrator the discretionary authority to construe the terms of the Plan.

PURPOSE

The purpose of this Plan document is to set forth the provisions that provide for the payment or reimbursement of all or a portion of eligible medical expenses.

EFFECTIVE DATE

The original effective date of the Plan is October 1, 1995. The Plan is hereby amended and restated effective October 1, 2010.

PLAN SUPERVISOR

The Plan Supervisor (or Third Party Administrator) of the Plan is Blue Cross Blue Shield of Texas.

PLAN ADMINISTRATOR

The Plan Administrator is the City of McAllen acting by and through the City Manager or his assigned representatives who shall have the authority to control and manage the operation and administration of the Plan. The City shall have the authority to amend the Plan, to determine its policies, to appoint and remove other supervisors, fix their compensation (if any), and exercise general administrative authority over them. The Administrator has the sole authority and responsibility to review and make final decisions on all claims to benefits hereunder.

PLAN INTERPRETATIONS AND BENEFIT DETERMINATIONS

The City of McAllen shall have the authority, in its sole discretion, to make any and all factual determinations, Plan interpretations, eligibility and/or other determinations that it deems necessary, and no determination or interpretation made by the City shall be subject to reversal or even review in any judicial or other proceeding except upon pleading and proof that the City's determination or interpretation constitutes an abuse of discretion and has resulted in an erroneous benefit determination.

DEFINITIONS

IMPORTANT: See the DEFINITIONS chapter for the meaning or explanation of the manner in which certain words and phrases are used in this Plan.

AMENDING AND TERMINATING THE PLAN

The City intends to maintain this Plan indefinitely; however, in its capacity as Plan Sponsor, the City reserves the right to amend, suspend or terminate the Plan, in whole or in part, at any time. This includes amending the benefits under the Plan or the Trust agreement (if any). Any such Amendment or termination shall be adopted by formal action by the officer(s) and/or other designated official representative(s) authorized to act for or on behalf of the City in this capacity. Nothing in the Plan shall be construed to limit the rights of the City of McAllen, which are set forth in this section.

PATIENT PROTECTION AND AFFORDABLE CARE ACT

The Patient Protection and Affordable Care Act, as amended by the Health Care and Education Reconciliation Act ("PPACA") imposes various requirements on the City to provide certain health care benefits under the Plan. Accordingly, the Plan shall at all times be administered and interpreted consistently with the requirements of PPACA and any related government guidance that is applicable to the City. To the extent the terms set forth in this Plan are inconsistent with or violate PPACA the City may modify and amend the Plan so as to be in compliance with PPACA.

CONTRIBUTIONS TO THE PLAN

A fund shall be established pursuant to the Plan to which Contributions shall be made. Contributions to the fund shall be deposited in a bank or similar financial institution. The fund shall be held in trust to be utilized for the purpose of providing benefits for Participants, and defraying reasonable expenses of administering the Plan.

The City shall from time to time evaluate the costs of the Plan and determine the amount to be contributed by the City and the amount to be contributed (if any) by each Covered Participant. Notwithstanding any other provision of the Plan, the City's obligation to pay claims otherwise allowable under the terms of the Plan shall be limited to its obligation to make Contributions to the Plan as set forth herein. Payment of the said claims in accordance with these procedures shall discharge completely the City's obligation with respect to such payments.

In the event the Plan is terminated, then as of the effective date of termination, the City shall have no further obligation to make additional Contributions to the Plan. All previous Contributions by the City shall continue to be issued for the purpose of paying benefits under the provisions of this Plan with respect to claims arising before such termination, or shall be used for the purpose of providing similar benefits to Participants, until all Contributions are exhausted.

PROTECTION AGAINST CREDITORS

No benefit payment under this Plan shall be subject in any way to alienation, sale, transfer, pledge, attachment, garnishment, execution or encumbrance of any kind, and any attempt to accomplish the same shall be void.

If the City shall find that such an attempt has been made with respect to any payment due or to become due to any Covered Participant, the City in its sole discretion may terminate the interest of such Covered Participant or former Covered Participant in such payment and in such case shall apply the amount of such payment to or for the benefit of such Covered Participant or former Covered Participant, as the City may determine, and any such application shall be a complete discharge of all liability with respect to such benefit payment.

PLAN NOT A CONTRACT OF EMPLOYMENT

This Plan will not be deemed to constitute a contract of employment or give any Employee Participant of the City the right to be retained in the service of the City or to interfere with the right of the City to discharge or otherwise terminate the employment of any Employee Participant. This Plan is also not to be considered a contract between the City and the Employee Participants but it is provided by the City as a benefit to the Employee Participants.

HOW BENEFITS ARE PAID/CLAIMS

Requests for Reimbursements

Requests for reimbursement for a covered benefit should be sent to the Plan Supervisor within ninety (90) days of date of service (or within ninety (90) days after a non compensable claim decision is made by Workers' Compensation). Claims filed later than that date may be declined or reduced unless:

- (i) It is not reasonably possible to submit the claim in that time; and
- (ii) The claim is submitted within one (1) year from the date Incurred. This one (1) year period will not apply when the person is not legally capable of submitting the claim.

Requests must include:

1. The Employee's name, address, social security number and group name;
2. The Covered Participant's name and relationship to the Employee;
3. The Health Care Provider's name, tax ID (or social security number) and address; and
4. A description of the service rendered including charges, diagnosis code, applicable procedure codes, and the date(s) of service.

Requests for reimbursements must be legible. If a request is not legible, it may be returned with a request to submit a legible copy. Electronic claim submissions must meet the standards for electronic transactions and codes as required and set forth by the appropriate regulatory body. Claims will be considered for payment in the order received.

Claim forms are not required for benefits to be payable under the Plan. The Plan Supervisor may request specific information from the Covered Participant or Employer in order to complete processing of the claim or verify eligibility in the Plan. The information requested may include but is not limited to:

1. Verification of employment status;
2. Proof of eligible Dependent status;

3. Information related to accidental injuries;
4. Information related to work related accidents or illness; and/or
5. Information regarding any other source of benefits.

Covered Participants need to keep the Plan Administrator informed of any change in address, phone number or Dependents.

As a Covered Participant under the Plan, you must supply the Plan Supervisor with the information necessary to determine whether the charges Incurred are for an eligible expense. Decisions with respect to the type of information necessary to determine coverage shall be made at the sole discretion of the Plan Supervisor. The Plan Supervisor reserves the right to withhold or deny payment until the requested information has been furnished.

The Plan Supervisor relies mainly on information provided when a claim is submitted. If the Plan Supervisor finds that additional information is needed to determine if benefits are payable under the Plan, a written request for such information will be made to the Covered Participant, or if necessary, the Health Care Provider. If the information is not provided within thirty (30) days of request, the claim will be denied. If the claim is denied because requested information is not provided, the claim may only be refilled as long as it is within ninety (90) days of the date of service (or within ninety (90) days of a non-compensable claim decision by Workers' Compensation). This time period will not apply when the person is not legally capable of submitting the claim.

CLAIM PROCEDURES

Claims for benefits under the Plan are filed with the Plan Supervisor. Your authorized representative may act on your behalf in making the claim, provided that the Covered Participant appoints the representative in writing and that the Covered Participant provides the written authorization to the Plan Supervisor. In the case of a claim involving urgent care, a physician or other health care professional licensed, accredited, or certified to perform specified health services consistent with state law and who has knowledge of your medical condition is always permitted to act as your authorized representative.

1. Types of Claims.

Under these procedures, there are three types of claims: Post-Service Claim, Precertification Claim, and Urgent Care Claim.

2. Post-Service Claims.

- a. Post-Service Claims are those claims that are filed for payment of benefits after medical care has been received. Most claims are considered Post-Service Claims. The Covered Participant will receive a written notice of determination (whether adverse or not) from the Plan Supervisor within thirty (30) days of receipt of the claim. If the claim does not contain all of the necessary information, the claim may be denied or the Covered Participant may be asked to provide the missing information. The thirty (30)-day period may be extended by an additional fifteen (15) days if the Plan Supervisor decides that such an extension is necessary due to matters beyond the Plan Supervisor's control. If the Plan Supervisor decides that a fifteen (15)-day extension period is necessary, the Plan Supervisor will notify the Covered Participant before the end of the thirty (30)-day period of the circumstances requiring the extension and the date by which the Plan Supervisor expects to render a decision. If such an extension is necessary due to the Covered Participant's failure to submit the information necessary to decide the claim, the notice of extension will specifically describe the required information. The Covered Participant will be given at least forty-five (45) days to provide the specified information, during which time the extension period will be suspended.
- b. The Covered Participant should follow this procedure if the Covered Participant is asked to pay the full cost of a prescription when it is filled at a retail or mail-order pharmacy and the Covered Participant believes that the Plan should have paid for it. The Covered Participant should also follow this procedure if the Covered Participant pays a co-payment and believes that the amount of the co-payment was incorrect.

3. Precertification Claims.

- a. Precertification Claims are those claims that require notification or approval by the Plan prior to receiving medical care, such as pre-certification for Hospitalization. If a Precertification Claim is submitted properly with all needed information, the Covered Participant will receive written notice of the claim decision (whether adverse or not) from the Plan Supervisor within fifteen (15) days of receipt of the claim. If the Covered Participant filed a Precertification Claim improperly, the Plan Supervisor will notify the Covered Participant of the improper filing and how to correct it within five (5) days after the Precertification Claim was received. This notification may be oral unless otherwise requested by the Covered Participant or the Covered Participant's authorized representative. If the claim does not contain all of the necessary information, the claim may be denied or the Covered Participant may be asked to provide the missing information. The fifteen (15)-day period may be extended by an additional fifteen (15) days if the Plan Supervisor decides that such an extension is necessary due to matters beyond the control of the Plan. If the Plan Supervisor decides that a fifteen (15) day extension period is necessary, the Covered Participant will be notified before the end of the original fifteen (15)-day period of the circumstances requiring the extension and the date by which a decision is expected.

to be rendered. If such an extension is necessary because the Covered Participant failed to submit the information necessary to decide the claim, the notice of the extension will specifically describe the required information. The Covered Participant will be given at least forty-five (45) days to provide the specified information, during which time the extension period will be suspended.

- b. The Covered Participant should follow this procedure if a retail or mail order pharmacy fails to fill a prescription that the Covered Participant has presented.
 - c. The Plan Supervisor is only required to provide a notice to the Covered Participant that the Covered Participant has failed to follow plan procedures for Precertification Claims if failure involves a communication by the Covered Participant or the Covered Participant's authorized representative and such communication names:
 - (i) a specific person claiming the benefits;
 - (ii) a specific medical condition or symptom; and
 - (iii) specific treatment, service, or product for which approval is requested.
4. Urgent Care Claims. As stated above, Urgent Care Claims are those claims that require notification or approval prior to receiving medical care, where a delay in treatment could seriously jeopardize the Covered Participant's life or health or the ability to regain maximum function or, in the opinion of a physician with knowledge of the Covered Participant's medical condition, could cause severe pain.
- a. A claim qualifies as an Urgent Care Claim that could seriously jeopardize the Covered Participant's life or your ability to regain maximum function if:
 - (i) a physician with knowledge of the medical condition determines that these factors are met; or
 - (ii) an individual acting on behalf of the Plan applying the judgment of a prudent layperson who possesses an average knowledge of health and medicine determines that the factors are met. The individual is required to consider only the information provided by the Covered Participant or the Covered Participant's representative in making the determination of whether the claim involves urgent care.
 - b. Urgent Care Claims arise only on rare occasions. In these situations:
 - (i) The Covered Participant will receive notice of the decision (whether adverse or not) concerning the Covered Participant's benefit in writing or electronically as soon as possible, but not later than twenty-four (24) hours after the Plan Supervisor receives all necessary information, taking into account the seriousness of the Covered Participant's condition.
 - (ii) A notice of the decision may be oral with a written or electronic confirmation to follow within forty-eight (48) hours.
 - c. If the Covered Participant files an Urgent Care Claim improperly, the Plan Supervisor will notify the Covered Participant of the improper filing and how to correct it as soon as possible, but not later than twenty-four (24) hours after the Urgent Care Claim is received. If additional information is needed to process the claim, the Plan Supervisor will notify the Covered Participant of the information needed as soon as possible, but not later than twenty-four (24) hours after the claim was received. The Covered Participant will then have forty-eight (48) hours to provide the requested information.
 - d. The Covered Participant will be notified of a determination (whether adverse or not) as soon as possible, but no later than twenty-four (24) hours after the earlier of:
 - (i) The Plan Supervisor's receipt of the requested information; or
 - (ii) The end of the forty-eight (48) hour period within which the Covered Participant was to provide the additional information, if the information is not received within that time.

5. Concurrent Care Claims.

- a. If a Plan has approved an ongoing course of treatment to be provided over a period of time or number of treatments, any reduction or termination by the Plan of such a course of treatment (other than by Plan Amendment or termination) before the end of such time or number of treatments will constitute a claim denial for purposes of these procedures. The Plan Supervisor will notify the Covered Participant of the reduction or termination sufficiently in advance of the reduction or termination in order to allow the Covered Participant to appeal and obtain a decision on the appeal before the benefits are reduced or terminated.
- b. If an ongoing course of treatment was previously approved for a specific period of time or number of treatments, and the Covered Participant requests to extend the treatment is an Urgent Care Claim as defined above, the request will be decided within twenty-four (24) hours, provided that the request is made at least twenty-four (24) hours prior to the end of the approved treatment. The Plan Supervisor will make a determination on the request for the extended treatment within twenty-four (24) hours from receipt of the request. If the Covered Participant's request for extended treatment as an Urgent Care Claim is not made at least twenty-four (24) hours prior to the end of the approved treatment, the request will be treated as an Urgent Care Claim and decided according to the time frames described above for other Urgent Care Claims.

- c. If an ongoing course of treatment was previously approved for a specific period of time or number of treatments and the Covered Participant asks to extend treatment under non-urgent circumstances, the request will be considered a new claim and decided according to Post-Service or Precertification Claim time frames described above, whichever applies

6. Procedures Applicable to All Claims.

- a. Plan Interpretation and Administration. In its consideration of the claim, the Plan Supervisor will consult the documents and instruments constituting the Plan and all other documents that may have a bearing on the interpretation of the Plan, including past interpretations or claims of the same general type. The Plan Supervisor will also, where appropriate, consult the Internal Revenue Service, the Department of Labor, or other governmental or private publications or authorities that may assist them in interpreting Plan language or administrative procedures.
- b. Contents of Notice of Denial. If a claim is denied (either in whole or in part), the Covered Participant will receive a written notice from the Plan Supervisor that includes the following information:
 - (i) claim identification information, including the date of service; health care provider's name, tax id and address; claim amount (if applicable); diagnosis code and corresponding meaning; treatment code and corresponding meaning;
 - (ii) the specific reason(s) for the denial, including the denial code and corresponding meaning;
 - (iii) a description of the specific Plan provisions upon which the decision is based;
 - (iv) a description and explanation of any additional material or information needed for the Covered Participant to perfect the claim;
 - (v) a description of the Plan's appeal procedures and applicable time limits;
 - (vi) if any internal rule, guideline, protocol, or other similar criterion was relied upon in denying the claim, either:
 - (a) a copy of such internal rule, guideline, protocol, or other similar criterion; or
 - (b) a statement that such internal rule, guideline, protocol, or other similar criterion was relied upon and that a copy is available to the Covered Participant at no charge upon request.
 - (vii) or if the denial is based on a Medical Necessity or Experimental Treatment or similar Exclusion or limit, either an explanation of the scientific or clinical judgment for the determination that applies the terms of the Plan to the Covered Participant's medical circumstances, or a statement that such explanation will be provided free of charge on request;
 - (viii) if the claim involved urgent care, a description of the expedited appeal process that applies to the claim;
 - (ix) a description of the internal appeal process, including how to initiate an internal appeal; and
 - (x) a description of the availability of, and contact information for, any applicable office of health insurance consumer assistance or ombudsman established under the Public Health Service Act § 2793 to assist individuals with the internal claims and appeals process.
- c. Notice of the denials described in this section shall be given in writing or electronically. If the denial concerns an Urgent Care Claim, the information described in this section may be communicated orally to the Covered Participant within the applicable time period, provided that written or electronic notice is furnished to the Covered Participant no later than forty-eight (48) hours after the oral notification.

INTERNAL APPEAL OF DENIED CLAIMS

1. If the Covered Participant's claim is entirely or partially denied by the Plan Supervisor, the Covered Participant may appeal the decision to the Plan Administrator, who will review the claim and the denial. The Covered Participant must make this request no later than one hundred eighty (180) days after receiving the written notice of denial described above.

The Plan Administrator for the Plan is:

Plan Administrator

City of McAllen

P.O. Box 220

McAllen, TX 78505

2. The Covered Participant may submit written comments, documents, records, or other information to the Plan Administrator relating to the claim for consideration in the appeal. The review on appeal shall take into account all such information submitted by the Covered Participant, regardless of whether it was previously submitted or considered. On appeal, no deference shall be given to the initial claim

denial. The appeal review shall be conducted by an Employee or group of Employees of the Plan Administrator, who shall not be the same individual or individuals who denied the claim that is the subject of the appeal, nor the subordinates of such individual or individuals. If in connection with the denial the Plan Administrator obtained on its behalf the advice of any medical or vocational experts, such expert(s) shall be identified, whether or not their advice was relied upon in the denial. In deciding an appeal of any denial that is based in whole or in part on a medical judgment, including determinations with regard to a particular treatment, drug, or other item is experimental, investigational, or not Medically Necessary or appropriate, the Plan Administrator shall consult with a health care professional who has appropriate training and experience in the field of medicine involved in the medical judgment. Such health care professional shall not be the individual or subordinate of the individual who was consulted in connection with the denial that is the subject of the appeal. Any medical or vocational experts whose advice was obtained on behalf of the Plan in connection with the denial shall be identified, regardless of whether such advice was relied upon in making the benefit determination. No decisions regarding hiring, compensation, termination, promotion, or other similar matters with respect to any claims adjudicator, medical expert, or any similar individual, will be made based upon the likelihood that the individual will support the denial of benefits.

3. As soon as possible, and sufficiently in advance of the date on which the final internal Adverse Benefit Determination is to be made, the Plan Administrator shall provide to the Covered Participant, free of charge, any new or additional evidence considered, relied upon, or generated by the Plan in connection with the claim, as well as any new or additional rationale. In addition, upon request, the Covered Participant has reasonable access to, and may obtain free copies of, all documents, records, and other information that are relevant to the claim. A document, record or other information is considered to be relevant to a claim if it:
 - a. was relied upon, submitted, considered, or generated in the course of making the benefit decision;
 - b. demonstrates compliance with the administrative processes and safeguards required in the making of the benefit decision; or
 - c. constitutes a statement of policy or guidance with respect to the Plan concerning the benefit denied for the Covered Participant's diagnosis, whether or not such advice or statement was relied upon in making the benefit decision.
4. A denial of an Urgent Care Claim is eligible for an expedited appeal. The Covered Participant may submit a request for an expedited appeal orally or in writing. All necessary information, including the decision on review, will be sent to the Covered Participant by telephone, fax, or other similar method that is available.
5. Notice of Decision on Appeal.
 - a. The Plan Administrator will notify the Covered Participant in writing of its decision on appeal. All necessary information, including the Plan's benefit determination on appeal, shall be transmitted between the Plan and the Covered Participant by telephone, fax, or other available method that is similarly quick.
 - (i) In the case of an Urgent Care Claim, the Plan Administrator shall notify the Covered Participant of the decision on appeal as soon as possible, taking into account the medical exigencies, but no later than twenty-four (24) hours after receipt of the Covered Participant's request for the appeal of the claim denial. If a request for urgent care treatment was denied and the Covered Participant obtained the treatment on his or her own, the appeal to the Plan Administrator shall not be treated as an Urgent Care Claim.
 - (ii) In the case of a Precertification Claim (i.e., not involving urgent care), the Plan Administrator shall notify the Covered Participant of the benefit determination on appeal within a reasonable period of time appropriate to the medical circumstances, but no later than thirty (30) days after receipt by the Plan of the Covered Participant's request for an appeal of the denial.
 - (iii) In the case of a Post-Service Claim, the Plan Administrator shall notify the Covered Participant of the benefit determination on appeal within a reasonable period of time, but no later than sixty (60) days after receipt by the Plan of the Covered Participant's request for an appeal of the denial.
 - b. For the purposes of this section, the period of time within which a benefit determination on appeal is required to be made shall begin at the time an appeal is filed with the Plan Administrator, without regard to whether all the information necessary to make a benefit determination on appeal accompanies the filing. If the appeal decision is adverse to the Covered Participant, the notification will contain:
 - (i) claim identification information, including the date of service; health care provider's name, tax id and address; claim amount (if applicable); diagnosis code and corresponding meaning; treatment code and corresponding meaning;
 - (ii) a description of the specific reason(s) for the adverse decision on appeal, including the denial code and corresponding meaning;
 - (iii) a description of the specific Plan provisions upon which the appeal decision is based and a discussion of the decision;
 - (iv) a statement that the Covered Participant is entitled to receive, upon request and free of charge, reasonable access to and copies of all documents, records, and other information relevant (as defined above) to the claim for benefits;
 - (v) if any internal rule, guideline, protocol, or other similar criterion was relied upon in denying the claim, either:
 - (a) a copy of such internal rule, guideline, protocol, or other similar criterion; or

- (b) a statement that such internal rule, guideline, protocol, or other similar criterion was relied upon and that a copy is available to the Covered Participant at no charge upon request;
 - (vi) if the Adverse Benefit Determination is based on a Medical Necessity or Experimental Treatment or similar Exclusion or limit, either an explanation of the scientific or clinical judgment for the determination, applying the terms of the Plan to the Covered Participant's medical circumstances, or a statement that such explanation will be provided free of charge upon request;
 - (vii) the following statement: "You and your plan may have other voluntary alternative dispute resolution options, such as mediation. One way to find out what may be available is to contact your local United States Department of Labor Office and your State insurance regulatory agency;"
 - (viii) a description of the external review process, including how to initiate an external review; and
 - (ix) a description of the availability of, and contact information for, any applicable office of health insurance consumer assistance or ombudsman established under the Public Health Service Act § 2793 to assist individuals with the external review process.
- c. These Claims Procedures are designed so that it does not contain any provisions that unduly inhibit or hamper the filing or processing of claims for benefits, nor will it be administered in such a manner. No fee shall be charged as a prerequisite to making a claim or seeking an appeal of a claim denial.
- d. Under these Claims Procedures, there is no requirement that claim denials must be submitted to binding arbitration. Also, no claim shall be denied for failure to obtain a prior approval under circumstances that would make obtaining such prior approval impossible or where application of the prior approval process could seriously jeopardize the Covered Participant's life or health.

EXTERNAL REVIEW OF DENIED APPEALS

The following external review process shall be interpreted and administered in accordance with the Department of Labor Technical Release 2010-01. See U.S. DEP'T OF LABOR, TECHNICAL RELEASE 2010-01, INTERIM PROCEDURES FOR FEDERAL EXTERNAL REVIEW RELATING TO INTERNAL CLAIMS AND APPEALS AND EXTERNAL REVIEW UNDER THE PATIENT PROTECTION AND AFFORDABLE CARE ACT (2010).

Upon receipt of an Adverse Benefit Determination or final internal Adverse Benefit Determination from the Plan Administrator, the Covered Participant may request an external review by an Independent Review Organization ("IRO"). If a final external review decision reverses the Adverse Benefit Determination or final internal Adverse Benefit Determination, the Plan will immediately provide coverage or payment (including immediately authorizing or immediately paying benefits) for the claim.

