MYPLANADVOCATE INSURANCE SOLUTIONS

460 WEST 50 NORTH STE 500
SALT LAKE CITY, UT 84101
(332) 248-2331

This Summary Plan Description describes the Medical and Prescription Drug benefits for Eligible Employees of MYPLANADVOCATE INSURANCE SOLUTIONS

Information Applicable to Plan 501

PLAN SPONSOR ID No. (EIN): 87-2644457

The Benefits In This Summary Plan Description Are Effective 1/1/2026

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How to Get Language Assistance

The Plan is committed to communicating with our members about their health benefits, no matter what their language is. Foreign language assistance is available if your Plan covers fewer than 100 Participants at the beginning of a Plan Year, and 25% or more of all plan Participants are literate only in the same non-English language. The Plan employs a language line interpretation service for use by our call center. Simply call the Member Services phone number on the back of your Identification Card and a representative will be able to help you. Translation of written materials about your benefits can also be asked for by contacting Member Services. TTY/TDD services also are available by dialing 711. A special operator will get in touch with us to help with your needs.

SECTION 1: KEY INFORMATION

Plan Name:
MYPLANADVOCATE INSURANCE SOLUTIONS Employee Benefits Plan ("Plan")

Plan Sponsor:
MYPLANADVOCATE INSURANCE SOLUTIONS
460 WEST 50 NORTH STE 500
SALT LAKE CITY, UT 84101

Plan Sponsor EIN:
87-2644457

Named Fiduciary and Agent of Legal Process:
MYPLANADVOCATE INSURANCE SOLUTIONS
Sean Gallagher
460 WEST 50 NORTH STE 500
SALT LAKE CITY, UT 84101

Plan Administrator
MYPLANADVOCATE INSURANCE SOLUTIONS
460 WEST 50 NORTH STE 500
SALT LAKE CITY, UT 84101

Plan Number:
501

SPD Effective Date:
1/1/2026

Source Of Funding:
Self-funded group health plan administered by contract with a Third-Party Administrator ("TPA"), funded from Plan Sponsor's General Assets. This is not an insured benefit plan.

Plan Status:
Non-Grandfathered

Plan Year:
1/1/2026 through 12/31/2026. The Plan Year ends the last day of each December.

Type of Plan:
Medical and Prescription Drug

Third-Party Administrator:
Allied Benefit Systems, LLC
P.O. Box 211651
Eagan, MN 55121
Phone: (312) 906-8080 or (800) 288-2078 (outside IL)

Network Contact information:

- For the purpose of obtaining Outpatient Prescription Drug Benefits or Specialty Pharmaceuticals, this Plan requires the use of Participating Pharmacies.

- For the purpose of obtaining transplant benefits, this Plan requires the use of Designated Transplant Providers.

Function	Network Name	Claims Filing Information	Phone Number	URL
PPO Network	CIGNA OAP Open Access Plus	Electronic Payer ID 62308 Cigna OAP P.O. Box 188061 Chattanooga, TN 37422-8061	800.621.0748	To find a provider visit www.mycigna.com.
Designated Transplant Provider	800-621-0748			
Pharmacy Network	Cigna PBM	RxBIN: 017010, RxPCN: 0519PAYR, RxGrp: 0790939	1-800-325-1404	www.mycigna.com

Selection of a Primary Care Provider
This plan generally allows for, but does not require, the designation of a primary care provider. You have the right to designate any primary care provider who participates in the network and who is available to accept you or your family members. For information on how to select a primary care provider, contact customer service at the phone number listed on your ID card. For a list of participating primary care providers, visit To find a provider visit www.mycigna.com.

SECTION 2: UTILIZATION REVIEW PROVISIONS

The Covered Person must call the toll-free number for Medical Services that require precertification, located on the identification (ID) card, to obtain authorization for the services listed under the When To Call provision in this section.

Benefits will be reduced or excluded as described in the Reduction of Payment provision in this section if a Covered Person does not comply with this Utilization Review Process and does not obtain precertification.

A review by the Medical Review Manager does not guarantee that benefits will be paid under this Plan. The Medical Review Manager only determines whether or not Medical Care is Medically Necessary.

Payment of benefits will be subject to all the terms, limits, and conditions in this Plan.

The review process must be repeated if treatment is received more than 30 days after review by the Medical Review Manager or if the type of treatment, admitting Provider or facility differs from what the Medical Review Manager authorized.

A determination by the Medical Review Manager does not alter, limit, or restrict in any manner the attending Provider's ultimate patient care responsibility.

Utilization Review Procedures
To obtain authorization, the Covered Person must contact the Medical Review Manager by calling the toll-free number for Medical Services that require precertification located on the ID card. Please have all of the following information on hand before calling:

1. The group number for this Plan.
2. The Provider's name and telephone number.
3. The service, procedure, and Diagnosis.
4. The proposed date of admission or date the service or procedure will be performed.
5. The facility's name and phone number.

The Medical Review Manager may review a proposed service or procedure to determine: Medical Necessity; whether it is a Cosmetic Treatment or an Experimental or Investigational Service; location of the treatment; and length of stay for an Inpatient confinement.

As part of the review process, the Medical Review Manager may require, at the Plan's expense, a second opinion from a Provider recommended by the Medical Review Manager.

When To Call
Contact the Medical Review Manager for precertification of the following services. The toll-free number You must use for Pre-Certification is shown on Your member ID card. Note: For exceptions, please refer to the section of this document entitled “Compliance Regulations,” and see the subheading “Statement of Rights Under the Newborns’ and Mothers’ Health Protection Act”.

Pre-Notification

The following procedures are generally not covered by the Plan unless medically appropriate. Therefore, it is strongly recommended that a pre-notification of the following procedures be obtained before treatment. The toll-free number You should use for pre-notification is (800) 892-1893.

Procedures for which pre-notification is recommended are:

1. Non-orthopedic imaging for CT, MRI, and PET Scans.
2. Neoplasm biopsies.

Failure to follow the guidelines listed below may subject Your benefits to a Penalty for Non-Compliance as discussed in this section.

All Inpatient Admissions. Call at least 7 days prior to an Inpatient Admission for a non-Emergency confinement, or within 24 hours of an Emergency confinement.

- Acute
- Long-Term Acute Care
- Mental Health / Substance Use Disorder
- Obstetric
- Rehabilitation
- Residential Treatment Facility
- Skilled Nursing Facility
- Transplant related services including initial consultation and evaluation

Outpatient and Physician – Surgery. Call at least 7 days prior to receiving any non-Emergency Outpatient services listed below, or within 24 hours of receiving Emergency services.

- Autologous chondrocyte implantation, Carticel
- Any service that is potentially cosmetic (i.e. Breast, Eyes/Nose, Head/Ear, Skin, Trunk/Body or vein therapy/treatment)
- Any service that is potentially investigational/experimental
- Maxillo-facial orthopedics and mandibular surgical procedures
- Osteochondral Allograft, knee
- Spinal procedures including spinal surgeries and hardware related to surgery
- Transplant related services including initial consultation and evaluation

Outpatient and Physician – Diagnostic Services. Call at least 7 days prior to receiving any of the following non-Emergency services.

- Cardiac blood pool imaging
- Cardiac tests including Diagnostic Cardiac Catheterizations and Stress Echocardiogram
- Computed Tomography (CT)
- Magnetic Resonance Angiography (MRA)
- Magnetic Resonance Imaging (MRI)
- Myocardial Perfusion Imaging
- Positron Emission Tomography (PET)

Outpatient and Physician – Continuing Care Services. Call at least 7 days prior to receiving any of the following non-Emergency services.

- After the 1st five (5) visits: Chiropractic Therapy, Physical Therapy, and Occupational Therapy
- Chemotherapy (including oral)
- All Oncology and transplant related injections, infusions, and treatments (e.g. CAR-T, endocrine and immunotherapy), excluding supportive Drugs (e.g. antiemetic and antihistamine)

- Durable Medical Equipment
- Home Health Care
- Home Infusion Therapy
- Injectable Medications
- Orthotics and Prosthetics. Note that foot orthotics are excluded from coverage under this Plan.
- Radiation Therapy

Air Ambulance. Call at least 7 days prior, or as soon as reasonably possible, prior to any non-Emergency professional air ambulance transportation.

Gene Therapy. Call at least 7 days prior to any Gene Therapy evaluation, testing, or preparative services.

Pharmaceuticals. The Drug List identifies which Prescription Drugs require Prior Authorization. In addition, call at least 7 days prior to obtaining any medication processed through the medical benefit which cost $2,000 or more per Drug per month.

Infusion: Call at least 7 days prior to any Infusion Therapy which encompasses intravenous and/or intramuscular injections.

If Your Physician recommends an Inpatient confinement or any of the services listed above, please follow these steps:

1. Notify Your Physician that You participate in a Pre-Certification Program. Please note that this applies even if this Plan is the secondary payer under Coordination of Benefits.

2. You or Your Physician must call the number shown on Your member ID card 2 weeks before or, if less than 2 weeks, as soon as scheduled for an elective Hospital admission. Note: For exceptions, please refer to the section of this document entitled "Compliance Regulations," and see the subheading "Statement of Rights Under the Newborns' and Mothers' Health Protection Act".

3. If You have an Emergency admission, Pre-Certification is required within 48 hours or the next business day following admission.

The following information will be needed to pre-certify:

Regarding Patient:	Regarding Employee:
Name	Name
Address	Address
Telephone #	Telephone #
Date of Birth	Date of Birth
Relationship to Employee	Gender
Physician's Name	Social Security Number
Physician's Phone Number	Name of Employer
Hospital/Address	Name of Third-Party Administrator: *Allied Benefit Systems, LLC*

4. A nurse may call Your Physician to review a proposed Inpatient admission or other listed service. If admission is necessary, an assigned length of stay will be determined. If additional days are later thought to be necessary, these additional days must also be pre-certified.

5. When You or Your Physician call to pre-certify an Inpatient admission or other listed service, the call will be logged so that:

a. The facility can verify that Pre-Certification has been done and can track expected length of stay.

b. The Third-Party Administrator can verify that the Pre-Certification requirements have been met when the claim is received for processing.

Note: Pre-Certification assists in determining Medical Necessity and the best place for treatment. This service, however, does not guarantee payment, which is subject to eligibility and coverage at the time services are rendered.

Penalty for Non-compliance:
Unless prohibited under federal law, the non-compliance penalty specified in the Summary of Benefits will apply under one or more of the following circumstances: a) a Pre-Certification call is not made according to the instructions within this section; b) an Inpatient stay exceeds the amount of days pre-certified; or c) a patient is admitted as an Inpatient when treatment could have been performed on an Outpatient basis.

This penalty will be applied in addition to any applicable Deductible and will not be applied to any Out-of-Pocket Maximum as specified in the Summary of Benefits. The penalty will be applied to covered expenses that were incurred during the days that were not pre-certified.

Continued Stay Review
The Medical Review Manager may request additional clinical information during an Inpatient confinement. Failure of the Provider or facility to provide the requested information will result in non-authorization of continued Inpatient confinement. No benefits will be considered until the additional information is received by the Medical Review Manager.

No benefits will be paid for the days of Inpatient confinement beyond the originally scheduled discharge date if the continued stay would not have been authorized by the Medical Review Manager based on review of the additional information provided.

Reduction Of Payment
The effect of noncompliance with the utilization review process is:

1. No benefits will be paid under this Plan for any transplant services that are not authorized by the Medical Review Manager prior to transplant evaluation, testing, preparative treatment, or donor search.
2. No benefits will be paid under this Plan for any Gene Therapy services that are not authorized by the Medical Review Manager before services are rendered.
3. No benefits will be paid under this Plan for any non-Emergency professional air or water transportation services that are not authorized by the Medical Review Manager prior to transport.
4. No benefits will be paid for Infusion Therapy of the associated medication(s) which encompasses intravenous and/or intramuscular injections, that are not authorized by the Medical Review Manager before services are rendered.

5. If authorization is not obtained for the Covered Person's course of treatment for other services as provided in the When to Call provision above, benefits will be reduced for otherwise Covered Services by 25%, but by no more than $1,000 per course of treatment.

Examples of failure to obtain precertification include:

a. The Covered Person fails to obtain authorization for the treatment from the Medical Review Manager.
b. The Covered Person does not contact the Medical Review Manager within the required timeframe.
c. The type of treatment, admitting Provider or facility differs from what was authorized by the Medical Review Manager.
d. The treatment is Incurred more than 30 days after review by the Medical Review Manager.

The reduced amount, or any portion thereof, under this section will not count toward satisfying any Coinsurance, Copayment, Deductible, or Out-of-Pocket Limit.

Utilization Review Decisions

The Medical Review Manager, upon notification, will determine (in consultation with the Covered Person's Provider) whether or not an Inpatient confinement, Surgery, or other Medical Care is Medically Necessary. The Medical Review Manager will certify all such Medical Care that is determined to be Medically Necessary or suggest other care options that may exist for treatment of the condition.

For Inpatient admissions, the Medical Review Manager will also certify the number of days of confinement that are considered to be Medically Necessary. If the attending Provider feels, due to extenuating circumstances, that additional days are required to treat the condition properly, he or she may contact the Medical Review Manager to discuss the Medical Necessity of an extended length of stay and request certification for additional days. Any Medical Care or confinement that is not determined to be Medically Necessary will not be certified and will not be eligible for benefits.

The Medical Review Manager will notify the Covered Person promptly of its determination. It will also notify the Facility Provider and the Covered Person's Provider.

If the Covered Person or his/her Provider does not agree with the decision of the Medical Review Manager, the decision may be appealed according to the appeal provisions listed in the General Provisions (appeals) section.

The Medical Review Manager only determines whether or not Medical Care is Medically Necessary. A utilization review decision certifying Medical Necessity does not guarantee that benefits will be paid under this Plan. The Plan will pay Covered Services only for the services and supplies listed in the SPD. Refer to the Exclusions section of the SPD for services and supplies that are not covered under this Plan.

SECTION 3: SUMMARY OF BENEFITS

The following benefits are per Participant per Benefit Period. Please refer to Definitions, Maximum Allowable Charge for important information about In-Network Providers and Out-of-Network Providers and how the Plan will calculate benefit payments.

Benefit	In-Network	Out-of-Network
General Provisions		
Benefit Period	Calendar Year	
Cross Accumulation of Benefits	In-Network and Out-of-Network Deductibles and Out-of-Pocket Limits are not aggregated or cross-accumulated. Covered Services applied to In-Network and Out-of-Network benefits do not apply to the other.	
Deductible (per benefit period) Individual Family *This is an Integrated Deductible. This means that there is no limit to the amount that an individual may apply towards the Family deductible. The Deductible can be met by one member or a combination of Family members. Please note that the entire Family Deductible amount must be met before any benefits are payable for any individual in the family (except for preventive care services benefits as specifically stated herein).*	 $2,500 $5,000	 $5,000 $10,000
Deductible Credit	A Covered Person who was covered under his or her Employer's prior group plan on the date this SPD replaces prior coverage, the Plan will credit the Deductible under this SPD by the amount that was Incurred and applied to Covered Person's deductible under the Prior Plan for the same Calendar Year in which the placement occurred. A Covered person must provide proof of the deductible amounts that was satisfied under the Prior Plan. No credit is giving for past Calendar Year Deductibles under this SPD.	
Coinsurance (Plan paid) – payment based on the plan Maximum Allowed Amount	80% after Deductible	50% after Deductible
Total Maximum Out-of-Pocket Limit Individual Family Includes Deductible, Coinsurance, Copays, Prescription Drug cost sharing and other qualified medical expenses.	 $4,000 $8,000	 $8,000 $16,000

Benefit	In-Network	Out-of-Network
Once met, the plan pays 100% of Covered Services for the rest of the benefit period for services applying to that particular limit. *This is an Integrated Maximum Out-of-Pocket Limit. All family members share the Family Maximum Out-of-Pocket Limit, regardless of the number of family members. The family satisfies the Family Maximum Out-of-Pocket Limit when the entire Family Maximum Out-of-Pocket Limit amount is met.*		
Precertification	Certain benefits are subject to a 25% penalty per occurrence (in addition to Deductible, capped at $1,000) for failure to follow the Pre-Certification Program provisions. Please refer to Utilization Review section for additional information. This penalty does not accrue to the Out-of-Pocket Limit.	
Overall Benefit Maximum	Unlimited	
Claims Filing Limit	All charges, and corresponding requested documentation, must be submitted within one (1) year of the date Incurred.	
Coordination of Benefits	If it is determined that this Plan is the secondary payer, benefits will be adjusted and reduced (standard). Benefits payable from both plans shall not exceed 100% of the eligible U&C charges.	
Office/Clinic/Urgent Care Visits		
Primary Care Provider Office Visits & Virtual Visits for Evaluation and Examination The Plan considers the following doctors as Primary Care Physicians, all others would be Specialist Physicians: General Practice, Family Practice, Internists, OB/Gyn, Internal Medicine, and Pediatricians.	80% after Deductible	50% after Deductible
Specialist Physician Office Visits & Virtual Visits for Evaluation and Examination	80% after Deductible	50% after Deductible
Surgery and Other Physician Services performed at a Physician's Office	80% after Deductible	50% after Deductible
Urgent Care Center Visits including any applicable Facility Fees	80% after Deductible	50% after Deductible
Preventive Care		
ACA Preventive Care	100%	50% after Deductible
Breast Pumps and Supplies	100%	100%

Benefit	In-Network	Out-of-Network
Family Planning including injections, implants, and intrauterine contraceptives including administration, insertion, and removal.	100%	50% after Deductible
Other Preventive Services	80% after Deductible	50% after Deductible
Emergency Services		
Emergency Room Services	80% after Deductible Use of an Emergency Room for a condition that is not an Emergency Medical Condition will result in a 25% reduction in covered charges. This penalty does not accrue to the Out-of-Pocket Maximum.	
Ambulance	80% after Deductible	
Hospital and Medical / Surgical Expenses (including maternity)		
Hospital Inpatient *Room and Board subject to the payment of Semi-Private room rate unless the Hospital only has private rooms.*	80% after Deductible	50% after Deductible
Inpatient Rehabilitation	80% after Deductible	50% after Deductible
	Any combination of Skilled Nursing Facility, Residential Treatment Facility, and Inpatient Rehabilitation is limited to 30 days per Covered Person per Benefit Period.	
Hospital Outpatient including Ambulatory Surgical Facilities	80% after Deductible	50% after Deductible
Medical Care (including Inpatient visits and consultations) and Surgical Expenses	80% after Deductible	50% after Deductible
Therapy and Rehabilitation Services		
Any combination of Outpatient Rehabilitation and Habilitative services is limited to 30 visits per Covered Person per Benefit Period. Does not apply to Infusion Therapy, Chemotherapy or Radiation Therapy.		
Cardiac Rehabilitation	80% after Deductible	50% after Deductible
Chiropractic Therapy	80% after Deductible	50% after Deductible
Cognitive Rehabilitation	80% after Deductible	50% after Deductible
Physical Therapy	80% after Deductible	50% after Deductible
Occupational Therapy	80% after Deductible	50% after Deductible
Pulmonary Rehabilitation	80% after Deductible	50% after Deductible
Respiratory Therapy	80% after Deductible	50% after Deductible
Speech Therapy	80% after Deductible	50% after Deductible
Spinal Manipulations	80% after Deductible	50% after Deductible
Mental Health / Substance Abuse		
Inpatient Mental Health Services	80% after Deductible	50% after Deductible
Inpatient Detoxification / Rehabilitation	80% after Deductible.	50% after Deductible

Benefit	In-Network	Out-of-Network
Outpatient Mental Health Services (includes virtual behavioral health visits)	80% after Deductible. Office visits are subject to same cost-sharing as Office Visit section above.	50% after Deductible
Substance Abuse Services	80% after Deductible. Office visits are subject to same cost-sharing as Office Visit section above.	50% after Deductible
Residential Treatment Facility	80% after Deductible	50% after Deductible
	Any combination of Skilled Nursing Facility, Residential Treatment Facility, and Inpatient Rehabilitation is limited to 30 days per Covered Person per Benefit Period.	
Other Services		
Allergy Extracts and Injections	80% after Deductible	50% after Deductible
Assistant Surgeon	80% after Deductible	50% after Deductible
	For surgical assistance provided by an assistant surgeon (when Medically Necessary), Covered Services of the assistant surgeon are limited to 20% of the Plan's Maximum Allowed Amount for the surgeon.	
Chemotherapy	80% after Deductible	50% after Deductible
Contact Lenses	80% after Deductible	50% after Deductible
	Limited to first pair of either contact lenses or glasses following cataract Surgery for initial replacement of natural lenses.	
Dental Services Covered only for an Accidental Injury when rendered by a Physician, Dentist, or oral surgeon for a fractured jaw or for Accidental Injuries to natural teeth within 6 months after the Accident.	80% after Deductible	50% after Deductible
Infusion Therapy which encompasses intravenous and/or intramuscular injections, as well as drugs administered through other non-oral routes, such as epidural routes.	80% after Deductible	50% after Deductible
Inpatient Diagnostic Services	80% after Deductible	50% after Deductible
Outpatient Diagnostic Services: Advanced (such as MRI, MRA, CT, CTA, PET, SPECT, and nuclear cardiology scans)	80% after Deductible	50% after Deductible
Outpatient Diagnostic Services: Basic (such as X-Ray imaging, diagnostic medical tests, laboratory and pathology testing and allergy testing)	80% after Deductible	50% after Deductible

Benefit	In-Network	Out-of-Network
Dialysis	80% after Deductible All Dialysis Providers are Out-of-Network. This Plan does not access or use the PPO Network for Dialysis Providers.	
Durable Medical Equipment and Ostomy Supplies	80% after Deductible	50% after Deductible
	Cost to purchase or rent is covered up to the purchase price.	
Home Health Care	80% after Deductible	50% after Deductible
	Limited to a Maximum of 45 home care visits per Covered Person per Benefit Period. Each 4 hours of service by a home health aide in a 24-hour period will be considered 1 home health visit. One visit by any other Provider of services will be counted as 1 visit.	
Hospice	80% after Deductible	50% after Deductible
	Limited to 180 days/ Lifetime	
Infertility Services	80% after Deductible, limited to $10,000 Maximum per Calendar Year	
Prosthetics	80% after Deductible	50% after Deductible
	Benefits are limited to a single Prosthetic device every three (3) years, In Network and Out of Network combinbed.	
Radiation Therapy	80% after Deductible	50% after Deductible
Maternity and Newborn Care	80% after Deductible	50% after Deductible
Second Surgical Opinion	80% after Deductible	50% after Deductible
Skilled Nursing Facility Care including Extended Care Facility Care and sub-acute rehabilitation.	80% after Deductible	50% after Deductible
	Any combination of Skilled Nursing Facility, Residential Treatment Facility, and Inpatient Rehabilitation is limited to 30 days per Covered Person per Benefit Period.	
Sleep Studies	80% after Deductible	50% after Deductible
Transplant Services	80% after Deductible Must utilize a Designated Transplant Provider. Travel and lodging expenses limited to $10,000 combined for member, companion, and donor.	Not Covered
Telehealth Services	Physician, Psychiatrist or Psychologist 100% after $0 copay	

Prescription Drugs	
Your Prescription Drug Benefit is administered by Cigna PBM.	For Prescription Drug questions please call 1-800-325-1404 or visit www.mycigna.com.
Prescription Drug Program Benefits are defined by the Pharmacy Network, not the medical PPO Network. Prescriptions filled at a non-Network Pharmacy are not covered.	*Plan Generic Policy: If member obtains a brand Drug when a generic is available, the member will be charged the generic co-pay plus the Cost Difference Between Generic Drugs and Brand Name Drugs. The amount of this cost difference does not apply to the Deductibles or Out-of-Pocket Maximums.*
Prescription Drug Card Benefit *(up to 30-day supply per Prescription through Participating pharmacies)*	**Retail Drugs (30-day Supply)** Generic Drug 80% after Deductible Preferred Prescription Drug 80% after Deductible Non-Preferred Prescription Drug 80% after Deductible
Extended Retail Pharmacy Drug Benefit *(up to 90-day supply per Prescription through Participating pharmacies)*	**Retail Drugs (90-day Supply)** Generic Drug 80% after Deductible Preferred Prescription Drug 80% after Deductible Non-Preferred Prescription Drug 80% after Deductible
Mail-Order Drug Benefit *(up to 90-day supply per Prescription through mail order, except where prohibited by state or federal law.)*	**Maintenance Drugs through Mail Order (90-day Supply)** Generic Drug 80% after Deductible Preferred Prescription Drug 80% after Deductible Non-Preferred Prescription Drug 80% after Deductible
Preventive Drug Benefits	*Certain Prescriptions shall be covered at 100%, and no co-pay will apply as per Federal Regulations*
Specialty Drugs	*Not Covered*
Your Benefit may include new Drugs that are in, or have finished, a phase 3 clinical investigation. It also includes Drugs prescribed and given to you as part of an approved FDA treatment protocol.	

SECTION 4: MEDICAL BENEFITS

Subject to the exclusions, conditions and limitations of the Plan, a Participant is entitled to Covered Services described in the Plan and is responsible for the Deductible, Copayment and Coinsurance, if any, as specified herein and in the Summary of Benefits. The Summary of Benefits specifies the Benefit Period selected by the Plan.

The Participant is always responsible for Copayments, Deductibles and Coinsurance in the amounts shown for Covered Services as included herein, in the Summary of Benefits that accompanies the Plan.

Pre-Certification requirements must be followed as discussed in the Utilization Review Provisions section.

It is the intent of the Plan to comply with all No Surprises Act ("NSA") requirements. To the extent any provision of this SPD is contrary to those requirements, the SPD shall be interpreted to comply with the NSA.

Emergency Services
In the event that the Participant requires Emergency Service, the Plan will provide coverage at the Participating Provider level and the Participant's Out-Of-Pocket expense will be no greater than the amount that would have been Incurred if the Participant had been able to choose a Participating Provider. For Inpatient Emergency admissions to a Non-Participating Provider, the Participant is responsible for notifying the Plan or its designated agent within forty-eight (48) hours of the Emergency Service or as soon as reasonably possible. Once an Insured is stabilized, to continue coverage at the higher reimbursement level, the Plan reserves the right to transfer the Participant's care from a Non-Participating Provider to a Participating Provider.

Medically Necessary Services
Medical Necessity for Covered Services will be initially determined prior to the service being rendered when Pre- Certification is required. When Pre-Certification is not required, the Plan may determine that a service was not Medically Necessary after service has been rendered. The Plan only covers services that it determines to be Medically Necessary. The Participant should be aware that services may be denied for lack of Medical Necessity after the service has been rendered. Therefore, if a Participant has a concern about a service requiring Pre-Certification, he/she should contact the Medical Review Manager prior to the service being rendered.

Based upon the evidence as required, the Medical Review Manager shall determine the Medical Necessity for Covered Services. However, the Participant shall have the right to appeal such determinations as set forth in the Plan.

Provider Charges and Maximum Allowable Amount Provisions
You and Your Covered Dependent(s) are free to use any Provider You choose. It is the Covered Person's responsibility to determine if a Provider is a Participating Provider or a Non-Participating Provider before services are rendered.

Please see the Benefit Summary for specific benefit levels that apply to each type of Provider. If You choose a Participating Provider, You will receive In-Network Benefits. Generally, If You choose a Non-Participating Provider, You will receive Out-of-Network Benefits.

The Covered Person is not responsible for payment of amounts billed by a Participating Provider in excess of the Maximum Allowable Amount for covered charges within the Covered Person's Network.

Non-participating Providers may charge more than the Plan determines to be a Maximum Allowable Amount and the Covered Person is responsible for payment of any amount billed above the Maximum Allowable Amount.

Participating Provider Benefits Provisions
A Covered Person may receive a higher benefit level for Covered Services received from a Participating Provider. The Participating Provider benefit levels are shown in the Benefit Summary. Network services and supplies for which the Plan has a negotiated rate are not subject to Maximum Allowable Amount reductions.

Using a Participating Provider is not a guarantee of coverage. To be considered for payment at the desired benefit level, You and Your Covered Dependents must meet the requirements for using a Participating Provider and must comply with all other Plan requirements.

It is the Covered Person's responsibility to verify a Provider's status within the Participating Provider Network at the time of service to ensure the Participating Provider benefit is received. Information on Participating Providers will be made available to You. If You or a Covered Dependent are having trouble locating a Participating Provider, please call the Network's phone number on the directory website or on Your identification (ID) card for assistance.

Maximum Allowable Amounts for Participating Providers Provision
For goods and services provided by a Participating Provider, Facility, or Supplier, the Maximum Allowable Amount is the lesser of Billed Charges or the negotiated rate. A Covered Person is not responsible for payment of amounts billed by a Participating Provider in excess of the Maximum Allowable Amount for Covered Services received within the Covered Person's Network.

Additional Provisions for Participating Provider Benefits
The Covered Person's benefits may also be affected based on the following factors:

1. Providers and/or Networks may join or leave the Participating Provider Network from time to time. The Covered Person is responsible for verifying the participation status of a Provider at the time of service. Prior to treatment, the Covered Person should call the Network Manager to verify whether a Provider's participation in the Network has terminated.

2. If the Covered Person incurs Covered Services after a Participating Provider's participation in the Participating Provider Network has terminated, Covered Services will be processed at the Non-Participating Provider benefit level.

3. The Plan will pay Covered Services at the Participating Provider benefit level under certain circumstances, such as if the Covered Person begins treatment with the Participating Provider prior to the Provider's date of termination as a Participating Provider.

4. If the Covered Person incurs Covered Services after a Provider's status within the Participating Provider Network has changed, Covered Services will be processed according to the participation level of the Provider as of the date the service or supply is received.

Non-Participating Provider Benefits Provision

Covered charges for treatment, services, and supplies received from Non-Participating Providers are generally paid at a lower level than Participating Provider benefits and are subject to satisfaction of the Non-Participating Provider Deductible as well as any Maximum Allowable Amount reductions.

Maximum Allowable Amounts for Non-Participating Providers Provisions
Providers who have not established a negotiated rate with Us or Our Network Manager may charge more than we determine to be a Maximum Allowable Amount for Covered Services and supplies. If You or Your Covered Dependent(s) choose to obtain Covered Services or supplies from such a Provider, Covered Services will be limited to what The Plan determines to be the Maximum Allowable Amount. A Covered Person may be billed by the Non-participating Provider for the portion of the bill we do not cover, in addition to any other applicable fees including, but not limited to, any Coinsurance, Copayment and Deductible, and any Non-covered Charges.

For goods and services provided by a Non-Participating Provider, Facility, or Supplier including, but not limited to, Professional, Inpatient and Outpatient claims, the Maximum Allowable Amount is the lesser of:

1) Billed Charges; or

2) A negotiated rate; or

3) If a negotiated rate is not available, in accordance the amount allowed by Medicare to Providers, or an equivalent of what Medicare would allow based on the use of Medicare data or independent relative value unit or other data, for the goods and services reported on the claim, established utilizing the most currently available reimbursement schedules and methodologies, or industry data sources. Please refer to DEFINITIONS, MAXIMUM ALLOWABLE AMOUNT for additional detail.

Ancillary Services
Certain Ancillary Services ordered by a Participating Provider, such as lab tests or services, are sometimes outsourced to Non-Participating Providers. Covered Services for such services rendered in association with direct treatment from a Participating Provider will be paid at the Out-of-Network benefit level.

Covered Medical Benefits
The Plan will pay Covered Services only for the services and supplies listed as Medical Benefits in this section of the SPD for You and Your Covered Dependents (if applicable).

How Covered Services are paid and the Maximum Benefit for the Covered Services and supplies listed in this section are shown in the Benefit Summary. Refer to the Exclusions section of the SPD for services and supplies that are not covered under this Plan.

The Covered Person must follow the Utilization Review Provisions section and the Provider Charges And Maximum Allowable Amount Provisions section to receive the Maximum benefits available under this Plan.

The Plan DOES NOT require the designation of a Primary Care Practitioner.

After the Covered Person has paid any applicable Coinsurance, Copayment, Deductible, or any other applicable fees, benefits will be paid by the Plan for Covered Services for medical benefits listed in this section of the SPD for each Covered Person. Separate Coinsurance, Copayments, Deductibles, or other fees may apply to specific types of services. Please review the Benefit Summary for additional information on any other Coinsurance, Copayment, Deductible, or other fees, and the Covered Services to which they apply.

Benefits paid under this section are subject to any Maximum Benefit provided under this Plan. Benefits are subject to all the terms, limits and conditions in this Plan. This Plan considers benefits for Behavioral Health and Substance Abuse disorders on the same basis as Sickness.

Prescription Drugs that are received on an Outpatient basis are considered for benefits under the Outpatient Prescription Drug Benefits section unless they are specifically listed as Covered Services in the Medical Benefits section, such as Specialty Drugs.

The Plan pays only for the following Covered Services:

1. **Allergy Extracts/Injections**
   Covered services are provided for allergy extracts and antigen injections.