The Plan's procedures for requesting an external review are as follows:

- a. Eligibility for External Review. A Covered Participant is eligible for external review if the Covered Participant:
 - i. was covered under the Plan at the time the health care item or service was requested or provided;
 - ii. was eligible under the Plan;
 - iii. exhausted the Plan's internal review and appeal process; and
 - iv. provides all the information and forms required for an external review.
- b. Request for External Review.
 - i. **Standard External Review.** A Covered Participant's request for standard external review must be submitted to the Plan Administrator no later than 4 months after the date on which the Covered Participant received a notice of final internal Adverse Benefit Determination.
 - ii. **Request for Expedited External Review.** A Covered Participant may request an expedited external review at the time the Covered Participant receives:
 - 1. an Adverse Benefit Determination, if:

- a. the Adverse Benefit Determination involves the Covered Participant's medical condition, for which the time frame for completion of an expedited internal appeal would seriously jeopardize the Covered Participant's life or health, or ability to regain maximum function; and
 - b. the Covered Participant has filed a request for an expedited internal appeal; or
 - 2. a final internal Adverse Benefit Determination, if:
 - a. the final internal Adverse Benefit Determination involves the Covered Participant's medical condition, for which the time frame for completion of a standard external review would seriously jeopardize the Covered Participant's life or health, or ability to regain maximum function; or
 - b. the final internal appeal concerns an admission, availability of care, continued stay, or health care item or service for which the Covered Participant received Emergency Services, but has not been discharged from a facility.
- c. Preliminary Review.
 - i. **Standard External Review.** Within 5 business days following receipt of the external review request, the Plan Administrator will complete a preliminary review to determine whether external review is available to the Covered Participant based on the eligibility requirements described in (a) above. The Plan Administrator will issue a written notification to the Covered Participant of its determination of the eligibility of the request for external review. If the request is complete but not eligible for external review, such notification will include the reasons for its ineligibility and contact information for the Employee Benefits Security Administration (toll-free number 866-444-EBSA (3272)). If the request is not complete, such notification will describe the information or materials needed to make the request complete and will allow the Covered Participant to perfect the request for external review within the 4-month filing period or within the 48-hour period following the receipt of the notification, whichever is later.
 - ii. **Expedited External Review.** The Plan Administrator will complete a preliminary review immediately upon receipt of the request for expedited external review. Immediately upon completion of the preliminary review, the Plan Administrator will provide a notice, in accordance with the requirements for a standard external review described above.
- d. Referral to an IRO. If the Covered Participant's claim is eligible for external review, the Plan Administrator will randomly assign a duly accredited IRO to conduct the external review.
- e. External Review Standards. The following standards apply to an external review:
 - i. The IRO will use legal experts to make coverage determinations;
 - ii. The IRO will timely notify the Covered Participant of acceptance for external review.
 - iii. Within 5 business days after the assignment of the IRO for a standard external review, the Plan Administrator will provide the IRO with the documents and information that were considered in making the Adverse Benefit Determination or final internal Adverse Benefit Determination that is the subject of the review.
 - iv. For an expedited external review, the Plan Administrator will provide or transmit to the IRO, electronically, by telephone or facsimile, or by any other available expeditious method, all necessary documents and information considered in making the Adverse Benefit Determination.
 - v. For a standard external review, the IRO will permit the Covered Participant to submit additional written evidence for a period of 10 business days after the Covered Participant's receipt of the notice of acceptance for external review, which additional evidence the IRO must consider in its review. The Covered Participant may submit evidence after the 10 business day period, however, the IRO is not required to consider the information in its review. Within 1 business day of receipt of any additional written evidence from the Covered Participant, the IRO will forward the evidence to the Plan Administrator, which may reconsider the Adverse Benefit Determination or final internal Adverse Benefit Determination that is the subject of the review.
 - vi. The IRO will review all of the information and documents timely received. In reaching its decision, the IRO will review the claim de novo, and not be bound by any of the Plan Administrator's decisions or conclusions during the internal claims and appeal process. The IRO will consider not only the documents and information provided by the Plan Administrator and the Covered Participant, but also other information or documents that are available to the IRO (e.g., the Plan's terms, appropriate practice guidelines, applicable review criteria, and the opinion of the IRO's clinical reviewer).

- f. Timing of Final External Review Decision.
- i. **Standard External Review.** The IRO will provide written notice to the Covered Participant and the Plan Administrator within 45 days after the IRO receives the request for a standard external review.
 - ii. **Expedited External Review.** The IRO will provide notice as expeditiously as the Covered Participant's medical condition or circumstances require, but in no event more than 72 hours after the IRO receives the request for an expedited external review. If the notice is not in writing, then within 48 hours after the date of providing the notice, the IRO will provide written confirmation of the decision to the Covered Participant and the Plan Administrator.
- g. Notice of Final External Review Decision. The IRO's final external review decision notice will contain the following information:
- i. A general description of the reason for the request for external review, including information sufficient to identify the claim, including the date or dates of service, the health care provider, the claim amount (if applicable), the diagnosis code and its corresponding meaning, the treatment code and its corresponding meaning, and the reason for the previous denial;
 - ii. The date the IRO received the assignment to conduct the external review and the date of the final external review decision;
 - iii. References to the evidence or documentation, including the specific coverage provisions and evidence-based standards, considered in reaching its decisions;
 - iv. A discussion of the principal reason or reasons for its decision, including the rationale for its decision and any evidence-based standards that were relied on in making the decision;
 - v. A statement that the determination is binding except to the extent that other remedies may be available under state or federal law to either the Plan or the Covered Participant.
 - vi. A statement that judicial review may be available to the Covered Participant; and
 - vii. Current contact information, including phone number, for any applicable office of health insurance consumer assistance or ombudsman established under the Public Health Service Act § 2793.
- h. Document Retention. The IRO will maintain the records of all claims and notices associated with the external review process for 6 years from the date of a final external review decision. The IRO will make these records available for examination, upon request by the Covered Participant, the Plan, or a state or federal oversight agency (unless such disclosure would violate state or federal privacy laws).

ELIGIBILITY FOR COVERAGE

Coverage provided under this Plan for Covered Participants shall be in accordance with the Eligibility, Effective Date, and Termination provisions as stated in this Plan. A Covered Participant is an Employee Participant or Dependent Participant that meets the eligibility requirements for of the Plan and Enrolls in coverage. A Covered Participant may be covered under this Plan as either an Employee Participant or Dependent Participant, but not both. An eligible Dependent may be covered as a Dependent Participant of only one employee or Retiree Participant under this Plan.

PARTICIPANT ELIGIBILITY AND EFFECTIVE DATE OF COVERAGE

*Also see Limitations of Coverage for Pre-Existing Conditions.

- a. With respect to Employee Participant coverage, an Employee is eligible to be a Participant if the Employee is regularly and directly employed full-time (at least 40 hours per week) in the normal business of; and compensated for services by, the City of McAllen or an Affiliate. The term "Participant" does not include a person who is employed on a contract, part-time or temporary basis, even if such person may, for a period of time, meet or exceed forty (40) hours per week. A full-time Employee who is on paid or unpaid leave under the Family and Medical Leave Act of 1993 ("FMLA") will be considered an inactive full-time Employee for the purpose of this Plan. The date of eligibility shall be the first day of the calendar month following thirty (30) days after the first initial date of full-time (at least forty (40) hours per week) employment. Example: If an Employee's date of employment is March 1st the effective date of coverage begins April 1st. If an Employee's date of employment is March 27th the effective date of coverage begins May 1st.
- b. With respect to Retiree Participant coverage, the following retirees are eligible: (a) an eligible SB 404 Retiree of the City of McAllen is eligible if, upon retirement, he or she has reached twenty (20) years of service or ten (10) years of service and age sixty (60); or (b) an Elected or Appointed Official who, upon retirement, has served two (2) full terms or eight (8) total years of service.
- c. COC Participants are eligible for coverage upon becoming COC qualified beneficiaries as set out under the COC section of this Plan.

- d. Dependent Participants are eligible for coverage upon Enrollment on the date the Employee Participant became eligible. If the Employee Participant does not Enroll Dependents upon initial eligibility then coverage can only be obtained during Open Enrollment, unless a special Enrollment period applies. If both husband and wife are Employees of the City of McAllen, either the husband or wife, but not both, may elect Dependent Coverage for the eligible Dependents.
- e. Dependents of Retirees must have been covered under the City's Plan for three (3) years or more prior to the Employee's retirement.
- f. A Dependent will be eligible for a thirty (30) day special Enrollment period to become a Participant under the following circumstances:
 - (i) Court Order
 - (ii) Decree
 - (iii) Marriage
 - (iv) Adoption or placement for adoption
 - (v) Legal Guardianship
- f. A Covered Participant will be eligible for a sixty (60) day special Enrollment period when the Covered Participant's Medicaid or State Child Health Insurance Plan (i.e. CHIP) coverage has terminated as a result of loss of eligibility and the Covered Participant requests coverage under the Plan within sixty (60) days after the termination or the Covered Participant becomes eligible for a premium assistance subsidy under Medicaid or a State Child Health Insurance Plan (i.e. CHIP), and the Covered Participant requests coverage under the Plan within sixty (60) days after eligibility is determined. The Plan provides for special Enrollment rights as required by Internal Revenue Code § 9801(f).
- g. The Dependent coverage commences on the first day of the calendar month following thirty (30) days after the first initial date of Enrollment. Example: If the Dependent is eligible to be added for coverage on March 1st, the effective date of coverage begins April 1st. If instead the Dependent is eligible to be added for coverage on March 27th, the effective date of coverage begins May 1st.
- h. To Enroll a newborn for Dependent Coverage, an Enrollment form must be completed and received by the Plan Administrator within thirty (30) days after birth. Coverage for the newborn will be effective on the date after the birth. The fact that you have Family coverage and have other Dependent children or a spouse covered does not automatically extend coverage to a newborn.
- i. The City of McAllen offers an Open Enrollment period. During this period, Employees may Enroll for any type of Participant coverage without evidence of good health. The Open Enrollment is usually the month of September. Employees must complete an Enrollment form during the open Enrollment period. Coverage will be become effective on the first day of the calendar month following the Open Enrollment period.
- j. Retirees who opted out of health coverage upon retirement have a one-time option to reinstate coverage upon reaching age 65 and enrolling in Medicare Parts A and B.
- k. Outside of Open Enrollment, additions, changes and cancellations to health coverage can only be made by the Employee when there is a qualifying event. Qualifying events include marriage, divorce, adoption, placement for adoption, leave of absence/return from leave, military leave/return from leave, change in employment status and death. Additionally, a chance or cancellation may be eligible if the employee and/or their dependents(s) become covered under another plan or experience loss of Medicare/Medicaid.

Active Duty Reservists

Active duty reservists or guard members and their covered Dependents can maintain eligibility on the Plan for up to twenty-four (24) months from being called to active duty. The date on which the Employee Participant's absence begins is the qualifying event for COC to be offered to the reservist or guard member and any Dependent Participants. Eligibility will meet or exceed requirements of the Uniformed Services Employment and Reemployment Rights Act ("USERRA") and any regulatory guidance.

In administering this coverage, the Plan Supervisor will follow the time guidelines of COC under 42 U.S.C. § 300bb-1 *et seq.* To qualify for this coverage, the Employee Participant must give written notice to the Employer within sixty (60) days of the qualifying event. The Employer must notify the Plan Supervisor that an Employee Participant has been called for active duty and submit a copy of the Employee Participant's active reservist policy.

If the Employee Participant will be on active duty for thirty-one (31) days or less, The Employer will keep the Employee Participant on the Plan with no change in coverage. If the Employee Participant will be on active duty for more than thirty-one (31) days, the Employer will notify the Plan Supervisor of the qualifying event.

For the Employee to return to the Plan and continue their benefits with no Waiting Period or pre-existing condition limitation, the Employee must return to work within the time period required by state and federal law for such return.

TERMINATION OF COVERAGE

Employee Participant and Retiree Participant Termination

Participant Coverage shall automatically terminate immediately upon the earliest of the following dates:

1. Last day of the calendar month coincident with or next following date of termination of employment for Participant. EXCEPT: This shall not apply to a person who qualifies as a Retiree Participant; or
2. Date the Participant ceases to be eligible for coverage; or
3. Date the Participant fails to pay the required Contribution for coverage; or
4. Date the Plan is terminated; the date of termination of the Plan as to that classification of Participant; or the date the plan is amended to delete a particular benefit; or
5. Date the City terminates coverage for Participant; or
6. Date the Participant dies.

For the purpose of coverage under this Plan, an Employee's employment is considered to terminate on the date the Employee ceases work with the City, except as follows:

1. The Participant is absent from work because of Illness or Injury, the coverage may be continued, until terminated by the City in accordance with the personnel policies of the City, but no longer than twelve (12) months.
2. The Participant is absent from work because of an approved leave of absence, the coverage may be continued, until terminated by the City in accordance with the personnel policies of the City, but no longer than twelve (12) months.

Continuation of Coverage During Family and Medical Leave

Regardless of the established leave policies of the City, the Plan shall at all times comply with the Family and Medical Leave Act of 1993 as outlined in regulations issued by the Department of Labor. During any leave taken under the Family and Medical Leave Act, the City will maintain coverage under this Plan on the same basis as coverage would have been provided if the Participant had been continuously employed during the entire leave period.

Dependent Participant Termination

The Participant Coverage of a Dependent shall automatically terminate immediately on the:

1. Date the Dependent Participant ceases to be an eligible Dependent as defined in the Plan; or
2. Date of termination of coverage for Employee or Retiree Participant under the Plan; or
3. Date the Participant fails to pay the required Contribution for Participant Coverage; or
4. Date the Plan is terminated; the date of termination if the Plan as to that classification of Participant or the date that the Plan is amended to delete a particular benefit; or
5. Date the City terminates coverage for Dependent; or
6. Date the Dependent Participant dies.

Rescission

The Plan prohibits an individual (or a person seeking coverage on behalf of the individual) from performing an act, practice, or omission that constitutes fraud, or making an intentional misrepresentation of material fact ("Prohibited Acts"). Upon the occurrence of a Prohibited Act, coverage for the individual and the individual's Dependents may be Rescinded by the Plan Administrator. This means that the coverage will be voided retroactively to the date of the Prohibited Act. If the Prohibited Act occurred upon Enrollment, the coverage will be voided retroactive to the time of the individual's Enrollment. If the Prohibited Act occurred after Enrollment, the coverage will be voided retroactive to the time of the fraud or intentional misrepresentation of material fact. The Plan shall provide at least thirty (30) days advance written notice to each Participant who would be affected before Rescinding the coverage.

MENTALLY OR PHYSICALLY HANDICAPPED CHILDREN

If a child of a Participant reaches twenty-six (26) years of age, at which time coverage would normally terminate, but the child is mentally or physically incapable of supporting his or herself and primarily dependent upon the Participant for support, coverage may be continued. The Participant must submit satisfactory proof of the child's incapacity to the City within thirty-one (31) days after the date the child reaches age twenty-six (26). Coverage may continue for such child as long as the incapacity continues, subject to payment of the required Contribution and all other terms of the plan.

The City may require satisfactory proof of the continued incapacity. Failure to submit proof when reasonably required or refusal to allow the Plan Supervisor to have the child examined will result in coverage for the child to be terminated.

CONTINUATION OF COVERAGE

In 1986, a Federal Law, the Consolidated Omnibus Budget Reconciliation Act ("COBRA"), was enacted requiring employers sponsoring group health plans to offer Employees and their families the opportunity for a temporary extension of health coverage at group rates in certain instances where coverage under the plan would otherwise end. This notice is intended to inform you, in summary fashion, of your rights and obligations under the law. **Both you and your spouse should take time to read this notice carefully. The entire cost for this continuation of coverage is to be paid by the Covered Participant(s).**

ELIGIBILITY FOR CONTINUATION OF COVERAGE

1. **TERMINATION OF EMPLOYMENT** – A Covered Participant may elect to continue coverage under the Plan for up to **eighteen (18) months**, if eligibility ends due to one of the following qualifying events:
 - a. the Employee Participant's employment is terminated (for reasons other than gross misconduct); or
 - b. the Employee Participant's number of hours is reduced.
2. **DISABILITY** – A Covered Participant may elect to continue coverage under the Plan for up to **twenty-nine (29) months** if:
 - a. such person is disabled (as defined by Title II or XVI of the Social Security Act) at the time of the qualifying event or becomes disabled under Social Security within the first sixty (60) days of his or her eligibility for COBRA continuation; and
 - b. such person is covered for Social Security disability income benefits.

The Covered Participant must send the City a copy of the Social Security office's letter within sixty (60) days after their determination of disability. The Covered Participant must send the City a copy of the Social Security office's letter within thirty (30) days after they determine that such person is no longer disabled. As used in this Continuation of Coverage provision, "City" means the Employer sponsoring this Plan.

3. **LOSS OF DEPENDENT ELIGIBILITY** – A Dependent Participant may elect to continue coverage under this Plan for up to **thirty-six (36) months**, if eligibility ends due to one of the following qualifying events:
 - a. the Employee or Retiree Participant death; or
 - b. the Employee or Retiree Participant's divorce; or
 - c. a Dependent child ceases to be a Dependent (as defined by the Plan).
 - d. the Employee or Retiree COC Participant loses COC coverage due to becoming eligible for Medicare.

The Covered Participant must notify the City within sixty (60) days of a divorce, a legal separation, or a child's ceasing to be a Dependent (as defined by the Plan). If a Dependent Participant:

- i. elects the eighteen (18) month continuation following an event shown in part 1; and
 - ii. later becomes entitled to a thirty-six (36) month continuation due to an event shown in part 3; then that covered Dependent may continue coverage for a maximum period not to exceed a total of thirty-six (36) continuous months from the first qualifying event.
4. **BANKRUPTCY** – If, and only if, the Plan includes Retiree coverage, a Retiree Participant (or Dependent of a Retiree Participant) may be able to continue coverage for a longer period when the City files for Chapter 11 Reorganization. This period will be as required by Section 4980B of the Internal Revenue Code.

ELECTION OF CONTINUATION OF COVERAGE OR COC

To continue coverage the Covered Participant must make written election within sixty (60) days following:

1. the date coverage would have terminated in the absence of this Continuation of Coverage provision; or
2. the date the Covered Participant is sent notice of the right to continue coverage, if later.

Within forty-five (45) days of the election date, the Covered Participant must pay all the required Monthly Cost for the entire Continuation of Coverage period prior to the election. The eighteen (18), twenty-nine (29) or thirty-six (36) month continuation period will begin on the earliest of the above qualifying events.

Under the law, you have the right to add a child to your Continuation of Coverage if you make the request within thirty (30) days of the birth, adoption or placement for adoption of a child .

MONTHLY COC COST

The COC Participant must pay the monthly cost to the City and/or the appropriate authority designated or required to perform such duties for the City. The first monthly cost payment must be applied to the period beginning on the day after the day on which coverage would be lost due to the qualifying event. Each subsequent monthly cost payment will cover the next succeeding period of one (1) month.

The monthly cost must be paid on a monthly basis, within thirty (30) days of the due date and in the manner prescribed by the City. The COC Participant may elect to pay the Cost on a quarterly, semi-annual or annual basis in advance.

PAYMENT OF CLAIMS

No claim will be payable under this Continuation of Coverage provision, until the City receives the applicable monthly cost for the COC Participant's Coverage.

TERMINATION OF COC COVERAGE

A COC Participant's coverage under this Continuation of Coverage provision will terminate on the **earliest** of:

1. the date on which the City ceases to provide a group health plan to any Employee;
2. the date the COC Participant is covered under any other group health plan (as an Employee or otherwise); however, subject to the coordination of benefits provisions of this Plan, the COC Participant can maintain any remaining months of COC available for coverage of a pre-existing condition if the COC Participant becomes insured under another group health plan with a pre-existing conditions limit applicable to a condition the COC Participant has, the COC Participant makes a written request to the Plan Administrator, and pays the required premium for coverage;
3. the date the COC Participant becomes covered by Medicare after the date Enrolled in this Continuation of Coverage;
4. the date the COC Participant fails to make timely payment of the monthly cost under the Plan;
5. for a disabled COC Participant who continues coverage beyond eighteen (18) months, the first day of the month which begins thirty (30) days after the COC Participant is no longer considered disabled by the Social Security office; or
6. the end of the applicable eighteen (18), twenty-nine (29), or thirty-six (36) month period.
7. The date fraud or misrepresentation has been made by or on behalf of the COC Participant relating to eligibility for coverage or payment of a claim. Any fraud or misrepresentation under this COC provision will be subject to the Rescission provisions under this Plan.

In no case will coverage continue beyond thirty-six (36) months from the original qualifying event, even if a second qualifying event occurs during the continuation of coverage period.

COST CONTAINMENT FEATURES

This program is included to assist you in making informed health care decisions. Occasionally, proposed healthcare is not Medically Necessary, or the scheduled length of stay or setting is inappropriate. Please read this provision so that you understand the admissions, continued stay and precertification process and are not faced with a penalty for non-compliance or a denial of benefits for or not obtaining certification. Even when services are certified as being medical necessary or a length of stay is approved as appropriate, reimbursement is subject to the terms and conditions of the plan including, but not limited to, all Plan Exclusions and Limitations. All procedures requiring precertification must meet criteria established by the Plan Supervisor's Medical Management Services staff. Medical Management does not verify eligibility or benefits. Precertification is not required for coordination of benefits when this Plan is not primary.

If Medical Management is not notified of a scheduled service requiring precertification the late notification penalty will apply. Claims for benefits will not be considered unless an appeal is filed and a retrospective review is granted.

HOW THE NOTIFICATION AND PRECERTIFICATION PROCESS WORKS

The 23-Hour Rule

Inpatient means Treatment or confinement in a Hospital or other medical facility for more than twenty-three (23) hours. Outpatient means Treatment or confinement in a Hospital or other medical facility for twenty-three (23) hours or less.

What is an admission?

When the Hospital or facility submits a bill to the Plan Supervisor, the length of time the Covered Participant was in their facility and a designation that can be Inpatient, Outpatient or observation is included. For the Plan, the number of hours, not the classification, determines if the stay is twenty-three (23) hours (or less) observation or inpatient. If it looks like the Covered Participant will stay more than twenty-three (23) hours, you must call Medical Management. The phone number for Medical Management is located on the back of your ID card.

Responsibilities of the Covered Participant

Between the hours of 8:00 AM - 5:00 PM central time, call the precertification number on the back of the ID card to notify Medical Management prior to any health care service that requires precertification. After hours, voice mail records your notification twenty-four (24) hours a day and a Medical Management nurse will return your call the next business day. Bilingual Medical Management staff is also available to take your call. All Inpatient admissions (other than Emergency admissions), transplant evaluations, hospice, physician home health and home health care services and DME purchase or rentals that exceed \$500 require the Covered Participant to notify Medical Management for precertification. Please refer to the precertification section for details. Physical Therapy and Occupational Therapy treatments that exceed twenty (20) visits per Calendar Year will also require precertification. Please refer to the Precertification Requirements chart in this Plan for specifics.

Responsibilities of Medical Management

Medical Management will render a determination of Medical Necessity and assign a length of stay for the health care service requiring precertification based on the information received from the Covered Participant, the attending physician and in some cases the Hospital or Home Health Care Agency. The determination to certify or deny will be communicated to the Health Care Provider verbally, followed by a written confirmation to the Health Care Provider. Medical Management will follow the Claim Procedures contained in this Plan for all Precertification Claims and will notify the Covered Participant accordingly.

What Happens on Inpatient Treatment?

The Covered Participant must notify Medical Management of a scheduled admission three (3) working days prior to the date of service. If the notification is made after the above-referenced time frame, a late notification penalty will apply. Concurrent stay review requirements apply to all Inpatient confinements period. No benefits will be paid for any charges related to non-certified days or services.

What Happens if Outpatient Services Go Over the 23-Hour Limit?