2. **Ambulance Services**
   Covered services are payable for Medically Necessary ambulance services by land, air or water, Advanced Life Support (ALS) or Basic Life Support (BLS) for local transportation. The ambulance must be transporting the Participant:

   a. From home or from the scene of an Accident or Medical Emergency to the nearest Hospital;
   b. Between Hospitals;
   c. Between a Hospital and Skilled Nursing Facility;
   d. From a Hospital or Skilled Nursing Facility to the Participant's home;
   e. From the Participant’s home or from a Facility Provider to an Outpatient treatment site; or
   f. From an Outpatient treatment site to the nearest Hospital.

   If there is no facility in the local area that can provide Covered Services for the Participant’s condition, then ambulance service means transportation to the closest facility outside the local area that can provide the necessary service. If the Participant chooses to go to another facility that is farther away, payment will be based on the Maximum Allowable Charge for transportation to the closest facility that can provide the necessary services.

3. **Anesthesia**
   Administration of general anesthesia in a Hospital or Ambulatory Surgical Facility when in connection with the performance of Covered Services and when rendered by or under the direct supervision of a Professional Provider other than the surgeon, assistant surgeon or attending Professional Provider is covered.

   Hospitalization and all related medical expenses normally Incurred as a result of the administration of general anesthesia in a Hospital or Ambulatory Surgical Facility in connection with the performance of non-covered dental procedures or non-covered oral Surgery, are covered when determined by the Plan to be Medically Necessary for the following Participants when a successful

result cannot be expected for treatment under local anesthesia and for whom a superior result can be expected under general anesthesia:

a. Adults who are developmentally Disabled;
b. Participants with complex medical conditions, when performing the Surgery/procedure in any setting other than a Hospital or Ambulatory Surgical Facility would present an unacceptable risk to the patient's health; or
c. When one of the following is present:
    i. It is a required part of a broader treatment plan requiring radiation of the head and/or neck;
    ii. There is non-dental Diseases eroding or invading the maxilla and/or mandible, the treatment of which necessitated removal of the Insured Person's teeth;
    iii. There is infection of the teeth and gums that places the Insured Person's health at risk if uncorrected prior to other Medically Necessary treatment such as but not limited to Chemotherapy or transplant; or
    iv. Local anesthesia and conscious sedation are covered regardless of setting.

4. Blood and Blood Plasma

Covered services will be provided for whole blood, blood plasma, the administration of blood and blood processing, and blood derivatives, which are not classified as Drugs by the U.S Food and Drug Administration ("FDA").

5. Chiropractic Manipulative Covered Services

Chiropractic Manipulative Treatments, consultations, and Adjunctive Procedures are limited to a combined Maximum per Benefit Period as set forth in the Summary of Benefits, if Medically Necessary.

6. Concurrent Care

Services rendered to an Inpatient in a Hospital, Rehabilitation Hospital or Skilled Nursing Facility by a Professional Provider who is not in charge of the case but whose particular skills are required for the treatment of complicated conditions. This does not include observation or reassurance of the Participant, standby services, routine pre-operative physical examinations, or Medical Care routinely performed in the pre- or post-operative or pre- or post-natal periods or Medical Care required by a Facility Provider's rules and regulations.

7. Consultations

Consultation services when rendered Inpatient in a Hospital, Rehabilitation Hospital or Skilled Nursing Facility by a Professional Provider at the request of the attending Professional Provider. Consultations do not include staff consultations, which are required by Facility Provider's rules and regulations.

8. Diabetes Education/Equipment/Supplies

a. <u>Diabetes Education</u>

Covered services are provided for diabetes education services as described herein or as indicated in the Summary of Benefits. Diabetes Outpatient self-management training and education shall be provided under the supervision of a licensed health care professional with expertise in diabetes to ensure that persons with diabetes are educated as to the proper self-management and treatment of their diabetes, including information on proper diets. Coverage for self-management education and education relating to diet and

prescribed by a licensed Physician shall include: (1) visits Medically Necessary upon the Diagnosis of diabetes; (2) visits under circumstances whereby a Physician identifies or diagnoses a significant change in the patient's symptoms or conditions that necessitates changes in a patient's self-management; and (3) where a new medication or therapeutic process relating to the person's treatment and/or management of diabetes has been identified as Medically Necessary by a licensed Physician.

b. Diabetic Equipment and Supplies
Equipment and supplies for the treatment of insulin-dependent diabetes, insulin-using diabetes, gestational diabetes, and non-insulin-using diabetes when prescribed by a health care professional legally authorized to prescribe such items or as indicated in the Summary of Benefits. Equipment and supplies shall include the following: blood glucose monitors, monitor supplies, insulin, injection aids, syringes, insulin infusion devices, pharmacological agents for controlling blood sugar and Orthoses.

9. Diagnostic Services--Outpatient

Covered services are provided for the following Diagnostic Services when ordered by a Professional Provider and billed by a Professional Provider, independent clinical laboratory, and/or a Facility Provider:

a. Diagnostic radiology, consisting of x-ray, ultrasound, and nuclear medicine;
b. Diagnostic mammograms including digital breast tomosynthesis ("3D mammography");
c. Diagnostic laboratory and pathology tests;
d. Diagnostic medical procedures consisting of electrocardiogram (ECG), electroencephalogram (EEG), and other diagnostic medical procedures approved by the Plan;
e. Diagnostic imaging procedures consisting of Magnetic Resonance Imaging (MRI), Magnetic Resonance Angiography (MRA), Computed Tomography (CT) scan, Computed Tomography Angiography (CTA) scan, Positron Emission Tomography (PET) scan, Single Photon Emission Computerized Tomography (SPECT), and nuclear cardiology studies approved by the Plan;
f. Allergy testing consisting of percutaneous, intracutaneous and patch tests.

Certain diagnostic tests/scans require Pre-Certification, regardless of Provider.

10. Durable Medical Equipment/Prostheses/Orthoses

Covered services are provided for Durable Medical Equipment, Prostheses, and orthoses when prescribed by a licensed health care professional. Except for initial and subsequent Prosthetic devices to replace the removed breast or portion thereof, replacements of Durable Medical Equipment, Prostheses and Orthoses are not included, other than as certified as Medically Necessary for Children due to the normal growth process.

Instructions regarding appropriate use of the item are covered.

Covered Durable Medical Equipment includes, but is not limited to, the following:

a. Hospital beds and related equipment (bed rails, mattresses);
b. Equipment to increase mobility (walkers, wheelchairs);
c. Commodes (elevated seats, portable bedside commodes);
d. Breathing apparatus (positive and intermittent positive pressure breathing machines, suction machines);
e. Therapeutic equipment;

f. Apnea monitors;
g. Jobst pressure garments used in burn treatment; and
h. Unna boots and air casts.

Covered Prostheses and Orthoses include, but are not limited to, the following:

a. Artificial limbs;
b. Knee braces, not made of elastic or fabric support;
c. Splints (acrimo-clavicular or zimmer, carpal tunnel, clavicle or “figure-8", finger, Pavlik harness and wrist);
d. Immobilizers;
e. Supportive back braces with metal stays;
f. Dynasplints; and
g. Cryocuffs.

Covered services are not payable for dental appliances or eyeglasses, except as specified in the Surgery section.

Wigs will be covered only for hair loss resulting from Chemotherapy treatment and will be subject to a Maximum of $300 per Benefit Period.

11. Emergency Care Covered Services

Emergency care Covered Services include treatment and services provided in the Outpatient department of a
Hospital for an Emergency Medical Condition.

a. Outpatient services and supplies provided by a Hospital or Facility Provider and/or Professional Provider for Emergency treatment of bodily Injury resulting from an Accident shall be covered;
b. Outpatient services and supplies provided by a Hospital or Facility Provider and/or Professional Provider for Emergency treatment of a medical condition with acute symptoms, which would result in requiring immediate Medical Care, shall be covered;
c. If Accident services are classified as Surgery (e.g., suturing, fracture care, etc.), payment to a Professional Provider will be made as a surgical covered service; and
d. Visits which are performed in the Outpatient department of a Hospital that are follow-up to Emergency Accident care and Emergency Medical Care are classified and payable as Outpatient Covered Services.

12. Experimental or Investigational Services

The Plan shall determine whether the use of any treatment, procedure, Provider equipment, Drug, device, or supply (each of which is hereafter called a “Service”) is Experimental or Investigational (that is not supported by evidence-based medicine). Services or treatments that are the subject of, or in some manner related to, the conduct of an Approved Clinical Trial are not considered Experimental or Investigational.

a. If, in making that determination, the Plan finds that the service, for which a claim for Covered Services is made, is either, (1) the subject of a written Investigational or research protocol used by the treating Provider or of a written Investigational or research protocol of another Provider studying substantially the same service; or (2) the subject of a written informed consent used by the treating Provider which refers to the service as Experimental,

Investigative, educational, or research; or (3) the subject of an on-going phase I or II clinical trial, the service shall be deemed to be Experimental or Investigative;

b. If, in making that determination, the Plan finds that neither a protocol, an informed consent, nor an on-going clinical trial, as described above, exist, then the Plan may require that demonstrated evidence exists, as reflected in the published Peer Reviewed Medical Literature that:
    i. The technology must have final approval from the appropriate governmental regulatory bodies;
    ii. The scientific evidence must permit conclusions concerning the effect of the technology on health outcomes;
    iii. The technology must improve the net health outcome;
    iv. The technology must be as beneficial as any established alternatives; and
    v. The improvement must be attainable outside the Investigational settings.

    Peer Review Medical Literature means two (2) or more U.S. scientific publications which require that manuscripts be submitted to acknowledge experts inside or outside the editorial office in their considered opinions or recommendations regarding publication of the manuscript. Additionally, in order to qualify as Peer Reviewed Medical Literature, the manuscript must actually have been reviewed by acknowledged experts before publications; and

c. If, in making the determination, the Plan finds that a Drug, a device, a supply, or equipment has not received marketing approval (permission for commercial distribution) by the United States Food and Drug Administration: (1) at the time the service is received; and (2) for the purpose for which it is rendered; and (3) for the manner in which it is rendered, the Drug, device, supply, or equipment shall be deemed to be Experimental or Investigational.

13. Home Health Care

Subject to the following provision, Covered Services will be provided for a Maximum of 45 Home Health Care visits per Benefit Period or as indicated in the Summary of Benefits.

Covered services will be provided for the following when performed by a licensed Home Health Care Agency:

a. Professional services of a Registered Nurse or Licensed Practical Nurse, but not including private duty nurses;
b. Home health aide services as assigned and supervised by a Registered Nurse or Licensed Practical Nurse;
c. Physical Therapy treatments performed by a licensed Physical Therapist;
d. Speech Therapy services when provided by a licensed Speech Therapist holding a Certificate of Clinical Competency;
e. Occupational Therapy treatments when provided by or supervised by a licensed Occupational Therapist;
f. Medical social service consultations when provided by a qualified medical social service worker holding a master's degree in social work;
g. Nutritional Therapy provided by a Licensed Dietitian;
h. Diagnostic and therapeutic radiology services;
i. Laboratory services;
j. Medical diagnostic tests and studies;

k. Oxygen and Respiratory Therapy;
l. Medical and surgical supplies, including bandages, Ostomy Supplies, dressings, and casts; and
m. The rental of Durable Medical Equipment but only on a short-term basis and if not owned by the Home Health Care Agency.
n. The Participant must be Homebound in order to receive home health Covered Services, except when services are provided in conjunction with:
    1. Home Infusion Therapy, including the care of venous lines;
    2. The post Mastectomy visit; and
    3. The postpartum visit; or
    4. When services are not routinely provided in a Physician's office or the Outpatient setting and are Medically Necessary and have approval of the Plan.

When a discharge occurs within forty-eight (48) hours following a Hospital admission for a Mastectomy, Covered Services will be provided for one (1) Home Health Care visit within forty-eight (48) hours of the Hospital discharge. Pre-Certification will not be required for this visit.

Covered services will be provided only for services if (a) the services are prescribed by the Participant's attending Physician, (b) the Participant received Pre-Certification approval from the Plan as set forth in the Cost Containment section, and (c) the Participant's Physician has furnished, in consultation with the Home Health Care Agency's professional personnel prior to the first visit, a plan of treatment stating that the services are Medically Necessary. Continuing eligibility requires that the attending Physician provide such a plan of treatment at intervals of no less than every thirty (30) days.

When a discharge occurs within forty-eight (48) hours following a Hospital admission for a normal vaginal delivery or within ninety-six (96) hours following a Hospital admission for cesarean delivery, Covered Services will be available for one (1) Home Health Care visit within forty-eight (48) hours of the Hospital discharge. Pre-Certification will not be required for this visit.

At the discretion of the mother, a visit may occur at home or at the facility of the Provider. It is necessary to use a Provider included in the Plan's Network of contracted Providers in order to avoid a covered service reduction of the eligible charges, except for Emergency Care or when Covered Services are not available from a Participating Provider. Postpartum Home Health Care visits are exempt from any Copayment, Coinsurance or Deductible amounts, except if you are enrolled in a Qualified High Deductible Health Plan. If you are enrolled in a Qualified High Deductible Health Plan, the benefit will be paid at 100% after your In-Network deductible is met.

No Home Health Care Covered Services will be provided for:

a. Food or home delivered meals;
b. Professional Medical Services billed by a Physician;
c. Custodial Care;
d. Services of a housekeeper;
e. Private Duty Nursing;
f. Ambulance service;
g. Drugs, including Prescription Drugs; and
h. Services provided by Immediate Family or members of the Participant's household.

14. Home Infusion Therapy

Covered services will be provided for the following services provided to a Participant by a Home Infusion Therapy Agency:

a. Total parenteral nutrition;
b. Enteral nutrition;
c. Intravenous therapy;
d. Cancer Chemotherapy and cancer hormone treatment;
e. Anti-infective therapy (Lyme Disease);
f. Pain management (continuous and epidural analgesics); and
g. Immune globulin therapy.

The Home Infusion Therapy Agency shall supply all items used directly with Home Infusion Therapy to achieve therapeutic benefits and to assure proper functioning of the system, including, but not limited to: catheters, concentrated nutrients, dressings, enteral nutrition preparation, extension tubing, filters, heparin sodium (parenteral only), infusion bottles, IV pole, liquid diet (for catheter administration), needles, pumps, tape and volumetric monitors.

All therapies are subject to prospective, concurrent and/or retrospective utilization review by health care professionals, and further may require Pre-Certification to determine if a therapy is Medically Necessary and appropriate. Before delivering the therapy, a preferred Home Infusion Therapy Agency will advise the Participant if Pre-Certification is required

Any therapy or Drug, the use of which is not FDA approved may be considered Experimental/Investigative and, therefore, must be Pre-Certified. Pre-Certification procedures apply as set forth in the Utilization Review Provisions section.

Home Infusion Therapy Covered Services will not be provided for:

a. Participants who are receiving Covered Services under the Hospice Care program;
b. Blood and blood products therapy; and
c. Any injectable Drugs covered under any other Covered Services section of the Plan.

15. Hospice Care

When the Participant's attending Physician certifies to the Plan that the Participant has a terminal Illness with a life expectancy of six (6) months or less and when the Participant elects to receive care primarily in the home to relieve pain and to enable the Participant to remain at home rather than to receive other types of care, the Participant shall be eligible for Hospice Care Covered Services.

Covered services for Hospice Care shall be provided as indicated in the Summary of Benefits. These Covered Services are in addition to, and not in lieu of, any other Covered Services in the Plan. If the Participant or the Participant's responsible party elects to institute curative treatment to sustain life, the Participant will not be eligible to receive further Hospice Care Covered Services until the cessation of such curative treatment.

The Hospice Care covered service will include coverage for continuous care consisting of nursing care for up to twenty-four (24) hours per day necessary to maintain the patient at home or acute Inpatient care for a period of crisis when Medically Necessary and not solely for comfort measures. A Maximum, as indicated in the Summary of Benefits, is available for continuous and/or Inpatient care. Covered services are payable according to the Maximums set forth in herein.

Covered services will be provided for supportive services at each level of care to a terminally ill Participant by a Hospice Care program in accordance with a treatment plan approved by and periodically reviewed by the Medical Review Manager. The following services provided to a Participant by an approved Hospice responsible for the patient's overall care will be eligible for coverage:

a. Professional services of a Registered Nurse or Licensed Practical Nurse;
b. Pain management;
c. Chemotherapy and/or Radiation Therapy;
d. Parenteral or enteral nutrition therapy;
e. Prescription Drugs;
f. Laboratory services;
g. Dietitian services;
h. Medical and surgical supplies, Ostomy Supplies, and Durable Medical Equipment;
i. Oxygen and its administration;
j. Medical social service consultation provided by a social worker;
k. Counseling services provided to the Participant and/or family members related to the patient's terminal condition, including bereavement counseling;
l. Home health aide and homemaker services; and
m. Any needed therapies.

16. Hospital Services

a. Room and Board

i. Covered services are payable for general nursing care and such other services as are covered by the Hospital's regular charges for accommodations in the following:

(1) A Semi-Private Room, as designated by the Hospital; or a private room, when designated by the Network as Semi-Private for the purposes of the Plan, in Hospitals having primarily private rooms;
(2) A private room. The private room Maximum Allowed Amount is the Semi-Private Room charge;
(3) A special care unit, such as intensive or coronary care, when such a designated unit with concentrated facilities, equipment and supportive services is required to provide an intensive level of care for a critically ill patient;
(4) A bed in a general ward; and
(5) Nursery facilities.

Covered services are payable for a length of stay following a Mastectomy that a treating Physician determines is necessary to meet generally accepted criteria for safe discharge.

Covered services are payable for Hospital services for an Inpatient admission resulting from an Accident or Emergency Medical Condition that a treating Physician determines is Medically Necessary. Covered services are provided for an unlimited number of days per Benefit Period.

In computing the number of days of Covered Services, the day of admission, but not the date of discharge, shall be counted. If the Participant is admitted and discharged on the same day, it shall be counted as one day.

Days available under the Plan shall be allowed only during uninterrupted stays in a Hospital. Covered services shall not be provided: (1) for any day during which a Participant interrupts his/her stay; or (2) after the discharge hour that the Participant's attending Physician has recommended that further Inpatient care is not required.

b. Ancillary Services
Covered services are payable for all ancillary services usually provided and billed for by Hospitals (except for personal convenience items), including, but not limited to the following:

i. Meals, including special meals or dietary services as required by the patient's condition;
ii. Use of operating, delivery, recovery, or other specialty service rooms and any equipment or supplies therein;
iii. Casts, surgical dressings, and supplies, devices or appliances surgically inserted within the body, except when considered Experimental or Investigative by the Plan;
iv. Oxygen and oxygen therapy;
v. Administration of blood and blood plasma, including the processing of blood from donors, but excluding the blood or blood plasma, except as provided under Blood and Blood Plasma in this section;
vi. Anesthesia and the supplies and use of anesthetic equipment;
vii. Diagnostic Services;
viii. Therapy Services;
ix. Inpatient Rehabilitation therapy limited as the Summary of Benefits indicates;
x. All FDA-approved Drugs (including intravenous solutions), cancer Chemotherapy and cancer hormone treatment for use while in the Hospital;
xi. Use of special care units, including, but not limited to, intensive or coronary care; and
xii. Pre-admission testing and studies required in connection with the Participant's admission rendered or accepted by a Provider on an Outpatient basis prior to a scheduled admission to a Hospital or Facility Provider. Pre-admission testing does not include tests or studies performed to establish a Diagnosis. Covered services for Pre-Admission Testing will not be provided if the Participant cancels or postpones the admission. If the Provider or Physician cancels or postpones the admission, Covered Services will be provided.

Covered services are payable for ancillary services provided for and billed for by the Hospital for an Inpatient admission resulting from an Accident or Emergency Medical Condition.

17. Maternity Services

Services rendered in the care and management of a Pregnancy for a Participant are Covered Services under the Plan. Covered services are payable for:

a. Normal Pregnancy
Normal Pregnancy includes any condition usually associated with the management of a difficult Pregnancy, but not considered a complication of Pregnancy;

b. Complications of Pregnancy
Physical effects directly caused by Pregnancy, but which were not considered from a medical viewpoint to be the effect of normal Pregnancy, including conditions related to ectopic Pregnancy or those that require cesarean section;

c. Minimum Length of Stay

Coverage will be provided for a minimum of forty-eight (48) hours of Inpatient care following normal vaginal delivery and ninety-six (96) hours of care following cesarean delivery. A shorter length of stay may be justified when the treating or attending Physician determines in consultation with the mother that she and the newborn meet medical criteria for safe discharge in accordance with guidelines of the American Academy of Pediatrics and the American College of Obstetricians and Gynecologists. Those guidelines determine appropriate length of stay based upon, but not limited to, the following: the evaluation of the antepartum, intrapartum and postpartum course of the mother and infant; the gestational stage, birth weight and clinical condition of the infant; the demonstrated ability of the mother to care for the infant post-discharge; and the availability of the post-discharge follow-up care to verify the condition of the infant and mother within forty-eight (48) hours after discharge.

When a discharge occurs within forty-eight (48) hours following a Hospital admission for a normal vaginal delivery or within ninety-six (96) hours following a Hospital admission for cesarean delivery, Covered Services will be available for one (1) Home Health Care visit within forty-eight (48) hours of the Hospital discharge. At the discretion of the mother, a visit may occur at home or at the facility of the Provider. Home health care visits shall include parent education, assistance and training in breast and bottle feeding, infant screening and clinical tests and the performance of any necessary maternal and neonatal physical assessments. The postpartum home health visit is exempt from any Deductibles, Copayments or Coinsurance, except if you are enrolled in a Qualified High Deductible Health Plan. If you are enrolled in a Qualified High Deductible Health Plan, the benefit will be paid at 100% after your In-Network deductible is met.

d. Interruptions of Pregnancy
   i. Miscarriage; and
   ii. Services, which are necessary to avert the death of the woman and services to terminate pregnancies caused by rape or incest;

e. Nursery Care
   Ordinary nursery care of the newborn infant;

f. Routine Newborn Care
   The newborn Child of any covered Participant or Spouse from the date of birth up to a Maximum of thirty (30) days shall be limited to well-baby and routine nursery care including a physical examination and administration of prophylactic medications and vaccines. The Child must be enrolled within 30 days from birth to obtain all other Covered Services.

   Routine neonatal circumcision is covered up to 1 year of age.

18. Mental Health Care Services

a. Covered services for the treatment of Mental or Nervous Disorders and for the treatment of Serious Mental Illness are based on the services provided and reported by the Provider. Those services provided by and reported by the Provider as mental health care are subject to any applicable mental health care limitations in the Plan. When a Provider renders Medical Care, other than mental health care, for a Participant with Serious Mental Illness or with a Mental or Nervous Disorder, payment for such Medical Care will be based on the medical Covered Services available and will not be subject to any applicable mental health care limitations in the Plan;

b. Except in an Emergency, Inpatient and Partial Hospitalization Covered Services are provided when Medically Necessary and when the Medical Review Manager is notified by the Provider or the Participant before the Covered Services are rendered.;

c. Inpatient Services

i. Inpatient Services will be provided for admissions for Serious Mental Illness and Mental or Nervous Disorders in an Inpatient Mental Health Hospital. Pre-Certification requirements must be followed as discussed in the Utilization Review Provisions section. A concurrent review is required for any continued length of stay beyond what has been pre-certified by Medical Review Manager;

d. Outpatient Services

i. Outpatient services will be provided during a Benefit Period for Mental or Nervous Disorders and for Serious Mental Illness; and
ii. Outpatient mental health care services include Outpatient professional visits and Outpatient Partial Hospitalization days;

19. Metabolic Formulas

Metabolic Formulas only for the therapeutic treatment of phenylketonuria (PKU), branched chain ketonuria, galactosemia and homocystinuria. This covered service does not include coverage for normal food products used in the dietary management of rare genetic metabolic disorders.

20. Observation Status

Services furnished on a Hospital's premises include use of a bed and periodic monitoring by Hospital's nursing or other staff, which are reasonable and necessary to evaluate an Outpatient's condition or determine the need for a possible admission to the Hospital as an Inpatient;

21. Ostomy Supplies

Covered Ostomy Supplies include and are limited to the following:

a. Ostomy appliances and supplies specifically relating to an Ostomy (colostomy, ileostomy, urostomy or tracheostomy) are limited to collection devices, irrigation equipment and supplies, skin barriers and skin protectors;
b. Urinary catheters, both reusable or disposable, whether or not used in conjunction with an Ostomy; and
c. Ostomy Supplies are covered up to a Maximum as indicated in the Summary of Benefits. Coverage is limited to supplies obtained from Participating Providers.

22. Oxygen and Related Equipment/Supplies

Oxygen and related equipment and supplies for use in the patient's home are covered;

23. Physician Office Visits

Covered services are provided for Medical Care, visits and consultations rendered and billed by a Professional Provider to a Participant on an Outpatient basis. Covered services are provided for the examination, Diagnosis, and treatment of an Illness or Injury and routine office visits. Adult care includes routine physical examinations, regardless of their Medical Necessity, including a complete medical history plus necessary Diagnostic Services.

24. ACA Preventive Care

Coverage will be provided for the Preventive Care services provided for in the ACA and Health Resources and Services Administration's (HRSA) Women's Preventive Services: Required Health Plan Coverage Guidelines. The frequency and eligibility of services are subject to change to conform to the guidelines and recommendations of the United States Preventive Services Task Force, the Advisory Committee on Immunization Practices of the Center for Disease Control, and the Health Resources and Services Administration. Preventive care services include, but are not limited to the following:

a. Immunizations
   i. Coverage will be provided for those pediatric immunizations, including immunizing agents, which, as determined by the Department of Health, conform with the standards of the Advisory Committee on Immunization Practices of the Center for Disease Control, U.S. Department of Health and Human Services. Pediatric immunizations are available until the Participant attains age twenty-one (21). Pediatric immunizations which are provided by a Participating Provider are exempt from Deductibles, Copayments, and Coinsurance; and
   ii. Covered services are also provided for other immunizations, including immunizing agents, which are determined to be Medically Necessary;

b. Routine Gynecological Examinations and Pap Smears
   Female Participants are covered for gynecological examinations, including pelvic examinations and clinical breast examinations and routine Pap smears. Covered services which are provided by a Participating Provider are exempt from Deductibles, Copayments, and Coinsurance;

c. Screening Mammograms
   Screening mammograms, including digital breast tomosynthesis ("3D mammography"), are covered for all Participants whether or not directed toward a definite condition of Disease or Injury. Covered services which are provided by a Participating Provider are exempt from all Deductibles, Copayments and Coinsurance;

d. Colorectal Cancer Screening
   Coverage for colorectal cancer screening is provided for covered individuals. Coverage for non-symptomatic covered individuals shall include, but is not limited to:

   i. One (1) fecal occult blood test per Benefit Period;
   ii. Sigmoidoscopy, screening barium enema, colonoscopy, or a test consistent with approved medical standards and practices to detect colon cancer, at a frequency determined by the covered individuals Physician;
   iii. Coverage for symptomatic covered individuals shall include a colonoscopy, sigmoidoscopy, or any combination of colorectal cancer screening tests at a frequency determined by a treating Physician; and
   iv. Screenings for colorectal cancer for non-symptomatic individuals are exempt from all Deductibles, payments, and Coinsurance, when provided by a Participating Provider.

e. Prostate Cancer Screening
   Coverage is provided for one (1) prostate specific antigen (PSA) and/or one (1) digital rectal exam per Benefit Period. Covered services are exempt from all Deductibles, Copayments and Coinsurance, when provided by a Participating Provider;

f. Preventive Drugs

Covered services are provided for those generic preventive Drugs with a Prescription, which as determined by the U.S. Preventive Services Task Force have a rating of A or B, in accordance with the Affordable Care Act of 2010.

Covered services are also provided for all FDA-approved contraceptives Drugs and methods, in accordance with the Health Resources and Services Administration's (HRSA) Women's Preventive Services: Required Health Plan Coverage Guidelines. The Summary of Benefits indicates whether contraceptives are covered. If contraceptives are not covered, coverage will not be provided for any Prescription Drug or supply including all dosage forms of contraceptives.

These generic preventive Drugs are exempt from Deductibles, Copayments, and Coinsurance, when dispensed by a Participating Pharmacy.

In order to receive Covered Services, the Participant must present the Prescription and the Network Identification Card to a Participating Pharmacy and the claim must be filed by a Participating Pharmacy;

g. Nutritional Therapy

Nutritional therapy to promote a healthy diet is available to Participants, when provided by a licensed health care professional, up to the Maximum as indicated in the Summary of Benefits. Covered services are exempt from all Deductibles, Coinsurance and Copayments, when provided by Participating Providers.

Diabetes Outpatient self-management training and education and Nutritional Therapy provided to a Homebound Participant, as described in Medical Benefits section, are exempt from this Benefit Maximum.

Coverage for Dependent Children, who are covered under the Plan, will be provided as follows:

i. Dependent Children, ages two (2) through twelve (12), when accompanied by a parent; and
ii. Dependent Children, ages thirteen (13) through seventeen (17), with parental consent.

No coverage is provided for Dependent Children under the age of two (2);

25. Other Preventive Services

Preventive Services are covered, subject to Deductible and Coinsurance, that are not otherwise covered first dollar under ACA Preventive Care benefits. Covered services will not include genetic testing and/or counseling, unless related to BRCA screening, testing and/or counseling.

26. Retail Clinic Care

Covered services are provided for Retail Clinic Care visits and consultations rendered and billed by a Professional Provider to a Participant on an Outpatient basis or as indicated in the Summary of Benefits;

27. Routine Patient Costs for Participation in an Approved Clinical Trial.

Charges for any Medically Necessary services, for which benefits are provided by the Plan, when a Plan Participant is participating in an Approved a phase I, II, III or IV clinical trial, conducted in relation to the prevention, detection or treatment of a life-threatening Disease or condition, provided:

The Plan will not 1) deny a Qualified Individual participation in an Approved Clinical Trial, 2) deny (or limit or impose additional conditions on) coverage of Routine Patient Costs for items and services furnished in connection with the Approved Clinical Trial, or 3) discriminate against the Qualified Individual based on his/her participation in the Approved Clinical Trial. However, if the Plan has a Network of Providers and one or more Network Providers is participating in an Approved Clinical Trial, the Qualified Individual must participate in the Approved Clinical Trial through such Network Provider if the Provider will accept the Qualified Individual as a participant in the trial. This requirement to use Network Providers will not apply to a Qualified Individual participating in an Approved Clinical Trial that is conducted outside the state in which the Qualified Individual resides (unless the Plan does not otherwise provide In-Network coverage generally).

The following definitions are applicable under this provision:

Approved Clinical Trial

A phase I, phase II, phase III, or phase IV clinical trial that is conducted in relation to the prevention, detection, or treatment of cancer or other Life-Threatening Disease or Condition and is described in any of the following subparagraphs:

A. The study or investigation is approved or funded (which may include funding through in-kind contributions) by one or more of the following:

   1. The National Institutes of Health.
   2. The Centers for Disease Control and Prevention.
   3. The Agency for Health Care Research and Quality.
   4. The Centers for Medicare & Medicaid Services.
   5. A cooperative group or center of any of the entities described in clauses 1 through 4 above or the Department of Defense or the Department of Veterans Affairs.
   6. A qualified non-governmental research entity identified in the guidelines issued by the National Institutes of Health for center support grants.
   7. Any of the following entities in clauses 7a. through 7c. below if the following conditions are met: the study or investigation has been reviewed and approved through a system of peer review that the Secretary of Health and Human Services determines to be comparable to the system of peer review of studies and investigations used by the National Institutes of Health, and assures unbiased review of the highest scientific standards by qualified individuals who have no interest in the outcome of the review.
      a. The Department of Veterans Affairs.
      b. The Department of Defense.
      c. The Department of Energy.

B. The study or investigation is conducted under an Investigational new Drug application reviewed by the Food and Drug Administration.

C. The study or investigation is a Drug trial that is exempt from having such an Investigational new Drug application.

Routine Patient Costs

All items and services consistent with the coverage provided by the Plan that is typically covered for a Qualified Individual who is not enrolled in a clinical trial. However, Routine Patient Costs do not include:

- the Investigational item, device, or service, itself;
- items and services that are provided solely to satisfy data collection and analysis needs and that are not used in the direct clinical management of the patient; or
- a service that is clearly inconsistent with widely accepted and established standards of care for a particular Diagnosis.

Life-Threatening Disease or Condition

Any Disease or condition from which the likelihood of death is probable unless the course of the Disease or condition is interrupted.

28. Second Surgical Opinion

Second opinion consultations for Surgery to determine the Medical Necessity of an Elective Surgical Procedure are covered. Elective Surgery is Surgery that is not for an Emergency or life-threatening condition.

Such Covered Services must be performed and billed by a Professional Provider other than the one who initially recommended performing the Surgery;

29. Skilled Nursing Facility

Covered services are provided for care in a Skilled Nursing Facility, when determined to be Medically Necessary by the Plan, as indicated in the Summary of Benefits. The Participant must require treatment by skilled nursing personnel, which can be provided only on an Inpatient basis in a Skilled Nursing Facility. Pre-Certification procedures apply as set forth in the Cost Containment section.