Outpatient Surgery not on the Precertification List

If you notify Medical Management within forty-eight (48) hours of an Outpatient surgery that exceeds the twenty-three (23) hour limit. It will be considered an admission and a late review will be performed. If the services are determined to be Medically Necessary and the length of stay appropriate, there is no penalty. If the services are determined to be Medical Necessary but the length of stay is inappropriate, charges for the non-certified time are not covered but no penalty is applied. If you do not notify Medical Management within forty-eight (48) hours of the admission, the Outpatient precertification penalty will apply. If no notification is received, the claim will be denied.

Maternity Care

Benefits for Maternity Care will be provided in compliance with the Newborns' and Mothers' Health Protection Act of 1996 ("NMHPA"). Under the NMHPA, group health plans and health insurance issuers generally may not restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than forty-eight (48) hours following a vaginal delivery, or less than ninety-six (96) hours following a cesarean section. However, federal law generally does not prohibit the mother's or newborn's attending provider, after consulting with the mother, from discharging the mother or her newborn earlier than forty-eight (48) hours (or ninety-six (96) hours as applicable). In any case, plans and issuers may not, under federal law, require that a provider obtain authorization from the plan or the issuer for prescribing a length of stay not in excess of forty-eight (48) hours (or ninety-six (96) hours). In no event will an "attending provider" include a plan, hospital, managed care organization, or other issuer.

Subject to PPACA, precertification is required for any Inpatient non-emergency expectant mother admission that will extend beyond forty-eight (48) hours (or ninety-six (96) hours as applicable).

If a newborn requires more than Routine nursery care, you must notify Medical Management so that a separate precertification can be issued for the baby. Newborns must be added to Plan within thirty (30) days after birth in order to be a Covered Participant.

Continued Stay Review

Medical Management does not solicit continued stay clinical information. At the time of precertification, the nurse will inform the facility or provider representative of the assigned length of stay based on the diagnosis provided. If a longer length of stay is required, the facility or provider representative must call Medical Management at (the number on the back of the ID card for certification).

Large Case Management

Large Case Management is designed to help manage the care of Covered Participants who have catastrophic or long-term illness or injuries requiring extensive care. The purpose of Large Case Management is to identify and coordinate cost effective medical care alternatives which meet accepted standards of medical practice. Large Case Management also monitors the care of the Covered Participants, offers emotional support to the Family and coordinates communications among Health Care Providers, Covered Participants and others. These objectives will be met through Plan benefits (and non-Plan benefits as arranged by Medical Management) to Covered Participants who are eligible.

Large Case Management is an option. However, should Large Case Management be refused by the Covered Participant or physician, benefits will pay at the Out-of-Network Benefit Percentage and will not, at any time, pay at 100% for any medical services under the Out-of-Pocket provision of the Plan. If Large Case Management is refused, all future payments for any medical services will be paid at the reduced benefit. The individual Deductible and Out-of-Pocket amount must be met each Calendar Year.

PRECERTIFICATION REQUIREMENTS

SERVICE NOTIFICATION	CERTIFICATION REQUIRED	LATE PENALTY
INPATIENT HOSPITAL ADMISSION		
Scheduled Admissions <ul style="list-style-type: none"> • Skilled Nursing Facility • Psychiatric/Chemical Dependency Admission • Psychiatric/Chemical Dependency Day Treatment • Psychiatric/Chemical Dependency Residential Treatment • All Scheduled Admissions 	Three (3) working days prior to admission	\$1,000
Newborn	Within forty-eight (48) hours (or ninety-six (96) hours as applicable) of admission if the care will extend beyond forty-eight (48) hours (or ninety-six (96) hours as applicable)	\$1,000
Pregnancy/Maternity	Within forty-eight (48) hours (or ninety-six (96) hours as applicable) of admission if the care will extend beyond forty-eight (48) hours (or ninety-six (96) hours as applicable)	\$1,000
MISCELLANEOUS		
Extended Care Facility	Prior to commencement	\$1,000
Home Health Care	Prior to commencement	\$1,000
Durable Medical Equipment	Prior to purchase or rental of DME over \$500	50% reduction in benefit
Hospice Care	Prior to commencement	\$1,000
Physical Therapy	Prior to commencement Beyond twenty (20) visits per Calendar Year	\$1,000
Occupational Therapy	Prior to commencement Beyond 20 visit per calendar year	\$1,000
TRANSPLANTS <i>Large Case Management Required</i>		
Pre-Transplant Evaluation	Ten (10) working days prior	No Benefits

Self-Audit Reimbursement

(Refer to the Schedule of Coverage)

Any Covered Participant who reviews eligible medical expenses and discovers an overcharge made by the medical facility or practitioner may provide the Plan Supervisor with a copy of the original billing, corrected billing and an explanation. The Covered Participant will be reimbursed thirty (30) percent of the amount of savings generated. The reimbursement may not exceed the Covered Participant's individual Calendar Year Deductible and Out-of-Pocket amount.

Weekend Admission Exclusion

Expenses associated with an elective, non-Emergency Hospital admission on a Friday, Saturday, or Sunday will not be considered as Covered Expenses, under the Plan. This exclusion will not apply if admission is due to a life threatening condition or a Medically Necessary admission for a surgical procedure which is performed within twenty-four (24) hours of such admission.

Expenses *Incurred*, but not paid due to this exclusion, will not count toward satisfaction of any Deductible, Benefit Percentage, or Out-of-Pocket maximums of this Plan.

DESCRIPTION OF MEDICAL PLAN BENEFITS

Plan Benefits

The following benefits are applicable to each Covered Participant for covered charges subject to the terms and conditions of this Plan. The medical benefits are provided for covered charges while you or your dependent(s) are covered under this Plan. All benefits provided are subject to Usual, Reasonable and Customary charges as determined by the Plan Supervisor.

In each Calendar Year, once the Deductible amount has been met, the Plan will pay benefits as stated in the Schedule of Coverage. Charges are processed in date order received or upon receipt of all required information.

Benefits payable for hospitalization, certain Outpatient surgical procedures and certain other benefits are subject to precertification requirements. Please refer to the Cost Containment Features section of this Plan.

Deductible Requirements

Refer to the Schedule of Coverage. Covered charges that are used toward satisfying the Deductibles must be Incurred during the Calendar Year. In-Network and Out-of-Network Deductibles are separate and do not accumulate toward one another.

Once the Family Deductible amount has been satisfied, then the Deductible will not apply for any other Family member's charges. Other Family members charges previously applied toward the Deductible will not be recalculated.

The In-Network Calendar Year Deductible will be waived for Retiree Participants. The annual Calendar Year Deductible for Retiree Dependent Participants is not waived.

Out-of-Pocket Requirements

Refer to the Schedule of Coverage. Covered charges are used toward satisfying the Out-of-Pocket amount must be Incurred during the Calendar Year. Charges previously applied toward the Employee's out-of-pocket amount for other Family members will not be recalculated.

Co-Pay Requirements

Refer to the Schedule of Coverage. Co-Pay charges do not apply toward the Deductible or Out-of-Pocket amounts.

ABOUT YOUR MEDICAL BENEFITS

All benefits that are provided under this Plan must satisfy some basic conditions. The following conditions are commonly included in health benefit plans but are often overlooked or misunderstood.

Medical Necessity

The Plan provides Medical Benefits only for covered services and supplies that are Medically Necessary for the Treatment of a covered Illness or Injury.

Usual, Reasonable and Customary Charges

The Plan provides benefits only for Covered Expenses that are equal to or less than the Usual, Reasonable and Customary charges in the geographic area where the services or supplies are provided. Any amounts that exceed the Usual, Reasonable and Customary charges are not recognized by the Plan for any purpose. Medically Necessary charges for Covered Participants for the following services will be reimbursed by the Plan, subject to the conditions described in this Plan and the Schedule of Coverage.

Health Care Providers

The Plan provides benefits only for covered services and supplies rendered by a Health Care Provider, Hospital, or specialized treatment facility.

Benefit Year

All Calendar Year benefit maximums and Deductibles accumulate during the Benefit Year.

PREFERRED PROVIDER NETWORK (PPN)

The Plan provides an option to use a Preferred Provider Network (PPN), which is a health care benefit program designed to give the Covered Participant a financial incentive to use a designated group of Providers.

The City will receive copies of a directory of participating PPN Health Care Providers or Hospitals. Inclusion of a Hospital and/or Health Care Provider on the list does not bind the Plan to provide coverage or benefits for any services which would not normally be covered under the Plan. Periodically, changes to the list of PPN Health Care Providers and/or Hospitals will occur. **Prior to receiving services the Covered Participant should verify that the Health Care Provider or Hospital selected is still an active member of the designated PPN.**

Under this option, the Covered Participant will continue to have complete freedom of choice of Hospitals and/or Health Care Providers. However, this Plan will pay higher benefits for certain Covered Expenses when the Covered Participant uses a PPN Provider.

The Schedule of Coverage shows the Deductibles, Benefit Percentages and maximums payable based on whether or not PPN **Health Care Providers or Hospitals** are used.

Following is a brief summary of the effects of use of the PPN on the Covered Participant's major medical benefits.

Attention Participants: Please verify if the listed PPN Provider is active on the PPN Provider Network. To locate a PPN Provider, please call the phone number listed on the back of your ID card or consult your printed PPN directory.

The Plan has already negotiated the charges for the Health Care Providers and Hospitals in the PPN. If you go to a Health Care Provider or Hospital outside of the PPN, your benefits may be less and you may be responsible to the Health Care Provider or Hospital for the difference to what was paid by the Plan (Usual, Reasonable and Customary) and what was actually charged to you. You should discuss payment with your Health Care Provider before you actually receive services.

HOSPITAL SERVICES

Benefit Percentage

The Benefit Percentage for covered services received in a PPN Hospital is higher than the Benefit Percentage for covered services received in a non-PPN Hospital. These Benefit Percentages are shown in the Schedule of Coverage.

When covered services are rendered in a PPN Hospital by an Emergency room physician, an anesthesiologist, radiologist or pathologist who is not a PPN Health Care Provider, Eligible Expenses will be processed on the same basis as that for services rendered by a PPN Health Care Provider.

Emergency Services

If a Covered Participant receives Emergency Services to treat an Emergency Medical Condition, the benefits for Covered Expenses will be paid on the basis of a PPN Provider, whether or not the services were performed by a PPN Health Care Provider. Notwithstanding any other provision of the Plan, the benefits for Covered Expenses for Emergency Services will be provided:

1. Without the need for any precertification, even if the Emergency Services are provided on an Out-of-Network basis;
2. Without regard to whether the Health Care Provider furnishing the Emergency Services is a PPN Health Care Provider with respect to the services;
3. If the Emergency Services are provided Out-of-Network, without imposing any administrative requirement or limitation on coverage that is more restrictive than the requirements or limitations that apply to Emergency Services received from a PPN Health Care Provider;
4. If the Emergency Services are provided Out-of-Network, by complying with the following cost-sharing requirements:
 - a. Co-Payments and Benefit Percentage. Any cost-sharing requirement expressed as a Co-Payment amount or Benefit Percentage rate imposed with respect to a Covered Participant for Out-of-Network Emergency Services cannot exceed the cost-sharing requirement imposed with respect to a Covered Participant if the services were provided In-Network. However, a Covered Participant may be required to pay, in addition to the In-Network cost-sharing, the excess of the amount the Out-of-Network Health Care Provider charges over the amount the Plan is required to pay. The Plan will provide benefits with respect to Emergency Services in an amount equal to the greatest of the following three amounts (which are adjusted for In-Network cost-sharing requirements):
 - i. The amount negotiated with In-Network Health Care Providers for the Emergency service furnished, excluding any In-Network Co-Payment or Benefit Percentage imposed with respect to the Covered Participant. If there is more than one amount negotiated with In-Network Health Care Providers for the Emergency service, the median of the negotiated amounts, excluding any In-Network Co-Payment or Benefit Percentage imposed with respect to the Covered Participant. In determining the median

described in the preceding sentence, the amount negotiated with each In-Network Health Care Provider is treated as a separate amount (even if the same amount is paid to more than one Health Care Provider). If there is no per-service amount negotiated with In-Network Health Care Providers (such as under a capitation or other similar payment arrangement), the amount under this paragraph is disregarded.

- ii. The amount for the Emergency service calculated using the same method the Plan generally uses to determine payments for Out-of-Network services (such as the usual, customary, and reasonable amount), excluding any In-Network Co-Payment or Benefit Percentage imposed with respect to the Covered Participant. The amount in this paragraph is determined without reduction for Out-of-Network cost sharing that generally applies under the Plan with respect to Out-of-Network services. Thus, for example, if the Plan pays seventy (70) percent of the Usual, Reasonable and Customary amount for Out-of-Network services, the amount in this paragraph for an Emergency service is the total (that is, one hundred (100) percent) of the Usual, Reasonable and Customary amount for the service, not reduced by the thirty (30) percent Benefit Percentage that would generally apply to Out-of-Network services (but reduced by the In-Network Co-Payment or Benefit Percentage that the individual would be responsible for if the Emergency service had been provided In-Network).
 - iii. The amount that would be paid under Medicare (part A or part B of title XVIII of the Social Security Act, 42 U.S.C. § 1395 et seq.) for the Emergency service, excluding any In-Network Co-Payment or Benefit Percentage imposed with respect to the Covered Participant.
- b. Other Cost Sharing. Any cost-sharing requirement other than a Co-Payment or Benefit Percentage requirement (such as a Deductible or Out-of-Pocket maximum) may be imposed with respect to Emergency Services provided Out-of-Network if the cost-sharing requirement generally applies to Out-of-Network benefits. A Deductible may be imposed with respect to Out-of-Network Emergency Services only as part of a Deductible that generally applies to Out-of-Network benefits. If an Out-of-Pocket maximum generally applies to Out-of-Network benefits, that Out-of-Pocket maximum must apply to Out-of-Network Emergency Services; and
5. Without regard to any other term or condition of the coverage, other than:
- a. The Exclusion of or Coordination of Benefits;
 - b. A Waiting Period; or
 - c. Applicable cost sharing.

ACCIDENT EXPENSE BENEFIT PERCENTAGE

The major medical Deductible is waived for the remainder of the Calendar Year, and Covered Expenses for Treatment of Injuries are paid at the usual and appropriate Benefit Percentage, for all Eligible Expenses Incurred as a result of any one Accident. See the Schedule of Coverage.

HOME HEALTH CARE PLAN

To be a covered benefit, a Home Health Care Plan must be in writing, ordered by the attending physician and certified by Medical Management that proper Treatment of the Disability would otherwise require confinement as an Inpatient in a Hospital, Extended Care Facility, or rehabilitative Hospital in the absence of the services and supplies provided as part of the Home Health Care Plan. Home health care expenses are paid per the Schedule of Coverage. The maximum number of visits per Calendar Year is sixty (60).

Home health care professional services include charges made by a Home Health Care Agency for the following Medically Necessary services:

1. Skilled nursing care under the supervision of a physician or registered nurse (R.N.);
2. Certified home health aide services for other than Custodial Care;
3. Rehabilitative therapy, and respiratory therapy provided by the home health care agency;
4. Nutrition counseling provided by or under the supervision of a registered dietitian;
5. Supplies, Durable Medical Equipment, Physical Therapy, Occupational Therapy, and speech therapy are covered under the major medical expense benefit. If prescription medication is part of the home health care plan please refer to the prescription drug benefit for coverage information.
6. Home Infusion Therapy.

Specifically **excluded** from coverage under this benefit are the following:

1. Services and supplies not included in the home health care plan.
2. Services of a person who ordinarily resides in the home of the Covered Participant, or is a Close Relative of the Covered Participant.
3. Services of any social worker.
4. Transportation services.
5. Food or home delivered meals.
6. Homemaker services.
7. Services provided primarily for Custodial Care.

HOSPICE CARE

Hospice Care requires precertification by Medical Management.

To be a covered benefit, a Hospice must have an inter-disciplinary group of personnel which includes at least one physician and one registered graduate nurse, and it must maintain central clinical records on all patients. A Hospice must meet the standards of the National Hospice Organization (NHO) and all applicable state licensing requirements.

COVERED EXPENSES

Covered Expenses shall include charges made by a Hospice for:

1. Nursing care by a registered graduate nurse, a Licensed Practical Nurse, a Vocational Nurse or a public health nurse who is under the direct supervision of a Registered Nurse.
2. Medical supplies, including drugs and biologicals and the use of medical appliances.
3. Physician services.
4. Services, supplies, and treatments deemed Medically Necessary and ordered by a licensed physician.
5. Home Infusion Therapy

CHEMICAL DEPENDENCY BENEFIT

Expenses for the Treatment of Chemical Dependency conditions are considered the same as any other Illness for the Plan's Deductible. Expenses for the Treatment of Chemical Dependency have a Lifetime maximum of three (3) Treatment programs.

Inpatient Benefit

All Inpatient confinements require precertification by Medical Management. **Please see the precertification requirements in the Cost Containment Features section of this Plan.**

Alternate Settings Benefit

Residential Treatment

Residential Treatment is considered an Inpatient confinement and requires precertification by Medical Management. Please see the precertification requirements in the Cost Containment Features section of this Plan. The Plan will reimburse up to twenty-one (21) days for the Medically Necessary Treatment of Chemical Dependency while confined in a residential treatment center and are subject to the following restrictions:

1. The Covered Participant must have a Chemical Dependency condition which would otherwise necessitate Hospital confinement.
2. The services must be based on an individual Treatment plan; and
3. The providers of services must be properly licensed.

Day Treatment

The Plan will reimburse up to twenty-six (26) treatment visits per Calendar Year. The facility must treat a patient for a minimum of four (4) hours in any twenty-four (24) hour period and a minimum of five (5) days per week. The attending physician must certify that such treatment is in lieu of hospitalization. **Precertification by Medical Management is required. Please see the Cost Containment Features section of this Plan.**

MENTAL AND NERVOUS DISORDERS

Expenses for the Treatment of Mental and Nervous Disorders are considered the same as any other Illness for the Plan's Deductible.

Outpatient Benefit

The Plan will reimburse up to twenty-six (26) Outpatient visits per Calendar Year, individual and/or group therapy sessions, and the Medically Necessary expenses for the Treatment of a Mental and/or Nervous Disorder.

Inpatient Benefit

All Inpatient confinements require precertification by Medical Management. **Please see the precertification requirements in the Cost Containment Features section of this Plan.** The Plan will reimburse up to twenty-one (21) Inpatient days for the Medically Necessary Treatment of Mental and/or Nervous Disorders.

Alternate Settings Benefit

Residential Treatment

Residential Treatment is considered an Inpatient confinement and requires precertification by Medical Management. Please see the precertification requirements in the Cost Containment Features section of this Plan. The Plan will reimburse up to twenty-one (21) days for the Medically Necessary Treatment of a Mental and/or Nervous condition while confined in a Residential Treatment center and are subject to the following restrictions:

1. The Covered Participant must have a Mental and/or Nervous Disorder which would otherwise necessitate Hospital confinement.
2. The services must be based on an individual Treatment plan; and
3. The providers of services must be properly licensed.

Day Treatment

The Plan will reimburse up to twenty-one (21) treatment visits per Calendar Year. The facility must treat a patient for a minimum of four (4) hours in any 24-hour period and a minimum of five (5) days per week. The attending physician must certify that such treatment is in lieu of hospitalization. **Precertification by Medical Management is required. Please see the Cost Containment Features section of this Plan.**

SERIOUS MENTAL ILLNESS

Expenses Incurred by a Covered Participant for the Treatment of a Serious Mental Illness is payable as any other Illness as stated in the Schedule of Coverage.

PRE-EXISTING CONDITIONS

Claims resulting from a Pre-Existing Condition are excluded from coverage under the Plan until the Covered Participant is covered under this Plan for a period of twelve (12) consecutive months. Thereafter, the Pre-Existing Condition limitation will no longer apply. You have the right to demonstrate any Creditable Coverage, and the applicable period will be reduced by any Creditable Coverage unless it occurred before a Significant Break in Coverage.

This Pre-existing Condition limitation does not apply to Covered Participants under the age of 19.

This Pre-existing Condition limitation applies to all late entrants except those that Enroll during a special Enrollment period.

STANDARD MEDICAL BENEFITS

In order to be eligible for benefits under this Plan expenses actually Incurred by a Covered Participant must meet all of the following requirements:

1. They are administered or ordered by a physician; or a covered Health Care Provider; and
2. They are Medically Necessary for the diagnosis and Treatment of an Illness or Injury unless otherwise specifically included as a Covered Expense; and
3. They are not excluded under any provision or section of this Plan.

Covered Expenses include, but are not limited to, the following:

1. Hospital (Inpatient - more than twenty-three (23) hours)
 - a) The Plan will cover Semi-Private Room and Board up to the Semi-Private rate; if the Hospital has only private rooms, 90% of the original room rate will be considered as Semi-Private rate; intensive care Room and Board up to Usual, Reasonable and Customary rate; and
 - b) Ancillary services and supplies.
2. Inpatient Newborn Care

Inpatient newborn care charges by a physician, Hospital or Health Care Provider for a newborn, if the mother is covered by the Plan, Incurred within four (4) days of delivery, and the baby is discharged within these four (4) days, will be covered as charges to the mother subject to the Benefit Percentages of the Schedule of Coverage. Newborns must be Enrolled in the Plan within thirty (30) days of birth. If the Mother is not covered and the newborn is Enrolled within thirty (30) days, the charges will be considered as charges to the newborn subject to the Deductible and Out-of-Pocket maximums. *If the newborn is not discharged within four (4) days of delivery, all charges will be considered as charges to the newborn subject to the Deductible and Out-of-Pocket maximums. The newborn must be Enrolled within thirty (30) days after birth for any charges to be considered. This benefit includes Routine circumcision.*
3. Hospital (Outpatient – twenty-three (23) hours or less)
4. Prescription

Outpatient prescription drugs when purchased through the prescription drug card program. Refer to the Schedule of Coverage.
5. Accidental Injury Benefit

Covered charges due to an Accidental Injury will not be subject to the Deductible.

6. Colon-Rectal Examination Benefit

Coverage for medically-recognized screening examination for the detection of colorectal cancer for Covered Participants who are fifty (50) years of age or older and at normal risk for developing colon cancer. This Benefit includes expenses Incurred while conducting a medically-recognized screening examination for the detection of colorectal cancer. This includes annual fecal occult blood tests and a flexible sigmoidoscopy (examination of the large intestine) performed every five (5) years or a colonoscopy performed every ten (10) years.

7. Benefits

Certain Preventive Care Benefits are provided, including screenings and immunizations. Please see Appendix A for a detailed list of many of the Preventive Care Benefits offered under the Plan. The Preventive Care Benefits are provided without any cost sharing (i.e., no Deductible, Co-Pay, or Benefit Percentage), as required by PPACA. Once the PPACA required Preventive Care Benefits have been utilized by a Covered Participant during a Calendar Year, any additional Preventive Care Benefits will be subject to the regular Deductibles, Co-Pays, and Benefit Percentages applicable to the Covered Expenses.

In addition to the Preventive Care Benefits described on Appendix A, the Plan will cover an annual exam benefit once per Calendar Year and an PSA (Prostate Specific Antigen Test after age 40). These benefits will be reimbursed per the Schedule of Coverage only if the provider's bill designates a Routine diagnosis code.