The Participant's attending Physician must provide the Plan with clinical information that skilled nursing care in a Skilled Nursing Facility is Medically Necessary pursuant to the Cost Containment section.

No Covered Services are payable:

a. After the Participant has reached the maximum level of recovery possible for his or her particular condition and no longer requires definitive treatment other than routine Custodial Care;
b. When confinement in a Skilled Nursing Facility is intended solely to assist the Participant with the activities of daily living or to provide an Institutional environment for the convenience of a Participant; or
c. For the treatment of alcoholism, drug addiction, or mental Illness;

30. Surgery

a. Surgical Covered Services

Surgery Covered Services will be provided for services rendered by a Professional Provider and/or Facility Provider in a Physician’s office or in a short procedure unit, Hospital, Outpatient department, or Freestanding Outpatient Facility for the treatment of Disease or Injury. Separate payment will not be made for Inpatient pre-operative care or all post-operative care normally provided by the surgeon as part of the Surgical Procedure.

For questions concerning Pre-Certification, the Participant should refer to the Utilization Review Provisions section and/or contact the Medical Review Manager prior to the service being rendered.

i. Reconstructive Surgery will only be covered when required to restore function following Accidental Injury, infection, or Disease in order to achieve reasonable physical or bodily function; in connection with congenital Disease or anomaly through the age of eighteen (18) unless specifically stated as not covered in Exclusions; or in connection with the treatment of malignant tumors or other destructive pathology which causes functional impairment; or breast reconstruction following a Mastectomy;

ii. Covered services are provided for a Mastectomy performed on an Inpatient or Outpatient basis, and for the following:
   (1) Surgery to reestablish symmetry or alleviate functional impairment, including, but not limited to augmentation, mammoplasty, reduction mammoplasty and mastopexy;
   (2) Coverage for initial and subsequent Prosthetic devices to replace the removed breast or portions thereof, due to a Mastectomy; and
   (3) Physical complications of all stages of Mastectomy, including lymphedemas. Coverage is also provided for one (1) Home Health Care visit, as determined by the Participant's Physician, received within forty-eight (48) hours after discharge.
   (4) The orthodontic treatment of congenital cleft palates involving the maxillary arch, performed in conjunction with bone graft Surgery to correct the bony deficits associated with extremely wide clefts affecting the alveolus is covered.

iii. Gender Reassignment Surgery: Coverage will be provided for gender reassignment surgery as the same cost sharing as other surgical procedures, subject to medical necessity. This coverage is intended to comply with Section 1557 of the Affordable Care Act (ACA).

Surgical Coverage is limited to the following procedures: Bilateral mastectomy or breast reduction, Clitoroplasty, Hysterectomy, Labiaplasty, Laser or electrolysis hair removal in advance of genital reconstruction prescribed by a physician for the treatment of Gender Dysphoria, Metoidioplasty, Orchiectomy, Penectomy, Penile prosthesis, Phalloplasty, Salpingo-oophorectomy, Scrotoplasty, Testicular prostheses, Urethroplasty, Urethroplasty, Vaginectomy, Vaginoplasty, and Vulvectomy.

b. Assistant Surgeon

Covered services will be payable for services by an assistant surgeon who actively assists the operating surgeon in the performance of covered Surgery for a Participant. The condition of the Participant or the type of Surgery must require the active assistance of an assistant surgeon as determined by the Plan. Surgical assistance is not covered when performed by a Professional Provider who himself performs and bills for another Surgical Procedure during the same operative session. Covered Services of the assistant surgeon are limited to 20% of the Plan's Maximum Allowed Amount for the surgeon.

c. Physician, Hospital or Ambulatory Surgical Facility Charges for Dental Procedures or Dental Surgery.

Dental procedures are not covered as set forth in the Exclusions or as specified by the Plan Specific Exclusions. Covered services will be payable for Physician, Hospital or Ambulatory Surgical Facility charges in connection with dental procedures or dental Surgery performed in a Hospital or Ambulatory Surgical Facility under the following circumstances:

i. Adults with significant cognitive impairment;
ii. Participants with complex medical conditions, when performing the Surgery/procedure in any setting other than a Hospital or Ambulatory Surgical Facility would present an unacceptable risk to the patient's health; or
iii. When one of the following is present:
iv. It is a required part of a broader treatment plan requiring radiation of the head and/or neck.
v. There is non-dental Disease eroding or invading the maxilla and/or mandible, the treatment of which necessitates removal of the Participant's teeth.
vi. There is infection of the teeth and gums that places the Participant's health at risk if uncorrected prior to other Medically Necessary treatment such as but not limited to Chemotherapy or transplant.

d. Oral Surgery
Oral Surgery rendered by a Professional Provider and/or Facility Provider will be a covered service only for treatment of Diseases and injuries of the jaw, head, and neck. Surgery for the treatment of Diseases of the teeth or gums, are not covered as set forth in the Exclusions.

Surgical removal of teeth and procedures performed for the preparation of the mouth for dentures are excluded from Covered Services for oral Surgery unless such procedures were for the treatment of Accidental Bodily Injury;

e. Dental Services Related to Accidental Injury
Dental services rendered by a Professional Provider and/or a Facility Provider, as a result of Accidental Injury to the jaws, natural teeth, mouth, or face, are covered when performed for immediate post Injury stabilization. Injury as a result of chewing or biting shall not be considered an Accidental Injury.

Dental implants are excluded from benefits as set forth in the General and Medical Limitations and Exclusions;

31. Therapeutic Drugs That are Not Self-Administrable
Covered services are provided for FDA-approved therapeutic Drugs, including cancer Chemotherapy and cancer hormone treatment that are not self-administrable and required in the treatment of an Illness or Injury in all medically appropriate treatment settings covered by the Plan;

32. Therapy Services—Outpatient
Covered services shall be provided for the following services prescribed by a Physician and performed by a Professional Provider and/or Facility Provider, which are used in treatment of an Illness or Injury to promote recovery of the Participant.

a. Cardiac Rehabilitation Therapy is limited to a Maximum as indicated in the Summary of Benefits per Benefit Period;
b. Dialysis Treatment;
c. Pulmonary Rehabilitation Therapy is limited to a Maximum as indicated in the Summary of Benefits per Benefit Period;
d. Radiation Therapy, including the cost of radioactive materials; and
e. Respiratory Therapy is limited to a Maximum as indicated in the Summary of Benefits per Benefit Period.
f. Short term therapy is Occupational, Physical, or Speech Therapy which:
    i. Is prescribed by a Physician;

ii. Is Medically Necessary to regain lost function after an Accidental Injury, Surgery, or an acute Illness; and
iii. Will result in improvement in the Participant's condition within a period of three (3) months from the initiation of therapy.

Outpatient Occupational, Physical, and Speech Therapy Covered Services are limited to a Maximum as indicated in the Summary of Benefits per Benefit Period.

33. Infertility Services

The following services for Diagnosis and treatment of Infertility, including, but not limited to the below:

- Services of an embryologist;
- Drugs administered by a Provider;
- Surgeries and other therapeutic procedures to promote conception;
- Lab tests;
- Sperm washing or preparation;
- Artificial insemination;
- Diagnostic evaluations;
- Gamete intrafallopian transfer (GIFT);
- In Vitro Fertilization (IVF); and,
- Zygote intrafallopian transfer (ZIFT).

34. Transplant Surgery

If a human organ or tissue transplant is provided from a human donor to a human transplant recipient:

a. When both the recipient and the donor are Participants, each is entitled to the Covered Services of the Plan;
b. When only the recipient is a Participant, both the donor and the recipient are entitled to the Covered Services of the Plan. The donor Covered Services are limited to only those not provided or available to the donor from any other source. This includes but is not limited to other insurance coverage, or coverage by the organ procurement network or any government program. Covered services provided to the donor will be charged against the recipient's coverage under the Plan to the extent Covered Services remain and are available to the Participant after the Covered Services of the recipient have been paid;
c. When only the donor is a Participant, no services will be covered by the Plan.
d. If any organ or tissue is sold rather than donated to the Participant recipient, no benefits will be payable for the purchase price of such organ or tissue; however, other costs related to evaluation and procurement are covered up to the Participant recipient's Plan limit; and
e. If the Participant's coverage includes Prescription Drug coverage, the immunosuppressant Drugs in connection with covered transplants will be provided under the Prescription Drug Coverage section of the Plan and the cost for these Drugs is detailed in the Summary of Benefits.

Pre-Certification is required.

Designated Transplant Provider

This is a facility that is contracted to furnish particular services and supplies to You in connection with one or more highly specialized medical procedures. The Maximum Allowable Charge made by

the Designated Transplant Provider for such services and supplies will be the amount agreed to between the Plan and the Designated Transplant Provider.

Transplant Expenses:
Once it has been determined that You or one of Your Dependents may require an organ transplant, You, or Your Physician should call the Pre-Certification department to discuss coordination of Your transplant care. The Third-Party Administrator will coordinate all transplant services. In addition, You must follow any Pre-Certification requirements. Organ means solid organ; stem cell; bone marrow; and tissue.

While all organ/tissue transplants (other than cornea or skin transplants) are covered only under these provisions, benefits are only available if a Designated Transplant Provider facility is used. The Designated Transplant Provider must be specifically approved and designated by the Plan to perform the procedure You require. A transplant will be covered as Network care only if performed in a facility that has been designated as a Designated Transplant Provider for the type of transplant in question. Any treatment or service related to transplants that is provided by a facility that is not specified as a Designated Transplant Provider, even if the facility is considered as a Network facility for other types of services, will not be considered Network care and benefits will not be provided.

Covered Transplant Expenses:
Covered transplant expenses include the following:

- Charges for activating the donor search process with national registries.
- Compatibility testing of prospective organ donors who are Immediate Family members. For the purpose of this coverage, an "immediate" family member is defined as a first-degree biological relative. These are Your: biological parent, sibling, or Child(ren).
- Inpatient and Outpatient expenses directly related to a transplant.
- Charges made by a Physician or transplant team.
- Charges made by a Hospital, Outpatient facility or Physician for the medical and surgical expenses of a live donor, but only to the extent not covered by another plan or program.
- Related supplies and services provided by the Designated Transplant Provider facility during the transplant process. These services and supplies may include: physical, speech and occupational therapy; bio-medicals and immunosuppressants; Home Health Care expenses and Home Infusion services.

Covered transplant expenses are typically incurred during the four phases of transplant care described below. Expenses Incurred for one transplant during these four phases of care will be considered one Transplant Occurrence.

A Transplant Occurrence is considered to begin at the point of evaluation for a transplant and end either: (1) 180 days from the date of the transplant; or (2) upon the date You are discharged from the Hospital or Outpatient facility for the admission or visit(s) related to the transplant, whichever is later.

The four phases of one Transplant Occurrence and a summary of covered transplant expenses during each phase are:

1. Pre-transplant Evaluation/Screening: Includes all transplant-related professional and technical components required for assessment, evaluation, and acceptance into a transplant facility's transplant program.

2. Pre-transplant/Candidacy Screening: Includes HLA typing/compatibility testing of prospective organ donors who are Immediate Family members.
3. Transplant Event: Includes Inpatient and Outpatient services for all covered transplant-related health services and supplies provided to You and a donor during the one or more Surgical Procedures or medical therapies for a transplant; Prescription Drugs provided during Your Inpatient stay or Outpatient visit(s), including bio-medical and immunosuppressant Drugs; physical, speech or occupational therapy provided during Your Inpatient stay or Outpatient visit(s); cadaveric and live donor organ procurement.
4. Follow-up Care: Includes all covered transplant expenses; Home Health Care services; Home Infusion services; and transplant-related Outpatient services rendered within 180 days from the date of the transplant event.

For the purposes of this section, the following will be considered to be one Transplant Occurrence:
- Heart.
- Lung.
- Heart/Lung.
- Simultaneous Pancreas Kidney (SPK).
- Pancreas.
- Kidney.
- Liver.
- Intestine.
- Bone marrow/stem cell transplant.
- Multiple organs replaced during one transplant Surgery.
- Tandem transplants (stem cell).
- Sequential transplants.
- Re-transplant of same organ type within 180 days of the first transplant.
- Any other single organ transplant, unless otherwise excluded under the Plan.

The following will be considered to be more than one Transplant Occurrence:
- Autologous blood/bone marrow transplant followed by allogenic blood/bone marrow transplant (when not part of a tandem transplant).
- Allogenic blood/bone marrow transplant followed by an autologous blood/bone marrow transplant (when not part of a tandem transplant).
- Re-transplant after 180 days of the first transplant.
- Pancreas transplant following a kidney transplant.
- A transplant necessitated by an additional organ failure during the original transplant Surgery/process.
- More than one transplant when not performed as part of a planned tandem or sequential transplant (e.g., a liver transplant with subsequent heart transplant).

Limitations:
The transplant coverage does not include charges for:
- Outpatient Drugs including bio-medicals and immunosuppressants not expressly related to an Outpatient Transplant Occurrence.
- Services and supplies furnished to a donor when recipient is not a Covered Person.
- Home infusion therapy after the Transplant Occurrence.
- Harvesting or storage of organs, without the expectation of immediate transplantation for an existing Illness.
- Harvesting and/or storage of bone marrow, tissue, or stem cells without the expectation of transplantation within 12 months for an existing Illness.

- Cornea (corneal graft with amniotic membrane) or cartilage (autologous chondrocyte or autologous osteochondral mosaicplasty) transplants, unless otherwise authorized by the Plan.

Optional Travel & Lodging Expenses:

Distance Requirement:
The Designated Transplant Provider facility must be more than 100 miles from the patient's residence.

Travel Allowances:
Travel is reimbursed between the patient's home and the facility for round trip (air, train, or bus) transportation costs (coach class only). If traveling by auto to the facility, mileage, parking, and toll cost are reimbursed. Mileage Reimbursement is $0.18/mile.

Lodging Allowances:
Reimbursement of expenses Incurred by patient and companion for hotel lodging away from home is reimbursed at a rate of $50 per night per person (or $100 per night total).

Overall Maximum:
Travel & lodging reimbursement is limited to $10,000 for any one transplant or procedure type, including tandem transplants. This is a combined Maximum for the member, companion, and donor.

Companions:
Adult – 1 companion is permitted.
Child – 1 parent or guardian is permitted

35. Treatment for Alcohol and/or Drug Abuse and Dependency

Covered services are available to a Participant who is certified by a licensed Physician or licensed Psychologist as a person who requires Substance Abuse treatment. Certification and referral by a licensed Physician or licensed Psychologist control the nature and duration of treatment for Inpatient or Outpatient Substance Abuse treatment. The precertification must be provided to Medical Review Manager before claims for treatment rendered will be processed for payment.

Inpatient Detoxification, Inpatient Non-Hospital Residential Care and Intensive Outpatient requests for Alcohol or Drug Abuse treatment by non-Physicians/Psychologists must be pre-certified with Medical Review Manager before services are rendered and must meet Medical Necessity criteria.

a. Inpatient Detoxification
   Covered services are provided for Inpatient Detoxification when provided in either a Hospital or in an Inpatient Non-Hospital Residential Facility. The following services will be covered when administered by an employee of the facility:

   i. Lodging and dietary services;
   ii. Rehabilitation therapy and counseling;
   iii. Diagnostic x-ray;
   iv. Psychiatric, psychological, and medical laboratory testing; and
   v. Drugs, medicines, equipment use and supplies.

b. Inpatient Non-Hospital Residential Care

Covered services are provided for Inpatient Non-Hospital Residential Care in an Inpatient Non-Hospital Residential Facility.

The following services will be covered when administered by an employee of the facility:

i. Lodging and dietary services;
ii. Physician, Psychologist, nurse, certified addiction counselors and trained staff services;
iii. Rehabilitation therapy and counseling;
iv. Family counseling and intervention;
v. Psychiatric, psychological, and medical laboratory testing; and
vi. Drugs, medicines, equipment use and supplies.

c. Outpatient Facility Services for Treatment of Alcohol or Drug Abuse
Covered services are provided for Outpatient Alcohol and/or Drug Abuse services when provided in a Substance Abuse Treatment Center. The following services will be covered when administered by an employee of the facility:

i. Physician, Psychologist, nurse, certified addiction counselors and trained staff services;
ii. Rehabilitation therapy and counseling;
iii. Family counseling and intervention;
iv. Psychiatric, psychological, and medical laboratory testing; and
v. Drugs, medicines, equipment use and supplies.

36. Treatment for Autism Spectrum Disorders

Benefits are provided for all Participants under twenty-one (21) years of age for the following:

1. Diagnostic Assessment of Autism Spectrum Disorders
Medically Necessary and Appropriate assessments, evaluations or tests performed by a Physician, licensed Physician assistant, Psychologist, or certified Registered Nurse practitioner to diagnose whether an individual has an Autism Spectrum Disorder.

2. Treatment of Autism Spectrum Disorders
Services must be specified in a treatment plan developed by a Physician or Psychologist following a comprehensive evaluation or reevaluation performed in a manner consistent with the most recent clinical report of recommendation of the American Academy of Pediatrics. The Plan may review a Treatment Plan for Autism Spectrum Disorders once every six (6) months, or as agreed upon between the Plan and the Physician or Psychologist developing the treatment plan.

Treatment of Autism Spectrum Disorders may include the following Medically Necessary and Appropriate Services, subject to any applicable day limits or visit limits on Mental Health Services:

a. Pharmacy Care
Pharmacy care for Autism Spectrum Disorders includes any assessment, evaluation or test prescribed or ordered by a Physician, licensed Physician assistant, Psychologist, or certified Registered Nurse practitioner to determine the need or effectiveness of a Prescription Drug approved by the Food and Drug Administration and designated by the Plan for the treatment of Autism Spectrum Disorders.
b. Psychiatric and psychological care

Direct or consultative services provided by a Physician or Psychologist who specializes in psychiatry.

c. Rehabilitative care
   Professional services and treatment programs, including Applied Behavioral Analysis, provided by an Autism Service Provider to produce socially significant improvements in human behavior or to prevent loss of attained kill or function.
d. Therapeutic care
   Services that are provided by a speech language pathologist, Occupational Therapist or Physical Therapist.

37. Cellular and Gene Therapy

Covered services are provided for Cellular Therapy and Gene Therapy received on an inpatient or outpatient basis. Covered services include the cost of the therapy product, medical, surgical, and facility services directly related to administration of the therapy product, and professional services.

No coverage is provided unless preauthorized by the Medical Review Manager, deemed medically necessary, and performed at a Designated Cellular and Gene Therapy Provider. See the Transplants section for benefits for any covered CAR-T therapy.

38. Hearing Aids

Benefits are provided for hearing aids. These benefits are limited to a single purchase per hearing impaired ear every 3 years. Repair and/or replacement of a hearing aid would apply to this limit in the same manner as a purchase. Benefit for hearing aids are further subject to a $2,500 annual maximum.

SECTION 5: PRESCRIPTION DRUG BENEFITS

Schedule for Covered Pharmacy Services
Except for special circumstances described in the following section, Prescription Drugs dispensed by a Non-Participating Pharmacy are not covered. Covered Services will be provided for covered Prescription Drugs dispensed by a Participating Pharmacy in the amount specified in the Benefit Summary.

Only the Prescription Drugs listed on the Drug List, obtained through a Provider participating in the Pharmacy Network, and received in accordance with this section of the SPD will be considered Covered Charges. How Covered Charges are paid, and the Maximum benefit for the covered Prescription Drugs listed in this section, are shown in the Benefit Summary. Refer to the exclusions section of the SPD for Drugs, medications and supplies that are not covered under this Plan. The Covered Person must follow the applicable Prior Authorization requirements in the Utilization Review provisions section and use the Participating Pharmacy Network to receive the Maximum benefits available under this Plan.

After the Covered Person has paid any applicable Ancillary Charge, Ancillary Pharmacy Network Charge, Coinsurance, Copayment, Deductible, Prescription Drug Coinsurance, Prescription Drug Copayment, Prescription Drug Deductible, or any other applicable fees, benefits will be paid by the Plan for Covered Charges for Outpatient Prescription Drugs listed in this section of the SPD. Any applicable Coinsurance, Copayment, Deductible Prescription Drug Coinsurance, Prescription Drug Copayment, Prescription Drug Deductible, or other fees, and the Prescription Drug Class to which they apply are shown in the Benefit Summary.

Benefits paid under this section are subject to any Maximum Benefit for Prescription Drugs provided under this Plan. Benefits are subject to all the terms, limits, and conditions in this SPD. Any Ancillary Charge, or Ancillary Pharmacy Network Charge, under this section will not apply toward satisfying any Coinsurance, Copayment, Deductible or Out-of-Pocket Limit under this Plan.

Unless a Prescription Drug is specifically listed as a Covered Charge in the Medical Benefits section, all Prescription Drugs that are received on an Outpatient basis are considered for benefits under the Outpatient Prescription Drug Benefits section. Any amount in excess of the Maximum amount provided under this section is not covered under any other section of this SPD. Expenses Incurred under this section apply toward any applicable Out-of-Pocket Limits under this SPD, as shown in the Benefit Summary.

Prior authorization may be required for certain Prescription Drugs before they are considered for coverage under the Outpatient Prescription Drug Benefits section. Please access the Pharmacy benefit website listed on your Identification (ID) Card to receive information on which Prescription Drugs require Prior Authorization, to check Prescription Drug coverage and pricing, or to locate a Participating Pharmacy.

There may be a Copayment specific to self-administrable Prescription Drugs and supplies. The Prescription Drug Copayment, payable directly to the Participating Pharmacy or to a Participating Mail Order Pharmacy for Maintenance Prescription Drugs, is outlined in the Prescription Drug Benefit Summary. This Prescription Drug Copayment is not subject to the Coinsurance limitation for Covered Services set forth in the Medical Benefits section.

Retail and Mail Order Prescription Drugs Benefits

Covered Services will be provided for covered Prescription Drugs dispensed by a Participating Pharmacy in the amounts specified in the Prescription Drug Benefit Summary, as follows:

1. Covered Drugs/supplies include: (a) Prescription Drugs which can be self-administered, including contraceptives for the use of birth control, if so specified in the Summary of Benefits, (b) insulin, (c) disposable syringes/needles for the administration of covered Prescription Drugs and insulin, (d) lancets, (e) glucose test strips, sensors, (f) spacer devices for use with metered-dose inhalers, (g) peak flow meters, (h) other Drugs/supplies which may be specifically designated by the Plan, and (i) the covered pharmaceutical services necessary to make such Drugs available, not including, however, any Drug or group of Drugs specifically excluded by the terms of the Plan;

2. Supply limits:
   a. Each Prescription Drug is limited to a thirty (30) day supply based on the Prescriber's directions for use and further subject to the quantity limits authorized by the Prescriber on the Prescription Order, Maximum daily dosages as indicated in the Drug information literature, and/or quantity limits allowed by the Plan; and
   b. Each Maintenance Prescription Drug is limited to a ninety (90) day supply based on the Prescriber's directions for use and further subject to the quantity limits authorized by the Prescriber on the Prescription Order, Maximum daily dosages as indicated in the Drug information literature, and/or quantity limits allowed by the Plan;

3. Prescriptions are refillable for a period not in excess of one (1) year from the date written and further subject to refill limitations as set forth in federal and/or state law or by the Prescriber;

4. Unless the Prescriber or Pharmacist has requested and received Prior Authorization for an early refill, the claim will be denied if a refill is requested before the time seventy-five percent (75%) of the days' supply of medication has passed. An early refill Prior Authorization can be granted for an additional supply for reasons such as vacation or business travel. A Participating Pharmacy may receive authorization by telephone to fill the Prescription early on a one-time-only basis any time before the next regular refill due-date;

5. In order to receive Covered Services, the Participant must present the Network Identification Card to a Participating Pharmacy and the claim must be filed by a Participating Pharmacy, except in special circumstances and such other situations as deemed appropriate by the Plan. In special circumstances, such as when a Participant needs an unexpected Prescription when beyond a reasonable distance from a Participating Pharmacy, while vacationing or traveling Out-of-Area, inaccessibility to a Participating Pharmacy, inaccessibility of the Network electronic claims/eligibility systems, or for urgent or Emergency needs, the Participant may request reimbursement for purchased Prescriptions from the Plan. Reimbursement will not be in excess of the amount which would otherwise have been payable to a Participating Pharmacy for the Prescription Drug, less the Copayment. Such requests are subject to a filing limit of one (1) year from the date of purchase. If the Network Identification Card is not used to obtain Prescription Drugs at a Participating Pharmacy, the Covered Person must pay the Participating Pharmacy the entire amount charged for the covered Prescription Drug. Complete a Prescription Drug claim form. Send it and any Prescription Drug receipts to the Prescription Card Service Administrator (PCSA) at the address shown on the form for reimbursement of Covered Charges. A Prescription Drug claim form can be obtained from the Plan.; and

6. All Prescription Drug claims are subject to prospective, concurrent and/or retrospective Drug utilization review by health care professionals, and further may require Prior Authorization to determine if a Prescription Drug is Medically Necessary. In the event the Prior Authorization is denied for lack of Medical Necessity, no benefits will be provided by the Plan when the Participant disregards the Prior Authorization denial and elects to purchase the Prescription Drug. Should a Prescription Drug, which requires Prior Authorization, be presented to a Participating Pharmacy without Prior Authorization, the Participating Pharmacy will advise the Participant prospectively that the claim was denied by the Plan because Prior Authorization is required for coverage of the Prescription Drug.

No Covered Services will be provided by the Plan when the Participant elects not to have the Participating Prescriber obtain Prior Authorization, disregards the Participating Pharmacy's notification of the claim denial and elects to purchase the Prescription Drug.

Miscellaneous Provisions
The amount paid by the Plan under this section may not reflect the ultimate cost for the Prescription Drug. Any amounts that the Covered Person is responsible for paying are paid on a per Prescription or refill basis and will not be adjusted if any retrospective volume Drug discounts or Prescription Drug rebates under any portion of this Plan are received.

Manufacturer product discounts, also known as rebates, may be provided, and may be related to certain Drug purchases under this Plan. These amounts will not be refunded to You. These rebates are not considered in calculating any co-payments or Coinsurance under the Plan. The Plan Sponsor applies these rebates toward Plan expenses.

Payment by the Plan for a Prescription Drug under this section does not constitute any assumption of liability for coverage of a Sickness or an Injury under the Medical Benefits section. It also does not constitute any assumption of liability for further coverage of the Prescription Drug under this section. For the purpose of the Coordination Of Benefits section, the Outpatient Prescription Drug Benefits section will be considered a separate medical plan, as defined in the Coordination Of Benefit section, and will be coordinated only with other Prescription Drug coverage. We will not provide any benefits for Prescription Drug charges that are paid by another medical plan defined in the Coordination Of Benefit section as the primary payor.

The Covered Person is responsible for any Prescription Drug Coinsurance, Coinsurance, Prescription Drug Copayment, Prescription Drug Deductible, and/or Deductible that is paid for a Prescription Order that is filled, regardless of whether the Prescription Order is revoked or changed due to adverse reaction or changes in dosage, dosage regimen, or Prescription Order. These charges will not be reimbursed by the Plan.

SECTION 6: EXCLUSIONS

The Plan does not pay Benefits for the following services, treatments or supplies even if they are recommended or prescribed by a Provider or are the only available treatment for your condition or are Medically Necessary.

Please note that in listing services or examples, when the SPD indicates "this includes," or "including but not limited to", it is not the intent to limit the description to that specific list. When the Plan does intend to limit a list of services or examples, the SPD specifically states that the list "is limited to".

Alternative Treatments
Alternative treatment as defined by the National Center for Complementary and Integrative Health (NCCIH) of the National Institutes of Health.

This includes but is not limited to Acupuncture; Acupressure; Aromatherapy; Herbal, vitamin or dietary products or therapies; Holistic medicine; Homeopathic medicine; Massage therapy; Naturopathy; Neurofeedback or Biofeedback; Rolfing; Adventure based therapy, wilderness therapy and outdoor therapy, or similar programs; and Art therapy, music therapy, dance therapy, and horseback therapy, or similar programs.

Dental
Dental care which includes dental X-rays, supplies and appliances and all related expenses, including hospitalizations and anesthesia.

- Endodontics, periodontal Surgery, and restorative treatment.
- Preventive care, Diagnosis, treatment of or related to the teeth, jawbones, or gums.
- Dental implants, bone grafts, and other implant-related procedures.
- Dental braces (orthodontics).
- Treatment of Temporomandibular Joint Dysfunction and Craniomandibular Joint Dysfunction, including diagnostic testing.
- Fixed or removable appliances that move or reposition the teeth, fillings, or Prosthetics (i.e. crowns, bridges, dentures).
- Surgery of the jaw (orthognathic).
- Treatment of congenitally missing, malpositioned, or supernumerary teeth, even if part of a congenital anomaly.
- Dental Services Related to Early Childhood Caries (ECC).
- Prevention or correction of teeth irregularities, including removal of impacted teeth and malocclusion of jaws by wire appliances, braces or other mechanical aids, or any other care, repair, removal, replacement, or treatment of or to the teeth or any surrounding tissues.
- Extraction of teeth, Surgery for impacted teeth and other oral surgeries to treat the teeth or bones and gums directly supporting the teeth, for which benefits are provided as described in this SPD.
- Dental care that is required to treat the effects of a medical condition, but that is not needed to directly treat the medical condition. Examples include treatment of tooth decay or cavities resulting from dry mouth after radiation treatment or due to medication.

These dental exclusions do not apply to Accident-related dental services for which benefits are provided as described in this SPD. These dental exclusions do not apply to dental care (oral exam, X-rays, extractions, and non-surgical elimination of oral infection) required for the direct treatment of a medical condition for which for which benefits are provided as described in this SPD.

Devices, Appliances and Prosthetics

- Devices used as safety items or to help performance in sports–related activities, splints or braces for non-medical purposes and Prosthetics for sports or Cosmetic purposes.
- Orthotic appliances that straighten or re-shape a body part.
- The following items are excluded, even if prescribed by a Physician: Blood pressure cuff/monitor; Enuresis alarm; Home coagulation testing equipment; Non-wearable external defibrillator; Trusses; Ultrasonic nebulizers; and Ventricular assist devices.
- Devices and computers to help in communication and speech except for speech aid Prosthetics and trachea-esophageal voice Prosthetics.
- Repair or replacement of Prosthetic devices due to misuse, malicious damage, or gross neglect or to replace lost or stolen items.
- Replacement or repair of purchased or rental equipment because of misuse, abuse, or loss/theft.
- Surgical supports, corsets, or articles of clothing unless needed to recover from Surgery or Injury.
- Non-Medically Necessary enhancements to standard equipment and devices.
- Diagnostic or monitoring equipment purchased for home use, unless otherwise described as a Covered Service.

Prescription Drugs

- Charges for Prescription Drugs, medications, or other substances dispensed or administered in an Outpatient setting that are filled by a Prescription order or refill.
- Non-injectable medications given in a Physician's office.
- Over-the-counter Drugs and treatments.
- Certain new pharmaceutical products and/or new dosage forms until the date as determined by the Third-Party Administrator or the Third-Party Administrator's designee, but no later than December 31st of the following calendar year.
- Benefits for pharmaceutical products for the amount dispensed (days' supply or quantity limit) which exceeds the supply limit.
- Charges for any injectable medications or Specialty Pharmaceuticals that are not specifically preauthorized by the Plan.
- Specialty Drugs, unless covered by Your Plan under Medical Benefits. Please refer to the Benefit Summary to determine if your Plan covers Specialty Drugs.
- Charges for the administration of any Drug except immunizations as approved by us, or any ancillary or administrative charges for any other Drugs.
- Certain Prescription Drugs may not be covered if you could use a clinically equivalent Drug, unless required by law. “Clinically equivalent” means Drugs that for most Participants, will give you similar results for a Disease or condition. If you have questions about whether a certain Drug is covered and which Drugs fall into this group, please call the number on the back of your Identification Card or visit our website at www.mycigna.com. If you or your doctor believes you need to use a different Prescription Drug, please have your doctor or Pharmacist get in touch with us. The Plan will cover the other Prescription Drug only if we agree that it is Medically Necessary and appropriate over the clinically equivalent Drug. The Plan will review benefits for the Prescription Drug from time to time to make sure the Drug is still Medically Necessary.
- Compound Drugs unless all of the ingredients are FDA approved, require a Prescription to dispense, and the Compound Medication is not essentially the same as an FDA-approved product from a Drug manufacturer.
- Charges for delivery of Prescription Drugs including charges for postage, handling, and shipping charges for any Drugs.
- Charges for Drugs that are dispensed at or by a Provider's office, clinic, Hospital, or other non-Pharmacy setting for take home by the Participant.

- Drugs not on the Drug List (a Formulary). You can get a copy of the list by calling us or visiting our website at www.mycigna.com.
- Charges for Drugs that are provided by, or obtained through, a Pharmacy that is not identified for this plan as a Participating Pharmacy or Specialty Pharmacy Provider.
- Drugs which are over any quantity or age limits set by us.
- Except as described under a Prescription Order, charges for devices or supplies including, but not limited to:
  - Blood/urine/glucose/acetone testing devices, needles, and syringes.
  - Support garments.
  - Bandages.
  - Other non-medical items, regardless of intended use.
- Any charge for administration of injectable insulin.
- Drugs that do not need a Prescription by federal law (including Drugs that need a Prescription by state law, but not by federal law), except for injectable insulin.
- Any treatment, device, Drug, service, or supply (including Surgical Procedures, devices to stimulate growth and growth hormones), solely to increase or decrease height or alter the rate of growth.
- Therapeutic DME, devices and supplies except peak flow meters, spacers, and glucose monitors.
- Charges for: duplicate Prescriptions; replacement of lost, stolen, destroyed, spilled, or damaged Prescriptions; Prescriptions refilled more frequently than the prescribed dosage indicates.
- Prescription Drugs dispensed by any Mail Order Provider other than the Designated Mail Order Provider unless we must cover them by law.
- Drugs not approved by the FDA.
- Nutritional and/or dietary supplements, except as described in this SPD or that we must cover by law.
- Charges for vitamins and/or vitamin combinations even if they are prescribed by a doctor except for legend prenatal vitamin Prescription Drugs when the prenatal vitamins are prescribed during Pregnancy, clinically proven vitamin deficiency syndromes that cannot be corrected by dietary intake, vitamins covered in accordance with the preventive medicine benefits as described in this SPD.
- Off label use, unless we must cover the use by law or if we approve it.
- Drugs for Onychomycosis (toenail fungus) except when we allow it to treat for Participants who are immuno-compromised or diabetic.
- Drugs, devices and products, or Prescription Drugs with over-the-counter equivalents and any Drugs, devices or products that are therapeutically comparable to an over-the-counter Drug, device, or product may not be covered, even if written as a Prescription.
- Hypodermic syringes except when given for use with insulin and other covered self-injectable Drugs and medicine.
- Charges for vaccines and other immunizing agents, except as covered under the Clinical Preventive Services or Preventive Medicine Services provisions of the Medical Benefits section
- Biological sera; blood or blood products.
- Charges for Drugs used to treat, impact or influence: obesity; Morbid Obesity; weight management; sexual function, dysfunction, or inadequacy; sexual energy, performance, or desire; skin coloring or pigmentation; slowing the normal processes of aging; memory improvement or cognitive enhancement; daytime drowsiness; dry mouth; excessive salivation; or hyperhidrosis (excessive sweating).
- Charges for DDAVP (desmopressin acetate) or other Drugs used in the treatment of nocturnal enuresis (bedwetting) for a Participant under the age of 8.

- Charges for Drugs used to treat, impact or influence quality of life or lifestyle concerns including, but not limited to: athletic performance; body conditioning, strengthening, or energy; prevention or treatment of hair loss; prevention or treatment of excessive hair growth or abnormal hair patterns.
- Medications for complexion or acne if the Participant is over 30 years of age.
- Charges for any Drug used for cosmetic services, as determined by us or botulinum toxin and its derivatives.
- Charges for Drugs for which Prior Authorization is required by and is not obtained.
- Charges for Prescription Drugs or supplies requiring injectable parenteral administration or use, except insulin, unless authorized by the Plan under the Outpatient Prescription Drug Benefits section before they are dispensed.
- Charges for any injectable Prescription Drugs or unless authorized by the Plan under this Outpatient Prescription Drug Benefits section before they are dispensed.
- Charges Incurred outside of the United States for Drugs; charges for Drugs obtained from Pharmacy Provider sources outside the United States, except for covered charges that are received for Emergency treatment or as otherwise pre-authorized by the Plan.
- Anti-smoking aids, including but not limited to Nicorette, Nicaderm, and Habitrol.
- Marijuana, even if they are prescribed for a medical use in a state. This includes, but is not limited to, items dispensed by a Physician.
- Charges for Drugs and medicines prescribed for treatment of a Sickness or an Injury that is not covered under this Plan.
- Specialty Drugs.

Experimental or Investigational Services or Unproven Services

- Experimental or Investigational services and unproven services and all services related to Experimental or Investigational services and unproven services are excluded. The fact that an Experimental or Investigational services and unproven service, treatment, device, or pharmacological regimen is the only available treatment for a particular condition will not result in benefits if the procedure is considered to be Experimental or Investigational or unproven in the treatment of that particular condition.
- Treatment not deemed clinically acceptable by (1) the National Institute of Health; or (2) the FDA; or (3) the Centers for Medicare and Medicaid Services (CMS); or (4) the AMA; or a similar national medical organization of the United States.
- This exclusion does not apply to covered health care services provided during a clinical trial for which benefits are provided as described in this SPD.
- Charges for any complications or other expenses arising from Experimental or Investigational services or treatment.

Foot Care

- Routine foot care. Examples include but are not limited to the cutting or removal of corns or calluses, and nail trimming, cutting, or debriding toenails. This exclusion does not apply to preventive foot care if you have diabetes, or in the treatment of a peripheral-vascular Disease when recommended by a medical doctor or doctor of osteopathy.
- Foot supportive devices, including orthotics, arch supports, shoes, and shoe inserts, except those included as part of a Medically Necessary orthopedic brace.

Hearing

- Hearing care that is routine, except as described in this SPD.
- Any artificial hearing device, cochlear implant, auditory Prostheses, or other electrical, digital, mechanical, or surgical means of enhancing, creating, or restoring auditory comprehension, other than a hearing aid.

Mental Health Care and Substance-Related and Addictive Services
In addition to all other exclusions, the exclusions listed directly below apply to mental health care and substance-related and addictive services.

- Outside of an initial assessment, services treatments for a primary Diagnosis of conditions and problems that may be a focus of clinical attention but are specifically noted not to be mental disorders within the current edition of the Diagnostic and Statistical Manual of the American Psychiatric Association or conditions not classified in the current edition of the International Classification of Diseases section on Mental and Behavioral Disorders
- Outside of initial assessment, services as treatments for the primary diagnoses of learning disabilities, conduct and impulse control disorders, pyromania, kleptomania, gambling disorder, and paraphilic disorder.
- For counseling pertaining to developmental delay, learning deficiencies, or behavioral problems unless the Diagnosis is listed in the Diagnostic and Statistical Manual of Mental Disorders published by the American Psychiatric Association that is current as of the date services are rendered, and the treatment provided, and the Provider of such treatment is not excluded under any other provisions of the Plan.
- Transitional Living Services.
- Charges for chelation therapy, except for laboratory proven toxic states as defined by peer-reviewed published studies and as approved by the Food and Drug Administration.
- Services and supplies related to narcotic maintenance for narcotic addiction.
- Charges for Services to address behavioral (conduct) problems; Services to build communication or social interaction or protocol skills; Services to address learning disabilities; Educational testing, training, or materials; Services to address cognitive enhancement, learning or training and Training for activities of daily living.
- Applied Behavioral Treatment (including, but not limited to, Applied Behavior Analysis and Intensive Behavior Interventions). This exclusion does not apply as related to treatment of Autism Spectrum Disorder(s).
- The following Exclusions apply to Autism: Services that are not Evidence-Based; Acupuncture; Animal-based therapy including hippotherapy; Auditory integration training; Chelation therapy; child care fees; Cranial sacral therapy; Custodial or Respite Care; Hyperbaric oxygen therapy; Special diets or supplements; Travel time by Qualified Providers, Qualified Supervising Providers, Qualified Professionals, Therapists or Qualified Paraprofessionals; Costs for the facility or location, or for the use of a facility or location, when treatment, therapy or services are provided outside of a Participant's home; Claims we have determined are fraudulent; and Treatment provided by parents or legal guardians who are otherwise Qualified Providers, Qualified Supervising Providers, Therapists, Qualified Professionals or Paraprofessionals.

Nutrition
- Individual and group nutritional counseling including nonspecific nutritional education such as general good eating habits, calorie control or dietary preferences.
- Food of any kind including modified food products such as low protein and low carbohydrate; enteral formula (including when administered using a pump), infant formula, and donor breast milk.
- Nutritional therapy using high dose or mega quantities of vitamins, minerals or elements, and other nutrition–based therapy.

- Any product, for which the primary use is a source of nutrition, nutritional supplements, or dietary management of Disease, and Prescription medical food products even when used for the treatment of sickness or Injury.
- Nutritional or dietary supplements, except as described in this SPD or that we must cover by law. This exclusion includes, but is not limited to, nutritional formulas and dietary supplements that you can buy over the counter and those you can get without a written Prescription.

Personal Care, Comfort or Convenience and Mobile/Wearable Devices

- Charges to address quality of life or lifestyle concerns and similar charges for non-functional conditions.
- Residential accommodations to treat medical or behavioral health conditions, except when provided in a Hospital, Hospice, Skilled Nursing Facility, or Residential Treatment Facility.
- Residential, auto, or place of business structural changes.
- Consumer wearable / personal mobile devices (such as a smart phone, smart watch, or other personal tracking devices), including any software or applications.
- Television; Telephone; Beauty/barber service; and Guest services.
- Supplies, equipment and similar incidental services and supplies for personal comfort. Examples include but are not limited to: Air conditioners; Air purifiers and filters; Batteries and battery chargers; Blood pressure kits; Car seats; Chairs, bath chairs, feeding chairs, toddler chairs, chair lifts, recliners; Dehumidifiers; Electric scooters; Elevators; Escalators; Exercise equipment; First aid supplies and other items kept in the home for general use (bandages, cotton-tipped applicators, thermometers, petroleum jelly, tape, non-sterile gloves, heating pads); Home modifications such as elevators, handrails and ramps; Home workout or therapy equipment, including treadmills and home gyms; Hot tubs; Humidifiers; Jacuzzis; Mattresses; Medical alert systems; Motorized beds; Music devices; Personal computers; Pillows; Pools, whirlpools, spas, or hydrotherapy equipment; Power-operated vehicles; Radios; Raised toilet seats; Safety equipment; Saunas; Shower chairs; Speech generating devices or aids for non-verbal communication; Sports helmets; Stair lifts and stair glides; Steam rooms; Strollers; Swimming pools; Vehicle modifications such as van lifts; Video players; Water purifiers; and Waterbeds.

Physical Appearance

- For charges in connection with cosmetic Surgery or treatment, except to correct deformities resulting from injuries sustained in an Accident; or due to an Illness such as breast cancer; or unless treatment is for correction of a functional abnormal congenital condition.
- Treatment of varicose veins or telangiectatic dermal veins by any method for cosmetic purposes.
- Treatment of abnormal breast enlargement in males (benign gynecomastia).
- Pharmacological regimens, nutritional procedures, or treatments.
- Scar or tattoo removal or revision procedures.
- Skin abrasion procedures performed as a treatment for acne.
- Treatment for skin wrinkles or any treatment to improve the appearance of the skin.
- Breast implants or replacement of an existing breast implant if the earlier breast implant was performed as a cosmetic procedure. Note: Replacement of an existing breast implant is considered reconstructive if the first breast implant followed Mastectomy.
- Physical conditioning programs such as athletic training, bodybuilding, exercise, fitness, or flexibility.
- Weight loss programs whether or not they are under medical supervision. Weight loss programs for medical reasons are also excluded.
- Cosmetic Treatments, including but not limited to the following: Abdominoplasty; Blepharoplasty; Breast enlargement, including augmentation mammoplasty and breast implants; Body contouring, such as lipoplasty; Brow lift; Calf implants; Cheek, chin, and nose implants; Dermal or chemo

abrasion or peels; Injection of fillers or neurotoxins; Face lift, forehead lift, or neck tightening; Facial bone remodeling for facial feminizations; Hair removal; Hair transplantation; Lift, stretch or reduction of abdomen, buttocks, thighs or upper arm; Lip augmentation; Lip reduction; Liposuction; Mastopexy; Otoplasty; Pectoral implants for chest masculinization; Rhinoplasty; Scar revision; Silicone injections to any part of the body; Skin resurfacing; Thyroid cartilage reduction, reduction thyroid chondroplasty or trachea shave; Voice modification Surgery and Voice lessons and voice therapy.

Procedures and Treatments

- Circumcision for males over the age of 1 years old.
- Removal of hanging skin on any part of the body. Examples include plastic Surgery procedures called abdominoplasty, panniculectomy, and brachioplasty.
- Medical and surgical treatment of excessive sweating (hyperhidrosis).
- Surgical and non-surgical for orthognathic and jaw alignment disorders, except as a treatment of obstructive sleep apnea.
- Speech therapy except as required for treatment of a speech impediment or speech dysfunction that results from Injury, stroke, cancer, or congenital anomaly.
- Biofeedback.
- Upper and lower jawbone Surgery except as required for direct treatment of sudden traumatic Injury, dislocation, tumors, or cancer.
- Surgical and non-surgical treatment of obesity. This includes but is not limited to: Roux-en-Y (RNY) Surgery, laparoscopic gastric bypass Surgery, or other gastric bypass Surgery, or gastric banding procedures.
- All Surgical Procedures for creation, reconstruction, repair, or reversal of gastric or jejunoileal bypass, and any complications associated with any such treatments or procedures.
- For procedures, devices, regimens, treatments, therapies, services, or products, including anorectics or any Drugs used for weight control, nutrition-based therapy and counseling for weight reduction or weight control.
- Stand-alone multi-disciplinary smoking cessation programs.
- For “nicotine patches”, any Drug containing nicotine for the purpose of use as a smoking deterrent, or other smoking deterrent medications or other forms of anti-smoking medication (except as covered under the Prescription Drug benefit).
- Helicobacter pylori (H. pylori) serologic testing.
- Intracellular micronutrient testing.
- Charges for Cellular or Gene Therapy services rendered by a Provider that is not a Designated Cellular and Gene Therapy Provider or that are not authorized by the Medical Review Manager before services are rendered.
- For genetic testing and counseling, services, and related procedures for screening purposes, except for BRCA screening, counseling, and testing in accordance with USPSTF A and B recommendations.
- Autopsies and post-mortem testing.

Providers

- Services prescribed, ordered, referred by or given by a Physician, Registered Nurse (R.N.), or a Licensed Practical Nurse (L.P.N) who is a family Participant by birth, marriage, or legal adoption to either the Participant or a Spouse. Examples include a Spouse, brother, sister, parent, or Child(ren). This includes any service the Provider may perform on himself or herself.
- Services performed by a Provider with your same legal address.
- Stand-by charges of a doctor or other Provider.
- Charges for specimen collection and lab handling fees.
- Services rendered by Hospital resident doctors or interns that are billed separately.

- Services provided at a free-standing or Hospital-based diagnostic facility without an order written by a Physician or other Provider.
- Foreign language and sign language interpreters.
- Charges for treatment, services, supplies or Drugs provided by or through any entity in which a Participant or their family Participant receives, or is entitled to receive, any direct or indirect financial benefit, including but not limited to an ownership interest in any such entity.
- Services from providers that are not licensed by law to provide covered benefits as described in this SPD. Examples include, but are not limited to, rolfers, masseurs or masseuses (massage therapists), and physical therapist technicians.
- Any service, Drug, Drug regimen, treatment, or supply, furnished, ordered, or prescribed by a Provider identified as an excluded individual or entity on the U.S. Department of Health and Human Services Office of Inspector General List of Excluded Individuals/Entities (OIG List), the General Services Administration System for Award Management (GSA List), State Medicaid exclusion lists, or other exclusion/sanctioned lists as published by Federal or State regulatory agencies. This exclusion does not apply to Emergency care.

Reproduction

- Umbilical cord stem cell, or other blood component, harvest, and storage in the absence of sickness or Injury.
- Male sterilization or the reversal of voluntary sterilization including reconstruction of vasectomy or reconstruction of tubal ligation.
- Penile implants.
- Charges for elective caesarean section.

Services Provided under another Plan

- For or in connection with an Injury, Sickness, or Illness for which the Employee or Dependent is entitled to benefits under any Workers' Compensation, Occupational Disease, or similar law even when the Participant does not file a claim for benefits and whether or not you get payments from any third party.
- For care and treatment of an Injury, Sickness or Illness arising out of, or during any employment for wage or profit.
- Services resulting from Accidental bodily injuries arising out of a motor vehicle Accident to the extent the services are payable under a medical expense payment provision of an automobile insurance policy.
- Health care services for treatment of military service-related disabilities when you are legally entitled to other coverage and facilities are reasonably available to you.
- Health care services while on active military duty.
- Physical exams required for enrollment in any insurance program, as a condition of employment, for licensing, sports programs, or for other purposes, which are not required by law under the Preventive Care benefit.
- Charges that are: Payable or reimbursable by Medicare Part A, Part B or Part D, where permitted by law; Payable or reimbursable by any other government law or program, except Medicaid (Medi-Cal in California); For free treatment provided in a federal, veteran's, state, or municipal medical facility; For free services provided in a student health center; For services that a Participant has no legal obligation to pay or for which no charge would be made if the Participant did not have a health plan or insurance coverage; Treatment, services, supplies or Drugs provided by a medical department,

treatment center, or clinic operated by or sponsored by a Participant's Employer; Services during a jail or prison sentence; and for services provided by or through a school system.

Sexual Dysfunction

- Treatment, therapies, Drugs, services, supplies or devices for the restoration or enhancement of sexual activity or for sexual dysfunction or for sexual inadequacy, including implants and related hormone treatment, regardless of underlying causes.
- Treatment to enhance, restore or improve sexual energy, performance, or desire.

Transplants

- Health care services connected with the removal of an organ or tissue from you for purposes of a transplant to another person.
- Health care services for transplants involving animal organs.
- Transplant services that are not performed at a designated facility. This exclusion does not apply to corneal transplants.
- For charges for any transplant not approved for Medicare coverage on the date the Transplant is performed.
- For any organ which is sold rather than donated to the Participant.

Travel

- For charges Incurred outside the United States if travel to such a location was for the primary purpose of obtaining Medical Services, Drugs, or supplies.
- For charges Incurred by individuals who are US Citizens and are assigned outside of the US or traveling outside of the US, except in Emergency situations.
- Travel or transportation expenses, even though prescribed by a Physician. This exclusion does not apply to ambulance transportation or to travel for transplantation services.
- Mileage, lodging, meals, and other Participant-related travel costs except as described in this plan.
- Physical exams and immunizations required for travel outside the United States, x-rays or tests not related to Diagnosis or treatment of sickness or Injury.

Types of Care

- Multi–disciplinary pain management programs provided on an Inpatient basis.
- Custodial Care. This exclusion does not apply to Hospice services.
- Services given in a home setting by Registered Nurses and other health workers who are not employees of or working under an approved arrangement with a Home Health Care Provider.
- Food, housing, homemaker services and home delivered meals.
- Provider administrative expenses including, but not limited to expenses for claim filing, contacting utilization review organizations, or case management fees.
- Domiciliary care.
- Phone consultations; internet consultations; e-mail consultations, except for Telehealth (virtual) visits as described in this SPD.
- Texting or chat services
- Rehabilitative treatment given when no further gains are clear or likely to occur.
- Charges for prophylactic treatment, services, or Surgery including, but not limited to prophylactic Mastectomy; or, any other treatment, services, or Surgery performed to prevent a Disease process from becoming evident in the organ or tissue at a later date. This does not apply to prophylactic Mastectomy/hysterectomy (oophorectomy) if the Participant has tested positive for BRCA gene, and the Participant meets the Plan's medical policies for prophylactic treatment.
- Services, supplies or Room and Board for teaching, vocational, or self-training purposes where the primary focus of the program is educational in nature rather than treatment based.

- Private Duty nursing.
- Respite care.
- Rest care or cures.
- Services of personal care aides.
- Work hardening (treatment programs designed to return a person to work or to prepare a person for specific work) or transitional living programs.
- Sales tax or gross receipt tax.
- Charges for services not described in your medical records.

Vision

- Routine vision exams, including refractive exams to determine the need for vision correction, except for diabetic benefits as described in this SPD.
- Cost and fitting charge for eyeglasses, eyeglass frames, corrective lenses, and contact lenses for vision correction or for cosmetic purposes.
- Safety glasses, Sunglasses and orthoptics, visual training, vision exercises, or vision therapy.
- Implantable lenses used only to fix a refractive error.
- Eye exercise therapy or vision therapy.
- Surgery that is intended to allow you to see better without glasses or other vision correction including to correct astigmatism, nearsightedness (myopia), or farsightedness (presbyopia).. This includes, but is not limited to, LASIK, radial keratotomy or keratomileusis, and excimer laser refractive keratectomy.
- Glasses or contact lenses, except when used to aid in healing an eye or eyes due to a covered sickness or an Injury.
- Charges for Cell and Gene Therapy to treat or cure vision loss or any eye disease or disorder.

All Other Exclusions

- Health care services and supplies that do not meet the definition of a covered health care service.
- Physical, psychiatric, or psychological exams, testing, vaccinations, immunizations, or treatments that are otherwise covered under the plan when: Required only for career, school, sports or camp, travel, employment, insurance, marriage, or adoption; Related to judicial or administrative proceedings or orders. This exclusion does not apply to services that are determined to be Medically Necessary; Conducted for purposes of medical research; or required to obtain or maintain a license of any type.
- Health care services related to a non-covered health care service.
- Complications of/or Services Related to Non-Covered Services, supplies, or treatment related to or, for problems directly related to a service that is not covered by this Plan.
- No benefits will be paid under this plan for, services, treatment or supplies that a Participant received before his or her effective date of coverage under this plan or after the date his or her coverage terminated under this plan.
- Benefits will not be given for any Illness or Injury that is a result of war, service in the armed forces, a nuclear explosion, nuclear Accident, release of nuclear energy, a riot, or civil disobedience. This exclusion does not apply to Participants who are civilians injured or otherwise affected by war, any act of war, or terrorism in non-war zones.
- Charges for treatment, services, supplies, or Drugs for which the plan is billed by a Provider who waives does not pursue, fails to collect, or reduces the Participant's payment obligation of any Copayment, Coinsurance, Deductible, or other amount owed by the Participant for such treatment, services, supplies or Drugs.
- Charges in excess of allowed amounts or in excess of any specified limitation.
- Long term (more than 30 days) storage. Examples include cryopreservation of tissue, blood, and blood products.

- For legal fees and expenses incurred in obtaining medical treatment.
- For research studies not reasonably necessary to the treatment of an Illness or Injury.
- For health club memberships, workout equipment, charges from a physical fitness or personal trainer, or any other charges for activities, equipment, or facilities used for physical fitness, even if ordered by a doctor.
- Charges for family or marriage counseling, Aversion Therapy, non-medical self-care, or self-help programs.
- Unless determined to be Medically Necessary, charges for any court-ordered: Hospitalization for evaluation; Inpatient civil commitment; Assisted Outpatient Treatment (AOT); Outpatient commitment; and Mandated Outpatient treatment.
- Treatment of an Injury or Illness that results from a crime you committed or tried to commit. This exclusion does not apply if your involvement in the crime was solely the result of a medical or mental condition, or where you were the victim of a crime, including domestic violence.
- Engaging in an illegal occupation.
- Injury sustained while legally intoxicated and operating a motor vehicle, including motorcycles, scooters, and ATV's; Injury caused by or sustained while under the influence of any illegal or controlled substance (unless prescribed by and taken under the direction of a doctor).
- The commission of, or attempting to commit, an assault, battery, or felony.
- The Participant is under the influence of any controlled substance, Drug, hallucinogen, or narcotic not administered on the advice of, and in accordance with the direction of a Physician.
- For non-medical expenses such as preparing medical reports, itemized bills, or charges for mailing.
- For Friday and Saturday admissions unless due to a medical Emergency or if Surgery is scheduled within the 24-hour period immediately following admission.
- Charges for missed or cancelled appointments.
- For newborn infant charges incurred on account of Pregnancy by a Dependent Child of an Employee (except as specifically described in this SPD). A Child of a Dependent Child is not an eligible Participant under the Plan.
- Charges over the Maximum Allowed Amount except for surprise billing claims as outlined in the “Consolidated Appropriations Act of 2021”.
- Charges for which the plan's liability cannot be determined because a Participant, Provider, facility, or other individual or entity within 30 days of the Plan's request, failed to: Authorize the release of all medical records to the plan and other information the plan requested; Provide the plan with information the plan requested about pending claims, other insurance coverage; Provide the plan with information that is accurate and complete; Have any examination completed as the plan requested; and, or, Provide reasonable cooperation to any requests made by the plan.
- Charges related to Provider assisted suicide.
- Charges for any condition, Illness or Injury, or complication thereof, arising out of engaging in a hazardous hobby or activity, which is an unusual activity characterized by a constant threat of danger. This does not include common recreational activities such as water or snow skiing, jet ski operating, horseback riding, boating, motorcycling, snowmobiling, all-terrain vehicle riding and team sports.
- Charges for treatment or services required due to Injury received while engaging in any hazardous occupation or other activity for which compensation is received including, but not limited to, the following: Participating, or instructing, or demonstrating, or guiding, or accompanying others, in parachute jumping; Participating, or instructing, or demonstrating, or guiding, or accompanying others, in hang-gliding; Participating, or instructing, or demonstrating, or guiding, or accompanying others, in bungee jumping; Racing any motorized or non-motorized vehicle; Skiing; and Rodeo activities. Also excluded are treatment and services required due to Injury received while practicing, exercising, undergoing conditioning, or physical preparation for any such compensated activity.

SECTION 7: DEFINITIONS

The following words and phrases shall have the following meanings when used in the Plan Document. The following definitions are not an indication that charges for particular care, supplies or services are eligible for payment under the Plan, however they may be used to identify ineligible expenses; please refer to the appropriate sections of the Plan Document for that information.

"ACCIDENT" or "ACCIDENTAL
"Accident" or "Accidental" shall mean a sudden and unforeseen event, or a deliberate act resulting in unforeseen consequences.

"ACCIDENTAL BODILY INJURY" OR "ACCIDENTAL INJURY"
"Accidental Bodily Injury" or "Accidental Injury" shall mean an Injury sustained as the result of an Accident and independently of all other causes by an outside traumatic event or due to exposure to the elements.

"ACTIVELY AT WORK" OR "ACTIVE EMPLOYMENT"
"Actively At Work" or "Active Employment "shall mean performance by the Employee of all the regular duties of his or her occupation at an established business location of the Employer, or at another location to which he or she may be required to travel to perform the duties of his or her employment. An Employee shall be deemed Actively at Work if the Employee is absent from work due to a health factor only if entitled under FMLA. In no event will an Employee be considered Actively at Work if he or she has effectively terminated employment.

"ADVERSE BENEFIT DETERMINATION"
"Adverse Benefit Determination" shall mean any of the following:

- A denial in benefits;
- A reduction in benefits;
- A rescission of coverage;
- A termination of benefits; 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 Claimant's eligibility to participate in the Plan.

"AFFORDABLE CARE ACT (ACA)"
"Affordable Care Act (ACA)" means the health care reform law enacted in March 2010. The law was enacted in two parts: The Patient Protection and Affordable Care Act was signed into law on March 23, 2010 and was amended by the Health Care and Education Reconciliation Act on March 30, 2010. The name "Affordable Care Act" is commonly used to refer to the final, amended versions of the law. In this document, the Plan uses the name Affordable Care Act (ACA) to refer to the health care reform law."

"AHA"
"AHA" shall mean the American Hospital Association.

"ALCOHOL AND/OR DRUG ABUSE"
"Alcohol and/or Drug Abuse" shall mean any use of alcohol or other drugs which produces a pattern of pathological use causing impairment in social or occupational functioning or which produces

physiological dependency evidenced by physical tolerance or withdrawal. For the purposes of the Plan, "drugs" shall be defined as addictive drugs and drugs of abuse listed as scheduled drugs in "The Controlled Substance, Drug, Device and Cosmetic Act" (35 P.S. §780-101 et seq.).

"AMA"
"AMA" shall mean the American Medical Association.

"AMBULATORY SURGICAL CENTER" or "AMBULATORY SURGICAL FACILITY"
"Ambulatory Surgical Center" or "Ambulatory Surgical Facility" shall mean any private or public establishment with: a) an organized medical staff of Physicians; b) permanent facilities that are equipped and operated primarily for the purpose of performing Outpatient Surgical Procedures; c) continuous Physician services and registered professional nursing services whenever a patient is in the facility and which does not provide services or other accommodations for patients to stay overnight.

"ANCILLARY CHARGE"
"Ancillary" Charge shall mean the difference in cost between a Brand Name Drug and what the Plan will pay for a Generic Drug when a Generic Drug substitute exists but the Brand Name Drug is dispensed. A Covered Person must pay any applicable Ancillary Charge directly to the Participating Pharmacy. Ancillary Charge also includes the difference in cost between a Brand Name Drug and Bio-Similar Drug when a Bio-Similar Drug substitute exists but the Brand Name Drug is dispensed. The Ancillary Charge does not count toward satisfying any Coinsurance, Copayment, Deductible or Out-of-Pocket Limit under any other section in this Plan.

"ANCILLARY PHARMACY NETWORK CHARGE"
"Ancillary Pharmacy Network Charge" shall mean the difference in cost between the actual charge and the Maximum Amount that a Participating Pharmacy has agreed to accept as total payment for the cost of a Prescription Drug. The Covered Person must pay any applicable Ancillary Pharmacy Network Charge directly to the Pharmacy. An Ancillary Pharmacy Network Charge may apply if the Covered Person does not use his or her identification (ID) card to obtain Prescription Drugs at a Participating Pharmacy or if Prescription Drugs are purchased at a Non-Participating Pharmacy. The Ancillary Pharmacy Network Charge does not count toward satisfying any Coinsurance, Copayment, Deductible, or other Out-of-Pocket Limit.

"APPLIED BEHAVIORAL ANALYSIS"
"Applied Behavioral Analysis" shall mean the design, implementation, and evaluation of environmental modifications, using behavioral stimuli and consequences, to produce socially significant improvement in human behavior or to prevent loss of attained skill or function, including the use of direct observation, measurement and functional analysis of the relations between environment and behavior.

"APPROVED CLINICAL TRIAL"
"Approved Clinical Trial "means a phase I, II, III or IV trial that is federally funded by specified Agencies (National Institutes of Health, CDCP, Agency for Health Care Research, CMS, Dept. of Defense or Veterans Affairs, or a non-governmental entity identified by NIH guidelines) or is conducted under an Investigational new Drug application reviewed by the FDA (if such application is required).

The Affordable Care Act requires that if a "qualified individual" is in an "Approved Clinical Trial," the Plan cannot deny coverage for related services ("routine patient costs").

A “qualified individual” is someone who is eligible to participate in an “Approved Clinical Trial” and either the individual’s doctor has concluded that participation is appropriate, or the Participant provides medical and scientific information establishing that their participation is appropriate.

“Routine patient costs” include all items and services consistent with the coverage provided in the plan that is typically covered for a qualified individual who is not enrolled in a clinical trial. Routine patient costs do not include 1) the Investigational item, device, or service itself; 2) items and services that are provided solely to satisfy data collection and analysis needs and that are not used in the direct clinical management of the patient; and 3) a service that is clearly inconsistent with the widely accepted and established standards of care for a particular Diagnosis. Plans are not required to provide benefits for routine patient care services provided outside of the Plan’s PPO Network area unless Out-of Network benefits are otherwise provided under the Plan.

“ASSIGNMENT OF BENEFITS”
“Assignment of Benefits” shall mean an arrangement whereby the Participant assigns their right to seek and receive payment of eligible Plan benefits, in strict accordance with the terms of this Plan Document, to a Provider. If a Provider accepts said arrangement, Providers’ rights to receive Plan benefits are equal to those of a Participant and are limited by the terms of this Plan Document. A Provider that accepts this arrangement indicates acceptance of an “Assignment of Benefits” as consideration in full for services, supplies, and/or treatment rendered.

“AUTISM SERVICE PROVIDER”
“Autism Service Provider” shall mean a person, entity or group providing treatment of Autism Spectrum Disorders, pursuant to a treatment plan, that is licensed or certified to do so. Any person, entity or group providing treatment of Autism Spectrum Disorders, pursuant to a treatment plan, that is enrolled in the Commonwealth’s medical assistance program on or before the effective date of this section.

“AUTISM SPECTRUM DISORDER (ASD)”
“Autism Spectrum Disorder (ASD)” shall mean any of the pervasive developmental disorders defined by the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM), or its successor, including autistic disorder, Asperger’s disorder and pervasive developmental disorders not otherwise specified.

“AVERSION THERAPY”
“Aversion Therapy” shall mean a series of procedures, medications or treatments that are designed to reduce or eliminate unwanted or dangerous behavior through the use of negative experience, such as pairing the behavior with unpleasant sensations or punishment.

“BENEFIT PERIOD”
“Benefit Period” shall mean the length of time during which charges for Covered Services must be Incurred in order to be eligible for payment (either Calendar Year or a Benefit Year).

“BIO-SIMILAR DRUG”
“Bio-Similar Drug” shall mean an FDA-approved biological product that is nearly the same as another US-licensed reference biological product except for differences in clinically inactive components and for which there are no clinically meaningful differences in safety and potency between the biological product and the reference product.