8. Newborn baby subject to separate Deductible and Co-Pay. Covers Hospital and physician charges.
9. Extended Care Facility Room and Board including necessary medical service and supplies.
10. Charges for chiropractic care subject to the Calendar Year maximum stated on the Schedule of Medical Benefits.
11. Charges for non-surgical Treatment of feet subject to Calendar Year maximum as stated on the Schedule of Coverage.
12. Charges for surgical Treatment of feet covered as any other Illness or Injury.
13. The services of a legally qualified physician for medical care and /or surgical Treatment including office visit, home visits, Hospital Inpatient care, Hospital Outpatient visits/exams, clinic care, and second opinion consultations. When charges are Incurred for multiple surgical procedures performed during the same operative session, the Usual, Reasonable and Customary charges for the major procedure will be considered in full. Charges for any incidental procedure (s) not Medically Necessary will not be considered eligible under this Plan. Other charges will be considered as follows:
 - a. The Covered Expenses for lesser procedures in the same operative field will be reduced and considered at a percentage of the Usual, Reasonable and Customary amount for each (50% for the second procedure, 25% for third procedure, 10% for the fourth procedure, 5% for the fifth procedure: no allowance for any additional procedures);
 - b. The maximum covered expense for bilateral procedures will not exceed 175% of the total Usual, Reasonable and Customary allowable amount;
 - c. The maximum Covered expense for a medical necessary Assistant Surgeon will not exceed 25% of the total Usual, Reasonable and Customary allowable amount.
14. Treatment or services rendered by a licensed physical therapist or occupational therapist in a home setting or at a facility or institution whose primary purpose is to provide medical care for an Illness or Injury.
15. Fees of a legally qualified physician or qualified speech therapist for restorative or rehabilitative speech therapy for speech loss or impairment due to an Illness or Injury, other than a functional Nervous Disorder, or due to surgery performed on account of an Illness or Injury. If the speech loss is due to a congenital anomaly of a covered Dependent child, surgery to correct the anomaly must have been performed prior to the therapy.
16. Ground transportation when Medically Necessary and used locally to or from the nearest Hospital qualified to render Treatment. Air ambulance where air transportation is Medically Necessary to transport a Covered Participant to the nearest Health Care Provider qualified to render Treatment.
17. Charges for X-rays, microscopic tests, and laboratory tests.
18. Charges for radiation therapy or Treatment.
19. Charges for the processing and administration of blood or blood components, but not for the cost of the actual blood or blood components if replaced.
20. Charges for oxygen and other gases and their administration.
21. Charges for electrocardiograms, electroencephalograms, pneumoencephalograms, basal metabolism tests, or similar well-established diagnostic tests generally approved by physicians throughout the United States.
22. Charges for the cost and administration of an anesthetic.
23. Charges for dressings, sutures, casts, splints, trusses, crutches, braces, or other Medically Necessary supplies, but not for dental braces, corrective shoes, orthotics or other supportive devices or appliances for the feet.
24. Charges for the rental of a wheelchair, Hospital bed or iron lung or other Durable Medical Equipment required for temporary therapeutic use, or the purchase of this equipment if economically justified, whichever is less. Durable Medical Equipment replacement will be covered only if

there is a change in medical condition that warrants a replacement. For purchases or rentals over \$500, Durable Medical Equipment must be approved by Medical Management or the benefits will be reduced by 50%.

25. Charges for artificial limbs, eyes or larynx, and other similar prosthetic devices, and for Medically Necessary repair or replacement thereof.
26. Charges for voluntary sterilization of an Employee Participant and or Dependent Participant that is a spouse.
27. Charges made by an Ambulatory Surgical Center or Minor Emergency Medical Clinic when treatment has been rendered.
28. Charges for Medically Necessary Alternative Care which might not otherwise be considered a Covered Expense under the Plan, subject to all of the following conditions:
 - a. Such care can be provided without impairing the quality of care;
 - b. Such care is approved by the attending physician, the Covered Participant, and the Plan Supervisor;
 - c. Such care is provided as a cost containment and/or case management program with significant savings.
29. Charges for prescribed contraceptive birth control pills.
30. Charges from a preferred lab. When you use a preferred lab, you pay nothing (no Deductible or Benefit Percentage) for Outpatient laboratory testing services covered by the Plan. This does not include STAT (same day testing or Inpatient testing). *The Preferred Lab Card program does not replace the benefits included in the Plan; it simply gives you the additional option of obtaining quality Outpatient lab testing at no cost.*
31. Home Infusion Therapy.

PREGNANCY EXPENSE BENEFITS

If a Covered Participant incurs expenses for or in connection with Pregnancy, the charges Incurred will be considered and processed the same as any illness and will be subject to the Termination of Coverage provisions. Under this Plan, the term "Pregnancy" shall not include any elective abortion other than one which is Medically Necessary to preserve the life of the mother.

Unscheduled admissions related to Pregnancy (including delivery) must be reported to the Medical Management within 48 hours (or 96 hours as applicable) after admission if the length of stay may extend beyond 48 hours (or 96 hours as applicable).

TRANSPLANT BENEFIT

Transplant benefits provided at a transplant center differs from those provided at a non-transplant center. At least ten (10) working days prior to any pre-transplant evaluation, the Covered Participant or a Family member must contact Medical Management for precertification; failure to do so will result in a late precertification penalty of \$1,000. **Medical case management by Medical Management is required and precertification and continued stay review procedures will apply.**

Eligible transplant expenses Incurred in connection with any organ or tissue transplant will be covered subject to Medical Management approval and Plan limitations. Under this provision, the term Transplant includes the pre-transplant evaluation, procurement, the transplant itself, and one year of post transplant follow-up care, excluding Outpatient prescription drugs covered elsewhere under the Plan. Transplant benefits are paid at the Benefit Percentages on the Schedule of Medical Benefits as long as services are provided at a Transplant Center and approved by Medical Management. Transplant Centers are considered as In-Network Providers.

Non- Designated Transplant Center

If the organ transplant is performed at a Non-Designated Transplant Center or Large Case Management is refused, the pre-transplant, transplant and post transplant care will not be covered.

Benefits will not be paid if the procedure is Experimental as defined in this Plan or if it involves an artificial (mechanical) organ or non-human tissue. A Cornea transplant is not covered as a transplant benefit, but will be covered as any other major medical expense.

Transplant Center

The transplant must be performed at a Hospital or facility designated by the Plan Administrator as a Designated Transplant Center. A list of such hospitals may be obtained from Medical Management.

These benefits will cover charges resulting from organ transplantation at a Designated Transplant Center plus expenses for:

1. travel and lodging if more than 50 miles one way from Hospital or facility;
2. organ transplantation;
3. donor medical expenses, not covered under the donor's plan of benefits, to a maximum of \$10,000;
4. locating and preserving the tissue for the transplant procedure; and
5. fees for maintenance on an organ transplant waiting list.

Reimbursement

Reimbursement requests for travel and lodging shall be submitted on an expense activity report to Medical Management. Reimbursement for food will be calculated and dispersed by the Plan Sponsor based on travel and lodging information as submitted on the Expense Activity Report. All benefits under this provision not directly billed to the Plan Sponsor will be paid to the Employee. The maximum travel, food and lodging benefit for the Covered Participant is \$10,000 and \$5,000 for an Eligible Companion. Eligible Companion is a person of the Covered Participant's choice.

TRAVEL

Eligible travel expense (ground, air transportation, lodging and food) will only be reimbursed for the Covered Participant or Eligible Companion if they live more than fifty (50) miles from the Hospital or facility designated by the Plan Administrator as a Transplant Center. Private vehicle use will be reimbursed at the maximum allowable amount as published by the Internal Revenue Service for the tax year in which the expense is Incurred. Reimbursement is limited to travel between home and the Designated Transplant Center. Airfare will be reimbursed at cost. The purchase of commercial airline tickets may be arranged by Medical Management.

The Plan provides for ground or air transportation for the Covered Participant to and from the pre-transplant evaluation, organ transplantation, and any other Medically Necessary Treatment or follow-up appointment.

The Plan provides for ground or air transportation of each Eligible Companion to and from the pre-transplant evaluation, organ transplantation, and any other Medically Necessary Treatment or follow-up appointment.

Lodging

The Plan will pay for the Covered Participant's reasonable lodging costs when not Hospital confined and the Eligible Companion's lodging as arranged by Medical Management.

Food

The Plan will pay for the Covered Participant and Eligible Companion's reasonable food costs during Medically Necessary transplant-related Outpatient Treatment at the Designated Transplant Center at a rate of thirty-five dollars (\$35) each per day.

GENERAL PLAN EXCLUSIONS AND LIMITATIONS

The following exclusions and limitations apply to expenses Incurred by all Covered Participants. Covered Expenses do not include:

1. Charges Incurred prior to the effective date of coverage under the Plan, or after coverage is terminated;
2. Charges Incurred as a result of war or any act of war, whether declared or undeclared, or caused during service in the armed forces of any country;
3. Charges arising out of or in the course of any occupation for wages or profit, or for which the Covered Participant is entitled to benefits under any workers' compensation or occupational disease law, or any such similar law; in applying this exclusion, work on the covered person's Family farm or ranch is not considered an employment arrangement;
4. Charges for Treatment of a service-connected Illness or Injury, if such charges are:
 - a. Incurred while confined in a Hospital owned or operated by the United States Government (or any Agency thereof), and/or
 - b. for services, Treatment or supplies furnished by the United States government (or any agency thereof);
5. Charges Incurred for which the Covered Participant is not, in the absence of this coverage, legally obligated to pay, or for which a charge would not ordinarily be made in the absence of this coverage; this includes charges for which the Covered Participant is billed for but not required to pay;
6. Charges for any Illness or Disability, resulting from or sustained as a result of being engaged in a felonious act as defined by Texas law;
7. Charges Incurred in connection with any intentionally self-inflicted Injury or Illness, whether sane or insane;
8. Except as specifically stated as a Covered Expense elsewhere in the Plan and as required by PPACA, charges Incurred for Routine medical examinations or Routine health check-ups, Routine Newborn or Well-Baby Care, immunizations not necessary for the Treatment of an Injury or Illness;
9. Charges Incurred for services or supplies which constitute personal comfort or beautification items, television or telephone use, or in connection with Custodial Care, education or training, or expenses actually Incurred by other persons.
10. Charges Incurred in connection with services and supplies which are not necessary for Treatment of the Injury or Illness, or are in excess of Usual, Reasonable and Customary charges or are not recommended and approved by a physician, unless specifically shown as a Covered Expense elsewhere in the Plan;
11. Charges Incurred in connection with the care or Treatment of, or surgery performed for a Cosmetic Procedure. This exclusion shall not apply when such treatment is for reconstructive surgery for a Covered Participant incidental to or following surgery resulting from trauma,

- infection, or other disease(s) which occur while coverage is in effect, or when rendered to correct a congenital anomaly, or procedures for post oncology restoration.
12. Charges for services, supplies, or Treatments not recognized by the American Medical Association as generally accepted and Medically Necessary for the diagnosis and/or Treatment of an active Illness or Injury; or charges for procedures, surgical or otherwise, which are specifically listed by the American Medical Association as having no medical value;
 13. Charges for services rendered by a physician, nurse, or licensed therapist, if such physician, nurse, or licensed therapist is a Close Relative of a Participant;
 14. Charges Incurred outside the United States if the Covered Participant traveled to such a location for the sole purpose of obtaining medical services, drugs, or supplies. However, this does not apply if the expense is Accident related;
 15. Charges for hospitalization when such confinement occurs primarily for physiotherapy, hydrotherapy, convalescent or rest care, or any Routine physical examinations or tests not connected with the actual Illness or Injury;
 16. Charges for physician fees for any Treatment which is not rendered by or in the physical presence of a physician;
 17. Charges Incurred in connection with eye refractions, the purchase or fitting of eyeglasses, contact lenses, hearing aids or such similar aid devices. This exclusion shall not apply to the initial purchase of eyeglasses or contact lenses following cataract surgery, nor does it apply to the initial purchase of a hearing aid if loss of hearing is the result of one of the following which occurs while coverage is in effect: a) Illness, b) Injury, or c) a surgical procedure. This exception shall not include charges related to loss or deterioration of hearing due to aging;
 18. Charges Incurred for or in connection with Treatment on or to the teeth, malocclusion, the nerves or roots of the teeth, gingival tissue or alveolar processes; EXCEPT, benefits will be payable for charges Incurred:
 - a. for Treatment required because of accidental bodily Injury to sound natural teeth sustained while covered. Such expenses must be Incurred within twelve (12) months of the date of the Accident. This exception shall not in any event be deemed to include charges for Treatment for the repair or replacement of a denture;
 - b. for Hospital and associated professional fees (other than surgeon and assistant surgeon) in connection with a dental procedure which must be performed at a Hospital due to documented Medical Necessity;
 19. Charges for or in connection with artificial reproduction; including (but not limited to) in-vitro fertilization, artificial insemination, gamete intra-fallopian transfer, and/or surrogate pregnancy. Charges related to or in connection with fertility studies, sterility studies, and/or any procedures to restore or enhance fertility; EXCEPT, this exclusion does not apply to such charges related to diagnosis and Treatment of underlying conditions or which result in In Vitro Fertilization total benefit payments not exceeding a Lifetime Maximum Benefit of \$5,000 per Covered Participant;
 20. Charges resulting from or in connection with the reversal of a sterilization procedure;
 21. Charges Incurred for or in connection with the Norplant Birth Control System for the purposes of birth control;
 22. Charges for services or supplies that are considered Experimental/Investigational for the Treatment of an Injury or Illness.
 23. Charges for services rendered as a result of (or due to complications resulting from) any surgery, services, Treatments or supplies specifically excluded from coverage under this Plan;
 24. Charges for the replacement of a lost, missing or stolen prosthetic device;
 25. Charges for vitamins; charges for dietary and/or nutritional supplements and education EXCEPT when documented as Medically Necessary to sustain life or for diabetic Treatment and education;
 26. Charges for biofeedback training; acupuncture;
 27. Charges for equipment and services for environmental control or general household use such as air filters or food liquidizers;
 28. Charges for sex transformation surgery and sex hormones related to such surgery;
 29. Charges for Treatment of obesity, including surgical procedures;
 30. Charges for vision therapy;
 31. Charges for radial keratotomy or keratoplasty to correct refractive refractive errors or other special vision procedures including but not limited to Laser Assisted In-Situ Keratomileusis (LASIK) and Excimer laser Photorefractive Keratectomy (PRK);
 32. Charges for chelation therapy;
 33. Charges for the following services and supplies received in connection with diagnosis and/or Treatment of a learning disability, developmental delay, learning impairment or behavioral problem(s), by any name called: remedial education or training; educational therapy (including therapeutic training exercises and multisensory teaching techniques); periodic achievement tests; tutoring; rental or purchase of books, tools, equipment, implements, or supplies of any kind; travel; recreational activities; or any other services rendered on an Inpatient or Outpatient basis. However, this exclusion shall not apply to charges Incurred for physician services, prescription medication, or medical laboratory tests required to monitor medication levels. Note: Covered Expenses by a psychologist or other professional counselor will be subject to Benefit Percentages and Plan limits shown for Mental and/or Nervous Disorders;
 34. Charges for or in connection with treatment of nicotine addiction;
 35. Charges for services that are provided due to a court order;
 36. Charges for marriage counseling;

37. Charges for professional chiropractic services in connection with diagnosis, care, and/or Treatment of any Illness or Injury; EXCEPT, this exclusion does not apply to such charges which result in benefit payments not exceeding a total of \$500 per Covered Participant per Calendar Year;
38. Charges for orthognathic surgery for any Covered Participant age 19 or over;
39. Charges Incurred for services or supplies in connection with any elective abortion other than one which is Medically Necessary to preserve the life of the mother;
40. Charges for prescription drugs dispensed on an Outpatient basis which are covered under a fixed Co-Pay prescription drug benefit program, including the Co-Pay amount or any required payment differential between generic and brand name drugs.

COORDINATION OF BENEFITS

The Coordination of Benefits provision is intended to prevent the payment of benefits which exceed expenses. It applies when a Covered Participant is also covered by any other plan or plans, as defined in this provision.

When more than one coverage exists, the maximum Out-of-Pocket provision of this Plan will NOT apply, and this Plan will ALWAYS pay a reduced amount which, when added to the benefits payable by the other plan or plans, will not exceed 100% of Allowable Expenses. Only the amount paid by this Plan will be charged against this Plan's maximums.

The Coordination of Benefits provision applies whether or not a claim is filed under the other plan or plans. If needed, authorization must be given to this Plan to obtain information as to benefits or services available from the other plan or plans, or to recover overpayments.

All benefits contained in the Plan document are subject to this provision.

The term "Plan" as used within the Coordination of Benefits Provision will mean any Plan providing benefits or services for or by reason of medical or dental Treatment, and such benefits or services provided by:

1. Group insurance or any other arrangement for coverage for Covered Participants in a group whether on an insured or uninsured basis, including but not limited to:
 - a. Hospital indemnity benefits; and
 - b. Hospital reimbursement-type plans which permit the Covered Participant to elect indemnity at the time of claims; or
2. Hospital or medical service organizations on a group basis, group practice and other group pre-payment plans; or
3. Hospital or medical service organizations on an individual basis having in effect a provision similar to this provision; or
4. Any coverage for students which is sponsored by, or provided through, a school or other educational institution; or
5. Any coverage under a governmental program, and any coverage required or provided by any statute; or
6. Group automobile insurance; or
7. Individual automobile insurance coverage on an automobile leased or owned by the City; or
8. Individual automobile insurance coverage based upon the principles of "no-fault" coverage.

The term "Plan" will be construed separately with respect to each policy, contract, or other arrangement for benefits or services, and separately with respect to that portion of any such policy, contract, or other arrangement which reserves the right to take the benefits or services of other plans into consideration in determining its benefits and that portion which does not.

COORDINATION PROCEDURES

Notwithstanding the other provisions of this Plan, benefits that would be payable under this Plan will be reduced so that the sum of benefits and all benefits payable under all other plans will not exceed the total of Allowable Expenses Incurred during any Claim Determination Period with respect to Covered Participants eligible for:

1. Benefits either as an insured person or Participant or as a Dependent under any other plan which has no provision similar in effect to this provision; or
2. Dependent benefits under this Plan for Dependents who are also eligible for benefits;
 - a. As an insured person or Participant under any other plan; or
 - b. As a Dependent child of an insured person or Participant covered under any other plan; or
3. Benefits under this Plan for Participants who are also eligible for benefits as an insured person or Participant under any other plan and have been covered continuously for a longer period of time under such other plan.

For the purpose of determining the applicability of and for implementing this Provision, or any provision of similar purpose in any other plan, the Plan Sponsor may, without the consent of or notice to any person, release to or obtain from any other insurance company or other organization or person any information with respect to any person, which the City deems to be necessary for such purposes.

Any Covered Participant claiming benefits under this Plan will furnish to the City such information as may be necessary to implement this provision or to determine its applicability.

COORDINATION BENEFITS WITH MEDICARE

Medicare is a federal health insurance program for people sixty-five (65) or older or certain disabled individuals provided by the Title XVIII of the Social Security Act, as amended.

Full Medicare coverage is coverage under both part "A" (Hospital Insurance) and Part "B" (Medical Insurance). If a person is eligible for premium free Part "A" that person will be deemed to have full Medicare coverage, even if they have not Enrolled in Part "B". No benefits are payable if the person is Enrolled in Part "C" (Medicare + Choice).

Who will pay first or primary usually depends on work status and the size of the Employer.

For an Employee (Participant) who is employed by the City, this Plan is primary and the normal benefits payable under the Plan will be paid without regard to Medicare.

Status	Age	Primary Plan
Retired	65+	Medicare
Spouse of Retiree	65+	Medicare
Spouse	<65	Employer
Active	65+	Employer
Spouse of Active EE	65+	Employer
Spouse	<65	Employer

There are special rules for people with permanent kidney failure and persons under sixty-five (65) who have Medicare because of disability.

If the Plan is primary, the normal benefits payable under the Plan will be paid without regard to Medicare. If Medicare is primary, the combined total payable by full Medicare coverage and the Plan will not exceed the normal benefit payable by the Plan. If the retiree is Enrolled in Medicare Part C, The Plan will not coordinate benefits.

The Plan Supervisor will determine which Plan is primary. The determination is based on the status of the Covered Participant on the date the expenses are Incurred.

Even if a Person does not Enroll for full Medicare coverage or make due claim for Medicare benefits, the Plan Supervisor will calculate the benefit which would have been paid by full Medicare coverage (see chart above) and adjust the Plan benefits payable according.

FILING DEADLINES

Employees must submit the claims within ninety (90) days from the date the claim was Incurred (or within ninety (90) days of a non-compensable claims decision by Workers' Compensation) **It is the Employee's responsibility to ensure claims are submitted within the Filing Deadline.**

PAYMENTS

Each plan makes its claim payments according to where it falls in this order, if Medicare is not involved:

1. a plan contains no provision for Coordination of Benefits, then it pays before all other plans.
2. plan which covers the claimant as an Employee (or named insured) pays first; remaining recognized charges are paid under a plan which covers the claimant as a Dependent.
3. the claimant is a Dependent child, then the benefits of the Plan for the parent whose date of birth (excluding year of birth) occurs earlier in the Calendar Year shall be determined before the benefits of a Plan covering the parent whose date of birth (excluding year of birth) occurs later in the Calendar Year. If both parents have the same birthday, the plan covering the parent longer pays first. However, if his parents are divorced, then,
 - a. plan of the parent with custody pays first, unless a court order or decree specifies the other parent to have financial responsibility, in which case the plan for that parent would pay first;
 - b. plan of a step-parent with whom the Dependent child lives pays second (if applicable).
4. The benefits of the plan covering the claimant as an Employee who is neither laid off nor retired, or as that Employee's Dependent are determined before those of a plan covering a person who is laid off or retired (or that person's Dependent).

5. If the order set out in A, B, C, or D above does not apply in a particular case, then the plan which has covered claimant for the longest period of time will pay first.

The Plan Sponsor has the right:

1. To obtain or share information with an insurance company or other organization regarding Coordination of Benefits without the consent of the claimant.
2. To require that the claimant provide the City with information on such other plans so that this provision may be implemented.
3. To pay over the amount due under this Plan to an insurer or other organization if this is necessary, in the opinion of the City, to satisfy the terms of this provision.

FACILITY OF PAYMENT

Whenever payments which would have been made under this Plan in accordance with this provision have been made under any other plan or plans, the City will have the right, exercisable alone and in its sole discretion, to pay to any insurance company or other organization or person making such payments any amounts it will determine in order to satisfy the intent of this provision, and amounts so paid will be deemed to be benefits paid under this Plan and to the extent of such payments, the Plan Sponsor will be fully discharged from liability under this Plan.

SUBROGATION/ACTS OF THIRD PARTY

ACTS OF THIRD PARTY

Benefits are not payable to or for a person covered under this Plan when the Injury or Illness of the Covered Participant occurs through the act or omission of another person, company or other entity. However, the Plan Supervisor may elect to advance payment of benefits available under this Plan for medical, dental and/or disability expenses Incurred for an Injury or Illness caused by a third party. The Covered Participant or guardian may be requested to sign an agreement to repay the Plan in full any sums advanced for such expenses. The Plan has the right to recover in full expenses advanced regardless of whether the person actually signs the repayment agreement. It is only necessary that the Injury or Illness occur through the act of a third party to establish the Plan's right of recovery. Such recovery may be from the third party, any liability or other insurance covering the third party, the Covered Participant's own (whether the primary insured or a covered Family member of the primary insured) uninsured motorist benefits, underinsured motorist benefits, or any medical pay or no-fault benefits which are paid or payable as a result of judgment, settlement or otherwise. The Plan will not pay fees or costs associated with the claim lawsuit without express written authorization.

SUBROGATION CLAUSE

As a condition of receiving benefits under this Plan, the Covered Participant receiving any such benefits agrees to transfer in full to the Plan his or her rights to recover damages for these benefits when the Injury or Illness occurs through the act or omission of another person, company or other entity. If a repayment agreement is requested to be signed, all rights of recovery are transferred to the Plan regardless of whether it is actually signed. It is only necessary that the Injury or Illness occur through the act of a third party to establish the Plan's right of full recovery. Such recovery may be from the third party, any liability or other insurance covering the third party, the Covered Participant's own (whether the primary insured or a covered Family member of the primary insured) uninsured motorist insurance, underinsured motorist insurance or any medical pay or no-fault benefits which are paid or payable as a result of judgment, settlement or otherwise. The Plan will not pay fees or costs associated with the claim/lawsuit without express written authorization.