“BRAND NAME DRUG”

"Brand Name Drug" shall mean a Prescription Drug for which a pharmaceutical company has received a patent or trade name.

"CALENDAR YEAR"
"Calendar Year" shall mean that period of time commencing at 12:01 a.m. on January 1st and ending at 12:01 a.m. on the next succeeding January 1st. Each succeeding like period will be considered a new Calendar Year.

"CASE MANAGEMENT PROGRAM"
"Case Management Program" shall mean a program of medical management typically utilized in situations involving extensive and on-going medical treatment, which provides a comprehensive and coordinated delivery of services under the oversight of a medically responsible individual or agency. Such programs may provide benefits not normally covered under Plan provisions in lieu of in-Hospital treatment.

If, at any point in the progress of a given medical situation, after having considered the opinions of the Covered Person (and/or his legally responsible representatives), the Covered Person's Physician and/or other medical authorities, the Plan Administrator determines that the benefits of this Plan may be best utilized through the implementation of a Case Management Program, the Plan reserves the right to require that further benefits be provided only under the administration of such a program.

"CHEMOTHERAPY"
"Chemotherapy" shall mean the treatment of Disease by chemical or biological therapeutic agents.

"CHILD(REN)"
"Child(ren)" shall mean, in addition to the Employee's own blood descendant of the first degree or lawfully adopted Child, a Child placed with a covered Employee in anticipation of adoption, a covered Employee's Child who is an Alternate Recipient under a Qualified Medical Child Support Order as required by the Federal Omnibus Budget Reconciliation Act of 1993, any stepchild, an "eligible foster Child(ren)," which is defined as an individual or individuals placed with the Employee by an authorized placement agency or by judgment, decree or other order of a court of competent jurisdiction or any other Child(ren) for whom the Employee has obtained legal guardianship.

"CHIP"
"CHIP" refers to the Children's Health Insurance Program or any provision or section thereof, which is herein specifically referred to; as such act, provision or section may be amended from time to time.

"CHIROPRACTIC MANIPULATIVE TREATMENT (CMT)" or "CHIROPRACTIC THERAPY"
"Chiropractic Manipulative Treatment (CMT)" or "Chiropractic Therapy" shall mean the detection and correction, by manual or mechanical means, of the interference with nerve transmissions and expressions resulting from distortion, misalignment, or dislocation of the spinal (vertebrae) column.

"CLAIMS FIDUCIARY"
"Claims Fiduciary" shall mean the entity to which the Plan Sponsor has allocated certain fiduciary responsibility as defined in this SPD.

"COBRA"
"COBRA" shall mean the Consolidated Omnibus Budget Reconciliation Act of 1985, as amended.

"COINSURANCE"

“Coinsurance” shall mean a specific percentage amount of the Maximum Allowable Charge, set forth in the Summary of Benefits, for which the Participant is responsible after the deduction of a Deductible or Copayment, if applicable.

“COMPOUNDED MEDICATION”
“Compounded Medication” shall mean a Drug product made up of one or more active parts or ingredients which must be specially prepared by a licensed Pharmacist pursuant to a Prescription Order. If covered, Compounded Medications will be considered to be Non-Preferred Brand Name Drugs.

“COPAYMENT (COPAY)”
“Copayment (Copay)” shall mean the amount, if any, a Participant must pay directly to Providers in connection with Covered Services set forth in the Plan and in the Summary of Benefits.

“COSMETIC”, “COSMETIC SURGERY” or “COSMETIC TREATMENT”
“Cosmetic”, “Cosmetic Surgery” or “Cosmetic Treatment” shall mean any Surgery, procedure, or treatment that is intended to improve the appearance of a patient or to preserve or restore a pleasing appearance and does not meaningfully promote the proper function of the body or prevent or treat Illness or Disease (except when necessary to improve a deformity arising from, or directly related to, a congenital abnormality, a personal Injury resulting from an Accident or trauma, or a disfiguring Disease).

“COST DIFFERENCE BETWEEN GENERIC DRUGS AND BRAND NAME DRUGS”
“Cost Difference Between Generic Drugs and Brand Name Drugs” shall mean if a Covered Person obtains a Brand Name Drug when a Generic Drug or Bio-Similar Drug is available and on the Drug List, the Covered Person must pay the difference in cost between the Brand Name Drug and the Generic Drug or Bio-Similar Drug (the "Ancillary Charge"), in addition to any applicable Copayment, Coinsurance, and Deductible for the Generic Drug.

In rare cases there may be potential bioequivalence inconsistencies between the Brand Name Drug and its generic version. In these cases, if the Covered Person's Physician provides documentation that the Generic Drug is demonstrated to have an adverse therapeutic effect, the Plan may approve the Ancillary Charge as Covered Charges. The Covered Person should call or write the Plan to request a review of the Covered Person's Prescription Drug in such cases.

Any Ancillary Charge will not count toward satisfying any Coinsurance, Copayment, Out-of-Pocket Limit, or Deductible under this Plan.

“COVERED PERSON”
“Covered Person” shall mean a covered Employee or a covered Dependent. No person is eligible for health care benefits both as an Employee and as a Dependent under this Plan. When the Employer employs both husband and wife, any Dependent Child(ren) may become covered hereunder only as Dependents of one Spouse. Covered Person and Participant have the same meaning within this SPD.

“COVERED PHARMACY EXPENSE”
“Covered Pharmacy Expense” shall mean a service or supply specified in the Plan for which Covered Services for Prescription Drugs and supplies will be provided pursuant to the terms of the Plan.

“COVERED SERVICES”

“Covered Services” shall mean all Medically Necessary expenses for certain Hospital and other medical services, Drugs, and supplies for the treatment of Injury or Illness. A detailed list of Covered Services is set forth in this booklet in the section entitled "Benefit Summary."

“CUSTODIAL CARE”
“Custodial Care” shall mean care or confinement provided primarily for the maintenance of the Participant, essentially designed to assist the Participant, whether or not Totally Disabled, in the activities of daily living, which could be rendered at home or by persons without professional skills or training. This care is not reasonably expected to improve the underlying medical condition, even though it may relieve symptoms or pain. Such care includes, but is not limited to, bathing, dressing, feeding, preparation of special diets, assistance in walking or getting in and out of bed, supervision over medication which can normally be self-administered and all domestic activities.

“DEDUCTIBLE”
“Deductible” shall mean a specified amount of Covered Services, as set forth in the Summary of Benefits, expressed in dollars that must be Incurred by a Participant before the Plan will assume any liability for all or part of the remaining Covered Services.

One or more of the following Deductibles may apply to Covered Services as shown in the Benefit Summary:

1. **Family Deductible:** The dollar amount that must be satisfied by all Covered Persons before benefits are payable by the Plan. The Individual Deductibles that all Covered Persons may have to pay are limited to the Family Deductible amount. When the Family Plan Deductible amount is reached, the Plan will consider the Deductible requirements for all Covered Persons in Your family to be satisfied for the remainder of the Year. The Family Plan Deductible applies to Family Plans. If a Family Plan only includes two Covered Persons, each Covered Person must meet the Individual Deductible.

2. **Individual Deductible:** The dollar amount of Covered Services each Covered Person must satisfy before benefits are payable by the Plan. When Covered Services equal to the Individual Deductible have been Incurred and processed by the Plan, the Individual Deductible for that Covered Person will be satisfied for the remainder of the Year. Once a Covered Person's Individual Deductible is satisfied, Covered Services for that Covered Person for the remainder of the Year will not count toward the Family Deductible.

3. **Integrated Deductible:** The shared dollar amount of Covered Services Incurred by all Covered Persons that must be satisfied before benefits are payable by the Plan. When Covered Services equal to the Integrated Deductible have been Incurred and processed by the Plan, the Integrated Deductible for all Covered Persons under the Plan will be satisfied for the remainder of the Year. The Individual Integrated Deductible applies to Single Plans. The Family Plan Integrated Deductible applies to Family Plans.

4. **Participating Provider Deductible:** The dollar amount of Covered Services received from Providers in the PPO Network that each Covered Person must satisfy before benefits are payable by Us. When Covered Services equal to the Participating Provider Deductible have been Incurred and processed by Us, the Participating Provider Deductible for that Covered Person will be satisfied for the remainder of the Year. Any amount You pay toward satisfaction of the Participating Provider Deductible will not apply toward satisfaction of the Non-Participating Provider Deductible.

5. **Non-Participating Provider Deductible:** The dollar amount of Covered Services received from Non-Participating Providers that each Covered Person must satisfy before benefits are payable by the Plan. When Covered Services equal to the Non-Participating Provider Deductible have been Incurred and processed by the Plan, the Non-Participating Provider Deductible for that Covered Person will be satisfied for the remainder of the Ye a r. Any amount You pay toward satisfaction of the Non-Participating Provider Deductible will not apply toward satisfaction of the Participating Provider Deductible.

"DENTIST"
"Dentist" shall mean an individual holding a D.D.S. or D.M.D. degree, licensed to practice dentistry in the jurisdiction where such services are provided.

"DEPENDENT"
"Dependent" shall mean one or more of the following person(s):

1. An Employee's lawfully married Spouse;
2. An Employee's, Employee's Spouse's Child who is less than twenty-six (26) years of age; or
3. An Employee's, Employee's Spouse's Child regardless of age, who was continuously covered prior to attaining the limiting age as listed in the numbers above, who is mentally or physically incapable of sustaining his or her own living. Such Child must have been mentally or physically incapable of earning his or her own living prior to attaining the limiting age as listed in the numbers above. Written proof of such incapacity and dependency satisfactory to the Plan must be furnished and approved by the Plan within thirty (30) days after the date the Child attains the limiting age as described above. The time limit for written proof of incapacity and dependency is 31 days following the original eligibility date for a new or re-enrolling Employee. The Plan may require, at reasonable intervals, subsequent proof satisfactory to the Plan during the next two years after such date. After such two-year period, the Plan may require such proof, but not more often than once each year.

"Dependent" does not include any person who is a member of the armed forces of any Country or who is a resident of a Country outside the United States.

The Plan reserves the right to require documentation, satisfactory to the Plan Administrator, which establishes a Dependent relationship.

"Michelle's Law" prohibits a group health plan from terminating coverage of a Dependent Child due to a qualifying "Medically Necessary Leave of Absence" from, or other change in enrollment at, a postsecondary educational Institution prior to the earlier of:

- The date that is one year after the first day of the Medically Necessary Leave of Absence; or
- The date on which such coverage would otherwise terminate under the terms of the Plan.

In order to be a Medically Necessary Leave of Absence the student's leave must:

1. Commence while the Dependent Child is suffering from a serious Illness or Injury;
2. Be Medically Necessary; and
3. Cause the Dependent Child to lose student status for purposes of coverage under the terms of the parents' plan or coverage.

A Child is a "Dependent Child" under the law if he or she:

1. Is a Dependent Child, under the terms of the Plan or coverage, is a Dependent of a Participant under the Plan or coverage; and
2. Was enrolled in the Plan or coverage, on the basis of being a student at a postsecondary educational institution, immediately before the first day of the Medically Necessary Leave of Absence.

A treating Physician of the Dependent Child must certify that the Dependent Child is suffering from a serious Illness or Injury and that the Leave of Absence (or other change of enrollment) described is Medically Necessary.

"DESIGNATED CELLULAR AND GENE THERAPY PROVIDER"
"Designated Cellular and Gene Therapy Provider" shall mean a Participating Provider that has been designated by the Plan for the specific Cellular Therapy or Gene Therapy being obtained. Each therapy product is disease-specific and administered in a specialized manner. This list is subject to change without notice.

"DETOXIFICATION"
"Detoxification" shall mean the process whereby an alcohol intoxicated or drug-intoxicated or alcohol-dependent or drug-dependent person is assisted, in a licensed facility, through the period of time necessary to eliminate, by metabolic or other means, the intoxicating alcohol or other Drugs, alcohol, Drug or other Drug dependency factors or alcohol in combination with Drugs as determined by a licensed Physician, while keeping the physiological risk to the patient at a minimum.

"DIAGNOSIS"
"Diagnosis" shall mean the act or process of identifying or determining the nature and cause of a Disease or Injury through evaluation of patient history, examination, and review of laboratory data.

"DIAGNOSTIC SERVICES"
"Diagnostic Services" shall mean the following procedures ordered by a Physician because of specific symptoms and signs to determine a definite condition or Disease. Diagnostic Services are covered to the extent specified in Medical Benefits section and include, but are not limited to:

1. Diagnostic imaging;
2. Diagnostic pathology, consisting of laboratory and pathology tests;
3. Diagnostic medical procedures, consisting of electrocardiogram (ECG), electroencephalogram (EEG), and other diagnostic medical procedures approved by the Plan; and
4. Allergy testing consisting of percutaneous, intracutaneous and patch tests.

"DISABLED OR DISABILITY"
"Disabled" or "Disability" shall mean a condition where you are not able to perform any occupation or business for which you are reasonably suited by your education, training, or experience. This also means that you are not, in fact, engaged in any occupation or business for wage or profit. It includes conditions where you are confined to a Hospital or are completely incapacitated and unable to perform normal activities of daily living. The Plan may require your doctor to send us proof of your condition.

"DISEASE"
"Disease" shall mean any disorder which does not arise out of, which is not caused or contributed to by, and which is not a consequence of, any employment or occupation for compensation or profit; however,

if evidence satisfactory to the Plan is furnished showing that the individual concerned is covered as an Employee under any workers' compensation law, occupational Disease law or any other legislation of similar purpose, or under the maritime doctrine of maintenance, wages, and cure, but that the disorder involved is one not covered under the applicable law or doctrine, then such disorder shall, for the purposes of the Plan, be regarded as a Sickness, Illness or Disease.

"DRUG"
"Drug" shall mean insulin and Prescription legend Drugs. A Prescription legend Drug is a Federal legend Drug (any medicinal substance which bears the legend: "Caution: Federal law prohibits dispensing without a Prescription") or a State restricted Drug (any medicinal substance which may be dispensed only by Prescription, according to State law) and which, in either case, is legally obtained from a licensed Drug dispenser only upon a Prescription of a currently licensed Physician.

"DRUG LIST", "DRUG FORMULARY" OR "FORMULARY"
"Drug List", "Drug Formulary" or "Formulary" shall mean a listing of Preferred Prescription Drugs and supplies covered by the Plan, which is subject to periodic review and modification at least annually by a committee of appropriate actively practicing preferred Physicians and Pharmacists. Prescription Drug inclusions in the Drug Formulary are based on a combination of criteria including clinical quality and cost effectiveness. The Drug Formulary is available upon request from www.mycigna.com. For Prescription Drug questions please call 1-800-325-1404 or visit www.mycigna.com.

"DURABLE MEDICAL EQUIPMENT"
"Durable Medical Equipment" shall mean equipment that:

1. Can withstand repeated use;
2. Is primarily and customarily used to serve a medical purpose;
3. Generally is not useful to a person in the absence of an Illness or Injury; and
4. Is appropriate for use in the home.

"ELECTIVE SURGICAL PROCEDURE"
"Elective Surgical Procedure" shall mean any non-Emergency Surgical Procedure which may be scheduled at a patient's convenience without jeopardizing the patient's life or causing serious impairment to the patient's bodily functions and which is performed while the patient is confined in a Hospital as an Inpatient or in an Ambulatory Surgical Center.

"ELIGIBLE PERSON"
"Eligible Person" shall mean a person entitled to be a Participant as specified in the Eligibility for Coverage section.

"EMERGENCY"
"Emergency" shall mean a situation where necessary treatment is required as the result of a sudden and severe medical event or acute condition. An Emergency includes poisoning, shock, and hemorrhage. Other Emergencies and acute conditions may be considered on receipt of proof, satisfactory to the Plan, that an Emergency did exist. The Plan may, at its own discretion, request satisfactory proof that an Emergency or acute condition did exist.

"EMERGENCY MEDICAL CONDITION"
"Emergency Medical Condition" shall mean 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 described in clause (i), (ii), or (iii) of section 1867(e)(1)(A) of the Social Security Act (42 U.S.C. 1395dd(e)(1)(A)). In that provision of the Social Security Act, clause (i) refers to placing the health of the individual (or, with respect to a pregnant woman, the health of the woman or her unborn Child) in serious jeopardy; clause (ii) refers to serious impairment to bodily functions; and clause (iii) refers to serious dysfunction of any bodily organ or part.

"EMERGENCY SERVICES"
"Emergency Services" shall mean, with respect to an Emergency Medical Condition:

1. A medical screening examination (as required under section 1867 of the Social Security Act, 42 U.S.C. 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
2. 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 patient.

"EMPLOYEE"
"Employee" shall mean a person in the service of another under any contract of hire, express or implied, oral or written, where the employer has the power or right to control and direct the employee in the material details of how the work is to be performed and such person is a regular full time Employee of the Employer regularly scheduled to work for the Employer in an Employer Employee relationship.

Such person must be scheduled to work at least a minimum of 30 hours per week based on job classification in order to be considered "full time." Employer shall track hours worked including those of any "commission only" employees in accordance with the Fair Labor Standards Act.

If an Employer has at least 50 full-time employees, including full-time equivalent employees, on average during the prior year, the employer is an Applicable Large Employer for the current calendar year, and is therefore subject to the employer shared responsibility provisions and the employer information reporting provisions of the Affordable Care Act. There are two methods for determining full-time employee status:

- The monthly measurement method, and
- The look-back measurement method.

If applicable, an ALE shall determine Employee eligibility based on the Internal Revenue Service (IRS) guidance under the Affordable Care Act with a The Look-Back Measurement Method or The Monthly Measurement Method.

"ENCOUNTER"
"Encounter" shall mean (a) an inpatient or outpatient admission of a patient during which a Participating Provider has direct, in-person contact with the patient; (b) the performance of procedure or diagnostic or therapeutic intervention for a patient by a Participating Provider; or (c) performance of a history and physical (including diagnostic impression with treatment plan and goals, and pre-operative assessment and recommendations) for inpatient and outpatient admissions.

"ENROLLMENT DATE"

"Enrollment Date" shall mean the first day of coverage or, if there is a Waiting Period, the first day of the Waiting Period.

"ERISA"
"ERISA" shall mean the Employee Retirement Income Security Act of 1974, as amended.

"EXPERIMENTAL or INVESTIGATIONAL"
"Experimental" and/or "Investigational" ("Experimental") shall mean services or treatments that are not widely used or accepted by most practitioners or lack credible evidence to support positive short or long-term outcomes from those services or treatments, and that are not the subject of, or in some manner related to, the conduct of an Approved Clinical Trial, as such term is defined herein; these services are not included under or as Medicare reimbursable procedures, and include services, supplies, care, procedures, treatments or courses of treatment which:

Do not constitute accepted medical practice under the standards of the case and by the standards of a reasonable segment of the medical community or government oversight agencies at the time rendered; or

Are rendered on a research basis as determined by the United States Food and Drug Administration and the AMA's Council on Medical Specialty Societies.

All phases of clinical trials shall be considered Experimental, except to the extent it would be considered an Approved Clinical Trial, as defined herein.

A Drug, device, or medical treatment or procedure is Experimental:

1. If the Drug or device cannot be lawfully marketed without approval of the U.S. Food and Drug Administration and approval for marketing has not been given at the time the Drug or device is furnished;
2. If reliable evidence shows that the Drug, device or medical treatment or procedure is the subject of ongoing Phase I, II, or III clinical trials or under study to determine its:
   a) Maximum tolerated dose;
   b) Toxicity;
   c) Safety;
   d) Efficacy; and
   e) Efficacy as compared with the standard means of treatment or Diagnosis; or
3. If reliable evidence shows that the consensus among experts regarding the Drug, device, or medical treatment or procedure is that further studies or clinical trials are necessary to determine its:
   a) Maximum tolerated dose;
   b) Toxicity;
   c) Safety;
   d) Efficacy; and
   e) Efficacy as compared with the standard means of treatment or Diagnosis.

Reliable evidence shall mean:

1. Only published reports and articles in the authoritative medical and scientific literature;
2. The written protocol or protocols used by the treating facility or the protocol(s) of another facility studying substantially the same Drug, device, or medical treatment or procedure; or

3. The written informed consent used by the treating facility or by another facility studying substantially the same Drug, device, or medical treatment or procedure.

Subject to a medical opinion, if no other FDA approved treatment is feasible and as a result the Participant faces a life-or-death medical condition, the Claims Fiduciary retains discretionary authority to cover the services or treatment.

The Claims Fiduciary retains maximum legal authority and discretion to determine what is Experimental.

"EXTENDED CARE FACILITY"
"Extended Care Facility" shall mean an institution (or a distinct part of an institution) which: (a) provides for Inpatients (1) 24-hour nursing care and related services for patients who require medical or nursing care, or (2) service for the Rehabilitation of injured or sick persons; (b) has policies developed with the advice of (and subject to review by) professional personnel to cover nursing care and related services; (c) has a Physician, a registered professional nurse or a medical staff responsible for the execution of such policies; (d) requires that every patient be under the care of a Physician and makes a Physician available to furnish Medical Care in case of Emergency; (e) maintains clinical records on all patients and has appropriate methods for dispensing Drugs and biologicals; (f) has at least one registered professional nurse employed full time; (g) provides for periodic review by a group of Physicians to examine the need for admissions, adequacy of care, duration of stay and Medical Necessity of continuing confinement of patients; (h) is licensed pursuant to law, or is approved by appropriate authority as qualifying for licensing and is also approved by Medicare; (i) is not primarily a place for the elderly, persons with substance use disorders, intellectually Disabled persons, or a place for rest, Custodial or educational care or for the care of mental disorders.

"FACILITY OTHER PROVIDER"
"Facility Other Provider" shall mean an Institution or entity, other than a Hospital, that is licensed, where required, to render Covered Services.

"FACILITY PROVIDER"
"Facility Provider" shall mean a Hospital or Facility Other Provider, licensed where required, to render Covered Services.

"FINAL INTERNAL ADVERSE BENEFIT DETERMINATION"
Final Internal Adverse Benefit Determination shall mean an Adverse Benefit Determination that has been upheld by the Plan at the conclusion of the internal claims and appeals process, or an Adverse Benefit Determination with respect to which the internal claims and appeals process has been deemed exhausted.

"FMLA"
"FMLA" shall mean the Family and Medical Leave Act of 1993, as amended.

"FMLA LEAVE"
"FMLA Leave" shall mean a Leave of Absence, which the Employer is required to extend to an Employee under the provisions of the FMLA.

"FREESTANDING OUTPATIENT FACILITY"
"Freestanding Outpatient Facility" shall mean a Facility Other Provider, which is primarily engaged in providing Outpatient Diagnostic and/or therapeutic services by or under the direction of Physicians.

“GENE THERAPY”
“Gene Therapy” shall mean therapeutic delivery of an FDA-approved pharmaceutical product into a patient’s cells to treat disease. Gene therapies can work by several mechanisms:

- Replacing a disease-causing gene with a healthy copy of the gene
- Inactivating a disease-causing gene that is not functioning properly
- Introducing a new or modified gene into the body to help treat a disease

“GENETIC INFORMATION”
The term "Genetic Information" is defined as 1) an individual's own genetic tests, 2) the genetic tests of family members of such individual, and 3) the manifestation of a Disease or disorder in family members of such individual. The term “genetic information” also encompasses family medical history. The term "genetic information" additionally extends to genetic information of any fetus carried by a pregnant woman. With respect to an individual or family member utilizing an assisted reproductive technology, genetic information includes the genetic information of any embryo legally held by the individual or family member. The term “genetic information” further extends to dependents and family members defined as first-degree, second-degree, third-degree, or fourth-degree relatives of the individual. The term additionally includes participation in clinical research involving genetic services.

“GENERIC DRUG OR GENERIC EQUIVALENT PRESCRIPTION DRUG”
“Generic Drug or Generic Equivalent Prescription Drug” shall mean any Prescription Drug that is considered to be therapeutically equivalent to other pharmaceutical equivalent products by the Food and Drug Administration, has received an “A Code” in the FDA “Approved Drug Products with Therapeutic Equivalence Evaluations,” and is in compliance with applicable state generic substitution laws and regulations.

A Generic Drug is a Prescription Drug that:

- Has the same active ingredients as an equivalent Brand Name Drug or that can be used to
- treat the same condition as a Brand Name Drug; and
- Does not carry any Drug manufacturer's brand name on the label; and
- Is not protected by a patent.

It must be listed as a Generic Drug by the national Drug data bank used to administer the Plan on the date it is purchased. Compounded Medications are not Generic Drugs. Medications that are commercially manufactured together and/or packaged together are not considered to be Generic Drugs, unless the entire combination product is specifically listed as a Generic Drug product by the national Drug data bank used to administer the Plan on the date it is purchased.

“HABILITATION/HABILITATIVE SERVICES”
“Habilitation/Habilitative Services” shall mean services designed to assist individuals in acquiring, retaining and improving the self-help, socialization and adaptive skills necessary to reside successfully in home and community-based settings.

“HIPAA”
“HIPAA” shall mean the federal Health Insurance Portability and Accountability Act of 1996.

“HOMEBOUND”
“Homebound” shall mean a Participant’s condition due to an Illness or Injury which restricts his/her ability to leave his/her place of residence except with the aid of supportive devices such as crutches, canes, wheelchairs, and walkers, the use of special transportation, or the assistance of another person,

or if he/she has a condition which is such that leaving his/her home is medically contraindicated. The condition of these Participants should be such that there exists a normal inability to leave home and, consequently, leaving their homes would require a considerable and taxing effort.

"HOME HEALTH CARE"
"Home Health Care" shall mean the continual care and treatment of an individual if:

1. The institutionalization of the individual would otherwise have been required if Home Health Care was not provided;
2. The treatment plan covering the Home Health Care service is established and approved in writing by the attending Physician; and
3. The Home Health Care is the result of an Illness or Injury.

"HOME HEALTH CARE AGENCY"
"Home Health Care Agency" shall mean an agency or organization which provides a program of Home Health Care and which:

1. Is approved as a Home Health Agency under Medicare;
2. Is established and operated in accordance with the applicable laws in the jurisdiction in which it is located and, where licensing is required, has been licensed and approved by the regulatory authority having the responsibility for licensing; or
3. Meets all of the following requirements:
    a. It is an agency which holds itself forth to the public as having the primary purpose of providing a Home Health Care delivery system bringing supportive services to the home;
    b. It has a full-time administrator;
    c. It maintains written records of services provided to the patient;
    d. Its staff includes at least one Registered Nurse (R.N.) or it has nursing care by a Registered Nurse (R.N.) available; and
    e. Its Employees are bonded and it provides malpractice insurance.

"HOME INFUSION THERAPY"
"Home Infusion Therapy" shall mean the preparation and administration of parenteral and enteral nutrition and/or intravenous solutions and Drugs, which are provided in the home or infusion center setting.

"HOME INFUSION THERAPY AGENCY"
"Home Infusion Therapy Agency" shall mean a Facility Other Provider, which has been approved by the Joint Commission on the Accreditation of Healthcare Organizations or a similar accrediting agency acceptable to the Plan; is recognized and licensed by the appropriate regulatory agency to provide services within the scope of its license; provides Home Infusion Therapy services in the Participant's home or an infusion center; and is responsible for supervising the delivery of such services under a plan authorized by the Physician.

"HOSPICE"
"Hospice" shall mean a Facility Other Provider, which is primarily engaged in providing supportive care to terminally ill individuals.

"HOSPICE CARE"

"Hospice Care" shall mean a health care program which provides an integrated set of services, primarily in the patient's home, designed to provide supportive care intended to promote comfort to terminally ill patients and their families. Services are coordinated through a Hospice interdisciplinary team and the Participant's Physician.

"HOSPITAL"
"Hospital" shall mean an Institution that meets all of the following requirements:

1. It provides medical and Surgical facilities for the treatment and care of Injured or Sick persons on an Inpatient basis;
2. It is under the supervision of a staff of Physicians;
3. It provides twenty-four (24) hour a day nursing service by Registered Nurses;
4. It is duly licensed as a Hospital, except that this requirement will not apply in the case of a State tax supported Institution;
5. It is not, other than incidentally, a place for rest, a place for the aged, a nursing home or a Custodial or training type Institution, or an Institution which is supported in whole or in part by a Federal government fund; and
6. It is accredited by the Joint Commission on Accreditation of Hospitals sponsored by the AMA and the AHA.

The requirement of surgical facilities shall not apply to a Hospital specializing in the care and treatment of mentally ill patients, provided such Institution is accredited as such a facility by the Joint Commission on Accreditation of Hospitals sponsored by the AMA and the AHA.

"Hospital" shall also have the same meaning, where appropriate in context, set forth in the definition of "Ambulatory Surgical Center."

"ILLNESS"
"Illness" shall have the meaning set forth in the definition of "Disease."

"IMMEDIATE FAMILY"
"Immediate Family" shall mean the Participant's Spouse, Child(ren), stepchild, parent, brother, sister, mother-in-law, father- in-law, sister-in-law, brother-in-law, daughter-in-law, or son-in-law.

"INFERTILITY TREATMENT"
"Infertility Treatment" shall mean any services, supplies or Drugs related to the Diagnosis or treatment of Infertility.

"INCURRED"
A Covered Expense is "Incurred" on the date the service is rendered or the supply is obtained. With respect to a course of treatment or procedure which includes several steps or phases of treatment, Covered Services are Incurred for the various steps or phases as the services related to each step are rendered and not when services relating to the initial step or phase are rendered. More specifically, Covered Services for the entire procedure or course of treatment are not Incurred upon commencement of the first stage of the procedure or course of treatment.

"INFERTILITY"
"Infertility" shall mean the medically documented diminished ability to conceive or induce conception. A couple is considered infertile if Pregnancy does not occur over a one-year period of normal coital activity

between a male and female partner without contraceptives. The cause of infertility can be a female or female factor, or a combination of both.

"INJURY"
"Injury" shall mean an Accidental Bodily Injury, which does not arise out of, which is not caused or contributed to by, and which is not a consequence of, any employment or occupation for compensation or profit.

"INPATIENT"
"Inpatient" shall mean a Participant who is treated as a registered bed patient in a Hospital or Facility Other Provider, who is expected to stay overnight and for whom a Room and Board charge is made.

"INPATIENT MENTAL HEALTH HOSPITAL"
"Inpatient Mental Health Hospital" shall mean a short-term acute care Hospital, which has been approved by the Joint Commission on the Accreditation of Healthcare Organizations, or the American Osteopathic Hospital Association, or a similar accrediting agency acceptable by the Plan and which provides services that are necessary for short-term evaluation, Diagnosis, and treatment (or crisis intervention) of Serious Mental Illness.

"INPATIENT NON-HOSPITAL RESIDENTIAL CARE"
"Inpatient Non-Hospital Residential Care" shall mean the provision of medical, nursing, counseling, or therapeutic
services to patients suffering from Mental or Nervous Disorders and for the treatment of Serious Mental Illness or Alcohol and/or Drug Abuse or dependency in a residential environment, according to individualized treatment plans.

"INPATIENT NON-HOSPITAL RESIDENTIAL FACILITY"
"Inpatient Non-Hospital Residential Facility" shall mean a Facility Other Provider licensed to render an Alcohol and/or Drug Abuse treatment program designed to provide Inpatient Non-Hospital Residential Care. (This is not a half-way house or group home.)

"INSTITUTION"
"Institution" shall mean a facility, operating within the scope of its license, whose purpose is to provide organized health care and treatment to individuals, such as a Hospital, Ambulatory Surgical Center, Psychiatric Hospital, community mental health center, residential treatment facility, psychiatric treatment facility, Substance Abuse Treatment Center, alternative birthing center, Home Health Care center, or any other such facility that the Plan approves.

"LATE ENROLLEE"
"Late Enrollee" shall mean a Participant who enrolls in the Plan other than:

1. On the earliest date on which coverage can become effective for the individual under the terms of the Plan; or
2. Through Special Enrollment.

"LEAVE OF ABSENCE"
"Leave of Absence" shall mean a Leave of Absence of an Employee that has been approved by his or her Employer, as provided for in the Employer's rules, policies, procedures, and practices.

"LICENSED PRACTICAL NURSE (LPN)"

"Licensed Practical Nurse (LPN)" shall mean a nurse who has graduated from a formal practical nursing education program and is licensed by appropriate state authority.

"LIFETIME"
"Lifetime" shall mean, "while covered under the Plan". Under no circumstances will the word "Lifetime" mean "during the lifetime of the Covered Person".

"MAIL ORDER PHARMACY"
"Mail Order Pharmacy" shall mean a Participating Pharmacy that is under contract with the Plan through the Plan's Pharmacy Provider Network. The Mail Service Prescription Drug Vendor dispenses selected Prescription Maintenance Drugs to Covered Persons through the mail.

"MAINTENANCE PRESCRIPTION DRUG"
"Maintenance Prescription Drug" shall mean any Prescription Drug, not including Specialty Injectable Drugs, which the Plan makes available through a Participating Mail Order Pharmacy, which is generally used to treat chronic medical conditions and is generally not needed urgently for an immediate acute Illness and which the Participant chooses to obtain, or the Plan requires be obtained, from a Participating Mail Order Pharmacy. The Plan may specify certain Prescription Drugs that are not available through a Participating Mail Order Pharmacy.

"MASTECTOMY"
"Mastectomy" shall mean removal of all or part of the breast for Medically Necessary reasons as determined by a licensed Physician.

"MAXIMUM"
"Maximum" shall mean the greatest covered service amount payable by the Plan. This could be expressed in dollars, number of days, or number of services for a specified period of time.

Benefit Maximum – The greatest covered service amount payable by the Plan for a specific covered service.

Lifetime Benefit Maximum – The greatest covered service amount payable by the Plan in the Participant's Lifetime set forth in the Summary of Benefits.

"MAXIMUM ALLOWABLE CHARGE" or "MAXIMUM ALLOWABLE AMOUNT"
"Maximum Allowable Charge" and/or "Maximum Allowable Amount" shall mean the benefit payable for a specific coverage item or benefit under the Plan. Maximum Allowable Charge(s) or Maximum Allowable Amount(s) will be the lesser of:

1. The negotiated rate established in a contractual arrangement with a Provider;
2. The actual billed charges for the Covered Services; or
3. If a negotiated rate is not available, as is the case for Non-Participating Providers, the allowable amount is developed in accordance with the amount allowed by Medicare to Providers, or an equivalent of what Medicare would allow based on the use of Medicare data or independent relative value unit or other data, for the goods and services reported on the claim, established utilizing the most currently available reimbursement schedules and methodologies, or industry data sources.

The Maximum Allowable Charge or the Maximum Allowable Amount will not include any identifiable billing mistakes including, but not limited to, up-coding, duplicate charges, and charges for services not performed.

1. In the case of an In-Network Participating Provider, the Maximum Allowable Charge or the Maximum Allowable Amount is established by a Provider Agreement or is the billed amount, whichever is less, and will be accepted by the Participating Professional Provider as payment in full for Covered Services. The Participant will be liable for any Deductibles, Coinsurance, Copayments, amounts exceeding any Benefit Maximums, amounts exceeding any Lifetime Benefit Maximums, charges after Covered Services have been exhausted, and charges for non-Covered Services.

   All Dialysis Providers are Out-of-Network. This Plan does not access or use the PPO Network for Dialysis Providers.

2. In the case of an Out-of-Network Non-Participating Provider, the Maximum Allowable Charge or the Maximum Allowable Amount is based on the payment rates allowed by Medicare as follows:

Payment of all covered Out-of-Network Outpatient facility and professional services will be limited to 110% of the Medicare Allowable fee schedule, with covered Out-of-Network Inpatient facility services limited to 125% of the Medicare Allowable fee schedule, except that the Plan may apply the following alternatives:

- Durable Medical Equipment will be limited to 100% of the Medicare Allowable fee schedule.
- Infusion Therapy will be limited to 100% of the Medicare Allowable fee schedule.
- Dialysis services will be limited to 100% of the Medicare Allowable fee schedule.
- Ambulance services will be limited to 100% of the Medicare Allowable fee schedule.

"MEDICAL CARE/MEDICAL SERVICES"
"Medical Care/Medical Services" shall mean services rendered by a Professional Provider intended to prevent Illness (routine Preventive Care) and/or restore health (treatment of an Illness or Injury).

"MEDICAL CHILD SUPPORT ORDER"
"Medical Child Support Order" shall mean any judgment, decree, or order (including approval of a domestic relations settlement agreement) issued by a court of competent jurisdiction that:

1. Provides for Child support with respect to a Participant's Child or directs the Participant to provide coverage under a health benefits plan pursuant to a State domestic relations law (including a community property law); or
2. Enforces a law relating to medical child support described in Social Security Act §1908 (as added by Omnibus Budget Reconciliation Act of 1993 §13822) with respect to a group health plan.

"MEDICAL CARE NECESSITY," "MEDICALLY NECESSARY," OR "MEDICAL NECESSITY"
"Medical Care Necessity," "Medically Necessary," "Medical Necessity" and similar language refers to health care services, procedures, supplies, equipment, Drugs, or habilitation services, that are needed to prevent, diagnose, or treat an Illness, Injury, condition, Disease, or its symptoms, which we conclude are:

- Appropriate for the symptoms, Diagnosis, or treatment of a medical condition; and
- Given for the Diagnosis or direct care and treatment of the medical condition; and
- Within the standards of good medical practice within the organized medical community; and

- Not mainly for the convenience of the Doctor or another Provider, and the most appropriate procedure, supply, equipment, or service which can be safely given.

The most appropriate procedure, supply, equipment, Drug, or service must meet the following requirements:

There must be valid scientific evidence to show that the expected health benefits from the procedure, supply, equipment, Drug, or service are clinically significant and will have a greater chance of benefit, without a disproportionately greater risk of harm or complications, than other possible treatments; and

Generally approved forms of treatment that are less invasive have been tried and did not work or were otherwise unsuitable; and

For Hospital stays, acute care as an Inpatient is needed due to the kind of services the patient needs or the severity of the medical condition, and that safe and adequate care cannot be given as an Outpatient or in a less intensive medical setting.

The most appropriate procedure, supply, equipment, Drug, or service must also be cost-effective compared to alternative interventions, including no intervention or the same intervention in an alternative setting. Cost effective does not always mean lowest cost. It does mean that as to the Diagnosis or treatment of your Illness, Injury or Disease, the service is:

(1) not more costly than another service or group of services that is medically appropriate, or
(2) the service is performed in the least costly setting that is medically appropriate. For example, we will not provide coverage for an Inpatient admission for Surgery if the Surgery could have been performed on an Outpatient basis or an infusion or injection of a Specialty Drug provided in the Outpatient department of a Hospital if the Drug could be provided in a Physician's office or the home setting.

Off-label Drug use is only considered Medically Necessary when all of the following conditions are met:

a. The Drug is approved by the FDA;
b. The prescribed Drug use is supported by one of the following standard reference sources:
    i. DRUGDEX;
    ii. The American Hospital Formulary Service Drug Information;
    iii. Medicare approved Compendia; or
    iv. Scientific evidence is supported in well-designed clinical trials published in peer-reviewed medical journals, which demonstrate that the Drug is safe and effective for the specific condition; and
c. The Drug is Medically Necessary to treat the specific condition, including life threatening conditions or chronic and seriously debilitating conditions.

"MEDICAL EMERGENCY"
A "Medical Emergency" is defined as 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 1) a condition placing the health of the individual (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy; 2) serious impairment to bodily functions; or 3) serious dysfunction of any bodily organ or part.

"MEDICAL REVIEW MANAGER"

The "Medical Review Manager" is the Plan, or designated organization or entity, which may review services as required by the Utilization Review Provisions section or evaluates the Medical Necessity of treatment, services, or supplies.

"MEDICALLY NECESSARY LEAVE OF ABSENCE"
"Medically Necessary Leave of Absence" shall mean a Leave of Absence by a full-time student Dependent at a postsecondary educational Institution that:

1. Commences while such Dependent is suffering from a serious Illness or Injury;
2. Is Medically Necessary; and
3. Causes such Dependent to lose student status for purposes of coverage under the terms of the Plan.

"MEDICARE"
"Medicare" shall mean the programs of health care for the aged and disabled established by Title XVIII of the Social Security Act of 1965, as amended.

"MENTAL HEALTH PARITY ACT (MHPA) OF 1996 AND MENTAL HEALTH PARITY AND ADDICTION EQUITY ACT OF 2008 (MHPAEA), COLLECTIVELY, THE MENTAL HEALTH PARITY PROVISIONS IN PART 7 OF ERISA"
"The Mental Health Parity Provisions" shall mean in the case of a group health plan (or health insurance coverage offered in connection with such a plan) that provides both medical and surgical benefits and mental health or substance use disorder benefits, such plan or coverage shall ensure that:

1. The financial requirements applicable to such mental health or substance use disorder benefits are no more restrictive than the predominant financial requirements applied to substantially all medical and surgical benefits covered by the Plan (or coverage) and that there are no separate cost sharing requirements that are applicable only with respect to mental health or substance use disorder benefits. If these benefits are covered by the group health plan (or health insurance coverage is offered in connection with such a plan); and
2. The treatment limitations applicable to such mental health or substance use disorder benefits are no more restrictive than the predominant treatment limitations applied to substantially all medical and surgical benefits covered by the Plan (or coverage), and that there are no separate treatment limitations that are applicable only with respect to mental health or substance use disorder benefits. If these benefits are covered by the group health plan (or health insurance coverage offered in connection with such a plan).

"MENTAL OR NERVOUS DISORDER"
"Mental or Nervous Disorder" shall mean any Disease or condition, regardless of whether the cause is organic, that is classified as a Mental or Nervous Disorder in the current edition of International Classification of Diseases, published by the U.S. Department of Health and Human Services, is listed in the current edition of Diagnostic and Statistical Manual of Mental Disorders, published by the American Psychiatric Association or other relevant State guideline or applicable sources.

The Mental Health Parity and Addiction Equity Act of 1996 (MHPAEA) provides that the criteria for Medical Necessity determinations with respect to mental health or substance use disorder benefits must be made available by the Plan Administrator to any current or potential Participant, beneficiary, or contracting Provider upon request. The Plan Administrator has delegated this responsibility to the Third-Party Administrator. Please contact the Third-Party Administrator if you have any questions or need any information.

“METABOLIC FORMULAS”
“Metabolic Formulas” shall mean special nutritional formulas administered under the direction of a Physician, which are necessary to sustain life for a genetic metabolic disorder.

“MORBID OBESITY”
“Morbid Obesity” shall mean the term that refers to patients who have a body mass index (BMI) of 40 or greater.

“NAMED FIDUCIARY”
“Named Fiduciary” shall mean the person or entity who has the complete authority to control and manage the operation and administration of the Plan. The Named Fiduciary for the Plan is the Plan Sponsor.

In exercising its fiduciary responsibilities, the Plan Sponsor shall have sole, full and final discretionary authority to determine eligibility for benefits, review denied claims for benefits, construe and interpret all Plan provisions, construe disputed Plan terms, select managed care options, determine all questions of fact and law arising under this Plan, and to administer the Plan’s subrogation and reimbursement rights. The Plan Sponsor shall be deemed to have properly exercised such authority unless it has abused its discretion by acting arbitrarily and capriciously.

Any other individual or entity exercising any discretionary authority with respect to the Plan shall also be deemed to have properly exercised such authority unless it has abused its discretion by acting arbitrarily and capriciously.

“NETWORK”
“Network” shall mean the medical Provider Network the Plan contracts to access discounted fees for service for Participants. The Network Provider will be identified on the Participant’s identification card.

“NO-FAULT AUTO INSURANCE”
“No-Fault Auto Insurance” is the basic reparations provision of a law providing for payments without determining fault in connection with automobile Accidents.

“NON-PREFERRED PRESCRIPTION DRUG”
“Non-Preferred Prescription Drug” shall mean any Prescription Drug listed as a non-formulary brand of the Plan Drug Formulary.

“NUTRITIONAL THERAPY”
“Nutritional Therapy” shall mean nutritional diagnostic, therapy, and counseling services for the purpose of Disease management which are furnished by a licensed health care professional to help a person make and maintain healthy dietary changes.

“OPEN ENROLLMENT PERIOD”
“Open Enrollment Period” shall mean the period of time, immediately prior to the annual renewal date, during which an Eligible Person may elect to enroll or change their current coverage. Open Enrollment activity is irrevocable, unless a qualifying event occurs as defined by Section 125 of the IRS Code, even if the Plan is not a qualified plan as defined by Section 125, including but not limited to: loss of coverage due to legal separation, divorce, death of an employee, termination, or reduction in hours of

employment, exhaustion of COBRA, Dependent reaching maximum age, and moving out of the Network service area. Loss of coverage does not include loss due to failure to pay premiums or termination for cause. Qualifying events also include marriage, birth, adoption, Placement for Adoption and change in the employer contribution.

"OSTOMY"
"Ostomy" shall mean an artificial stoma or opening into the urinary tract, gastrointestinal canal, or the trachea.

"OSTOMY SUPPLIES"
"Ostomy Supplies" shall mean generally non-reusable items or appliances, such as pouches, irrigation equipment and skin barriers, specifically used in the maintenance of hygiene and skin protection in Ostomy patients, ordered by or used on the advice of a healthcare Provider.

"OTHER PLAN"
"Other Plan" shall include, but is not limited to:

1. Any primary payer besides the Plan;
2. Any other group health plan;
3. Any other coverage or policy covering the Participant;
4. Any first party insurance through medical payment coverage, personal injury protection, no-fault coverage, uninsured or underinsured motorist coverage;
5. Any policy of insurance from any insurance company or guarantor of a responsible party;
6. Any policy of insurance from any insurance company or guarantor of a third party;
7. Workers' compensation or other liability insurance company; or
8. Any other source, including but not limited to crime victim restitution funds, any medical, disability or other benefit payments, and school insurance coverage.

"OUT-OF-AREA"
"Out of Area" shall mean a geographic area, as determined by the Claims Fiduciary at the time each Participant becomes eligible for coverage under this Plan.

"OUT-OF-POCKET" OR "OUT-OF-POCKET MAXIMUM"
"Out-of-Pocket" or "Out-of-Pocket Maximum" shall mean a dollar amount paid by the Participant which includes Deductible, Coinsurance, and Copayment amounts. It does not include penalties for failure to obtain Pre-Certification, premiums, amounts in excess of the Maximum Allowable Charge, Amounts not paid by the Plan due to the difference between the Non-Participating Provider benefit and the benefit that would have been paid had a Participating Provider been used, charges for non-Covered Services, charges after Covered Services have been exhausted, and ancillary fees for a brand-name Drug product when a generic equivalent Prescription Drug is available for substitution.

The Out-of-Pocket Limit is the sum of the Covered Services each Year for which the Plan does not pay benefits because of any applicable Deductible, Coinsurance or Copayments. When Covered Services equal to the Out-of-Pocket Limit have been Incurred and processed by the Plan, the Out-of-Pocket Limit will be satisfied for the remainder of the Year. The Out-of-Pocket Limit applies separately to each Covered Person, except as otherwise provided by this Plan.

The Benefit Summary identifies the following Out-of-Pocket Limits, if applicable:

1) **Family Out-of-Pocket Maximum:** The total dollar amount of Covered Services that must be paid by You and Your Covered Dependents before The Plan will consider the Out-of-Pocket Limit for all Covered Persons under the same Family Plan to be satisfied.

2) **Individual Out-of-Pocket Maximum:** The dollar amount of Covered Services that must be paid by each Covered Person before the Out-of-Pocket Limit is satisfied for that Covered Person.

3) **Non-Participating Provider Out-of-Pocket Maximum**: The dollar amount of Covered Services for services received from Non-Participating Providers that must be paid by each Covered Person before the Non-Participating Provider Out-of-Pocket Limit is satisfied for that Covered Person.

4) **Participating Provider Out-of-Pocket Maximum:** The dollar amount of Covered Services for services received from Participating Providers that must be paid by each Covered Person before the Participating Provider Out-of-Pocket Limit is satisfied for that Covered Person.

"OUTPATIENT"
"Outpatient" shall mean a Participant who receives services or supplies while not an Inpatient. A Covered Person shall be considered to be an "Outpatient" if he is treated at a Hospital and is confined less than 23 consecutive hours.

"PARTIAL HOSPITALIZATION for PSYCHIATRIC CARE SERVICES"
"Partial Hospitalization for Psychiatric Care Services" shall mean the provision of diagnostic and therapeutic services for the treatment of Mental Illness on an Outpatient basis only during the day or night through a Hospital or Psychiatric Hospital based program which is approved by the Joint Commission on the Accreditation of Healthcare Organizations.

"PARTIAL HOSPITALIZATION for SUBSTANCE ABUSE SERVICES"
"Partial Hospitalization for Substance Abuse Services" shall mean the provision of medical, nursing, counseling, or therapeutic services on a planned and regularly scheduled basis in a Hospital or non-Hospital facility licensed by the Department of Health or provide an alcohol or drug addiction treatment program designed for a patient or client who would benefit from more intensive services than are offered in Outpatient treatment but who does not require Inpatient care.

"PHARMACY PROVIDER" OR "PARTICIPATING PHARMACY PROVIDER"
"Pharmacy Provider" or "Participating Pharmacy Provider" shall mean any Pharmacy, which has entered into a participating Pharmacy agreement with the Plan or other entity contracted by the Plan to furnish a Pharmacy Provider Network. Participating Pharmacy Providers include: Participating Pharmacy Providers, Mail Order Pharmacy Providers and Participating Pharmacy Providers for Specialty Drugs.

"PARTICIPATING PHARMACY PROVIDER FOR SPECIALTY DRUGS"
"Participating Pharmacy Provider for Specialty Drugs" shall mean a Participating Pharmacy Provider, which has entered into a Specialty Drug Provider agreement with the Plan.

"PARTICIPANT"
"Participant" shall mean a covered Employee or a covered Dependent. No person is eligible for health care benefits both as an Employee and as a Dependent under this Plan. When the Employer employs both husband and wife, any Dependent Child(ren) may become covered hereunder only as Dependents of one Spouse. Participant and Covered Person have the same meaning within this SPD.

"PHARMACIST"

"Pharmacist" shall mean an individual who has been issued a license by the appropriate state licensing agency to engage in the practice of Pharmacy, including the preparation and dispensing of Prescription Drugs and the dissemination of Drug information to patients and health professionals.

"PHARMACY"
"Pharmacy" shall mean an establishment which has been issued a permit by the appropriate state licensing agency wherein the practice of pharmacy is conducted under the direct supervision and control of a licensed Pharmacist.

"PHARMACY CARE"
"Pharmacy Care" shall mean medications prescribed by a licensed Physician, licensed Physician Assistant or Certified Registered Nurse Practitioner and any assessment, evaluation or test prescribed or ordered by a licensed Physician, licensed Physician Assistant or Certified Registered Nurse Practitioner to determine the need or effectiveness of such medications.

"PHYSICIAN"
"Physician" shall mean a person, who is a Doctor of Medicine (M.D.) or a doctor of osteopathy (D.O.), licensed and legally entitled to practice medicine in all of its branches, perform Surgery and prescribe and administer Drugs.

"PLACEMENT FOR ADOPTION"
"Placement for Adoption" shall mean the assumption and retention of a legal obligation for total or partial support in anticipation of adoption.

"PLAN ADMINISTRATOR"
"Plan Administrator" shall mean the entity responsible for the day-to-day functions and overall management of the Plan. The Plan Administrator may employ persons or firms to process claims and perform other Plan connected services.

"PLAN YEAR"
"Plan Year" shall mean a period commencing on the Effective Date or any anniversary of the adoption of this Plan and continuing until the next succeeding anniversary.

"PRE-CERTIFICATION"
"Pre-Certification" shall mean the process whereby a Provider or a Participant, as applicable, is required to obtain certification from Medical Review Manager for Covered Services prior to the date of service.

"PREFERRED PRESCRIPTION DRUG"
"Preferred Prescription Drug" shall mean any Prescription Drug, which is listed in the Drug Formulary and preferred by the Plan.

"PREFERRED PROVIDER ORGANIZATION (PPO)", "PPO NETWORK" or "PPO"
"Preferred Provider Organization (PPO)", "PPO Network" or "PPO" shall mean an organization that contracts with a Network of Providers from which the health plan Participant can choose. Participants do not need to select a Primary Care Physician (PCP) and do not need referrals to see other Providers in the Network.

"PREGNANCY"

"Pregnancy" shall mean carrying a child, resulting childbirth, miscarriage, and non-elective abortion. The Plan considers Pregnancy as a Sickness for the purpose of determining benefits.

"PRESCRIBER"
"Prescriber" shall mean an individual who has been issued a license by the appropriate state licensing agency to engage in a health care professional practice, who, acting within the scope of his/her license, is duly authorized by law to prescribe Prescription Drugs.

"PRESCRIPTION" OR "PRESCRIPTION ORDER"
"Prescription" or "Prescription Order" shall mean an order from a Prescriber for a single Prescription Drug of a particular strength and/or dosage form.

"PRESCRIPTION DRUG"
"Prescription Drug" shall mean any medication, which by federal and/or state law may not be dispensed without a Prescription Order issued by a Prescriber.

"PRESCRIPTION DRUG COPAYMENT"
"Prescription Drug Copayment" shall mean the amount a Participant must pay directly to Pharmacy Providers in connection with Covered Pharmacy Expenses as set forth in the Benefit Summary.

"PRESCRIPTION DRUG MAXIMUM"
"Prescription Drug Maximum" shall mean the greatest covered service amount payable by the Plan for Covered Pharmacy Expenses as set forth in the Benefit Summary.

"PREVENTIVE CARE"
"Preventive Care" shall mean certain Preventive Care services.

This Plan intends to comply with the Affordable Care Act's (ACA's) requirement to offer In-Network coverage for certain preventive services without cost-sharing. To comply with the ACA, and in accordance with the recommendations and guidelines, the Plan will provide In-Network coverage for:

1. Evidence-based items or services rated A or B in the United States Preventive Services Task Force recommendations;
2. Recommendations of the Advisory Committee on Immunization Practices adopted by the Director of the Centers for Disease Control and Prevention;
3. Comprehensive guidelines for infants, Children, and adolescents supported by the Health Resources and Services Administration (HRSA); and
4. Comprehensive guidelines for women supported by the Health Resources and Services Administration (HRSA).

Copies of the recommendations and guidelines may be found here: http://www.uspreventiveservicestaskforce.org or at https://www.healthcare.gov/preventive-care-benefits/. For more information, you may contact the Plan Administrator or Employer.

"PRIMARY CARE PHYSICIAN"
"Primary Care Physician" shall mean a Physician, who supervises, coordinates, and provides initial care and basic Medical Services to Participant's as a general or family care practitioner, an internist, or a pediatrician, and maintains continuity of patient care.

"PRIOR AUTHORIZATION"

"Prior Authorization shall mean with regard to Prescription Drug Covered Services, the process whereby the Prescriber and/or the Participant is given prior approval by the Plan for certain Prescription Drugs, including Drug Formulary exceptions, and utilization review criteria, which have been designated by the Plan as requiring Prior Authorization.

"PRIOR PLAN"
"Prior Plan" shall mean the coverage provided on a group or group type basis by the group insurance policy, benefit plan or service plan that was terminated on the day before the Effective Date of the Plan and replaced by the Plan.

"PRIVACY STANDARDS"
"Privacy Standards" shall mean the standards of the privacy of individually identifiable health information, as pursuant to HIPAA.

"PRIVATE DUTY NURSING"
"Private Duty Nursing" shall mean total patient care provided by a Registered Nurse or Licensed Practical Nurse on an individual basis.

"PROFESSIONAL PROVIDER"
"Professional Provider" shall mean an individual or practitioner, who is licensed/certified to render Covered Services. Professional Providers include, but are not limited to:

- Certified Addiction Counselor;
- Clinical Psychologist;
- Chiropractor;
- Clinical Nurse Specialist;
- Dentist;
- Licensed Dietitian;
- Licensed Practical Nurse;
- Nurse Midwife;
- Nurse Practitioner;
- Occupational Therapist;
- Optometrist;
- Physical Therapist;
- Physician;
- Physician Assistant;
- Podiatrist;
- Registered Nurse;
- Clinical Social Worker; and
- Speech Therapist

"PROSTHESIS", "PROSTHETIC DEVICE", or "PROTHESES"
"Prosthesis", "Prosthetic device", or "Protheses" shall mean an artificial body part, which replaces all or part of a body organ or which replaces all or part of the function of a permanently inoperative or malfunctioning body part.

"PROVIDER"
"Provider" shall mean a Physician, a licensed speech or occupational therapist, licensed professional physical therapist, physiotherapist, audiologist, speech language pathologist, licensed professional

counselor, certified nurse practitioner, certified psychiatric/mental health clinical nurse, or other practitioner or facility defined or listed herein, or approved by the Third-Party Administrator.

"PARTICIPATING PROVIDER", "PARTICIPATING PROFESSIONAL PROVIDER", OR "PARTICIPATING FACILITY PROVIDER"
"Participating Provider", "Participating Professional Provider", or "Participating Facility Provider" shall mean a Provider who signed a Provider Agreement with the PPO Network.

"NON-PARTICIPATING PROVIDER", "NON-PARTICIPATING PROFESSIONAL PROVIDER", OR "NON-PARTICIPATING FACILITY PROVIDER"
"Non-Participating Provider", "Non-Participating Professional Provider", or "Non-Participating Facility Provider" shall mean a Provider who has not signed a Provider Agreement with the PPO Network.

"PROVIDER AGREEMENT"
"Provider Agreement" shall mean an agreement between a Provider and the Plan pursuant to which negotiated rates are established for payment of Covered Services rendered to Participant.

"PSYCHIATRIC CARE"
"Psychiatric Care" shall mean direct or consultative service provided by a Physician who specializes in psychiatry.

"PSYCHIATRIC HOSPITAL"
"Psychiatric Hospital" shall mean an Institution constituted, licensed, and operated as set forth in the laws that apply to Hospitals, which meets all of the following requirements:

1. It is primarily engaged in providing psychiatric services for the Diagnosis and treatment of mentally ill persons either by, or under the supervision of, a Physician;
2. It maintains clinical records on all patients and keeps records as needed to determine the degree and intensity of treatment provided;
3. It is licensed as a Psychiatric Hospital;
4. It requires that every patient be under the care of a Physician; and
5. It provides twenty-four (24) hour a day nursing service.

The term Psychiatric Hospital does not include an Institution, or that part of an Institution, used mainly for nursing care, rest care, convalescent care, care of the aged, Custodial Care or educational care.

"PSYCHOLOGICAL CARE"
"Psychological Care" shall mean direct or consultative services provided by a Psychologist.

"PSYCHOLOGIST"
"Psychologist" shall mean a licensed clinical Psychologist.

"QUALIFIED MEDICAL CHILD SUPPORT ORDER" OR "QMCSO"
"Qualified Medical Child Support Order" or "QMCSO" is a Medical Child Support Order that creates or recognizes the existence of an Alternate Recipient's right to, or assigns to an Alternate Recipient the right to, receive benefits for which a Participant or eligible Dependent is entitled under this Plan.

If Your Employer determines that a separated or divorced Spouse or any state child support or Medicaid agency has obtained a legal QMCSO, and Your current plan offers Dependent coverage, You will be

required to provide coverage for any Child(ren) named in the QMCSO. If You do not enroll the Child(ren), Your Employer must enroll the Child(ren) upon application from Your separated/divorced Spouse, the state child support agency or Medicaid agency and withhold from Your pay Your share of the cost of such coverage. You may not drop coverage for the Child(ren) unless You submit written evidence to Your Employer that the child support order is no longer in effect. The plan may make benefit payments for the Child(ren) covered by a QMCSO directly to the custodial parent or legal guardian of such Child(ren). ERISA preemption of state laws does not apply to Qualified Medical Child Support Orders and provisions of state laws requiring medical child support. Group health plans may not deny enrollment of a child under the health coverage of the child's parent on the ground that the child is born out of wedlock, not claimed as a dependent on the parent's tax return, or not in residence with the parent or in the applicable service area. Additional information concerning "QMCSO" procedures are available from the Plan Administrator at no charge upon request.

"REASONABLE OR REASONABLENESS"
"Reasonable" or "Reasonableness "shall mean in the Plan Administrator's discretion, services or supplies, or charges for services or supplies, which are necessary for the care and treatment of Illness or Injury. Determination that charges or services/supplies are Reasonable will be made by the Plan Administrator, taking into consideration unusual circumstances or complications requiring additional time, skill, and experience in connection with a particular service or supply; industry standards and practices as they relate to similar scenarios; and/or the cause of Injury or Illness necessitating the service(s) and/or charge(s).

This determination may consider, but not be limited to, the findings and assessments of the following entities: (a) national medical associations, societies, and organizations; and (b) The Food and Drug Administration. To be Reasonable, services, supplies and/or charges must follow the Plan Administrator's policies and procedures relating to billing practices for unbundling or multiple procedures. The Plan Administrator retains discretionary authority to determine whether services, supplies and/or charges are Reasonable based upon information presented to the Plan Administrator.

Reasonable or Reasonableness shall include the least expensive professionally acceptable treatment if multiple treatment options are available. When there are multiple viable options of treatment available for a specific condition, the Plan will only pay for the least expensive treatment alternative.

The Plan reserves for itself and parties acting on its behalf the right to review charges processed and/or paid by the Plan, and to identify charges and/or services that are not Reasonable, and therefore not eligible for payment by the Plan.

"REGISTERED NURSE (RN)"
"Registered Nurse (RN)" shall mean a nurse who has graduated from a formal program of nursing education (diploma school, associate degree or baccalaureate program) and is licensed by appropriate state authority.

"REHABILITATION HOSPITAL"
"Rehabilitation Hospital" shall mean a Facility Provider approved by the appropriate accrediting agency or a similar accrediting agency acceptable to the Plan, which is primarily engaged in providing Rehabilitation care services on an Inpatient basis. Rehabilitation care services consist of the combined use of medical, social, educational, and vocational services to enable patients Disabled by Disease or Injury to achieve the highest possible level of functional ability. Services are provided by or under the

supervision of an organized staff of Physicians. Continuous nursing services are provided by or under the supervision of a Registered Nurse.

"RESPITE CARE"
"Respite Care" shall mean Residential Medical Care given in a setting outside the patient's home, such as in a Skilled Nursing Facility, in order to provide a brief interval of relief for the patient's primary caregiver, which is usually a family member.

"RETAIL CLINIC CARE"
"Retail Clinic Care" shall mean the treatment of common minor ailments (in a health care facility located in a convenient setting, such as a retail store, grocery store or Pharmacy, which offers unscheduled, walk-in care) including, but not limited to, sore throat, coughs, or pink eye.

"ROOM AND BOARD"
"Room and Board" shall mean a Hospital's charge for:

1. Room and linen service;
2. Dietary service, including meals, special diets, and nourishment;
3. General nursing service; and
4. Other conditions of occupancy which are Medically Necessary.

"SECOND SURGICAL OPINION"
"Second Surgical Opinion" shall mean a written statement on the necessity for the performance of a covered Surgical Procedure. This Second Surgical Opinion must be given by a board-certified Specialist Physician who, by the nature of the Physician's specialty, qualifies the Physician to consider the Surgical Procedure being proposed and who is otherwise not associated with the surgeon who initially recommended the Surgery.

"SECURITY STANDARDS"
"Security Standards" shall mean the final rule implementing HIPAA's Security Standards for the Protection of Electronic PHI, as amended.

"SEMI-PRIVATE ROOM"
"Semi-Private Room" shall mean the bed, board and nursing care regularly provided to patients in a room which is designated as semi-private by the Provider of care and which contains more than one bed.

"SERIOUS MENTAL ILLNESS"
"Serious Mental Illness" shall mean any of the following mental Illnesses, as defined by the American Psychiatric Association; schizophrenia, bipolar disorder, obsessive-compulsive disorder, major depressive disorder, panic disorder, anorexia nervosa, bulimia nervosa, schizo-affective disorder, and delusional disorder.

"SERVICE AREA"
"Service Area" shall mean the geographical areas designated by the PPO as meeting Provider adequacy in coverage standards.

"SICKNESS"
"Sickness" shall have the meaning set forth in the definition of "Disease."

“SKILLED NURSING FACILITY”
“Skilled Nursing Facility” shall mean a Facility Other Provider, which is an Institution or a distinct part of an Institution, other than one which is primarily for the care and treatment of Mental Disorders, alcoholism, or drug addiction, which is certified as a Skilled Nursing Facility under the Medicare Law, or is qualified to receive such approval, if so requested.

“SPECIAL ENROLLMENT”
“Special Enrollment” shall mean an enrollment which takes place during the 30-day period following the date of the event which triggers the Special Enrollment period. See “Eligibility” section for details.

“SPECIALIST PHYSICIAN”
“Specialist Physician” shall mean a Physician who provides Medical Care in any generally accepted medical specialty or subspecialty.

“SPECIALTY DRUG”
“Specialty Drug” shall mean any Prescription Drug, which has been specifically designated by the Plan as being available from only a Participating Pharmacy for Specialty Drugs. Such Prescription Drugs classes include, but are not limited to self-administrable injectables, such as antihemophilic agents, hematopoietic agents, growth hormones, enzyme replacement agents, immunomodulators, immunosuppressives, monoclonal antibodies, and other biotech Drugs. From time-to-time, such as when new biotech Drugs become available, the Plan may specify certain Prescription Drugs that are available from only a Participating Pharmacy for Specialty Drugs.

Specialty Drugs do not include:
- Anti-coagulants
- Anti-rejection drugs following an organ transplant
- Drugs provided in an Emergency as determined by the Plan Administrator

“SPOUSE”
“Spouse” shall mean an Employee’s spouse, under a legally valid existing marriage. This Plan defines “marriage” as both 1) a legal union between one man and one woman as husband and wife, legally married in a jurisdiction (domestic or foreign) that recognizes their marriage, and 2) a legal union between two persons of the same sex, legally married in a jurisdiction (domestic or foreign) that recognizes their marriage. Marriage does not include a civil union, domestic partnership, or any other similar arrangement.