RIGHT TO RECEIVE AND RELEASE NECESSARY INFORMATION

For the purposes of determining the applicability of and implementing the terms of this provision of the Plan or any provision of similar purpose of any other plan the Plan Sponsor may, without the consent of or notice to any person, subject to regulations issued pursuant to Title II of HIPAA, release to or obtain from any insurance company or other organization or person any information, with respect to any person, which the Plan Supervisor deems to be necessary for such purposes.

Any person claiming benefits under this Plan shall furnish to the Plan Sponsor such information as may be necessary to implement this provision.

HIPAA PRIVACY RULE

Plan's Designation Of Person/Entity To Act On Its Behalf. The Plan has determined that it is a group health plan within the meaning of the HIPAA Privacy Rule, and the Plan designates the Employer to take all actions required to be taken by the Plan in connection with the HIPAA Privacy Rule (e.g., entering into business associate contracts and accepting certification from the Employer).

The Plan's Disclosure Of PHI To The Employer/Required Certification Of Compliance By Employer. Except as provided below with respect to the Plan's disclosure of summary health information, the Plan will (a) disclose PHI to the Employer, or (b) provide for or permit the disclosure of PHI to the Employer by a health insurance insurer or Health Maintenance Organization ("HMO") with respect to the Plan, **only if** the Plan has received a certification (signed on behalf of the Employer) that:

1. the Plan has been amended to establish the permitted and required uses and disclosures of such information by the Employer, consistent with the HIPAA Privacy Rule;
2. the Plan has been amended to incorporate the Plan provisions set forth in this section; and
3. the Employer agrees to comply with the Plan provisions as modified by this section.

Permitted Disclosure Of Individuals' PHI To The Employer. The Plan (and any business associate acting on behalf of the Plan), or any health insurance issuer or HMO servicing the Plan, will disclose individuals' PHI to the Employer only to permit the Employer to carry out plan administration functions. Such disclosure will be consistent with the provisions of this section.

All disclosures of the PHI of the Plan's individuals by the Plan's business associate, health insurance issuer, or HMO to the Employer will comply with the restrictions and requirements set forth in this section and in the HIPAA Privacy Rule.

The Plan (and any business associate acting on behalf of the Plan) may not, and may not permit the health insurance issuer or HMO to, disclose individuals' PHI to the Employer for employment-related actions and decisions, or in connection with any other benefit or employee benefit plan of the Employer.

The Employer will not use or further disclose individuals' PHI other than as described in the Plan and permitted by the HIPAA Privacy Rule.

The Employer will ensure that any agent(s), including a subcontractor, to whom it provides individuals' PHI received from the Plan (or from the Plan's health insurance issuer or HMO), agrees to the same restrictions and conditions that apply to the Employer with respect to such PHI.

The Employer will not use or disclose individuals' PHI for employment-related actions and decisions, or in connection with any other benefit or employee benefit plan of the Employer.

The Employer will report to the Plan any use or disclosure of PHI that is inconsistent with the uses or disclosures provided for in the Plan (as amended) and in the HIPAA Privacy Rule, of which the Employer becomes aware.

Disclosure Of Individuals' PHI/Disclosure By The Employer. The Employer will make the PHI of the individual who is the subject of the PHI available to such individual in accordance with 45 C.F.R. Section 164.524.

The Employer will make individuals' PHI available for amendment and incorporate any amendments to individuals' PHI in accordance with 45 C.F.R. Section 164.526 for an individual who requests amendment of his or her PHI.

The Employer will make and maintain an accounting so that it can make available those disclosures of individuals' PHI that it must account for in accordance with 45 C.F.R. Section 164.528.

The Employer will make its internal practices, books and records relating to the use and disclosure of individuals' PHI received from the Plan available to the U.S. Department of Health and Human Services for purposes of determining compliance by the Plan with the HIPAA Privacy Rule.

The Employer will, if feasible, return or destroy all individuals' PHI received from the Plan (or a health insurance issuer or HMO with respect to the Plan) that the Employer still maintains in any form after such information is no longer needed for the purpose for which the use or disclosure was made. Additionally, the Employer will not retain copies of such PHI after such information is no longer needed for the purpose for which the use or disclosure was made. If, however, such return or destruction is not feasible, the Employer will limit further uses and disclosures to those purposes that make the return or destruction of the information infeasible.

The Employer will ensure that adequate separation is established and maintained between the Plan and the Employer as required by the HIPAA Privacy Rule.

Disclosures Of Summary Health Information And Enrollment And Disenrollment Information To The Employer. The Plan, or a health insurance issuer or HMO with respect to the Plan, may disclose summary health information to the Employer without the need to amend the Plan as provided for in the HIPAA Privacy Rule, if the Employer requests the summary health information for the purpose of:

1. obtaining premium bids from health plans for providing health insurance coverage under the Plan; or
2. modifying, amending, or terminating the Plan.

The Plan, or a health insurance issuer or HMO with respect to the Plan, may disclose enrollment and disenrollment information to the Employer without the need to amend the Plan as provided for in the HIPAA Privacy Rule.

Required Separation Between The Plan And The Employer. In accordance with the HIPAA Privacy Rule, the following is a description of the employees, classes of employees, or workforce members under the control of the Employer who may be given access to individuals' PHI received from the Plan or from a health insurance issuer or HMO servicing the Plan:

1. Benefits Coordinator; and
2. Senior Clerk – Insurance Benefits Department.

The above list reflects the employees, classes of employees, or other workforce members of the Employer who receive individuals' PHI relating to payment under, health care operations of, or other matters pertaining to plan administration functions that the Employer provides for the Plan. These individuals will have access to individuals' PHI solely to perform these identified functions, and they will be subject to disciplinary action and/or sanctions (including termination of employment or affiliation with the Employer) for any use or disclosure of individuals' PHI in violation of, or noncompliance with, the provisions of this section.

The Employer will promptly report any such breach, violation, or non-compliance to the Plan and will cooperate with the Plan to correct the violation or noncompliance, to impose appropriate disciplinary action and/or sanctions, and to mitigate any deleterious effect of the violation or noncompliance.

HIPAA SECURITY RULE

Plan's Designation Of Person/Entity To Act On Its Behalf. The Plan has determined that it is a health plan within the meaning of the HIPAA Security Rule, and the Plan designates the Employer to take all actions required to be taken by the Plan in connection with the HIPAA Security Rule (e.g., entering into business associate contracts and accepting certification from the Employer).

Employer's Requirements For Safeguarding EPHI. EPHI will be safeguarded as follows:

1. The implementation of administrative, physical, and technical safeguards that reasonably and appropriately protect the confidentiality, integrity, and availability of the EPHI created, received, maintained, or transmitted by the Employer on behalf of the Plan. These administrative, physical, and technical safeguards are implemented through the HIPAA Security Policies and Procedures.
2. The Plan is allowed to disclose to the Employer information on whether the individual is participating in the Plan, or is enrolled in or has disenrolled from a health insurance issuer or HMO offered by the Plan. Except for such authorized disclose, the Employer is required to ensure that adequate separation exists between the Employer and the Plan through the implementation of reasonable and appropriate security measures.
3. The Employer must ensure that any agent, including a subcontractor, to whom it provides EPHI agrees to implement reasonable and appropriate security measures to protect the EPHI.
4. The Employer is required to report to the Plan any security incident of which it becomes aware.

Exceptions To Employer's Safeguarding of EPHI. The Employer will reasonably and appropriately safeguard EPHI created, received, maintained, or transmitted to or by the Employer on behalf of the Plan, except as disclosed pursuant to:

1. A request for summary health information to obtain premium bids from health plans for providing health insurance coverage under the Plan or modifying, amending, or terminating the Plan.
2. A request for information on whether the individual is participating in the group health plan, or is enrolled in or has disenrolled from a health insurance issuer or HMO offered by the Plan.
3. The following HIPAA Policies and Procedures:
 - a. Uses and Disclosures of PHI Based On Patient Authorization;
 - b. Uses and Disclosure of Psychotherapy Notes;
 - c. Uses and Disclosure of PHI for Marketing;
 - d. Revocation of Authorization to Release PHI; and
 - e. Authorization Form.

GENERAL PROVISIONS

EXAMINATION

The Plan Sponsor shall have the right and opportunity to have the Covered Participant (whose Injury or Illness is the basis of a claim hereunder) examined when and so often as it may reasonably require during pendency of claim hereunder.

The Plan Sponsor shall also have the right and opportunity to have an autopsy performed in case of death where it is not forbidden by law.

FREE CHOICE OF PHYSICIAN

The Covered Participant shall have free choice of any legally qualified physician, and the physician – patient relationship shall be maintained; however, all services are subject to the Plan's conditions, limitations and exclusions, and this statement of privilege will not and does not bind the Plan to provide coverage or benefits for any physician's service(s).

PAYMENT OF CLAIMS

All Plan benefits are payable to the Participant, or subject to any written direction of the Participant. All or a portion of any indemnities provided by the Plan on account of Hospital, nursing, medical or surgical services may, at the Participant's option and unless the Participant requests otherwise in writing not later than the time of filing proofs of such loss, be paid directly to the Hospital or person rendering such services; however, if any benefit remains unpaid at the death of the Participant or if the Participant is a minor or is, in the opinion of the Plan Sponsor, legally incapable of giving a valid receipt and discharge for any payment, the Plan Sponsor may, at its option, pay such benefits to any one or more of the following relatives of the Participant; wife, husband, mother, father, child or children, brother or brothers, sister or sisters. Any payment(s) so made will constitute a complete discharge of the Plan Sponsor's obligation to the extent of such payment(s) and the Plan Sponsor will not be required to see the application of the money so paid.

RIGHTS OF RECOVERY

Whenever any payment has been made by the Plan Sponsor which does not strictly comply with the terms and conditions of the Plan and/or is in excess of the maximum amount of payment necessary to satisfy the intent of this Plan, the City shall have the right, exercisable alone and in its sole discretion, to recover such payment(s).

LEGAL PROCEEDINGS

No action at law or in equity shall be brought to recover on the Plan prior to exhaustion of the Plan's claims procedures. No such action shall be brought at all unless brought within three (3) years from the expiration of the time within which proof of loss is required by the Plan.

TIME LIMITATIONS

If any time limitation of the Plan with respect to giving notice of a claim or furnishing proof of loss, or the bringing of an action at law or in equity, is less than that permitted by the laws of the state of Texas, such limitation is hereby extended to agree with the minimum period permitted by such law.

WORKERS' COMPENSATION NOT AFFECTED

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

CONFORMITY WITH LAW

If any provision of this Plan is contrary to any law to which it is subject, such provision is hereby amended to conform thereto.

STATEMENT

In the absence of fraud, all statements made by a Covered Participant will be deemed representations and not warranties. No such representations will void the Plan benefits or be used in defense to a claim hereunder unless a copy of the instrument containing such representation is or has been furnished to such Covered Participant.

MISCELLANEOUS

Section titles are for convenience of reference only and are not to be considered in interpreting this Plan. No failure to enforce any provision of this Plan shall affect the right thereafter to enforce such provision of this Plan.

DEFINITIONS

Certain words and phrases which may be used in this Plan are listed below, along with the definition or explanation of the manner in which the term is used for the purposes of this Plan. Masculine pronouns used in this Plan shall include masculine or feminine gender unless the context indicates otherwise. Wherever any words are used herein in the singular or plural, they shall be construed as though they were in the plural or singular, as the case may be, in all cases where they would so apply.

Accident means a traumatic bodily injury definite as to time and place sustained independently of all other causes by outside event, external force, or due to exposure to the elements.

Adverse Benefit Determination means any of the following: a denial, reduction, or termination of, or a failure to provide or make payment (in whole or in part) for, a benefit, including any such denial, reduction, termination, or failure to provide or make payment that is based on a determination of a participant's or beneficiary's eligibility to participate in a plan, and including, with respect to group health plans, a denial, reduction, or termination of, or a failure to provide or make payment (in whole or in part) for, a benefit resulting from the application of any utilization review, a failure to cover an item or service for which benefits are otherwise provided because it is determined to be experimental or investigational or not Medically Necessary or appropriate, as well as a Rescission of coverage.

Affiliates mean entities that are owned and operated by the City of McAllen which include the McAllen Chamber of Commerce, Affordable Homes of South Texas, McAllen Housing Authority, International Museum of Art & Science (IMAS) and McAllen Economic Development Corporation/ Foreign Trade Zone (MEDC/FTZ) .

Allowable Expenses mean any necessary item of expense, the charge for which is Usual, Reasonable and Customary, at least a portion of which is covered under at least one of the plans covering the person from who the claim is made. When a plan provides benefits in the form of services rather than cash payments, then the reasonable cash value of each service rendered will be deemed to both an allowable expense and a benefit paid.

Ambulatory Surgical Center means an institution or facility, either free-standing or as part of a Hospital with permanent facilities, equipped and operated for the primary purpose of performing surgical procedures and to which a patient is admitted to and discharged from within a twenty-four (24) hour period. Any office maintained by a physician for the practice of medicine or dentistry, or for the primary purpose of performing terminations of Pregnancy, shall not be considered to be an Ambulatory Surgical Center.

Amendment means a formal document that changes the provisions of the Plan document, duly signed by the authorized person or persons as designated by the Plan Administrator.

Benefit Percentage means that portion of Eligible Expenses to be paid by the Plan in accordance with the coverage provisions as stated in the Plan. It is the basis used to determine any Out-of-Pocket expenses in excess of the Deductible(s) which are to be paid by the Covered Participant.

Benefit Year means a period of time commencing with the effective date of this Plan or the Plan Anniversary, and terminating on the date of the next succeeding Plan Anniversary.

Calendar Year means a period of 12 consecutive months beginning 12:01 am on January 1 and ending at midnight, December 31.

Chemical Dependency means habituation, abuse and/or addiction to alcohol or other chemical substance not including nicotine. This includes physiological and/or psychological dependence.

Chemical Dependency or Substance Abuse Treatment Facility means a facility which provides a program for the treatment of Chemical Dependency pursuant to a written Treatment plan approved and monitored by a physician and which facility meets the requirements under #1, #2 and #3 or the requirements under #4:

1. affiliated with a Hospital under a contractual agreement with an established system for Covered Participant referral;
2. accredited as a such a facility by the Joint Commission for Accreditation of Healthcare Organization (JCAHO); and
3. licensed as a Chemical Dependency treatment program by the Texas Commission on Alcohol and Drug Abuse (TCADA); or
4. licensed, certified or approved as a Chemical Dependency treatment program or center by any other state agency having legal authority to so license, certify or approve and is also an approved health care facility.

City of McAllen or City means the City of McAllen, the City of McAllen Public Utilities, and the Board of Trustees of the City of McAllen.

Claim Determination Period means a Calendar Year or that portion of a Calendar Year during which the Covered Participant from claim is made has been covered under this plan.

Clinical Trials are clinical trials are controlled scientific studies designed to access the effectiveness of procedures, drugs and devices. Typically, clinical trials are performed after Treatment shows promise during limited testing.

Close Relative means the spouse, parent, brother, sister, child, or spouse's parent of the Covered Participant.

COC Participant means a Covered Participant who has terminated coverage, meets the requirements for COC coverage as set forth in this Plan, and elects and pays for COC coverage.

Contribution means the amount payable by the Employer, the amount payable by the Employer, or the amount payable by the Employer/Employee jointly for participation in the benefits of the plan.

Co-Payment means a specified amount that is Covered Participant's responsibility to pay to Health Care Provider. Co-Payments are usually connected with specific benefits and may be in addition to or instead of Plan Deductible.

Cosmetic Procedure means a procedure performed solely for the improvement of a Covered Participant's appearance rather than for the improvement or restoration of bodily function.

Covered Expenses means costs Incurred for any Medically Necessary Treatments, services, or supplies that are not specifically excluded from coverage elsewhere in this Plan. Covered Expenses include the Usual, Reasonable, and Customary fees charged for Medically Necessary Treatments, services or supplies covered by the Plan that are not specifically excluded from coverage elsewhere in the Plan. Any agreement as to fees or charges made between the Covered Participant and the Health Care Provider shall not bind the Plan in determining its liability with respect to expenses Incurred. The Covered Participant must also have an obligation to pay the expense.

Covered Participant means: an Employee Participant, Retiree Participant, COC Participant, or Dependent Participant that meets the eligibility requirements of the Plan and Enrolls in coverage.

Creditable Coverage means prior medical coverage that a person had from any of the following sources: a group health plan, health insurance coverage, Medicare, Medicaid, medical and dental care for members and former members of the uniformed services and their dependents, a medical care program of the Indian Health Service or a tribal organization, a state health benefits risk pool, certain other state sponsored arrangements established primarily to provide medical benefits to persons who have difficulty in obtaining affordable coverage because of a medical condition, a health plan offered under the Federal Employees Health Benefits Program, a public health plan, or a health benefit plan under the Peace Corps Act.

Custodial Care means that type of care or service, wherever furnished and by whatever name called, which is designed primarily to assist a Covered Participant, whether or not Totally Disabled, in the activities of daily living. Such activities include, but are not limited to: bathing, dressing, feeding, and preparation of special diets, assistance in walking or in getting in and out of bed, and supervision over medication which can normally be self-administered.

Day Treatment means a psychiatric or Chemical Dependency treatment facility that meets all of the following requirements:

1. provides treatment for individuals suffering for acute mental/nervous disorders and/or chemical dependency in a structured program using individual treatment plans with specific attainable goals and objectives appropriate for the Covered Participant;
2. clinically supervised by a physician who is certified in psychiatry by the American Board of Psychiatry and Neurology; and
3. accredited by the Program for Psychiatric Facilities and is licensed by the Joint Commission for Accreditation of Healthcare Organizations (JCAHO) or is a community health center, health center or day treatment center which furnished health services subject to the approval of the Department of Mental Health.

Deductible is the annual amount of Eligible Expenses which are the responsibility of the Employee Participant before benefits become payable by this Plan.

Dependent means:

1. A spouse who is a resident of the same country in which the Participant resides. Such spouse must have met all requirements of a valid marriage contract in the State of marriage of such parties.
2. A child of the Participant who meets the following conditions and is under the age of 26:

- a. a natural child of the Participant, or
 - b. a step-child, or
 - c. a legally adopted child (including a child for whom legal adoption has been started), or
 - d. a child under Qualified Medical Child Support Order, court order or divorce decree requiring coverage by the Participant.
3. A grandchild whose primary residence is the household of the Employee Participant and for whom the Employee Participant is legal guardian or related by blood or marriage, and is dependent upon the Participant for more than one-half of the support as defined by the IRS.

Those situations specifically excluded from the definition of a Dependent are:

- a. A spouse who is legally divorced from the Participant; or
- b. A Covered Participant may be covered under this Plan as either a Participant or Dependent, but not both;
- c. An eligible Dependent may be covered as a Dependent of only one Participant under this Plan.

Dependent Participant means a Dependent of the Employee Participant who is eligible for coverage and who has Enrolled in the Plan.

Disability means any of the following conditions:

1. Illness;
2. Bodily malfunction-(impairment, disturbance or abnormality of the functioning of an organ or limb);
3. Accidental injury;
4. Pregnancy
5. Mental/nervous conditions; or
6. Chemical dependency

All expenses Incurred as a result of the same or a related cause are considered one disability.

Durable Medical Equipment means equipment which Medically Necessary and appropriate only if the treatment or management of an illness or injury and is accepted in the medical community as safe and effective is:

1. Able to withstand repeated use; and
2. Primarily and customarily used to serve a medical purpose; and
3. Not generally useful to a person in the absence of Illness or Injury.

Elected or Appointed Official means the Mayor, City Commissioners, Utility Board Trustees and current Bridge Board Members.

Emergency Medical Condition means a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) so that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in a condition that would place the health of the Covered Participant in serious jeopardy, seriously impair the Covered Participant's bodily functions; or result in serious dysfunction of any bodily organ or part. Such term shall not include medical attention received through the emergency department of a Hospital for purposes of convenience or solely because services are received after normal business hours.

Emergency Services means, with respect to an Emergency Medical Condition, a medical screening examination (as required under section 1867 of the Social Security Act, 42 U.S.C. section 1395dd) that is within the capability of the emergency department of a Hospital, including ancillary services routinely available to the emergency department to evaluate such Emergency Medical Condition, and such further medical examination and treatment, to the extent they are within the capabilities of the staff and facilities available at the Hospital, as are required under section 1867 of the Social Security Act (42 U.S.C. 1395dd) to Stabilize the Covered Participant.

Employee means a person who works a minimum of forty (40) hours per week for an Employer in the course of the Employer's business. An Elected or Appointed Official while holding office is considered an Employee for purposes of this Plan.

Employee Participant means an Employee or Elected or Appointed Official who is eligible for coverage and who has Enrolled in the Plan.

Employer means the City or an Affiliate.

Enroll means to make a written request and complete an application for coverage on the prescribed forms. Enrollment is not completed until such forms are accepted and received by the City's Plan Supervisor.

Exclusions mean the charges for which benefits are not provided. Such charges are listed in the section entitled General Plan Exclusions and Limitations.

Experimental/Investigational means expenses for treatments, procedures, devices or drugs which the Plan Supervisor determines, in the exercise of its discretion, are *experimental, investigational* or done primarily for research, including but not limited to the following:

1. it fully involves the use of a drug, substance or device that has not been approved by the United States Food and Drug Administration; or
2. reliable evidence shows the following:
 - a. the treatment, procedure, device or drug is the subject of ongoing phase I, II or III Clinical Trials or under study to determine its maximum tolerated dose, its toxicity, its safety, its efficacy or its efficacy as compared with the standard means of treatment for diagnoses; and
 - b. the consensus of opinion among experts regarding the treatment, procedure, device or drug is that further studies or Clinical Trials are necessary to determine its maximum tolerated dose, its toxicity, its safety, its efficacy or its efficacy as compared with the standard means of treatment or diagnoses.Reliable evidence includes anything determined to be such by the *Plan Supervisor*, within the exercise of its discretion, and may include published reports and articles in the medical and scientific, literature generally considered to be authoritative by the national medical professional community.

Extended Care Facility is an institution or a distinct part of an institution which meets all of the following criteria:

1. is primarily engaged in providing for inpatient skilled nursing care and related services for patients who require medical or nursing care, or rehabilitation of injured or sick persons;
2. have *policies* which are developed with the advice of (and with provision for review of such policies from time to time by) a group of professional personnel, including one or more physicians and one or more registered professional nurses, to govern the skilled nursing care and related medical care or other services provided;
3. has a physician, a registered nurse (RN) and a medical staff responsible for the execution of such policies;
4. has a requirement that the health care of every patient must be under the supervision of a physician, and provides for having a physician available to furnish necessary medical care in case of emergency;
5. maintains clinical records on all patients;
6. if required, provides 24-hour nursing care under the supervision of a registered nurse (RN);
7. provides appropriate methods and procedures for the dispensing and administering of drugs and biologicals;
8. has in place a utilization review plan which provides for the review of admissions to the institution, the duration of stays, and the professional services furnished with respect to Medical Necessity;
9. is licensed by the appropriate state or local agency; and
10. is Medicare or Medicaid eligible.

A skilled nursing facility meets the definition of an Extended Care Facility but does not include any institution which is primarily for Custodial Care or for care of the aged or senile.

Family means a Covered Participant and his eligible Dependents.

Filing Deadline means the claim submission time frame. All claims and additional information must be received no later than ninety (90) days from the date the claim was Incurred (or within ninety (90) days of non-compensable claims decision by Worker's Compensation).