The Plan Administrator has discretionary authority to interpret these terms, and determine spousal status as defined herein, to the extent allowed by law.

“STEP THERAPY”
“Step Therapy” shall mean when alternative Prescription Drug treatments are available, the Plan considers Covered Charges for Prescription Drugs in accordance with Our Drug List for the most cost-effective option. Before the Plan authorizes coverage of a particular Prescription Drug, the Plan may require the Covered Person's Provider to prescribe one or more different Prescription Drugs first, unless all such other Prescription Drugs have been demonstrated to be clinically: 1) adverse or 2) non-effective for the Covered Person. Requiring a particular Drug or Drugs to be prescribed and attempted first before authorizing a different Drug is called Step Therapy. Even if the Covered Person had previously taken the Prescription Drug being requested, the Plan may require Step Therapy under this Plan. The Step Therapy could include changes to the dosage of the Prescription Drug or substituting the Prescription Drug with a

different Drug(s) or Drug regimen in the same or similar therapeutic classification. Covered Persons should call the Plan to discuss options available to them. An Ancillary Charge may still apply.

"SUBACUTE MEDICAL CARE"
"Subacute Medical Care" shall mean a short-term comprehensive Inpatient program of care for a Covered Person who has a Sickness or an Injury that: 1) Does not require the Covered Person to have a prior admission as an Inpatient in a licensed medical facility; and 2) Does not require intensive diagnostic and/or invasive procedures; and 3) Requires Health Care Practitioner direction, intensive nursing care, significant use of ancillaries, and an outcome-focused, interdisciplinary approach using a professional medical team to deliver complex clinical interventions.

"SUBSTANCE ABUSE"
"Substance Abuse" shall mean any use of alcohol, any drug (whether obtained legally or illegally), any narcotic, or any hallucinogenic or other illegal substance, which produces a pattern of pathological use, causing impairment in social or occupational functioning, or which produces physiological dependency evidenced by physical tolerance or withdrawal. It is the excessive use of a substance, especially alcohol or a drug. The Diagnostic and Statistical Manual of Mental Disorders (DSM) definition of "Substance Use Disorder" is applied as follows:

1. A maladaptive pattern of substance use leading to clinically significant impairment or distress, as manifested by one (or more) of the following, occurring within a twelve (12)-month period:
    a. Recurrent substance use resulting in a failure to fulfill major role obligations at work, school, or home (e.g., repeated absences or poor work performance related to substance use; substance-related absences, suspensions, or expulsions from school; neglect of Children or household);
    b. Recurrent substance use in situations in which it is physically hazardous (e.g., driving an automobile or operating a machine when impaired by substance use);
    c. Craving or a strong desire or urge to use a substance; or
    d. Continued substance use despite having persistent or recurrent social or interpersonal problems caused or exacerbated by the effects of the substance (e.g., arguments with Spouse about consequences of intoxication, physical fights); and
2. The symptoms have never met the criteria for Substance Dependence for this class of substance.

"SUBSTANCE ABUSE TREATMENT CENTER"
"Substance Abuse Treatment Center" shall mean an Institution which provides a program for the treatment of Substance Abuse by means of a written treatment plan approved and monitored by a Physician. This Institution must be:

1. Affiliated with a Hospital under a contractual agreement with an established system for patient referral;
2. Accredited as such a facility by the Joint Commission on Accreditation of Hospitals; or
3. Licensed, certified, or approved as an Alcohol or Drug Abuse treatment program or center by a State agency having legal authority to do so.

Substance Dependence: Substance use history which includes the following: (1) Substance Abuse (see above); (2) continuation of use despite related problems; (3) development of tolerance (more of the Drug is needed to achieve the same effect); and (4) withdrawal symptoms.

"SUPPLIER"

"Supplier" shall mean an individual or entity that is in the business of leasing and selling Durable Medical Equipment and supplies, Prostheses and Orthoses.

"SURGERY"
"Surgery" shall mean any of the following:

1. The incision, excision, debridement or cauterization of any organ or part of the body, and the suturing of a wound;
2. The manipulative reduction of a fracture or dislocation or the manipulation of a joint including application of cast or traction;
3. The removal by endoscopic means of a stone or other foreign object from any part of the body or the diagnostic examination by endoscopic means of any part of the body;
4. The induction of artificial pneumothorax and the injection of sclerosing solutions;
5. Arthrodesis, paracentesis, arthrocentesis and all injections into the joints or bursa;
6. Obstetrical delivery and dilatation and curettage; or
7. Biopsy.

"SURGICAL PROCEDURE"
"Surgical Procedure" shall have the same meaning set forth in the definition of "Surgery."

"TELEHEALTH SERVICES"
Members may be provided with 24/7 access to consultations with licensed physicians. Members can choose to consult with a doctor by telephone or video conferencing where available. Prescriptions for medications may be available, incident to establishment of physician-patient relationship and a diagnostic consultation as permitted by law. Physician consultation services may not be offered in states that are restrictive of telemedicine services. The Plan does not provide, direct or control medical care or treatment and medical providers are not the agents or employees of the Plan. All decisions regarding medical care or treatment and the results thereof are solely within the control of the Participant and Provider.

"THERAPEUTIC CARE"
"Therapeutic Care" shall mean services provided by Speech Language Pathologists, Occupational Therapists or Physical Therapists.

"THERAPY SERVICE"
"Therapy Service" shall mean services or supplies used for the treatment of an Illness or Injury to promote the recovery of a Participant. Therapy Services are covered to the extent specified in the Plan.

1. Cardiac Rehabilitation therapy – An exercise program, which is effective in the physiological and psychological Rehabilitation of patients with cardiac conditions;
2. Cognitive Rehabilitation therapy – A structured set of therapeutic activities designed to retain an individual's ability to think, use judgment and make decisions. The focus is on improving deficits in memory, attention, perception, learning, planning, and judgment. The term, cognitive Rehabilitation, is applied to a variety of intervention strategies or techniques that attempt to help patients reduce, manage, or cope with cognitive deficits caused by brain Injury;
3. Dialysis treatment – The treatment of acute renal failure or chronic irreversible renal insufficiency or removal of waste materials from the body to include hemodialysis or peritoneal dialysis;
4. Occupational therapy – The treatment of a physically Disabled person by means of constructive activities designed and adapted to promote the restoration of the person's ability to satisfactorily

accomplish the ordinary tasks of daily living and those required by the person's particular occupational role;

5. Physical therapy – The treatment by physical means, hydrotherapy, heat, or similar modalities, physical agents, bio-mechanical and neuro-psychological principles, and devices to relieve pain, restore maximum function, and prevent Disability following Disease, Injury or loss of body part performed by a licensed Physical Therapist;
6. Pulmonary Rehabilitation therapy – A program of exercise training, psychological support and pulmonary physiotherapy education which is intended to improve the patient's functioning and quality of life by controlling and alleviating symptoms, including complications of pulmonary disorders;
7. Radiation therapy – The treatment of Disease by x-ray, gamma ray, accelerated particles, mesons, neutrons, radium, or radioactive isotopes;
8. Respiratory therapy – The introduction of dry or moist gases into the lungs for treatment purposes; and
9. Speech therapy – The treatment for the correction of a speech impairment resulting from Disease, Surgery, Injury, anomalies, or previous therapeutic processes.

"THIRD PARTY ADMINISTRATOR"
"Third-Party Administrator" shall mean the claims administrator which provides customer service and claims payment services only and does not assume any financial risk or obligation with respect to those claims.

"TOTAL DISABILITY"
"Total Disability" shall mean an individual is determined as being disabled for Social Security purposes and provides such evidence to the Plan of the determination as the Plan Administrator may, in its sole discretion, require.

"TOTALLY DISABLED"
"Totally Disabled" shall have the same meaning set forth in the definition of "Total Disability."

"TRANSITIONAL LIVING FACILITY"
"Transitional Living Facility" shall mean a facility that renders long-term residential care. This type of facility can be licensed, however, a facility providing long-term residential care is not to be considered an Inpatient Non-Hospital Residential Facility rendering Inpatient Non-Hospital Residential Care. Specific Transitional Living Facilities include half-way houses, group homes or supervised apartment settings.

"TREATMENT PLAN FOR AUTISM SPECTRUM DISORDERS"
"Treatment Plan for Autism Spectrum Disorders" shall mean a plan for the treatment of Autism Spectrum Disorders developed by a licensed Physician or licensed Psychologist pursuant to a comprehensive evaluation or re-evaluation performed in a manner consistent with the most recent clinical report or recommendations of the American Academy of Pediatrics.

"UNIFORMED SERVICES"
"Uniformed Services" shall mean the Armed Forces, the Army National Guard, the Air National Guard, and Military Sealift Command when engaged in active duty for training, inactive duty training, or full time National Guard duty, the commissioned corps of the Public Health Service, and any other category of persons designated by the President of the United States in time of war or Emergency.

"URGENT CARE"

"Urgent Care" shall mean the provision of immediate medical service offering Outpatient care (in a facility dedicated to the delivery of unscheduled, walk-in care outside of a Hospital emergency department) for the treatment of acute and chronic Illness or Injury.

"USERRA"
"USERRA" shall mean the Uniformed Services Employment and Reemployment Rights Act of 1994 ("USERRA").

"WAITING PERIOD"
"Waiting Period" shall mean the period before an individual is eligible to be covered under the terms of a group health plan. Any period before a Late Enrollment, Open Enrollment, Status Changes, or Special Enrollment is not a Waiting Period.

"YOU, YOUR, YOURSELF"
"You", "Your", "YOURSELF" shall mean a covered Employee or a covered Dependent. No person is eligible for health care benefits both as an Employee and as a Dependent under this Plan. When the Employer employs both husband and wife, any Dependent Child(ren) may become covered hereunder only as Dependents of one Spouse.

All other defined terms in this Plan Document shall have the meanings specified in the Plan Document where they appear.

SECTION 8: ELIGIBILITY

The following persons are eligible to enroll in the Plan. Please refer to the Definitions for additional information.

- Employees
- Dependents Including:
    - Spouse
    - Dependent Child(ren)
    - Domestic Partners: In order to qualify as a domestic partner of an Employee of this Plan and to be considered as an eligible Dependent of the Plan, if requested, evidence of joint responsibility must be provided.

      Further, the Employee and partner qualifying for domestic partnership coverage under this Plan must agree, upon termination of the Domestic Partnership, to notify the Plan Sponsor within 30 days of such termination.

      The Internal Revenue Service generally does not consider Domestic Partners and their Child(ren) eligible Dependents. Therefore, the value of Plan Sponsor's cost in covering a Domestic Partner may be imputed to the Employee as income. In addition, the share of the Employee's contribution that covers a Domestic Partner and their Child(ren) may be paid using after-tax payroll deductions.

An Eligible Person and their Dependents may elect to be covered under this Plan by completing and signing an enrollment form that is approved by the Plan Administrator and/or its designee. This form may contain health or other information. Verification of eligibility may also be required.
This Plan does not cover:

- Independent Contractors or their Dependents.

Non-Discrimination
In regard to the offering of coverage, the Plan will not discriminate against any individual on the basis of health status, medical condition (physical or mental), claims experience, receipt of health care, medical history, Genetic Information, evidence of insurability or disability. No otherwise eligible individual will be refused the opportunity to enroll in the Plan due to participation in any particular activity, regardless of its hazardous nature. The Plan will not discriminate against similarly situated individuals in regard to eligibility or benefits (however, this does not limit the Plan's ability to treat Participants classifiable through non-health related criteria as different groups in different ways.) The Plan will not knowingly discriminate against any individual on the basis of health factors. However, the Plan may impose coverage limits or exclusions on all similarly situated individuals which may have an effect on only some individuals.

Enrollment

- **Enrollment Waiting Period:**

All Employees shall be eligible on the first day of the month following 30 days of employment. Provided the new Employee is Actively at Work on at least the first day of employment, the Plan will not exclude absences from work due to health-related reasons from credit towards the waiting period.

An Employee rehired after a break in service of ninety-one (91) days is considered to be a new hire and must meet the applicable Enrollment Waiting Period.

- **Dependent Coverage:**
  Each Dependent of the eligible Employee becomes eligible for Dependent coverage under the Plan on the later of the following:
  1. The date the Employee is eligible; or
  2. The date the individual becomes a Dependent of the Employee if on that date the Employee is covered.

- **Individual Effective Date:**
  All persons become covered, as they become eligible subject to the following:
  1. All Employees, who are eligible Employees, shall be covered on the latest of the following dates:
     a. The date the Employer's Plan first becomes effective provided that You are eligible, have satisfied any Waiting Period, and enroll for coverage during the initial enrollment period
     b. The date specified in the Enrollment Waiting Period provided that You are Actively at Work, have satisfied the Waiting Period, and enroll for coverage within 31 days after You first become eligible
     c. On the date provided in accordance with Special Enrollment
  2. Eligible Dependents shall be covered on the latest of the following two dates:
     a. Your Effective Date, if your Dependent was included on Your initial enrollment form for coverage
     b. The first day of the calendar month following Your Enrollment Date if You apply for coverage with 61 days of the Dependent first becoming eligible
  3. Coverage for a Spouse or Stepchild due to marriage will be effective no later than the first of the month beginning after the date the plan receives the request for enrollment. The Spouse or Stepchild must be formally enrolled and appropriate coverage arranged within 30 days from date of marriage.
  4. Coverage for a newborn birth Child will begin from the date of birth. The Child must be formally enrolled and appropriate coverage arranged within 30 days from birth.
  5. Coverage for a Child placed under legal guardianship, an adopted Child or a Child placed for adoption with the Employee will begin from the date of Placement for Adoption. The Child must be formally enrolled and appropriate coverage arranged within 30 days from the date of Placement For Adoption.
  6. Coverage for a stepchild or foster Child(ren) will begin from the date the Child meets the definition of "Dependent." The Child must be formally enrolled and appropriate coverage arranged within 30 days from the date that the Child meets the definition of "Dependent."

- **Open Enrollment Period:**
  Each year, a period may be designated as an Open Enrollment period. Except for Special Enrollment or Late Enrollment, if applicable, it is only during this period that an Employee or Dependent who did not enroll during their initial eligibility period may enroll in a Plan. It is also only during this period that an Employee who is currently covered under one Plan may switch to another. Coverage will become effective on the date specified by Your Employer.

- **Late Enrollment Period:**

This Plan does not have a Late Enrollment period.

Updating Coverage and/or Removing Dependents
You are required to notify the Plan Sponsor of any changes that affect your eligibility or the eligibility of your Dependents for this Plan. When any of the following occurs, contact the Plan Sponsor, and complete the appropriate forms or update the appropriate systems.

- Change in address.
- Death of an enrolled family member (a different type of coverage may be necessary).
- Marriage or divorce.
- Enrollment in another health plan or in Medicare.
- Eligibility for Medicare.
- Dependent Child reaching the Dependent Age Limit.
- Enrolled Dependent Child either becomes Totally Disabled or is no longer Totally Disabled.

Failure to notify us of individuals no longer eligible for services will not obligate us to cover such services. All notifications must be in writing and on approved forms.

IMPORTANT Medicare Information

Failure to enroll in Medicare may result in significant Out-of-Pocket expenses. If you are eligible for Medicare, the Plan may pay secondary to Medicare in certain situations (i.e., Medicare pays first). Examples of when Medicare is primary are when the sponsoring Employer has less than 20 employees and your Medicare eligibility is based on age, or when the sponsoring Employer has less than 100 employees and your Medicare eligibility is based on disability, or when you have been eligible for Medicare for more than 30 months based on End-Stage Renal Disease (ESRD). If the Covered Person is eligible for Medicare to pay as primary, the Plan will pay secondary to Medicare whether or not he is actually enrolled in Medicare. This means that benefits will still be reduced by the amount Medicare would have paid (under Parts A and B), even if the Covered Person has failed to enroll in Medicare Part A or B. Therefore, if you are eligible for Medicare, you are strongly encouraged to enroll in both Parts A and B of Medicare.

Termination of coverage

Employee
The coverage of any Employee covered under this Plan shall terminate on the earliest of the following:

- The last day of the month in, or with respect to which, the Employee requests that such coverage be terminated, provided such request is made on or before such date and the Employee had a qualifying event
- The last day of the month in which the Employer terminates the Plan
- The last day of the month for which the Employee has made a contribution, in the event of his or her failure to make, when due, any contribution for coverage for himself or herself to which he or she has agreed in writing
- The last day of the month in which the Employee is no longer Actively at Work, including if this is due to the Employee being laid off or a retirement
- The last day of the month in which the Employee is no longer Actively at Work due to temporary layoff or an approved personal or medical Leave of Absence. In no event will coverage be continued more than ninety (90) days from the date the Employee was last Actively at Work unless the employer is subject to FMLA
- The last day of the month in which an Employee or his or her Dependent submits, or has knowledge of the submission of, a fraudulent claim or any fraudulent information to the Plan, including enrollment information

- The last day of the month in which the Employee becomes a temporary, seasonal, or part-time Employee of the Employer, unless the Employer has elected to cover temporary, seasonal, or part-time Employees or as required by law
- The last day of the month in which the Employee joins, on a full-time basis, the military forces of any country or the service of any governmental agency involving employment outside the United States, except to the extent coverage is required by USERRA or other applicable law

Dependent
The coverage of any Dependent covered under this Plan shall terminate on the earliest of the following:

- The last day of the month upon the discontinuance of coverage for Dependents under the Plan.
- The last day of the month of termination of the Employee's coverage for himself or herself under the Plan.
- The last day of the month for which the Employee has made a contribution, or in the event of his or her failure to make, when due, any contribution for coverage for Dependents to which he or she has agreed in writing.
- For Your Spouse's coverage only, when You and Your Spouse are legally divorced.
- The last day of the month in which a Child attains age twenty-six (26).
- In the case of a Child aged twenty-six (26) or older for whom coverage is being continued due to mental or physical inability to earn his or her own living, coverage will terminate on the last day of the month, on the earliest to occur of:
  - Cessation of such inability.
  - Failure to furnish any required proof of the uninterrupted continuance of such inability or to submit to any required examination; or
  - Upon the Child's no longer being dependent on the Employee for his or her support.
- When a covered Dependent joins, on a full-time basis, the military forces of any country or the service of any governmental agency involving employment outside the United States, except to the extent coverage is required by USERRA or other applicable law.
- The last day of the month in which an Employee or his or her Dependent submits, or has knowledge of the submission of, a fraudulent claim or any fraudulent information to the Plan, including enrollment information.
- When this Plan terminates

Status Changes
Any Participant may change a benefit election after the Plan Year (to which such election relates) has commenced and make new elections with respect to the remainder of such Plan Year if, under the facts and circumstances, the changes are necessitated by and are consistent with a change in status which is acceptable under rules and regulations adopted by the Department of the Treasury, the provisions of which are incorporated by reference. Notwithstanding anything herein to the contrary, if the rules and regulations conflict, then such rules and regulations shall control.

Any new election shall be effective at such time as the Plan Sponsor shall prescribe, but not earlier than the first pay period beginning after the election form is completed and returned to the Plan Sponsor. For the purposes of this subsection, a change in status shall only include the following events or other events permitted by Treasury regulations:

(1) Legal Marital Status: events that change a Participant's legal marital status, including marriage, divorce, death of a Spouse, legal separation, or annulment;

(2) Number of Dependents: Events that change a Participant's number of Dependents, including birth, adoption, Placement for Adoption, or death of a Dependent;

(3) Employment Status: Any of the following events that change the employment status of the Participant, Spouse, or Dependent: termination or commencement of employment, a strike or lockout, commencement or return from an unpaid Leave of Absence, or a change in worksite. In addition, if the eligibility conditions of this Plan or other employee benefit plan of the Employer of the Participant, Spouse, or Dependent depend on the employment status of that individual and there is a change in that individual's employment status with the consequence that the individual becomes (or ceases to be) eligible under the plan, then that change constitutes a change in employment under this subsection;

(4) Dependent satisfies or ceases to satisfy the eligibility requirements: An event that causes the Participant's Dependent to satisfy or cease to satisfy the requirements for coverage due to attainment of age, student status, or any similar circumstance; and

(5) Residency: A change in the place of residence of the Participant, Spouse or Dependent, that would lead to a change in status (such as a loss of HMO coverage).

Special Enrollment
Notwithstanding status changes, Participants may change an election for group health coverage during a Plan Year and make a new election that corresponds with the Special Enrollment rights provided in Code Section 9801(f), including those authorized under the provisions of the Children's Health Insurance Program Reauthorization Act of 2009 (CHIP); provided that such Participant meets the sixty (60) day notice requirement imposed by Code Section 9801(f) (or such longer period as may be permitted by the Plan and communicated to Participants). Such change shall take place on a prospective basis, unless otherwise required by Code Section 9801(f) to be retroactive.

The Plan permits a Special Enrollment period for an Employee (or a Dependent), who is eligible for coverage, but not enrolled, to enroll if the Employee (or Dependent) had other coverage and loses it, or if a person becomes a Dependent of the Employee through marriage, birth, adoption, or Placement for Adoption. A person who enrolls during a Special Enrollment period is not treated as a Late Enrollee.

An individual may be eligible for Special Enrollment if the Employee, at the time coverage is declined, provides a statement, in writing, indicating the reason for declining coverage. To be eligible for Special Enrollment, the Employee must have declined coverage due to coverage under another plan. However, Special Enrollment will be available to Employees that decline coverage without having coverage under another plan and subsequently enroll in other coverage and lose that coverage. The Employee must have had an opportunity for Late Enrollment, Open Enrollment or Special Enrollment under this Plan but again chose not to enroll. Special Enrollment is also available to an Employee or Dependent who becomes eligible for a premium assistance subsidy under Medicaid or a state Children’s Health Insurance (CHIP) program with respect to this Plan.

If the Employee declined coverage because the other coverage was COBRA coverage, then the COBRA coverage must be exhausted before Special Enrollment will be available. If the other coverage is not COBRA coverage, then to be eligible for Special Enrollment, the other coverage must be lost due to a loss of eligibility, or employer contributions must have ended. Loss of eligibility includes a loss of coverage due to:

- divorce;
- legal separation;
- death;

- termination of employment, or reduction in hours of employment;
- relocating outside of an HMO's service area (only if there is no access to other coverage through the HMO);
- a plan no longer offering benefits to a class of similarly situated individuals even if the plan continues to provide coverage to other individuals;
- the Employee or Dependent is covered under a Medicaid plan or under a state CHIP program, and coverage of the Employee or Dependent under such a plan/program is terminated as a result of loss of eligibility for such coverage.

An Employee who is already enrolled in a benefit option may enroll in another benefit option under the Plan if their Dependent has a Special Enrollment right because the Dependent lost other health coverage.

Under Special Enrollment, the Employee must request enrollment, in writing within 30 days after the exhaustion of COBRA, or termination of the other coverage (other than Medicaid or Children's Health Insurance, see below), or the date of the marriage, birth, adoption or Placement for Adoption. If eligible, enrollment in the Plan, in cases of marriage, birth or adoption/Placement for Adoption, will be effective as of the date of the event; otherwise, coverage will be available no later than the first day of the first month beginning after the completed request for enrollment is received.

Under Special Enrollment, the Employee must request enrollment, in writing within 60 days after the termination of Medicaid or Children's Health Insurance (CHIP) coverage, or when eligible for a premium assistance subsidy under Medicaid or a state CHIP program. If eligible, enrollment in the Plan will be effective no later than the first day of the first month beginning after the completed request for enrollment is received.

SECTION 9: GENERAL PROVISIONS

Administration Of The Plan
The Plan is administered by an independent Third-Party Administrator experienced in claims processing. Fiscal records are maintained for a Plan Year ending as of the date specified under the Key Information section at the beginning of this document.

The Plan is a legal entity. Legal notices may be filed with, and legal process served upon, the Plan Sponsor at the address specified in the Key Information section at the beginning of this document.

Appeals

1. CLAIMS PROCEDURES

An explanation of benefits or other written or electronic notification will be provided by the Third-Party Administrator, or their designee, showing the calculation of the total amount payable for the claim, charges not payable, and the reason. If the claim is denied or reduced in whole or in part, it is considered an "Adverse Benefit Determination." An Adverse Benefit Determination also includes a rescission of coverage, whether or not the rescission has an adverse effect on any particular benefit at the time of the rescission. A rescission is a cancellation or discontinuance of coverage that has retroactive effect, except to the extent it is attributable to a failure to timely pay required premiums or contributions towards the cost of coverage. An Adverse Benefit Determination is subject to the provisions detailed below.

Decision and Notice Requirements
We will review requests for benefits according to the timeframes listed below. The timeframes and requirements listed are based on federal laws.

Type of Review Timeframe Requirement for Decision and Notification:

Urgent Pre-service Review	72 hours from the receipt of request
Non-Urgent Pre-service Review	15 calendar days from the receipt of the request
Urgent Continued Stay/Concurrent Review when request is received more than 24 hours before the end of the previous authorization	24 hours from the receipt of the request
Urgent Continued Stay/Concurrent Review	72 hours from the receipt of the request when request is received less than 24 hours before the end of the previous authorization or no previous authorization exists
Non-urgent Continued Stay/Concurrent Review	15 calendar days from the receipt of the request Review for ongoing outpatient treatment
Post-Service Review	30 calendar days from the receipt of the request

If more information is needed to make our decision, we will tell the requesting Provider of the specific information needed to finish the review. If we do not get the specific information we need by the

required timeframe, we will make a decision based upon the information we have. We will notify you and your Provider of our decision as required by federal law. Notice may be given by one or more of the following methods: verbal, written, and/or electronic.

The Third-Party Administrator will notify the claimant of an Adverse Benefit Determination within 30 days after receipt of the claim. However, in certain cases an extension of up to 15 days may be utilized if the Third-Party Administrator determines that the extension is necessary due to matters beyond the control of the Plan and the claimant is notified prior to the expiration of the initial 30-day period of the circumstances requiring the extension of time and the date by which the Third-Party Administrator expects to render a decision. If such an extension is necessary due to a failure of claimant to submit the information necessary to decide the claim, the notice of extension shall specifically describe the required information, and the claimant shall be given at least 45 days within which to provide the specified information. A notice of Adverse Benefit Determination will include the following:

a. Sufficient information to identify the claim involved, including the date(s) of service, health care Provider, and claim amount.

b. The specific reason or reasons for the Adverse Benefit Determination, as well as the Plan's standard that was used in denying the claim, if applicable, and including identifying denial codes and providing their meaning.

c. Reference to specific Plan provisions on which the Adverse Benefit Determination is based.

d. A description of any additional material or information necessary for the claimant to perfect the claim and an explanation of why such material or information is necessary.

e. A description of the Plan's first level appeal procedures and the time limits applicable to such procedures, including information on how to initiate an appeal, the contact information for the Employee Benefits Security Administration (1-866-444-EBSA (3272)) to assist individuals with the first level claim and appeal process and second level (external) appeal process if applicable (see below), and a statement of claimant's right to bring a civil action under Section 502(a) of ERISA following a determination on appeal.

f. If an internal rule, guideline, protocol, or other similar criterion was relied upon in making the adverse determination, either the specific rule, guideline, protocol, or other similar criterion will be set forth in the notice of Adverse Benefit Determination; or the notice will contain a statement that such a rule, guideline, protocol, or other similar criterion was relied upon in making the Adverse Benefit Determination and that a copy of such rule, guideline, protocol, or other criterion will be provided free of charge to the claimant upon request.

g. 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 claimant's medical circumstances, will be set forth in the notice of Adverse Benefit Determination, or the notice will contain a statement that such explanation will be provided free of charge upon request.

2. FIRST LEVEL APPEALS PROCEDURE

If You receive an Adverse Benefit Determination, You or Your authorized representative may appeal the determination by filing a written application with the Plan Administrator. In appealing an Adverse Benefit Determination, the Plan Administrator, or their designee, will provide You or Your authorized representative:

a. The opportunity to submit written comments, documents, records, and other information relating to the claim for benefits.

b. Upon request and free of charge, reasonable access to, and copies of, all documents, records, the claim file, and other information relevant to the claim.

c. A full and fair review that takes into account all comments, documents, records, and other information submitted by You relating to the claim, without regard to whether such information was submitted or considered in the initial benefit determination. You must also be provided, free of charge, with any new or additional evidence considered, relied upon, or generated by the Plan Administrator, as well as any new or additional rationale relied upon by the Plan Administrator in reaching its determination on appeal, that differs from that which the Plan Administrator relied on in its Adverse Benefit Determination. Such evidence and/or rationale must be provided as soon as possible and sufficiently in advance of the date on which the Plan Administrator's determination is required to be provided to give You a reasonable opportunity to respond prior to that date.

d. A full and fair review that does not afford deference to the initial benefit determination and is conducted by an appropriate Named Fiduciary of the Plan who is neither the individual who made the initial Adverse Benefit Determination that is the subject of the appeal, nor the subordinate of such individual.

e. In deciding an appeal of an Adverse Benefit Determination that is based in whole or in part on a medical judgment, including determinations with regard to whether a particular treatment, Drug, or other item is Experimental, Investigational, or not Medically Necessary or appropriate, that the appropriate Named Fiduciary shall consult with a health care professional who has appropriate training and experience in the field of medicine involved in the medical judgment and that the health care professional consulted shall neither be an individual who was consulted in connection with the initial Adverse Benefit Determination that is the subject of the appeal, nor the subordinate of any such individual.

f. Upon request, the identification of medical or vocational experts whose advice was obtained on behalf of the Plan in connection with a claimant's Adverse Benefit Determination, without regard to whether the advice was relied upon in making the benefit determination.

A first level appeal must be filed within 180 days after the Adverse Benefit Determination is received. The Plan Administrator will notify You or Your authorized representative of its determination within 60 days after receipt of an appeal.

The Plan Administrator's determination:

a. Will contain sufficient information to identify the claim involved, including the date(s) of service, health care Provider, claim amount, denial codes and their meaning, as well as the Plan's standard used in denying the claim.

b. Will be in writing, setting forth specific reasons for the decision and reference to the specific Plan provisions upon which the determination is based.

c. Will contain a statement that You are entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the claim for benefits.

d. Will contain a statement of Your right to bring an action under Section 502(a) of ERISA if a second level (external) review is inapplicable.

e. Will contain a description of the Plan's second level (external) review process (applicable solely where the Plan's underlying determination involved 1) a rescission of coverage or 2) medical judgment), including information on how to initiate a second level appeal, and the contact information for the Employee Benefits Security Administration to assist individuals with the second level review process (1-866-444-EBSA (3272)), as well as a statement of Your right to bring a civil action under Section 502(a) of ERISA following the determination of the external review.

f. If an internal rule, guideline, protocol, or other similar criterion was relied upon in making the Adverse Benefit Determination, either the specific rule, guideline, protocol, or other similar criterion will be set forth in the determination; or the determination will contain a statement that such rule, guideline, protocol, or other similar criterion was relied upon in making the Adverse Benefit Determination and that a copy of the rule, guideline, protocol, or other similar criterion will be provided free of charge to the claimant upon request.

g. 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 claimant's medical circumstances, will be set forth in the determination or the determination will contain a statement that such explanation will be provided free of charge upon request.

If the Plan does not strictly adhere to all the requirements of the first level claims and appeals process with respect to a claim, You are deemed to have exhausted the first level claims and appeals process (unless the Plan's failure to strictly adhere to these requirements is 1) de minimis, 2) non-prejudicial, 3) attributable to good cause or matters beyond the Plan's control, 4) in the context of an ongoing good faith exchange of information, and 5) not reflective of a pattern or practice of non-compliance). Accordingly, upon such a failure, You may initiate a second level (external) review (see below) or, if not applicable, pursue any available remedies under applicable law.

To the extent the Plan contends that it did not commit a procedural violation based on the five criteria referenced immediately above, You will be entitled, upon written request, to an explanation of the Plan's basis for such an assertion (to be provided within ten days), so that You can make an informed judgment about whether to seek immediate review from an external reviewer or, if not applicable, a court of law. Finally, if the external reviewer or the court of law (as applicable) rejects Your request for immediate review on the basis that the Plan did not engage in a violation, You have the right to resubmit and pursue the first level claims and appeals process.

If the Plan denies Your first level appeal, in whole or in part, and You choose to bring a civil action, such action must be filed within 365 days of the date of the Plan's denial of Your first level appeal. This 365 day time period, however, will be temporarily suspended to the extent You are entitled to file a second level (external) appeal (see below) and do in fact file such an appeal. Under such circumstances, this 365 day time period will be suspended from the date You submit a request for a second level (external) appeal that is both complete and eligible until the date of the Independent Review Organization's decision (see below).

3. SECOND LEVEL (EXTERNAL) APPEALS PROCEDURE

If the Plan denies Your first level appeal, in whole or in part, such denial is called a Final Internal Adverse Benefit Determination. You or Your authorized representative may file a second level (external) appeal of the Final Internal Adverse Benefit Determination where the Plan's underlying determination involved 1) a rescission of coverage or 2) medical judgment. To file a second level appeal, You must file a written application with the Plan Administrator.