He/Him/His means whenever the masculine pronoun is used in the Plan it shall include the feminine gender as well, unless the context clearly indicates otherwise.

Health Care Provider is a physician (M.D.) or a person acting within the scope of applicable state of licensing/certification requirements, including, but not limited to, the following designations: Doctor of Osteopathy (D.O.), Doctor of Optometry (O.D.), Certified Nurse Midwife (C.N.M.), Registered Respiratory Therapist (R.R.T.), Licensed Physical Therapist (L.P.T.), Licensed Psychologist, Doctor of Chiropractic (D.C.), Doctor of Podiatry Medicine (D.P.M.), Podiatrist (D.S.C.), Registered Nurse (R.N.), Licensed Vocational Nurse (L.V.N.), Licensed Practical Nurse (L.P.N.), Speech Therapist, Audiologist, Occupational Therapist, Licensed Registered Dietician (L.D. or R.D.) or Certified Nurse Anesthetist (C.R.N.A.).

HIPAA means a Federal Law referred to as the Health Insurance Portability and Accountability Act of 1996. HIPAA went into effect for most group health plans on the anniversary that occurred on or after July 1, 1997, HIPAA provides individuals certain rights and protection relating to health care coverage. Federal law gives the plan sponsor of non-Federal Governmental Plans the right to exempt the plan in whole or in part from requirements of Title I except for the creditable coverage certificate requirements. The City of McAllen has opted out of HIPAA and is exempt for the Title I HIPAA requirements.

Title I:

- Refers to creditable coverage, restrictions on pre-existing conditions, special Enrollments, non-discrimination based on Health Status Factors, Newborns' and Mothers Health Protection Act, Mental Health Protection Act, Mental Health Parity Act and Women's Health and Cancer Right Act;
- Has an exemption option for self funded, non-federal governmental plans out of certain requirements.

Title II

- Effective April 14, 2003 Administrative Simplification guidelines have been mandated. The administrative simplification process includes standards for electronic transaction and code sets, national identifiers (for employers, health plan and providers), Security and Electronic Signature Standards (final rule was published February 20, 2003) and Standards for Privacy of Individually Identifiable Health Information (Privacy Rule);

A self-funded, non-federal, governmental health plan cannot exempt itself from the Title II requirement.

Home Health Care Agency means a public or private agency or organization that specializes in providing medical care and treatment in the home. Such a provider must meet all of the following conditions:

1. It is primarily engaged in and duly licensed, if such licensing is required, by the appropriate licensing authority to provide skilled nursing services and other therapeutic services; and
2. It has policies established by a professional group associated with the agency or organization. This professional group must include at least one physician and at least one registered graduate nurse (R.N.) to govern the services provided and it must provide for full-time supervision of such services by a physician or registered graduate nurse; and
3. It maintains a complete medical record on each individual; and
4. Has a full-time administrator.

Home Infusion Therapy means the administration of fluids, nutrition, or medication (including all additives and chemotherapy) by intravenous or gastrointestinal (enteral) infusion or by the intravenous injection in the home setting. Home Infusion Therapy shall include:

1. Drugs and IV solutions;
2. Pharmacy compounding and dispensing services;
3. All equipment and ancillary supplies necessitated by the defined therapy;
4. Delivery services;
5. Patient and family education; and
6. Nursing services.

Over-the-counter products which do not require a physician's or Health Care Provider's prescription, including but not limited to standard nutritional formulations used for enteral nutrition therapy, are not included within this definition.

Home Infusion Therapy Provider means an entity that is duly licensed by the appropriate state agency to provide Home Infusion Therapy.

Hospice means a health care program providing a coordinating set of services rendered at home, in Outpatient settings or in institutional settings for Covered Participants suffering from a condition that has a terminal prognosis.

Hospital means a legally operated institution which: is supervised by a staff of physicians, has twenty-four (24) hour a day nursing services, is primarily engaged in providing treatment to patients confined more than twenty-four (24) hours; charges patients for its services; and

1. Is an accredited facility under the accreditation program of the Joint Commission on the Accreditation of Health Organizations and is a provider of services under Medicare with medical, diagnostic, and major surgical facilities on its premises or under its control; or
2. Is licensed as a Hospital engaged mainly in providing psychiatric services for the diagnosis and treatment of mentally ill persons; or
3. In the case of treatment of Substance Abuse Conditions, it is licensed, certified or approved as a treatment center by the appropriate agency of the state in which it is located; or
4. In the case of treatment of pregnancy or childbirth, it is licensed, certified or approved as a birthing center by the appropriate agency of the state in which it is located.

In no event will the term "Hospital" include a nursing home or an institution or part of one which:

1. Is primarily a facility for convalescence, nursing, rest, or aged, or;
2. Furnishes primarily domiciliary or Custodial Care, including training in daily living Routines, or is operated primarily as a school.

Hospital Miscellaneous Expenses means the actual charges made by a Hospital in its own behalf for services and supplies rendered to the Covered Participant which are Medically Necessary for the treatment of such Covered Participant. Hospital Miscellaneous Expenses do not include charges for Room and Board or for professional services (including intensive nursing care by whatever name called), regardless of whether the services are rendered under the direction of the Hospital or otherwise.

Illness means sickness or disease which requires treatment by a licensed health care provider.

Incurred means the date of which a service is rendered or supply is obtained.

Injury or Injuries means a condition caused by accidental means which results in damage to the Covered Participant's body from a sudden, violent, unexpected and external event. Any loss which is caused by or contributed to by a hernia of any kind will be considered a loss under the definition of Illness, and not as a loss resulting from accidental Injury.

In-Network means Treatment or services rendered by Health Care Providers that are included as contracted providers in the Preferred Provider Network.

Inpatient means Treatment of confinement to a Hospital for more than twenty-three (23) hours.

Large Case Management means management of the care of Covered Participants who have catastrophic or long-term Illnesses or Injuries requiring extensive care.

Late Entrant means a person who makes an application for coverage more than thirty-one (31) days after the Covered Participant's initial eligibility date or who reapplies for coverage after the coverage on such person was terminated.

Lifetime in reference to benefit maximums and limitations is understood to mean "while covered under the City's Employee Benefit Plan." Under no circumstances does "Lifetime" mean "during the lifetime of the Covered Participant."

Maternity Care means services rendered to treat and maintain a Pregnancy that is covered under this Plan. Maternity Care includes prenatal visits and testing, delivery of the child, post-partum care, and Routine care of the newborn child while the mother is Hospital confined. Cost sharing for Routine care will only be imposed in compliance with PPACA.

Medical Management Services or Medical Management means a system that includes precertification, concurrent review, discharged planning and retrospective review of the Medical Necessity and appropriateness of healthcare services. Medical Management Services does not include elective requests for clarification of coverage.

Medically Necessary or Medical Necessity means the appropriate therapeutic procedure, service or supply used in the medical Treatment of a Disability in accordance with generally accepted standards of medical practice that is both:

1. the most appropriate supply of level of service which can be provided (for Inpatient stays, this means acute care is necessary due to the kinds of services the Covered Participant is receiving or the severity of the Covered Participant's condition and that safe adequate care cannot be received on an Outpatient basis); and
2. Not primarily for the convenience of the Covered Participant, Covered Participant's Family, physician or another provider.

The Treatment must not be Experimental or Investigational.

Medicare means Title XVIII, Health Insurance for the Aged and Disabled, of the United States Social Security Act or as later amended.

Mental and/or Nervous Disorder means a mental health condition as defined by the American Psychiatric Association Diagnostic and Statistical Manual (DSM). Mental and/or Nervous Disorder does not include conditions which are expressly excluded in the list of General Plan Exclusions and Limitations (i.e. childhood learning and behavior disorders, hypnotherapy, marriage and family counseling, sex counseling, sex therapy and vocational testing and training).

Minor Emergency Medical Clinic means a free-standing facility which is engaged primarily in providing a minor emergency and episodic medical care to a Covered Participant. A licensed physician, a Registered Nurse, and a Registered X-Ray Technician must be in attendance at all times that the clinic is open. Clinic facilities must include x-ray and laboratory equipment and a life support system. For the purposes of this Plan, a clinic meeting these requirements will be considered to be a Minor Emergency Medical Clinic, by whatever actual name it may be called; however, a clinic located on or in conjunction with or in any way made a part of a regular Hospital shall be excluded from the terms of this definition.

Occupational Therapy means treatment which is rendered for reasons other than restoration of bodily function and the prevention of disability. Such treatment is usually rendered by the use of work-related skills and leisure time tasks for the evaluation of an individual's behavior and/or abilities of self-care, work or play.

Open Enrollment means the thirty (30) day period prior to the new plan year in which Dependents who are not currently covered by the Plan can be added. Coverage for the Dependents will become effective at the beginning of the new Plan Year. The pre-existing condition limitations will apply to eligible Dependents who have attained age nineteen (19) or older that are added during Open Enrollment time period.

Outpatient means Treatment or confinement to a medical facility for twenty-three (23) hours or less.

Outpatient Substance Abuse Treatment Facility means an institution which provides a program for diagnosis, evaluation, and effective treatment of Substance Abuse Conditions (including, but not limited to conditions resulting from use of amphetamines, barbiturates, cocaine and its derivatives, methaqualone and opium alkaloids, and/or alcohol); provides detoxification and services needed with its effective treatment program; provides infirmity-level medical services or arranges with a Hospital in the area for any other medical services that may be required; is at all times supervised by a staff of physicians; provides at all times skilled nursing care by licensed nurses who are directed by a full-time registered graduate nurse (R.N.); prepares and maintains a written plan of treatment for each patient based on medical, psychological and social needs which is supervised by a physician; and is licensed, certified, or approved by any State agency with legal authority to so act.

Out-of-Network means treatment or services rendered by providers that are not included as contracted providers in the preferred provider network.

Out-of-Pocket means the portion of Eligible Expenses for which an Employee Participant is responsible to pay.

Participant Coverage means coverage hereunder providing benefits payable as a consequence of an Injury or Illness of a Covered Participant.

Physical Therapy means treatment which is rendered to restore a certain degree of bodily function or prevent disability following Illness, Injury or loss of a body part.

Plan means the plan provisions for coverage and payment of benefits as described in this document.

Plan Administrator means the City of McAllen. The Plan Administrator is the named fiduciary for purposes of the claims procedures contained in this Plan.

Plan Supervisor or Third Party Administrator means Blue Cross Blue Shield of Texas.

Plan Year means the period beginning October 1 thru September 30.

Post-Service Claim means a regular claim for benefits after the Covered Participant has received medical Treatment.

Precertification Claim means a claim for benefits before the Covered Participant receives medical Treatment, such as a request for pre-authorization.

Pre-Existing Condition means any Injury or Illness of a Covered Participant for which the Covered Participant has been diagnosed and/or treated by a licensed physician or has received medical consultation, care or other services (including prescription drugs) within the three (3) month period immediately preceding the effective date of coverage.

Preferred Provider Network (PPN): a group of medical providers (physicians, practitioners, and/or hospital) who as a group or individually agree to specified fee schedules, utilization review, and cost containment procedures for the delivery of health care and have contracted for such with the Fund or Plan Supervisor.

Pregnancy under the terms of this Plan, pregnancy includes one or more of the following:

1. Period from conception through childbirth;
2. Miscarriage;
3. Any complications arising wholly from pregnancy, childbirth or miscarriage;
4. Any pregnancy complications arising from any trauma and/or;
5. Extra-uterine pregnancies are considered to be genitourinary conditions.

Preventive Care Benefits means preventive care benefits provided in accordance with Public Health Service Act § 2713.

Psychiatric Care (also known as psychoanalytic care), means Treatment for Mental Illness or Disorder, or a functional Nervous Disorder.

Psychiatric Day Treatment Facility means a mental health facility which is: (1) accredited by the Program for Psychiatric Facilities (or its successor) or by the Joint Commission on Accreditation of Hospitals; and (2) provides Treatment for acute Mental or Nervous Disorders; and (3) provides such Treatment for up to eight (8) hours in any twenty-four (24) hour period. Treatment must be given in a structured psychiatric program using a personalized Treatment plan. The Treatment plan must have specific attainable goals which are appropriate both to the Covered Participant and the program. The Treatment plan must be supervised by a doctor of medicine who is certified in psychiatry by the American Board of Psychiatry and Neurology.

Rescission means a cancellation or discontinuance of coverage that has retroactive effect, including a cancellation that treats a policy as void from the time of the individual's or group's enrollment or a cancellation that voids benefits paid up to a year before the cancellation. Rescission does not include a cancellation or discontinuance of coverage if the cancellation or discontinuance of coverage has only a prospective effect or the cancellation or discontinuance of coverage is effective retroactively to the extent it is attributable to a failure to timely pay required premiums or contributions towards the cost of coverage.

Retiree means (a) an Employee who ceased Full-Time, active employment with the City of McAllen or an Affiliate and retired under TMRS or the Firemen's Pension System. Refer to the definition of Covered Participant for additional information; or (b) an Elected or Appointed Official (excluding Bridge Board Members).

Retiree Participant means a Retiree who is eligible for coverage and who has Enrolled in the Plan.

Room and Board refers to all charges by whatever name called which are made by a Hospital, Hospice, or convalescent nursing facility as a condition of occupancy. Such charges do not include the professional services of physicians nor intensive nursing care by whatever name called.

Routine means being in accordance with established procedure.

Schedule of Coverage means the document provided by the Plan Supervisor summarizing the cost-sharing requirements under the Plan.

Semi-Private refers to a class of accommodations in a Hospital, Hospice or convalescent nursing facility in which at least two patient beds are available per room.

Serious Mental Illness means the following psychiatric illnesses as defined by the American Psychiatric Association in the latest version of the Diagnostic and Statistical Manual (DSM):

1. Schizophrenia;
2. Paranoia and other psychotic disorders;
3. Bipolar disorders (mixed, manic, depressive and hypo manic)
4. Major depressive disorders (single episode or recurrent);
5. Schizo-affective disorders (bipolar or depressive);
6. Pervasive Developmental disorders;
7. Obsessive Compulsive disorders (OCD) and;
8. Depression in childhood and adolescence.

Significant Break in Coverage means a period of sixty-three (63) consecutive days during all of which an individual did not have any Creditable Coverage, but does not include Waiting Periods and affiliation periods.

Stabilize means , with respect to an Emergency Medical Condition, the meaning given in section 1867(e)(3) of the Social Security Act (42 U.S.C. 1395dd(e)(3)).

Treatment means any specific procedure or service which is Medically Necessary and used for the cure or improvement or Illness, Disability or Injury.

Urgent Care Claim means a claim for benefits that is a Precertification Claim that must be handled urgently because failure to do so would either (1) seriously jeopardize the Covered Participant's life or health or his or her ability to regain maximum functions; or (2) subject the Covered Participant, in the opinion of a physician (who knows about the medical condition), to severe pain that cannot be adequately managed without the medical Treatment that is the subject of the claim.

Usual, Reasonable and Customary a usual, reasonable and customary charge is based on the geographical area in which services were provided. The geographical area is a county or greater area as necessary to establish a representative cross-section of Health Care Providers regularly furnishing the services.

Waiting Period means a period of continuous active, full-time employment, required by the Employer that must be completed before an Employee or his or her eligible Dependents can be effective for coverage under this Plan.

Well-Baby Care means medical Treatment, services or supplies rendered to a child or newborn solely for the purpose of health maintenance and not for the Treatment of an Illness or Injury.

PLAN INFORMATION

1. Name And Type Of Administration Of The Plan:

City of McAllen Employee Benefit Plan.
Plan Providing Benefits for Reimbursement of Medical Expenses.

2. Name And Address Of The Person Designated As Agent For The Service Of Legal Process:

Plan Administrator
City of McAllen
1300 Houston St.
McAllen, TX 78501-0220

3. Name And Address Of The Plan Administrator/Sponsor And Named Fiduciary:

Plan Administrator
City of McAllen
PO Box 220
McAllen, TX 78505

4. Name And Address Of Plan Supervisor:

Blue Cross Blue Shield of Texas
9442 Capital of TX Hwy. N.
Suite 500, Arboretum Plaza II
Austin, TX 78759-6389

5. Name And Address Of The Trustee:

Plan Administrator
City of McAllen
PO Box 220
McAllen, TX 78505

6. Contributions To The Fund:

Contributions are made to the fund by the City and Covered Participants, and are held by the Trustee. Contributions are calculated and based upon the cost of coverages and benefits. Benefits for Covered Expenses are provided directly from the Plan, through the Plan Supervisor and under the direction of the Plan Administrator.

7. Date of the End of the Plan Year: **September 30th**

8. Internal Revenue Service Identification Number: **74-6001650**

9. Additional Information:

The Plan must be managed prudently and in the interest of all Covered Participants. No one may be fired or in any way discriminated against because of a disputed claim or due to the exercise of any rights under the law.

Covered Participants may examine, without charge, at the office of the Plan Supervisor and other specified locations, such as worksites, all documents pertaining to the Plan, including reports, insurance contracts and the like. Copies of any such documents are available from the Plan Supervisor, for which a reasonable charge may be made. Covered Participants will also receive a summary of the annual financial report, if required by law.

The Covered Participant should contact the Plan Administrator with any questions about the Plan.

SIGNATURE PAGE

The effective date of the City of McAllen Group Benefit Plan is October 1, 2010. It is hereby agreed by the City of McAllen that the provisions of this document are correct and will be the basis for the administration of the City of McAllen Group Benefit Plan.

Authorized By: Muh R. Puy
Title: City Manager
Date: 3-15-11

APPENDICES

The Preventive Care Benefits described below or in the attached documents are subject to modification. Preventive Care Benefits will be covered beginning one (1) year after the effective date of the modifications (e.g., additions of benefits, changes to requirements under a benefit, etc.). For example, screening and counseling for obesity in children was effective on January 31, 2010; therefore, this benefit will be covered beginning on January 31, 2011.

The Preventive Care Benefits described below are not subject to copayment or coinsurance in certain circumstances and may be subject to certain annual maximums. Please contact the Plan Supervisor for more information.

For more detailed information on these benefits, please see
<http://www.healthcare.gov/center/regulations/prevention/recommendations.html>.

U.S. Preventive Services Task Force Recommendations, Grades A & B

Topic	Text	Grade	Date In Effect
Screening for abdominal aortic aneurysm	The USPSTF recommends one-time screening for abdominal aortic aneurysm (AAA) by ultrasonography in men aged 65 to 75 who have ever smoked.	B	Feb 28, 2005
Screening and counseling to reduce alcohol misuse	The U.S. Preventive Services Task Force (USPSTF) recommends screening and behavioral counseling interventions to reduce alcohol misuse (go to Clinical Considerations) by adults, including pregnant women, in primary care settings.	B	April 30, 2004
Aspirin to prevent CVD: men	The USPSTF recommends the use of aspirin for men age 45 to 79 years when the potential benefit due to a reduction in myocardial infarctions outweighs the potential harm due to an increase in gastrointestinal hemorrhage.	A	March 30, 2009
Aspirin to prevent CVD: women	The USPSTF recommends the use of aspirin for women age 55 to 79 years when the potential benefit of a reduction in ischemic strokes outweighs the potential harm of an increase in gastrointestinal hemorrhage.	A	March 30, 2009
Screening for bacteriuria	The USPSTF recommends screening for asymptomatic bacteriuria with urine culture for pregnant women at 12 to 16 weeks' gestation or at the first prenatal visit, if later.	A	July 31, 2008
Screening for high blood pressure	The U.S. Preventive Services Task Force (USPSTF) recommends screening for high blood pressure in adults aged 18 and older.	A	Dec 31, 2007

Counseling related to BRCA screening	The USPSTF recommends that women whose family history is associated with an increased risk for deleterious mutations in BRCA1 or BRCA2 genes be referred for genetic counseling and evaluation for BRCA testing.	B	Sept 30, 2005
Screening for breast cancer (mammography)	The USPSTF recommends screening mammography for women with or without clinical breast examination (CBE), every 1-2 years for women aged 40 and older.	B	September 30, 2002
Chemoprevention of breast cancer	The USPSTF recommends that clinicians discuss chemoprevention with women at high risk for breast cancer and at low risk for adverse effects of chemoprevention. Clinicians should inform patients of the potential benefits and harms of chemoprevention.	B	July 31, 2002
Interventions to support breast feeding	The USPSTF recommends interventions during pregnancy and after birth to promote and support breastfeeding.	B	Oct 31, 2008
Screening for cervical cancer	The USPSTF strongly recommends screening for cervical cancer in women who have been sexually active and have a cervix.	A	Jan 31, 2003
Screening for chlamydial infection: non-pregnant women	The U.S. Preventive Services Task Force (USPSTF) recommends screening for chlamydial infection for all sexually active non-pregnant young women aged 24 and younger and for older non-pregnant women who are at increased risk.	A	June 30, 2007
Screening for chlamydial infection: pregnant women	The USPSTF recommends screening for chlamydial infection for all pregnant women aged 24 and younger and for older pregnant women who are at increased risk.	B	June 30, 2007
Screening for cholesterol abnormalities: men 35 and older	The U.S. Preventive Services Task Force (USPSTF) strongly recommends screening men aged 35 and older for lipid disorders.	A	June 30, 2008

Screening for cholesterol abnormalities: men younger 35	The USPSTF recommends screening men aged 20 to 35 for lipid disorders if they are at increased risk for coronary heart disease.	B	June 30, 2008
Screening for cholesterol abnormalities: women 45 and older	The USPSTF strongly recommends screening women aged 45 and older for lipid disorders if they are at increased risk for coronary heart disease.	A	June 30, 2008
Screening for cholesterol abnormalities: women younger than 45	The USPSTF recommends screening women aged 20 to 45 for lipid disorders if they are at increased risk for coronary heart disease.	B	June 30, 2008
Screening for colorectal cancer	The USPSTF recommends screening for colorectal cancer (CRC) using fecal occult blood testing, sigmoidoscopy, or colonoscopy, in adults, beginning at age 50 years and continuing until age 75 years. The risks and benefits of these screening methods vary.	A	Oct 31, 2008
Chemoprevention of dental caries	The USPSTF recommends that primary care clinicians prescribe oral fluoride supplementation at currently recommended doses to preschool children older than 6 months of age whose primary water source is deficient in fluoride.	B	April 30, 2004
Screening for depression: adults	The USPSTF recommends screening adults for depression when staff-assisted depression care supports are in place to assure accurate diagnosis, effective treatment, and follow-up.	B	Dec 31, 2009
Screening for depression: adolescents	The USPSTF recommends screening of adolescents (12-18 years of age) for major depressive disorder (MDD) when systems are in place to ensure accurate diagnosis, psychotherapy (cognitive-behavioral or interpersonal), and follow-up.	B	March 30, 2009
Screening for diabetes	The USPSTF recommends screening for type 2 diabetes in asymptomatic adults with sustained blood pressure (either treated or untreated) greater than 135/80 mm Hg.	B	June 30, 2008

Counseling for a healthy diet	The USPSTF recommends intensive behavioral dietary counseling for adult patients with hyperlipidemia and other risk factors for cardiovascular and diet-related chronic disease. Intensive counseling can be delivered by primary care clinicians or by referral to other specialists, such as nutritionists or dietitians.	B	Jan 30, 2003
Supplementation with folic acid	The USPSTF recommends that all women planning or capable of pregnancy take a daily supplement containing 0.4 to 0.8 mg (400 to 800 µg) of folic acid.	A	May 31, 2009
Screening for gonorrhea: women	The U.S. Preventive Services Task Force (USPSTF) recommends that clinicians screen all sexually active women, including those who are pregnant, for gonorrhea infection if they are at increased risk for infection (that is, if they are young or have other individual or population risk factors; go to Clinical Considerations for further discussion of risk factors).	B	May 31, 2005
Prophylactic medication for gonorrhea: newborns	The USPSTF strongly recommends prophylactic ocular topical medication for all newborns against gonococcal ophthalmia neonatorum.	A	May 31, 2005
Screening for hearing loss	The USPSTF recommends screening for hearing loss in all newborn infants.	B	July 31, 2008
Screening for hemoglobinopathies	The U. S. Preventive Services Task Force (USPSTF) recommends screening for sickle cell disease in newborns.	A	Sept 30, 2007
Screening for hepatitis B	The U.S. Preventive Services Task Force (USPSTF) strongly recommends screening for hepatitis B virus (HBV) infection in pregnant women at their first prenatal visit.	A	June 30, 2009
Screening for HIV	The U.S. Preventive Services Task Force (USPSTF) strongly recommends that clinicians screen for human immunodeficiency virus (HIV) all adolescents and adults at increased risk for HIV infection (go to Clinical Considerations for discussion of risk factors).	A	July 31, 2005
Screening for congenital hypothyroidism	The USPSTF recommends screening for congenital hypothyroidism (CH) in newborns.	A	March 31, 2008

Screening for iron deficiency anemia	The USPSTF recommends routine screening for iron deficiency anemia in asymptomatic pregnant women.	B	May 31, 2006
Iron supplementation in children	The U.S. Preventive Services Task Force (USPSTF) recommends routine iron supplementation for asymptomatic children aged 6 to 12 months who are at increased risk for iron deficiency anemia (go to Clinical Considerations for a discussion of increased risk).	B	May 30, 2006
Screening and counseling for obesity: adults	The USPSTF recommends that clinicians screen all adult patients for obesity and offer intensive counseling and behavioral interventions to promote sustained weight loss for obese adults.	B	Dec 31, 2003
Screening and counseling for obesity: children	The USPSTF recommends that clinicians screen children aged 6 years and older for obesity and offer them or refer them to comprehensive, intensive behavioral interventions to promote improvement in weight status.	B	Jan 31, 2010
Screening for osteoporosis	The U.S. Preventive Services Task Force (USPSTF) recommends that women aged 65 and older be screened routinely for osteoporosis. The USPSTF recommends that routine screening begin at age 60 for women at increased risk for osteoporotic fractures. (Go to Clinical Considerations for discussion of women at increased risk.)	B	Sept 30, 2002
Screening for PKU	The USPSTF recommends screening for phenylketonuria (PKU) in newborns.	A	March 31, 2008
Screening for Rh incompatibility: first pregnancy visit	The U.S. Preventive Services Task Force (USPSTF) strongly recommends Rh (D) blood typing and antibody testing for all pregnant women during their first visit for pregnancy-related care.	A	Feb 29, 2004
Screening for Rh incompatibility: 24-28 weeks gestation	The USPSTF recommends repeated Rh (D) antibody testing for all unsensitized Rh (D)-negative women at 24-28 weeks' gestation, unless the biological father is known to be Rh (D)-negative.	B	Feb 29, 2004

Counseling for STIs	The USPSTF recommends high-intensity behavioral counseling to prevent sexually transmitted infections (STIs) for all sexually active adolescents and for adults at increased risk for STIs.	B	Oct 31, 2008
Screening for syphilis: non-pregnant persons	The U.S. Preventive Services Task Force (USPSTF) strongly recommends that clinicians screen persons at increased risk for syphilis infection.	A	July 31, 2004
Screening for syphilis: pregnant women	The USPSTF recommends that clinicians screen all pregnant women for syphilis infection.	A	July 31, 2004
Counseling for tobacco use	The USPSTF recommends that clinicians ask all adults about tobacco use and provide tobacco cessation interventions for those who use tobacco products.	A	April 30, 2009
Counseling for tobacco use	The USPSTF recommends that clinicians ask all pregnant women about tobacco use and provide augmented, pregnancy-tailored counseling for those who smoke.	A	April 30, 2009
Screening for visual acuity in children	The USPSTF recommends screening to detect amblyopia, strabismus, and defects in visual acuity in children younger than age 5 years.	B	May 31, 2004

1. Recommendations of the Advisory Committee on Immunization Practices

See attached documents:

- Recommended Immunization Schedule for Persons Aged 0 Through 6 Years
- Recommended Immunization Schedule for Persons Aged 7 Through 18 Years
- Catch-up Immunization Schedule for Persons Aged 4 Months Through 18 Years Who Start Late or Who are More Than 1 Month Behind
- Recommended Adult Immunization Schedule

Immunizations included in the attached documents that are not yet covered due to the effective date include:

- HPV (in effect January 8, 2010)
- Influenza (in effect March 2, 2010)
- Pneumococcal vaccine (in effect March 12, 2010)
- Combination Measles, Mumps, Rubella, and Varicella Vaccine (in effect May 7, 2010)

2. Comprehensive Guidelines Supported by the Health Resources and Services Administration (HRSA) with Respect to Infants, Children, and Adolescents

See attached documents:

- Recommendations for Preventive Pediatric Health Care
- Recommendations of the Secretary's Advisory Committee on Heritable Disorders in Newborn and Children

3. Comprehensive Guidelines Supported by the Health Resources and Services Administration (HRSA) with Respect to Women
These guidelines have not yet been developed by the Department of Health and Human Services.

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

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

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

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

Range of recommended ages for certain high-risk groups

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

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

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

At birth:

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

After the birth dose:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Vaccine ▼	Age ►	7–10 years	11–12 years	13–18 years	
Tetanus, Diphtheria, Pertussis ¹			Tdap	Tdap	Range of recommended ages for all children except certain high-risk groups
Human Papillomavirus ²	see footnote 2		HPV (3 doses)	HPV series	
Meningococcal ³		MCV	MCV	MCV	Range of recommended ages for catch-up immunization
Influenza ⁴		Influenza (Yearly)			
Pneumococcal ⁵		PPSV			Range of recommended ages for certain high-risk groups
Hepatitis A ⁶		HepA Series			
Hepatitis B ⁷		Hep B Series			
Inactivated Poliovirus ⁸		IPV Series			
Measles, Mumps, Rubella ⁹		MMR Series			
Varicella ¹⁰		Varicella Series			

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

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

1. Tetanus and diphtheria toxoids and acellular pertussis vaccine (Tdap).

(Minimum age: 10 years for Boostrix and 11 years for Adacel)

- Administer at age 11 or 12 years for those who have completed the recommended childhood DTP/DaP vaccination series and have not received a tetanus and diphtheria toxoid (Td) booster dose.
- Persons aged 13 through 18 years who have not received Tdap should receive a dose.
- A 5-year interval from the last Td dose is encouraged when Tdap is used as a booster dose; however, a shorter interval may be used if pertussis immunity is needed.

2. Human papillomavirus vaccine (HPV). (Minimum age: 9 years)

- Two HPV vaccines are licensed: a quadrivalent vaccine (HPV4) for the prevention of cervical, vaginal and vulvar cancers (in females) and genital warts (in females and males), and a bivalent vaccine (HPV2) for the prevention of cervical cancers in females.
- HPV vaccines are most effective for both males and females when given before exposure to HPV through sexual contact.
- HPV4 or HPV2 is recommended for the prevention of cervical precancers and cancers in females.
- HPV4 is recommended for the prevention of cervical, vaginal and vulvar precancers and cancers and genital warts in females.
- Administer the first dose to females at age 11 or 12 years.
- Administer the second dose 1 to 2 months after the first dose and the third dose 6 months after the first dose (at least 24 weeks after the first dose).
- Administer the series to females at age 13 through 18 years if not previously vaccinated.
- HPV4 may be administered in a 3-dose series to males aged 9 through 18 years to reduce their likelihood of acquiring genital warts.

3. Meningococcal conjugate vaccine (MCV4).

- Administer at age 11 or 12 years, or at age 13 through 18 years if not previously vaccinated.
- Administer to previously unvaccinated college freshmen living in a dormitory.
- Administer MCV4 to children aged 2 through 10 years with persistent complement component deficiency, anatomic or functional asplenia, or certain other conditions placing them at high risk.
- Administer to children previously vaccinated with MCV4 or MPSV4 who remain at increased risk after 3 years (if first dose administered at age 2 through 6 years) or after 5 years (if first dose administered at age 7 years or older). Persons whose only risk factor is living in on-campus housing are not recommended to receive an additional dose. See *MMWR* 2009;58:1042–3.

4. Influenza vaccine (seasonal).

- Administer annually to children aged 6 months through 18 years.
- For healthy nonpregnant persons aged 7 through 18 years (i.e., those who do not have underlying medical conditions that predispose them to influenza complications), either LAIV or TIV may be used.
- Administer 2 doses (separated by at least 4 weeks) to children aged younger than 9 years who are receiving influenza vaccine for the first time or who were vaccinated for the first time during the previous influenza season but only received 1 dose.
- For recommendations for use of influenza A (H1N1) 2009 monovalent vaccine. See *MMWR* 2009;58(No. RR-10)

5. Pneumococcal polysaccharide vaccine (PPSV).

- Administer to children with certain underlying medical conditions, including a cochlear implant. A single revaccination should be administered after 5 years to children with functional or anatomic asplenia or an immunocompromising condition. See *MMWR* 1997;46(No. RR-8).

6. Hepatitis A vaccine (HepA).

- Administer 2 doses at least 6 months apart.
- HepA is recommended for children older than 23 months of age who live in areas where vaccination programs target older children or who are at increased risk for infection or for whom immunity against hepatitis A is desired.

7. Hepatitis B vaccine (HepB).

- Administer the 3-dose series to those not previously vaccinated.
- A 2-dose series (separated by at least 4 months) of adult formulation Recombivax HB is licensed for children aged 11 through 15 years.

8. Inactivated poliovirus vaccine (IPV).

- The final dose in the series should be administered on or after the fourth birthday and at least 6 months following the previous dose.
- If both OPV and IPV were administered as part of a series, a total of 4 doses should be administered, regardless of the child's current age.

9. Measles, mumps, and rubella vaccine (MMR).

- If not previously vaccinated, administer 2 doses or the second dose for those who have received only 1 dose, with at least 28 days between doses.

10. Varicella vaccine.

- For persons aged 7 through 18 years without evidence of immunity (see *MMWR* 2007;56[No. RR-4]), administer 2 doses if not previously vaccinated or the second dose if only 1 dose has been administered.
- For persons aged 7 through 12 years, the minimum interval between doses is 3 months. However, if the second dose was administered at least 28 days after the first dose, it can be accepted as valid.
- For persons aged 13 years and older, the minimum interval between doses is 28 days.

Catch-up Immunization Schedule for Persons Aged 4 Months Through 18 Years Who Start Late or Who Are More Than 1 Month Behind—United States • 2009

The table below provides catch-up schedules and minimum intervals between doses for children whose vaccinations have been delayed. A vaccine series does not need to be restarted, regardless of the time that has elapsed between doses. Use the section appropriate for the child's age.

CATCH-UP SCHEDULE FOR PERSONS AGED 4 MONTHS THROUGH 6 YEARS					
Vaccine	Minimum Age for Dose 1	Minimum Interval Between Doses			
		Dose 1 to Dose 2	Dose 2 to Dose 3	Dose 3 to Dose 4	Dose 4 to Dose 5
Hepatitis B ¹	Birth	4 weeks	8 weeks (and at least 16 weeks after first dose)		
Rotavirus ²	6 wks	4 weeks	4 weeks ²		
Diphtheria, Tetanus, Pertussis ³	6 wks	4 weeks	4 weeks	6 months	6 months ³
<i>Haemophilus influenzae</i> type b ⁴	6 wks	4 weeks if first dose administered at younger than age 12 months 8 weeks (as final dose) if first dose administered at age 12-14 months No further doses needed if first dose administered at age 15 months or older	4 weeks ⁴ if current age is younger than 12 months 8 weeks (as final dose) ⁴ if current age is 12 months or older and second dose administered at younger than age 15 months No further doses needed if previous dose administered at age 15 months or older	8 weeks (as final dose) This dose only necessary for children aged 12 months through 59 months who received 3 doses before age 12 months	
Pneumococcal ⁵	6 wks	4 weeks if first dose administered at younger than age 12 months 8 weeks (as final dose for healthy children) if first dose administered at age 12 months or older or current age 24 through 59 months No further doses needed for healthy children if first dose administered at age 24 months or older	4 weeks if current age is younger than 12 months 8 weeks (as final dose for healthy children) if current age is 12 months or older No further doses needed for healthy children if previous dose administered at age 24 months or older	8 weeks (as final dose) This dose only necessary for children aged 12 months through 59 months who received 3 doses before age 12 months or for high-risk children who received 3 doses at any age	
Inactivated Poliovirus ⁶	6 wks	4 weeks	4 weeks	4 weeks ⁶	
Measles, Mumps, Rubella ⁷	12 mos	4 weeks			
Varicella ⁸	12 mos	3 months			
Hepatitis A ⁹	12 mos	6 months			
CATCH-UP SCHEDULE FOR PERSONS AGED 7 THROUGH 18 YEARS					
Tetanus, Diphtheria/ Tetanus, Diphtheria, Pertussis ¹⁰	7 yrs ¹⁰	4 weeks	4 weeks if first dose administered at younger than age 12 months 6 months if first dose administered at age 12 months or older	6 months if first dose administered at younger than age 12 months	
Human Papillomavirus ¹¹	9 yrs	Routine dosing intervals are recommended ¹¹			
Hepatitis A ⁹	12 mos	6 months			
Hepatitis B ¹	Birth	4 weeks	8 weeks (and at least 16 weeks after first dose)		
Inactivated Poliovirus ⁶	6 wks	4 weeks	4 weeks	4 weeks ⁶	
Measles, Mumps, Rubella ⁷	12 mos	4 weeks			
Varicella ⁸	12 mos	3 months if the person is younger than age 13 years 4 weeks if the person is aged 13 years or older			

1. Hepatitis B vaccine (HepB).

- Administer the 3-dose series to those not previously vaccinated.
- A 2-dose series (separated by at least 4 months) of adult formulation Recombivax HB[®] is licensed for children aged 11 through 15 years.

2. Rotavirus vaccine (RV).

- The maximum age for the first dose is 14 weeks 6 days. Vaccination should not be initiated for infants aged 15 weeks or older (i.e., 15 weeks 0 days or older).
- Administer the final dose in the series by age 8 months 0 days.
- If Rotarix[®] was administered for the first and second doses, a third dose is not indicated.

3. Diphtheria and tetanus toxoids and acellular pertussis vaccine (DTaP).

- The fifth dose is not necessary if the fourth dose was administered at age 4 years or older.

4. *Haemophilus influenzae* type b conjugate vaccine (Hib).

- Hib vaccine is not generally recommended for persons aged 5 years or older. No efficacy data are available on which to base a recommendation concerning use of Hib vaccine for older children and adults. However, studies suggest good immunogenicity in persons who have sickle cell disease, leukemia, or HIV infection, or who have had a splenectomy; administering 1 dose of Hib vaccine to these persons is not contraindicated.
- If the first 2 doses were PRP-OMP (PedvaxHib[®] or Comvax[®]), and administered at age 11 months or younger, the third (and final) dose should be administered at age 12 through 15 months and at least 8 weeks after the second dose.
- If the first dose was administered at age 7 through 11 months, administer 2 doses separated by 4 weeks and a final dose at age 12 through 15 months.

5. Pneumococcal vaccine.

- Administer 1 dose of pneumococcal conjugate vaccine (PCV) to all healthy children aged 24 through 59 months who have not received at least 1 dose of PCV on or after age 12 months.
- For children aged 24 through 59 months with underlying medical conditions, administer 1 dose of PCV if 3 doses were received previously or administer 2 doses of PCV at least 8 weeks apart if fewer than 3 doses were received previously.
- Administer pneumococcal polysaccharide vaccine (PPSV) to children aged 2 years or older with certain underlying medical conditions (see *MMWR* 2000;49[No. RR-9]), including a cochlear implant, at least 8 weeks after the last dose of PCV.

6. Inactivated poliovirus vaccine (IPV).

- For children who received an all-IPV or all-oral poliovirus (OPV) series, a fourth dose is not necessary if the third dose was administered at age 4 years or older.
- If both OPV and IPV were administered as part of a series, a total of 4 doses should be administered, regardless of the child's current age.

7. Measles, mumps, and rubella vaccine (MMR).

- Administer the second dose at age 4 through 6 years. However, the second dose may be administered before age 4, provided at least 28 days have elapsed since the first dose.
- If not previously vaccinated, administer 2 doses with at least 28 days between doses.

8. Varicella vaccine.

- Administer the second dose at age 4 through 6 years. However, the second dose may be administered before age 4, provided at least 3 months have elapsed since the first dose.
- For persons aged 12 months through 12 years, the minimum interval between doses is 3 months. However, if the second dose was administered at least 28 days after the first dose, it can be accepted as valid.
- For persons aged 13 years and older, the minimum interval between doses is 28 days.

9. Hepatitis A vaccine (HepA).

- HepA is recommended for children older than 1 year who live in areas where vaccination programs target older children or who are at increased risk of infection. See *MMWR* 2006;55(No. RR-7).

10. Tetanus and diphtheria toxoids vaccine (Td) and tetanus and diphtheria toxoids and acellular pertussis vaccine (Tdap).

- Doses of DTaP are counted as part of the Td/Tdap series
- Tdap should be substituted for a single dose of Td in the catch-up series or as a booster for children aged 10 through 18 years; use Td for other doses.

11. Human papillomavirus vaccine (HPV).

- Administer the series to females at age 13 through 18 years if not previously vaccinated.
- Use recommended routine dosing intervals for series catch-up (i.e., the second and third doses should be administered at 2 and 6 months after the first dose). However, the minimum interval between the first and second doses is 4 weeks. The minimum interval between the second and third doses is 12 weeks, and the third dose should be given at least 24 weeks after the first dose.

Recommended Adult Immunization Schedule

UNITED STATES • 2010

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

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

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

*Covered by the Vaccine Injury Compensation Program.

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

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

No recommendation

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

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

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

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

Figure 2. Vaccines that might be indicated for adults based on medical and other indications

VACCINE ▶	INDICATION ▶	Pregnancy	Immuno-compromising conditions (excluding human immunodeficiency virus [HIV]) ^{3,4,5,13}	HIV infection ^{3,5,12,13} CD4+ T lymphocyte count <200 cells/μL >200 cells/μL	Diabetes, heart disease, chronic lung disease, chronic alcoholism	Asplenia ¹² (including elective splenectomy and persistent complement deficiencies)	Chronic liver disease	Kidney failure, end-stage renal disease, receipt of hemodialysis	Health-care personnel
Tetanus, diphtheria, pertussis (Td/Tdap) ^{1,2*}		Td	Substitute 1-time dose of Tdap for Td booster; then boost with Td every 10 yrs						
Human papillomavirus (HPV) ^{2,*}			3 doses for females through age 26 yrs						
Varicella ^{3,*}		Contraindicated	2 doses						
Zoster ⁴		Contraindicated	1 dose						
Measles, mumps, rubella (MMR) ^{5,*}		Contraindicated	1 or 2 doses						
Influenza ^{6,*}			1 dose TIV annually						1 dose TIV or LAIV annually
Pneumococcal (polysaccharide) ^{7,8}			1 or 2 doses						
Hepatitis A ^{9,*}			2 doses						
Hepatitis B ^{10,*}			3 doses						
Meningococcal ^{11,*}			1 or more doses						

* Covered by the Vaccine Injury Compensation Program.

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

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

No recommendation

These schedules indicate the recommended age groups and medical indications for which administration of currently licensed vaccines is commonly indicated for adults ages 19 years and older, as of January 1, 2010. Licensed combination vaccines may be used whenever any components of the combination are indicated and when the vaccine's other components are not contraindicated. For detailed recommendations on all vaccines, including those used primarily for travelers or that are issued during the year, consult the manufacturers' package inserts and the complete statements from the Advisory Committee on Immunization Practices (www.cdc.gov/vaccines/pubs/acip-list.htm).

The recommendations in this schedule were approved by the Centers for Disease Control and Prevention's (CDC) Advisory Committee on Immunization Practices (ACIP), the American Academy of Family Physicians (AAFP), the American College of Obstetricians and Gynecologists (ACOG), and the American College of Physicians (ACP).



Footnotes

Recommended Adult Immunization Schedule—UNITED STATES - 2010

For complete statements by the Advisory Committee on Immunization Practices (ACIP), visit www.cdc.gov/vaccines/pubs/ACIP-list.htm.

1. Tetanus, diphtheria, and acellular pertussis (TdTdap) vaccination

Tdap should replace a single dose of Td for adults aged 19 through 64 years who have not received a dose of Tdap previously.

Adults with uncertain or incomplete history of primary vaccination series with tetanus and diphtheria toxoid-containing vaccines should begin or complete a primary vaccination series. A primary series for adults is 3 doses of tetanus and diphtheria toxoid-containing vaccines; administer the first 2 doses at least 4 weeks apart and the third dose 6–12 months after the second; Tdap can substitute for any one of the doses of Td in the 3-dose primary series. The booster dose of tetanus and diphtheria toxoid-containing vaccine should be administered to adults who have completed a primary series and if the last vaccination was received ≥ 10 years previously. Tdap or Td vaccine may be used, as indicated.

If a woman is pregnant and received the last Td vaccination ≥ 10 years previously, administer Td during the second or third trimester; if the woman received the last Td vaccination < 10 years previously, administer Tdap during the immediate postpartum period. A dose of Tdap is recommended for postpartum women, close contacts of infants aged < 12 months, and all health-care personnel with direct patient contact if they have not previously received Tdap. An interval as short as 2 years from the last Td is suggested; shorter intervals can be used. Td may be deferred during pregnancy and Tdap substituted in the immediate postpartum period, or Tdap can be administered instead of Td to a pregnant woman. Consult the ACIP statement for giving Td as prophylaxis in wound management.

2. Human papillomavirus (HPV) vaccination

HPV vaccination is recommended at age 11 or 12 years with catch-up vaccination at ages 13 through 26 years.

Ideally, vaccine should be administered before potential exposure to HPV through sexual activity; however, females who are sexually active should still be vaccinated consistent with age-based recommendations. Sexually active females who have not been infected with any of the four HPV vaccine types (types 6, 11, 16, 18 all of which HPV4 prevents) or any of the two HPV vaccine types (types 16 and 18 both of which HPV2 prevents) receive the full benefit of the vaccination. Vaccination is less beneficial for females who have already been infected with one or more of the HPV vaccine types. HPV4 or HPV2 can be administered to persons with a history of genital warts, abnormal Papanicolaou test, or positive HPV DNA test, because these conditions are not evidence of prior infection with all vaccine HPV types.

HPV4 may be administered to males aged 9 through 26 years to reduce their likelihood of acquiring genital warts. HPV4 would be most effective when administered before exposure to HPV through sexual contact.

A complete series for either HPV4 or HPV2 consists of 3 doses. The second dose should be administered 1–2 months after the first dose; the third dose should be administered 6 months after the first dose.

Although HPV vaccination is not specifically recommended for persons with the medical indications described in Figure 2, “Vaccines that might be indicated for adults based on medical and other indications,” it may be administered to these persons because the HPV vaccine is not a live-virus vaccine. However, the immune response and vaccine efficacy might be less for persons with the medical indications described in Figure 2 than in persons who do not have the medical indications described or who are immunocompetent. Health-care personnel are not at increased risk because of occupational exposure, and should be vaccinated consistent with age-based recommendations.

3. Varicella vaccination

All adults without evidence of immunity to varicella should receive 2 doses of single-antigen varicella vaccine if not previously vaccinated or the second dose if they have received only 1 dose, unless they have a medical contraindication. Special consideration should be given to those who 1) have close contact with persons at high risk for severe disease (e.g., health-care personnel and family contacts of persons with immunocompromising conditions) or 2) are at high risk for exposure or transmission (e.g., teachers; child-care employees; residents and staff members of institutional settings, including correctional institutions; college students; military personnel; adolescents and adults living in households with children; nonpregnant women of childbearing age; and international travelers).

Evidence of immunity to varicella in adults includes any of the following: 1) documentation of 2 doses of varicella vaccine at least 4 weeks apart; 2) U.S.-born before 1980 (although for health-care personnel and pregnant women, birth before 1980 should not be considered evidence of immunity); 3) history of varicella based on diagnosis or verification of varicella by a health-care provider (for a patient reporting a history of or presenting with an atypical case, a mild case, or both, health-care providers should seek either an epidemiologic link with a typical varicella case or to a laboratory-confirmed case or evidence of laboratory confirmation, if it was performed at the time of acute disease); 4) history of herpes zoster based on diagnosis or verification of herpes zoster by a health-care provider; or 5) laboratory evidence of immunity or laboratory confirmation of disease.

Pregnant women should be assessed for evidence of varicella immunity. Women who do not have evidence of immunity should receive the first dose of varicella vaccine upon completion or termination of pregnancy and before discharge from the health-care facility. The second dose should be administered 4–8 weeks after the first dose.

4. Herpes zoster vaccination

A single dose of zoster vaccine is recommended for adults aged ≥ 60 years regardless of whether they report a prior episode of herpes zoster. Persons with chronic medical conditions may be vaccinated unless their condition constitutes a contraindication.

5. Measles, mumps, rubella (MMR) vaccination

Adults born before 1957 generally are considered immune to measles and mumps.

Measles component: Adults born during or after 1957 should receive 1 or more doses of MMR vaccine unless they have 1) a medical contraindication; 2) documentation of vaccination with 1 or more doses of MMR vaccine; 3) laboratory evidence of immunity; or 4) documentation of physician-diagnosed measles.

A second dose of MMR vaccine, administered 4 weeks after the first dose, is recommended for adults who 1) have been recently exposed to measles or are in an outbreak setting; 2) have been vaccinated previously with killed measles vaccine; 3) have been vaccinated with an unknown type of measles vaccine during 1963–1967; 4) are students in postsecondary educational institutions; 5) work in a health-care facility; or 6) plan to travel internationally.

Mumps component: Adults born during or after 1957 should receive 1 dose of MMR vaccine unless they have 1) a medical contraindication; 2) documentation of vaccination with 1 or more doses of MMR vaccine; 3) laboratory evidence of immunity; or 4) documentation of physician-diagnosed mumps.

A second dose of MMR vaccine, administered 4 weeks after the first dose, is recommended for adults who 1) live in a community experiencing a mumps outbreak and are in an affected age group; 2) are students in postsecondary educational institutions; 3) work in a health-care facility; or 4) plan to travel internationally.

Rubella component: 1 dose of MMR vaccine is recommended for women who do not have documentation of rubella vaccination, or who lack laboratory evidence of immunity. For women of childbearing age, regardless of birth year, rubella immunity should be determined and women should be counseled regarding congenital rubella syndrome. Women who do not have evidence of immunity should receive MMR vaccine upon completion or termination of pregnancy and before discharge from the health-care facility.

Health-care personnel born before 1957: For unvaccinated health-care personnel born before 1957 who lack laboratory evidence of measles, mumps, and/or rubella immunity or laboratory confirmation of disease, health-care facilities should consider vaccinating personnel with 2 doses of MMR vaccine at the appropriate interval (for measles and mumps) and 1 dose of MMR vaccine (for rubella), respectively.

During outbreaks, health-care facilities should recommend that unvaccinated health-care personnel born before 1957, who lack laboratory evidence of measles, mumps, and/or rubella immunity or laboratory confirmation of disease, receive 2 doses of MMR vaccine during an outbreak of measles or mumps, and 1 dose during an outbreak of rubella.

Complete information about evidence of immunity is available at www.cdc.gov/vaccines/recs/provisional/default.htm.

6. Seasonal Influenza vaccination

Vaccinate all persons aged ≥50 years and any younger persons who would like to decrease their risk of getting influenza. Vaccinate persons aged 19 through 49 years with any of the following indications.

Medical: Chronic disorders of the cardiovascular or pulmonary systems, including asthma; chronic metabolic diseases, including diabetes mellitus; renal or hepatic dysfunction, hemoglobinopathies, or immunocompromising conditions (including immunocompromising conditions caused by medications or HIV); cognitive, neurologic or neuromuscular disorders; and pregnancy during the influenza season. No data exist on the risk for severe or complicated influenza disease among persons with asplenia; however, influenza is a risk factor for secondary bacterial infections that can cause severe disease among persons with asplenia.

Occupational: All health-care personnel, including those employed by long-term care and assisted-living facilities, and caregivers of children aged <5 years.

Other: Residents of nursing homes and other long-term care and assisted-living facilities; persons likely to transmit influenza to persons at high risk (e.g., in-home household contacts and caregivers of children aged <5 years, persons aged ≥50 years, and persons of all ages with high-risk conditions).

Healthy, nonpregnant adults aged <50 years without high-risk medical conditions who are not contacts of severely immunocompromised persons in special-care units may receive either intranasally administered live, attenuated influenza vaccine (FluMist) or inactivated vaccine. Other persons should receive the inactivated vaccine.

7. Pneumococcal polysaccharide (PPSV) vaccination

Vaccinate all persons with the following indications.

Medical: Chronic lung disease (including asthma); chronic cardiovascular diseases; diabetes mellitus; chronic liver diseases, cirrhosis; chronic alcoholism; functional or anatomic asplenia (e.g., sickle cell disease or splenectomy [if elective splenectomy is planned, vaccinate at least 2 weeks before surgery]); immunocompromising conditions including chronic renal failure or nephrotic syndrome; and cochlear implants and cerebrospinal fluid leaks. Vaccinate as close to HIV diagnosis as possible.

Other: Residents of nursing homes or long-term care facilities and persons who smoke cigarettes. Routine use of PPSV is not recommended for American Indians/Alaska Natives or persons aged <65 years unless they have underlying medical conditions that are PPSV indications. However, public health authorities may consider recommending PPSV for American Indians/Alaska Natives and persons aged 50 through 64 years who are living in areas where the risk for invasive pneumococcal disease is increased.

8. Revaccination with PPSV

One-time revaccination after 5 years is recommended for persons with chronic renal failure or nephrotic syndrome; functional or anatomic asplenia (e.g., sickle cell disease or splenectomy); and for persons with immunocompromising conditions. For persons aged ≥65 years, one-time revaccination is recommended if they were vaccinated ≥5 years previously and were younger than aged <65 years at the time of primary vaccination.

9. Hepatitis A vaccination

Vaccinate persons with any of the following indications and any person seeking protection from hepatitis A virus (HAV) infection.

Behavioral: Men who have sex with men and persons who use injection drugs.

Occupational: Persons working with HAV-infected primates or with HAV in a research laboratory setting.

Medical: Persons with chronic liver disease and persons who receive clotting factor concentrates.

Other: Persons travelling to or working in countries that have high or intermediate endemicity of hepatitis A (a list of countries is available at www.cdc.gov/travel/content/diseases.aspx). Unvaccinated persons who anticipate close personal contact (e.g., household contact or regular babysitting) with an international adoptee from a country of high or intermediate endemicity during the first 60 days after arrival of the adoptee in the United States should consider vaccination. The first dose of the 2-dose hepatitis A vaccine series should be administered as soon as adoption is planned, ideally ≥2 weeks before the arrival of the adoptee.

Single-antigen vaccine formulations should be administered in a 2-dose schedule at either 0 and 6–12 months (Havrix), or 0 and 6–18 months (Vaqta). If the combined hepatitis A and hepatitis B vaccine (Twinrix) is used, administer 3 doses at 0, 1, and 6 months; alternatively, a 4-dose schedule, administered on days 0, 7, and 21–30 followed by a booster dose at month 12 may be used.

10. Hepatitis B vaccination

Vaccinate persons with any of the following indications and any person seeking protection from hepatitis B virus (HBV) infection.

Behavioral: Sexually active persons who are not in a long-term, mutually monogamous relationship (e.g., persons with more than one sex partner during the previous 6 months); persons seeking evaluation or treatment for a sexually transmitted disease (STD); current or recent injection-drug users; and men who have sex with men.

Occupational: Health-care personnel and public-safety workers who are exposed to blood or other potentially infectious body fluids.

Medical: Persons with end-stage renal disease, including patients receiving hemodialysis; persons with HIV infection; and persons with chronic liver disease.

Other: Household contacts and sex partners of persons with chronic HBV infection; clients and staff members of institutions for persons with developmental disabilities; and international travelers to countries with high or intermediate prevalence of chronic HBV infection (a list of countries is available at www.cdc.gov/travel/content/diseases.aspx).

Hepatitis B vaccination is recommended for all adults in the following settings: STD treatment facilities; HIV testing and treatment facilities; facilities providing drug-abuse treatment and prevention services; health-care settings targeting services to injection-drug users or men who have sex with men; correctional facilities; end-stage renal disease programs and facilities for chronic hemodialysis patients; and institutions and nonresidential daycare facilities for persons with developmental disabilities.

Administer or complete a 3-dose series of HepB to those persons not previously vaccinated. The second dose should be administered 1 month after the first dose; the third dose should be administered at least 2 months after the second dose (and at least 4 months after the first dose). If the combined hepatitis A and hepatitis B vaccine (Twinrix) is used, administer 3 doses at 0, 1, and 6 months; alternatively, a 4-dose schedule, administered on days 0, 7, and 21–30 followed by a booster dose at month 12 may be used.

Adult patients receiving hemodialysis or with other immunocompromising conditions should receive 1 dose of 40 µg/mL (Recombivax HB) administered on a 3-dose schedule or 2 doses of 20 µg/mL (Engerix-B) administered simultaneously on a 4-dose schedule at 0, 1, 2 and 6 months.

11. Meningococcal vaccination

Meningococcal vaccine should be administered to persons with the following indications.

Medical: Adults with anatomic or functional asplenia, or persistent complement component deficiencies.

Other: First-year college students living in dormitories; microbiologists routinely exposed to isolates of *Neisseria meningitidis*; military recruits; and persons who travel to or live in countries in which meningococcal disease is hyperendemic or epidemic (e.g., the “meningitis belt” of sub-Saharan Africa during the dry season [December through June]), particularly if their contact with local populations will be prolonged. Vaccination is required by the government of Saudi Arabia for all travelers to Mecca during the annual Hajj.

Meningococcal conjugate vaccine (MCV4) is preferred for adults with any of the preceding indications who are aged ≤ 55 years; meningococcal polysaccharide vaccine (MPSV4) is preferred for adults aged ≥ 56 years. Revaccination with MCV4 after 5 years is recommended for adults previously vaccinated with MCV4 or MPSV4 who remain at increased risk for infection (e.g., adults with anatomic or functional asplenia). Persons whose only risk factor is living in on-campus housing are not recommended to receive an additional dose.

12. Selected conditions for which *Haemophilus influenzae* type b (Hib) vaccine may be used

Hib vaccine generally is not recommended for persons aged ≥ 5 years. No efficacy data are available on which to base a recommendation concerning use of Hib vaccine for older children and adults. However, studies suggest good immunogenicity in patients who have sickle cell disease, leukemia, or HIV infection or who have had a splenectomy. Administering 1 dose of Hib vaccine to these high-risk persons who have not previously received Hib vaccine is not contraindicated.

13. Immunocompromising conditions

Inactivated vaccines generally are acceptable (e.g., pneumococcal, meningococcal, influenza [inactivated influenza vaccine]) and live vaccines generally are avoided in persons with immune deficiencies or immunocompromising conditions. Information on specific conditions is available at www.cdc.gov/vaccines/pubs/acip-list.htm.



Each child and family is unique; therefore, these **Recommendations for Preventive Pediatric Health Care** are designed for the care of children who are receiving competent parenting, have no manifestations of any important health problems, and are growing and developing in satisfactory fashion. **Additional visits may become necessary** if circumstances suggest variations from normal.

Developmental, psychosocial, and chronic disease issues for children and adolescents may require frequent counseling and treatment visits separate from preventive care visits.

These guidelines represent a consensus by the American Academy of Pediatrics (AAP) and Bright Futures. The AAP continues to emphasize the great importance of **continuity of care** in comprehensive health supervision and the need to avoid **fragmentation of care**.

The recommendations in this statement do not indicate an exclusive course of treatment or standard of medical care. Variations, taking into account individual circumstances, may be appropriate.

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AGE ¹	INFANCY										EARLY CHILDHOOD						MIDDLE CHILDHOOD						ADOLESCENCE												
	PRENATAL ²	NEWBORN ³	3–5 d ⁴	By 1 mo	2 mo	4 mo	6 mo	9 mo	12 m	15 mo	18 mo	24 mo	30 mo	3 y	4 y	5 y	6 y	7 y	8 y	9 y	10 y	11 y	12 y	13 y	14 y	15 y	16 y	17 y	18 y	19 y	20 y	21 y			
HISTORY Initial/Interval	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●		
MEASUREMENTS Length/Height and Weight Head Circumference Weight for Length Body Mass Index Blood Pressure ⁵		●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●		
SENSORY SCREENING Vision Hearing		★	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★		
DEVELOPMENTAL/BEHAVIORAL ASSESSMENT Developmental Screening ⁸ Autism Screening ⁹ Developmental Surveillance ⁸ Psychosocial/Behavioral Assessment Alcohol and Drug Use Assessment		●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	
PHYSICAL EXAMINATION ¹⁰		●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	
PROCEDURES ¹¹ Newborn Metabolic/Hemoglobin Screening ¹² Immunization ¹³ Hematocrit or Hemoglobin ¹⁴ Lead Screening ¹⁵ Tuberculin Test ¹⁷ Dyslipidemia Screening ¹⁸ STI Screening ¹⁹ Cervical Dysplasia Screening ²⁰		●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●
ORAL HEALTH ²¹		●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	
ANTICIPATORY GUIDANCE ²³	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●

1. If a child comes under care for the first time at any point on the schedule, or if any items are not accomplished at the suggested age, the schedule should be brought up to date at the earliest possible time.
2. A prenatal visit is recommended for parents who are at high risk, for first-time parents, and for those who request a conference. The prenatal visit should include anticipatory guidance, pertinent medical history, and a discussion of benefits of breastfeeding and planned method of feeding per AAP statement "The Prenatal Visit" (2001) [URL: <http://aapolicy.aapublications.org/cgi/content/full/pediatrics;107/6/1456>].
3. Every infant should have a newborn evaluation after birth, breastfeeding encouraged, and instruction and support offered.
4. Every infant should have an evaluation within 3 to 5 days of birth and within 48 to 72 hours after discharge from the hospital, to include evaluation for feeding and jaundice. Breastfeeding infants should receive formal breastfeeding evaluation, encouragement, and instruction as recommended in AAP statement "Breastfeeding and the Use of Human Milk" (2005) [URL: <http://aapolicy.aapublications.org/cgi/content/full/pediatrics;115/2/496>]. For newborns discharged in less than 48 hours after delivery, the infant must be examined within 48 hours of discharge per AAP statement "Hospital Stay for Healthy Term Newborns" (2004) [URL: <http://aapolicy.aapublications.org/cgi/content/full/pediatrics;113/5/1434>].
5. Blood pressure measurement in infants and children with specific risk conditions should be performed at visits before age 3 years.
6. If the patient is uncooperative, rescreen within 6 months per the AAP statement "Eye Examination in Infants, Children, and Young Adults by Pediatricians" (2007) [URL: <http://aapolicy.aapublications.org/cgi/content/full/pediatrics;111/4/902>].
7. All newborns should be screened per AAP statement "Year 2000 Position Statement: Principles and Guidelines for Early Hearing Detection and Intervention Programs" (2000) [URL: <http://aapolicy.aapublications.org/cgi/content/full/pediatrics;106/2/3143>].

8. AAP Council on Children With Disabilities, AAP Section on Developmental Behavioral Pediatrics, AAP Bright Futures Steering Committee, AAP Medical Home Initiatives for Children With Special Needs Project Advisory Committee. Identifying infants and young children with developmental disorders in the medical home: an algorithm for developmental surveillance and screening. *Pediatrics*. 2006;118:405–420 [URL: <http://aapolicy.aapublications.org/cgi/content/full/pediatrics;118/1/405>].
9. Gupta VB, Hyman SL, Johnson CP, et al. Identifying children with autism early? *Pediatrics*. 2007;119:152–153 [URL: <http://pediatrics.aapublications.org/cgi/content/full/119/1/152>].
10. At each visit, age-appropriate physical examination is essential, with infant totally unclothed, older child undressed and suitably draped.
11. These may be modified, depending on entry point into schedule and individual need.
12. Newborn metabolic and hemoglobinopathy screening should be done according to state law. Results should be reviewed at visits and appropriate retesting or referral done as needed.
13. Schedules per the Committee on Infectious Diseases, published annually in the January issue of *Pediatrics*. Every visit should be an opportunity to update and complete a child's immunizations.
14. See *AAP Pediatric Nutrition Handbook*, 5th Edition (2003) for a discussion of universal and selective screening options. See also Recommendations to prevent and control iron deficiency in the United States. *MWPA*. 1998;47(RR-3):1–36.
15. For children at risk of lead exposure, consult the AAP statement "Lead Exposure in Children: Prevention, Detection, and Management" (2005) [URL: <http://aapolicy.aapublications.org/cgi/content/full/pediatrics;116/4/1036>]. Additionally, screening should be done in accordance with state law where applicable.

16. Perform risk assessments or screens as appropriate, based on universal screening requirements for patients with Medicaid or high prevalence areas.
17. Tuberculosis testing per recommendations of the Committee on Infectious Diseases, published in the current edition of *Red Book: Report of the Committee on Infectious Diseases*. Testing should be done on recognition of high-risk factors.
18. "Third Report of the National Cholesterol Education Program (NCEP) Expert Panel on Detection, Evaluation, and Treatment of High Blood Cholesterol in Adults (Adult Treatment Panel III) Final Report" (2002) [URL: <http://circ.ahajournals.org/cgi/content/full/106/25/3143>] and "The Expert Committee Recommendations on the Assessment, Prevention, and Treatment of Child and Adolescent Overweight and Obesity." Supplement to *Pediatrics*. In press.
19. All sexually active patients should be screened for sexually transmitted infections (STIs).
20. All sexually active girls should have screening for cervical dysplasia as part of a pelvic examination beginning within 3 years of onset of sexual activity or age 21 (whichever comes first).
21. Referral to dental home, if available. Otherwise, administer oral health risk assessment. If the primary water source is deficient in fluoride, consider oral fluoride supplementation.
22. At the visits for 3 years and 6 years of age, it should be determined whether the patient has a dental home. If the patient does not have a dental home, a referral should be made to one. If the primary water source is deficient in fluoride, consider oral fluoride supplementation.
23. Refer to the specific guidance by age as listed in Bright Futures Guidelines. (Hagan JF, Shaw JS, Duncan PM, eds. *Bright Futures: Guidelines for Health Supervision of Infants, Children, and Adolescents*. 3rd ed. Elk Grove Village, IL: American Academy of Pediatrics; 2008.)

KEY

● = to be performed ★ = risk assessment to be performed, with appropriate action to follow, if positive ◀ → = range during which a service may be provided, with the symbol indicating the preferred age

SACHDNC Recommended Uniform Screening Panel¹
CORE² CONDITIONS³
(as of February 2010)

ACMG Code	Core Condition	Metabolic Disorder			Endocrine Disorder	Hemoglobin Disorder	Other Disorder
		Organic acid condition	Fatty acid oxidation disorders	Amino acid disorders			
PROP	Propionic academia						
MUT	Methylmalonic acidemia (methylmalonyl-CoA mutase)						
Cbl A,B	Methylmalonic acidemia (cobalamin disorders)						
IVA	Isovaleric acidemia						
3-MCC	3-Methylcrotonyl-CoA carboxylase deficiency						
HMG	3-Hydroxy-3-methylglutaric aciduria						
MCD	Holocarboxylase synthase deficiency						
BKT	β-Ketothiolase deficiency						
GA1	Glutaric acidemia type I						
CUD	Carnitine uptake defect/carnitine transport defect						
MCAD	Medium-chain acyl-CoA dehydrogenase deficiency						
VLCAD	Very long-chain acyl-CoA dehydrogenase deficiency						
LCHAD	Long-chain L-3 hydroxyacyl-CoA dehydrogenase deficiency						
TFP	Trifunctional protein deficiency						
ASA	Argininosuccinic aciduria						
CIT	Citrullinemia, type I						
MSUD	Maple syrup urine disease						
HCY	Homocystinuria						
PKU	Classic phenylketonuria						
TYR I	Tyrosinemia, type I						
CH	Primary congenital hypothyroidism						
CAH	Congenital adrenal hyperplasia						
Hb SS	S,S disease (Sickle cell anemia)						
Hb S/BTh	S, β-thalassemia						
Hb S/C	S,C disease						
BIOT	Biotinidase deficiency						
GALT	Classic galactosemia						
SCID	Severe Combined Immunodeficiencies						
CF	Cystic fibrosis						
HEAR	Hearing loss						

1. The selection of these conditions is based on the report "Newborn Screening: Towards a Uniform Screening Panel and System. Genet Med. 2006; 8(5) Suppl: S12-S252" as authored by the American College of Medical Genetics (ACMG) and commissioned by the Health Resources and Services Administration (HRSA).
2. Disorders that should be included in every Newborn Screening Program
3. The Nomenclature for Conditions is based on the report "Naming and Counting Disorders (Conditions) Included in Newborn Screening Panels" Pediatrics 2006; 117 (5) Suppl: S308-S314

SACHDNC Recommended Uniform Screening Panel¹
SECONDARY² CONDITIONS³
(as of February 2010)

ACMG Code	Secondary Condition	Metabolic Disorder			Hemoglobin Disorder	Other Disorder
		Organic acid condition	Fatty acid oxidation disorders	Amino acid disorders		
Cbl C,D	Methylmalonic acidemia with homocystinuria					
MAL	Malonic acidemia					
IBG	Isobutyrylglycinuria					
2MBG	2-Methylbutyrylglycinuria					
3MGA	3-Methylglutaconic aciduria					
2M3HBA	2-Methyl-3-hydroxybutyric aciduria					
SCAD	Short-chain acyl-CoA dehydrogenase deficiency					
M/SCHAD	Medium/short-chain L-3-hydroxyacyl-CoA dehydrogenase deficiency					
GA2	Glutaric acidemia type II					
MCAT	Medium-chain ketoacyl-CoA thiolase deficiency					
DE RED	2,4 Dienoyl-CoA reductase deficiency					
CPT IA	Carnitine palmitoyltransferase type I deficiency					
CPT II	Carnitine palmitoyltransferase type II deficiency					
CACT	Carnitine acylcarnitine translocase deficiency					
ARG	Argininemia					
CIT II	Citrullinemia, type II					
MET	Hypermethioninemia					
H-PHE	Benign hyperphenylalaninemia					
BIOPT (BS)	Biopterin defect in cofactor biosynthesis					
BIOPT (REG)	Biopterin defect in cofactor regeneration					
TYR II	Tyrosinemia, type II					
TRY III	Tyrosinemia, type III					
Var Hb	Various other hemoglobinopathies					
GALE	Galactoepimerase deficiency					
GALK	Galactokinase deficiency					
	T-cell related lymphocyte deficiencies					

1. The selection of these conditions is based on the report "Newborn Screening: Towards a Uniform Screening Panel and System. Genet Med. 2006; 8(5) Suppl: S12-S252" as authored by the American College of Medical Genetics (ACMG) and commissioned by the Health Resources and Services Administration (HRSA).
2. Disorders that can be detected in the differential diagnosis of a core disorder
3. The Nomenclature for Conditions is based on the report "Naming and Counting Disorders (Conditions) Included in Newborn Screening Panels" Pediatrics 2006; 117 (5) Suppl: S308-S314

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