A second level appeal must be filed within 4 months after the Final Internal Adverse Benefit Determination is received. If the last filing date would fall on a Saturday, Sunday, or Federal holiday, the last filing date is extended to the next day that is not a Saturday, Sunday, or Federal holiday. The Plan reserves the right to charge a nominal filing fee, as allowed by applicable law.

Preliminary review. Within 5 business days following the date of receipt of the second level (external) review request, the Plan must complete a preliminary review of the request to determine whether:

a. The claimant is or was covered under the Plan at the time the health care service was requested or, in the case of a retrospective review, was covered under the Plan at the time the health care service was provided;

b. The Plan's underlying determination involved 1) a rescission of coverage or 2) medical judgment;

c. The claimant has exhausted the Plan's first level appeal process; and

d. The claimant has provided all the information and forms required to process a second level review.

Within one business day after completion of the preliminary review, the Plan must issue a notification in writing to the claimant. If the request is complete but not eligible for a second level review, such notification must include the reasons for its ineligibility and contact information for the Employee Benefits Security Administration (toll-free number 866-444-EBSA). If the request is not complete, such notification must describe the information or materials needed to make the request complete, and the Plan must allow a claimant to perfect the request for the second level review within the four-month filing period or within the 48 hour period following the receipt of the notification, whichever is later.

Referral to Independent Review Organization. The Plan must assign an independent review organization ("IRO") to conduct the second level (external) review. The assigned IRO will timely notify the claimant in writing of the acceptance for the second level review. This notice will include a statement that the claimant may submit in writing to the IRO within 10 business days following the date of receipt of the notice additional information that the IRO must consider when conducting the second level review. The IRO is not required to, but may, accept and consider additional information submitted after 10 business days.

Within 5 business days after the date of assignment of the IRO, the Plan must provide to the assigned IRO the documents and any information considered in making the Final Internal Adverse Benefit Determination. If the Plan fails to timely provide the documents and information, the IRO may terminate the second level review and make a decision to reverse the Final Internal Adverse Benefit Determination. Within one business day after making the decision, the IRO must notify the claimant and the Plan.

Upon receipt of any information submitted by the claimant, the IRO must within one business day forward the information to the Plan. Upon receipt of any such information, the Plan may reconsider its Final Internal Adverse Benefit Determination that is the subject of the second level review. The second level review may be terminated as a result of the reconsideration only if the Plan decides, upon completion of its reconsideration, to reverse its Final Internal Adverse Benefit Determination and provide coverage or payment. Within one business day after making such a decision, the Plan must provide written notice of its decision to the claimant and the IRO. The IRO must terminate the second level review upon receipt of the notice from the Plan.

The IRO will review all of the information and documents timely received. In reaching a decision, the IRO will review the claim without deference to the Plan and not be bound by any decisions or conclusions

reached during the Plan's internal claims and appeals process. The IRO may also consider the following additional information:

a. The claimant's medical records;

b. The attending health care professional's recommendation;

c. Reports from other health care professionals and other documents submitted by the Plan, claimant or claimant's treating Provider;

d. The terms of the Plan to ensure that the IRO's decision is not contrary to the terms of the Plan, unless the terms are inconsistent with applicable law;

e. Appropriate practice guidelines, including evidence-based standards and other guidelines developed by the Federal government, national or professional medical societies, boards and associations;

f. Any applicable clinical review criteria developed and used by the Plan, unless such criteria are inconsistent with the terms of the Plan or applicable law; and

g. The opinion of the IRO's clinical reviewer(s) to the extent the information or documents are available and the clinical reviewer(s) considers appropriate;

The IRO must provide written notice of its second level review decision within 45 days after it receives the request for the second level review. The notice must be provided to both the claimant and the Plan, and must include the following:

a. A general description of the reason for the request for the review with enough information to identify the claim, and reason for the Final Internal Adverse Benefit Determination;

b. The date the IRO received the assignment to conduct the second level review;

c. The date of the IRO's decision;

d. References to the evidence or documentation, including specific coverage provisions and evidence-based standards, considered in reaching its decision;

e. A discussion of the principal reason(s) for its decision, including the rationale and any evidence-based standards used;

f. A statement that the determination is binding, except to the extent other legal remedies may be available under Federal or state law to the Plan or claimant;

g. A statement that judicial review may be available to the claimant; and

h. Current contact information for the Employee Benefits Security Administration (toll-free number 866-444-EBSA (3272)).

The IRO must maintain records of all claims and notices associated with the second level review process for 6 years. An IRO must make such records available for examination by the claimant, Plan, or state or federal oversight agency upon request, except where such disclosure would violate state or federal privacy laws.

Reversal of the Plan's decision. Upon receipt of a notice of a final external review decision reversing the Final Internal Adverse Benefit Determination, the Plan must immediately pay the claim.

For questions about Your appeal rights or for assistance, You can contact the Employee Benefits Security Administration at 1-866-444-EBSA (3272).

Assignment Of Benefits
The Plan will not recognize any assignment of a Covered Person's right to bring a cause of action or otherwise initiate a legal proceeding arising from an Adverse Benefit Determination when services are provided by a Non-Participating Provider. When payment is made directly to the Covered Person (with or without an assignment), it is solely the responsibility of the Covered Person to reimburse the Provider.

Binding Arbitration
Note: *You are enrolled in a plan provided by your Employer that is subject to ERISA, any dispute involving an adverse benefit decision must be resolved under ERISA's claims procedure rules and is not subject to mandatory binding arbitration. You may pursue voluntary binding arbitration after you have completed an appeal under ERISA. If you have any other dispute which does not involve an adverse benefit decision, this Binding Arbitration provision applies.*

Any dispute or claim, of whatever nature, arising out of, in connection with, or in relation to this Plan, or breach or rescission thereof, or in relation to care or delivery of care, including any claim based on contract, tort or statute, must be resolved by arbitration if the amount sought exceeds the jurisdictional limit of the small claims court. Any dispute regarding a claim for damages within the jurisdictional limits of the small claims court will be resolved in such court.

The Federal Arbitration Act shall govern the interpretation and enforcement of all proceedings under this BINDING ARBITRATION provision. To the extent that the Federal Arbitration Act is inapplicable or is held not to require arbitration of a particular claim, State law governing agreements to arbitrate shall apply.

The Participant and the Plan Sponsor agree to be bound by this Binding Arbitration provision and acknowledge that they are each giving up their right to a trial by court or jury.

The Participant and the Plan Sponsor agree to give up the right to participate in class arbitration against each other. Even if applicable law permits class actions or class arbitrations, the Participant waives any right to pursue, on a class basis, any such controversy or claim against the Plan Sponsor and the Plan Sponsor waives any right to pursue on a class basis any such controversy or claim against the Participant.

The arbitration findings will be final and binding except to the extent that State or Federal law provides for the judicial review of arbitration proceedings.

The arbitration is begun by the Participant making written demand on the Plan Sponsor. The arbitration will be conducted by Judicial Arbitration and Mediation Services ("JAMS") according to its applicable Rules and Procedures. If, for any reason, JAMS is unavailable to conduct the arbitration, the arbitration will be conducted by another neutral arbitration entity, by mutual agreement of the Participant and the Plan Sponsor, or by order of the court, if the Participant and the Plan A Sponsor cannot agree.

The costs of the arbitration will be allocated per the JAMS Policy on Consumer Arbitrations. If the arbitration is not conducted by JAMS, the costs will be shared equally by the parties, except in cases of extreme financial hardship, upon application to the neutral arbitration entity to which the parties have agreed, in which cases, the Plan Sponsor will assume all or a portion of the costs of the arbitration.

Claim Audit

Once a written claim for benefits is received, the Plan Administrator, at its discretion, may elect to have such claim reviewed or audited for accuracy and Reasonableness as part of the adjudication process. This process may include, but not be limited to, identifying charges for items/services that may not be covered or may not have been delivered, duplicate charges, and Medical Necessity determinations as determined by the Plan Administrator.

Compliance
The Plan shall comply with all federally mandated benefit laws and regulations pertaining to employee benefit plans. The intent of the Plan is to assure full compliance with all appropriate federal laws, rules and regulations and any act or omission through negligence or otherwise which results in any such violation, shall be construed as unintentional.

Conflict
In the event of any conflict between this Summary Plan Description and any other written instrument, the terms of this Summary Plan Description will prevail.

Contributions
All benefits under the Plan are paid from the Employer's general assets and Employee contributions toward the cost of coverage. Employee contributions are the Employees' share of the costs of Plan benefits, as determined in the sole and absolute discretion of the Employer and communicated in advance to Employees. Employee contributions generally are made on a pre-tax basis and may change from time to time, as determined by the Employer.

ERISA Amendments
Any provision of this Plan that is in conflict with ERISA, which governs this Plan, shall be deemed amended to conform to the minimum requirements of the law.

Liens
To the full extent permitted by law, all rights and benefits accruing under this Plan shall be exempt from execution, attachment, garnishment, or other legal or equitable process, for the debts or liabilities of any Employee.

This Plan is not a substitute for and does not affect any requirement for coverage by Workers' Compensation Insurance.

No Waiver
A failure to enforce any provision of this Plan shall not affect any right thereafter to enforce any such provision, nor shall such failure affect any right to enforce any other provision of this Plan.

Plan Is Not A Contract
The Plan shall not be deemed to constitute a contract between the Employer and any Employee or to be a consideration for, or an inducement or condition of, the employment of any Employee. Nothing in the Plan shall be deemed to give any Employee the right to be retained in the service of the Employer or to interfere with the right of the Employer to discharge any Employee at any time.

Plan Amendment, Modification Or Termination
The Plan Sponsor reserves the right to amend, modify, revoke, or terminate the Plan, in whole or in part, at any time and such amendment, modification, revocation or termination of the Plan shall be made by a written Plan endorsement signed by an authorized representative of the Plan Sponsor. Any such

changes to the Plan, which affect Participants, will be communicated to such Participants by the Plan Sponsor. Upon termination of the Plan, the rights of Participants to benefits are limited to claims Incurred and due up to the date of termination. Plan provisions governing the allocation and disposition of assets of the Plan upon termination may be obtained by contacting the Plan Sponsor.

Notwithstanding any other provision of the Plan, the Plan Sponsor'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 in the preceding paragraph "CONTRIBUTIONS". Payment of said claims in accordance with these procedures shall discharge completely the Plan Sponsor's obligation with respect to such payments.

If the Plan Sponsor terminates the Plan, then as of the effective date of termination, the Employer and eligible Employees shall have no further obligation to make additional contributions to the Plan and the Plan shall have no obligation to pay claims Incurred after the termination date of the Plan.

Procedures For Filing Out-of-Network Claims
Remember to Pre-Certify by calling the toll-free number shown on Your ID card if required by Your Plan.

KEY POINTS TO REMEMBER

The claims filing address You must use for filing all medical claims is shown on Your ID card.

- Each bill should be itemized as to services, show payment status, and include the name of the patient, the Employee's social security number or unique identification number ("UID"), and the name and/or group number of the Employer.
- It is Your responsibility to see that all bills are submitted as indicated above. Proper payment cannot be made without the proper bills.
- All charges, and corresponding requested documentation, must be submitted within the time frame specified in the Benefit Summary. Failure to do so will result in the denial of the charges.
- From time to time, additional information may be requested to process Your claim. Any additional information, i.e. other insurance payments or information, completed claim forms or subrogation forms, Accident details, police reports, etc. must be submitted by You or Your Provider(s) when requested within the time frame specified in the Benefit Summary. Your failure to do so will result in the denial of the claim.
- Only clean claims will be adjudicated by the Plan. A clean claim is one that is complete and accurate, does not require further information for processing from the Provider, patient, or any other person or entity, and leaves no issues regarding the Plan's responsibility for payment.

FILING A HOSPITAL CLAIM

When a Covered Person is admitted as an Inpatient or is treated as an Outpatient, secure an itemized Hospital bill, including an admitting Diagnosis. Check Your bill for any possible errors and then submit the charges as indicated above.

Always retain a copy of the Hospital bill for Your records.

MISCELLANEOUS CLAIMS FILING CONSIDERATIONS

It is necessary to keep separate records of Your expenses with respect to each of Your Dependents and Yourself. The following items are important and should be carefully kept to be submitted with Your claim:

- All Physician's bills should show the following:
  i. Name of patient and adequate membership information
  ii. Dates and charges for services, and payment status of each
  iii. Types of service rendered and procedure codes
  iv. Diagnosis information

- Prescription Drug expenses should show the following:
  i. Name of patient and adequate membership information
  ii. Prescription number and name of Drug
  iii. Cost of the Drug and date of purchase. Cash register receipts and canceled checks cannot be accepted for payment.
  iv. Generic Drugs should be indicated on the Drug bill

- Bills for all other covered medical charges, such as for ambulance service, Durable Medical equipment, etc. should show the following:
  i. Name of patient and adequate membership information
  ii. Date of service
  iii. Charge and description of each service/item
  iv. Diagnosis information

Always retain a copy of the bill for Your records.

Prohibition On Rescission

The Plan cannot rescind coverage except in the case of fraud or an intentional misrepresentation of a material fact. A rescission is a cancellation or discontinuance of coverage that has retroactive effect unless it is attributable to a failure to pay timely required premiums or contributions towards the cost of coverage. The Plan must provide 30 calendar days advance notice to an individual before coverage may be rescinded.

Reimbursement And Subrogation Provisions

PAYMENT CONDITION

The Plan, in its sole discretion, may elect to conditionally advance payment of benefits in those situations where an Illness, Injury, or Disability is caused in whole or in part by, or results from the acts or omissions of, a Covered Person or a third party, where any party besides the Plan may be responsible for expenses arising from an incident, and/or other funds are available, including but not limited to no-fault, uninsured motorist, underinsured motorist, medical payment provisions, third party assets, third party insurance, and/or grantor(s) of a third party (collectively "Coverage").

However, such payment of benefits by the Plan shall be made only if the Covered Person first provides a reimbursement agreement in writing. Notwithstanding the foregoing, payment of any claim in the absence of a signed reimbursement agreement shall not invalidate the obligation of the Covered Person to otherwise reimburse the Plan.

The Covered Person (including his attorney, and/or legal guardian of a covered minor or incapacitated individual) agrees that acceptance of the Plan's conditional payment of medical benefits is constructive notice of these provisions in their entirety and agrees to maintain the full extent of payment from any one or combination of first- and third-party sources in trust, without disruption except for reimbursement to the Plan or the Plan's assignee. By accepting benefits, the Covered Person agrees the Plan shall have an equitable lien on any funds received by the Covered

Person and/or his attorney from any source and said funds shall be held in trust until such time as the obligations under this provision are fully satisfied. The Covered Person agrees to include the Plan's name as a co-payee on any and all settlement drafts. Further, by accepting benefits, the Covered Person understands that any recovery obtained pursuant to this section is an asset of the Plan to the extent of the amount of benefits paid by the Plan and that the Covered Person shall be a trustee over those Plan assets.

In the event a Covered Person settles, recovers, or is reimbursed by any Coverage, the Covered Person agrees to reimburse the Plan for all benefits paid or that will be paid by the Plan on behalf of the Covered Person. If the Covered Person fails to reimburse the Plan out of any judgment or settlement received, the Covered Person will be responsible for any and all expenses (fees and costs) associated with the Plan's attempt to recover such money.

If there is more than one party responsible for charges paid by the Plan, or who may be responsible for charges paid by the Plan, the Plan will not be required to select a particular party from whom reimbursement is due. Furthermore, unallocated settlement funds meant to compensate multiple injured parties of which the Covered Person is only one, that unallocated settlement fund is considered designated as an "identifiable" fund from which the Plan may seek reimbursement.

SUBROGATION

As a condition to participating in and receiving benefits under this Plan, the Covered Person agrees to assign to the Plan the right to subrogate and pursue any and all claims, causes of action or rights that may arise against any person, corporation and/or entity and to any Coverage to which the Covered Person is entitled, regardless of how classified or characterized, at the Plan's discretion.

If a Covered Person receives or becomes entitled to receive benefits, an automatic equitable lien attaches in favor of the Plan to any claim, which any Covered Person may have against any Coverage and/or party causing the Illness, Injury, or Disability to the extent of such conditional payment by the Plan plus reasonable costs of collection. The Covered Person is obligated to notify the Plan or its authorized representative of any settlement prior to finalization of the settlement, execution of a release, or receipt of applicable funds. The Covered Person is also obligated to hold any and all funds so received in trust on the Plan's behalf and function as a trustee as applied to those funds until the Plan's rights described herein are honored and the Plan is reimbursed.

The Plan may, at its discretion, in its own name or in the name of the Covered Person commence a proceeding or pursue a claim against any party or Coverage for the recovery of all damages to the full extent of the value of any such benefits or conditional payments advanced by the Plan.

If the Covered Person fails to file a claim or pursue damages against

1. the responsible party, its insurer, or any other source on behalf of that party,
2. any first party insurance through medical payment coverage, personal injury protection, no-fault coverage, uninsured or underinsured motorist coverage,
3. any policy of insurance from any insurance company or guarantor of a third party,
4. worker's compensation or other liability insurance company, or
5. any other source, including but not limited to crime victim restitution funds, any medical, disability or other benefit payments, and school insurance coverage,

then the Covered Person authorizes the Plan to pursue, sue, compromise and/or settle any such claims in the Covered Person's and/or the Plan's name and agrees to fully cooperate with the Plan in

the prosecution of any such claims. The Covered Person assigns all rights to the Plan or its assignee to pursue a claim and the recovery of all expenses from any and all sources listed above.

RIGHT OF REIMBURSEMENT

The Plan shall have the specific right of first recovery ("reimbursement"), and as such, shall be entitled to recover 100% of the benefits paid, without deduction for attorneys' fees and costs or application of the common fund doctrine, make whole doctrine, or any other equitable and/or legal theory, without regard to whether the Covered Person is fully compensated by his recovery from all sources. The Plan shall have an equitable lien which supersedes all common law or statutory rules, doctrines, and laws of any state prohibiting assignment of rights which interferes with or compromises in any way the Plan's equitable lien and right to reimbursement. The obligation to reimburse the Plan in full exists regardless of how the judgment or settlement is classified and whether or not the judgment or settlement specifically designates the recovery or a portion of it as including medical, disability, or other expenses. If the Covered Person's recovery is less than the benefits paid, then the Plan is entitled to be paid all of the recovery achieved. Any funds received by the Covered Person are deemed held in constructive trust and should not be dissipated or disbursed until such time as the Covered Person's obligation to reimburse the Plan has been satisfied in accordance with these provisions. The Covered Person is also obligated to hold any and all funds so received in trust on the Plan's behalf and function as a trustee as it applies to those funds until the Plan's rights described herein are honored and the Plan is reimbursed.

No court costs, experts' fees, attorneys' fees, filing fees, or other costs or expenses of litigation may be deducted from the Plan's recovery without the prior, express written consent of the Plan.

The Plan's right of subrogation and reimbursement will not be reduced or affected as a result of any fault or claim on the part of the Covered Person, whether under the doctrines of causation, comparative fault or contributory negligence, or other similar doctrine in law. Accordingly, any lien reduction statutes, which attempt to apply such laws and reduce a subrogating Plan's recovery will not be applicable to the Plan and will not reduce the Plan's reimbursement rights.

These rights of subrogation and reimbursement shall apply without regard to whether any separate written acknowledgment of these rights is required by the Plan and signed by the Covered Person.

This provision shall not limit any other remedies of the Plan provided by law. These rights of subrogation and reimbursement shall apply without regard to the location of the event that led to or caused the applicable Sickness, Injury, Disease, or Disability.

COVERED PERSON IS A TRUSTEE OVER PLAN ASSETS

Any Covered Person who receives benefits and is therefore subject to the terms of this section is hereby deemed a recipient and holder of Plan assets and is therefore deemed a trustee of the Plan solely as it relates to possession of any funds which may be owed to the Plan as a result of any settlement, judgment or recovery through any other means arising from any Injury or Accident. By virtue of this status, the Covered Person understands that he/she is required to:

a) notify the Plan or its authorized representative of any settlement prior to finalization of the settlement, execution of a release, or receipt of applicable funds;

b) instruct his/her attorney to ensure that the Plan and/or its authorized representative is included as a payee on all settlement drafts;

c) in circumstances where the Covered Person is not represented by an attorney, instruct the insurance company or any third party from whom the Covered Person obtains a settlement,

judgment, or other source of coverage to include the Plan or its authorized representative as a payee on the settlement draft; and,

d) hold any and all funds so received in trust, on the Plan's behalf, and function as a trustee as it applies to those funds, until the Plan's rights described herein are honored and the Plan is reimbursed.

To the extent the Covered Person disputes his/her obligation to the Plan under this section, the Covered Person or any of his/her agents or representatives is also required to hold any/all settlement funds, including the entire settlement if the settlement is less than the Plan's interests, and without reduction in consideration of attorney's fees, for which he/she exercises control, in an account segregated from his/her general accounts or general assets until such time as the dispute is resolved.

No Covered Person, beneficiary, or the agents or representatives thereof, exercising control over Plan assets and incurring trustee responsibility in accordance with this section will have any authority to accept any reduction of the Plan's interest on the Plan's behalf.

SEPARATION OF FUNDS

Benefits paid by the Plan, funds recovered by the Covered Person, and funds held in trust over which the Plan has an equitable lien exist separately from the property and estate of the Covered Person(s), such that the death of the Covered Person, or filing of bankruptcy by the Covered Person(s), will not affect the Plan's equitable lien, the funds over which the Plan has a lien, or the Plan's right to subrogation and reimbursement.

WRONGFUL DEATH

In the event that the Covered Person dies as a result of his injuries and a wrongful death or survivor claim is asserted against a third party or any Coverage, the Plan's subrogation and reimbursement rights shall still apply.

OBLIGATIONS

It is the Covered Person's obligation at all times, both prior to and after payment of medical benefits by the Plan:

a) to cooperate with the Plan, or any representatives of the Plan, in protecting its rights, including discovery, attending depositions, and/or cooperating in trial to preserve the Plan's rights;

b) to provide the Plan with pertinent information regarding the Illness, Injury, or disability, including Accident reports, settlement information and any other requested additional information;

c) to take such action and execute such documents as the Plan may require facilitating enforcement of its subrogation and reimbursement rights, including providing to the Plan an executed reimbursement agreement;

d) to do nothing to prejudice the Plan's rights of subrogation and reimbursement;

e) to promptly reimburse the Plan when a recovery through settlement, judgment, award, or other payment is received; and

f) to not settle or release, without the prior consent of the Plan, any claim to the extent that the Covered Person may have against any responsible party or Coverage.

If the Covered Person and/or his attorney fails to reimburse the Plan for all benefits paid or to be paid, as a result of said Injury or condition, out of any proceeds, judgment or settlement received,

the Covered Person will be responsible for any and all expenses (whether fees or costs) associated with the Plan's attempt to recover such money from the Covered Person.

The Plan's rights to reimbursement and/or subrogation are in no way dependent upon the Covered Person's cooperation or adherence to these terms.

OFFSET

Failure by the Covered Person and/or his attorney to comply with any of these requirements may, at the Plan's discretion, result in a forfeiture of payment by the Plan of medical benefits, and any funds, or payments due under this Plan on behalf of the Covered Person may be withheld until the Covered Person satisfies his obligation.

MINOR STATUS

In the event the Covered Person is a minor as that term is defined by applicable law, the minor's parents or court-appointed guardian shall cooperate in any and all actions by the Plan to seek and obtain requisite court approval to bind the minor and his estate insofar as these subrogation and reimbursement provisions are concerned.

If the minor's parents or court-appointed guardian fail to take such action, the Plan shall have no obligation to advance payment of medical benefits on behalf of the minor. Any court costs or legal fees associated with obtaining such approval shall be paid by the minor's parents or court-appointed guardian.

SEVERABILITY

In the event that any section of this provision is considered invalid or illegal for any reason, said invalidity or illegality shall not affect the remaining sections of this provision and Plan. The section shall be fully severable. The Plan shall be construed and enforced as if such invalid or illegal sections had never been inserted in the Plan.

RIGHT TO RECEIVE AND RELEASE NECESSARY INFORMATION

For the purpose of determining the applicability of and implementing the terms of these benefits, the Plan Administrator may, without the consent of or notice to any person, release, or obtain any information necessary to determine acceptability of any applicant for participation in the Plan.

In so acting, the Plan Administrator shall be free from any liability that may arise regarding such action. Any person claiming benefits under this Plan shall furnish to the Plan Administrator such information as may be necessary to implement this provision.

RIGHTS OF RECOVERY

Whenever payments have been made by the Plan which are in excess of the Maximum amount allowed under the Plan or are otherwise not covered under any provision of the Plan, the Third-Party Administrator or Plan Administrator shall have the right to recover such payments from among one or more of the following: any persons to, for or with respect to whom such payments were made; any Providers of service; any insurance companies or any other organizations. Current benefit payments may be reduced to satisfy outstanding reimbursements.

Severability

Should any provision of this Summary Plan Description be declared invalid or illegal for any reason, such invalidity or illegality shall not affect the remaining portions of the Summary Plan Description. Any remaining portions shall remain in full force and effect, as if this Summary Plan Description did not contain the invalid or illegal provision.

Submission Of Claim
All charges, and corresponding requested documentation, must be submitted by the date specified in the Benefit Summary. Failure to do so will result in the denial of the charges.

Summary Of Material Modifications
Covered Persons shall be furnished summary descriptions of material modifications in the terms of this Plan and changes in the information required to be included in the Summary Plan Description pertaining to this Plan not later than 210 days after the end of the Plan Year in which the change is adopted. However, in the case of any modification or change that is a material reduction in Covered Services or benefits provided under the Plan, Covered Persons will be furnished a summary of such modification or change not later than 60 days after the adoption of the modification or change, unless the Plan Sponsor provides summaries of modifications or changes at regular intervals of not more than 90 days.

Summary Plan Description
The Plan Sponsor will issue to each Employee under the Plan, a document that shall summarize the benefits to which the person is entitled, to whom the benefits are payable, and the provisions of the Plan principally affecting the Employee. This document is intended to satisfy the requirement for both a Summary Plan Description and Plan Description as specified under ERISA.

System For Processing Claims
Claims will be processed on the following basis: 1) first, any non-Covered Services or services in excess of Plan provisions will be subtracted from billed charges; 2) then, any reduction authorized by agreements with Provider Networks will be applied to charges from Network Providers; and 3) then, any Deductible/Co-Insurance or uncollected co-pays will be deducted from the remaining eligible amount prior to payment.

Alternative Benefit Provision
In certain cases of severe or chronic Illness or Injury, the Plan Administrator may:

1) Extend Covered Services beyond the Maximum Allowable Amount for certain claims.
2) Provide coverage for select Specialty Pharmaceuticals from the program's designated specialty pharmacy provider in certain situations subject to Deductible and Coinsurance.

The Plan will make our decision case-by-case, if in our discretion the alternate or extended benefit is in the best interest of you and the Plan and you or your authorized representative agree to the alternate or extended benefit in writing. A decision to provide extended benefits or approve alternate care in one case does not obligate us to provide the same benefits again to you or to any other Member. The Plan reserves the right, at any time, to alter or stop providing extended benefits or approving alternate care. In such case, we will notify you or your authorized representative in writing.

SECTION 10: COORDINATION OF BENEFITS (COB)

The Coordination of Benefits provision is intended to prevent payments of benefits that exceed expenses. It applies when any Other Plan or plans also cover the person covered by this Plan. When more than one coverage exists, one plan normally pays its benefits in full, and the Other Plans pay a reduced benefit. This Plan will always pay either its benefits in full or 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 the Plan will be charged against the Plan Maximums. See the Benefit Summary to determine the type of Coordination of Benefits this Plan provides.

To coordinate benefits, it is necessary to determine in what order the benefits of various Plans are payable. This is determined as follows:

1. If a plan does not have a provision for the coordination of benefits, its benefits are payable before this Plan.
2. If a plan covers a person other than as a Dependent, its benefits are payable before this Plan. This includes Medicare covering a person other than as a Dependent (e.g. a retired Employee) and any Medicare Supplement Plan. However, in all instances, federal regulations regarding Medicare as a secondary payer will apply.
3. If a plan covers an active Employee, its benefits are payable before this Plan. This order of determination does not supersede No. 2 above.
4. If an individual is covered as a Dependent under 2 separate plans, the benefits are payable first under the Employee's plan having the earliest birthday in a Calendar Year. However, if the Dependent is a Child whose parents are separated or divorced, the "birthday rule" does not apply. The following order to determination will apply:

   If the parent with custody has not remarried:
   a) The plan of the parent with custody is primary.
   b) The plan of the parent without custody is secondary.

   If the parent with custody has remarried:
   a) The plan of the parent with custody is primary.
   b) The plan of the stepparent with custody is secondary.
   c) The plan of the parent without custody is tertiary (third).

   There may be a court decree that makes one parent financially responsible for the health care expenses incurred by the Child. If a plan covers the Child as a Dependent of that parent, its benefits are payable before those of a plan that covers the Child as a Dependent of the parent without financial responsibility.
5. If a plan covers an individual who is also allowed to be covered by this Plan pursuant to COBRA continuation coverage, its benefits are payable before this Plan.
6. If items 1, 2, 3, 4 or 5 do not apply, the benefits of a plan that has covered the person for the longest period will be payable before those of the Other Plan.

To the extent that the Plan would be secondary to Medicare, if a Covered Person is eligible for Medicare Part A and/or Part B and does not elect to enroll in such Medicare coverage, then Plan benefits will be coordinated based on an estimate of what Medicare would have paid, regardless of whether benefits are actually received from Medicare.

Any other "plan" means and includes, but is not necessarily limited to the following: any policy, contract or other arrangement for group insurance benefits, including any Hospital or medical service organization plan or other service or prepayment plan arranged through any employer, union, trustee,

Employee benefit association, government agency or professional association; or any homeowner's policy or other policy providing liability coverage; or any coverage for students sponsored by or provided through a school or other educational institution; or any coverage provided by a licensed Health Maintenance Organization (HMO); or any individual or non-group health coverage, of which the Plan Administrator is actually aware, including but not limited to a plan or policy purchased or made available through a state or federally managed Health Insurance Marketplace; or any benefits payable under Medicare (to the extent permitted by law); or any government program or any coverage provided by statute.

The term "plan" shall also mean any mandatory No-Fault Automobile Insurance coverage providing benefits under a medical expense reimbursement provision for Hospital, medical, or other health care services and treatment because of Accidental bodily Injuries arising out of a motor vehicle Accident; and any other payment received under any automobile policy.

To administer this provision, the Plan Administrator has the right to:

1. Release or obtain data needed to determine the benefits payable under this provision
2. Recover any sum paid above the amount that is required by this provision and
3. Repay any party for a payment made by the party when the Plan Administrator should have made the payment.

Coordination with Medicare

1. Individuals who have earned the required number of quarters for Social Security benefits within the specified time frame are eligible for Medicare Part A at no cost. Participation in Medicare Part B is available to all individuals who make application and pay the full cost of the coverage.
2. When an Employee becomes entitled to Medicare coverage and is still Actively at Work, the Employee may continue health coverage under this Plan at the same level of benefits and contribution rate that applied before reaching Medicare entitlement.
3. When a Dependent becomes entitled to Medicare coverage and the Employee is still Actively at Work, the Dependent may continue health coverage under this Plan at the same level of benefits and contribution rate that applied before reaching Medicare entitlement.
4. For Employers with 20 or more Employees, if the Employee is still Actively at Work, and the Employee and/or Dependent are also enrolled in Medicare, this Plan shall pay as the primary plan. Medicare will pay as secondary plan.
5. For Employers with fewer than 20 Employees, if the Employee is still Actively at Work, and the Employee and/or Dependent are also enrolled in Medicare, this Plan shall pay as the secondary plan. Medicare will pay as the primary plan.
6. If the Employee and/or Dependent elect to discontinue health coverage and enroll under the Medicare program, no benefits will be paid under this Plan. Medicare will be the only payor.

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

SECTION 11: COMPLIANCE NOTICES

Newborns' And Mothers' Health Protection Act
Under federal law, group health plans and health insurance issuers offering group health insurance coverage generally may not restrict benefits for any Hospital length of stay in connection with childbirth for the mother or newborn Child to less than 48 hours following a vaginal delivery, or less than 96 hours following a delivery by cesarean section. However, the plan or issuer may pay for a shorter stay if the attending Provider (e.g., Your Physician, nurse midwife or Physician assistant), after consultation with the mother, discharges the mother or newborn earlier.

Also, under federal law, plans and issuers may not set the level of benefits or Out-of-Pocket costs so that any later portion of the 48-hour (or 96 hour) stay is treated in a manner less favorable to the mother or newborn than any earlier portion of the stay.

In addition, a plan or issuer may not, under federal law, require that a Physician or other health care Provider obtain authorization for prescribing a length of stay of up to 48 hours (or 96 hours). However, to use certain Providers or facilities, or to reduce Your Out-of-Pocket costs, You may be required to obtain Pre-Certification. For information on Pre-Certification, contact Your Plan Administrator.

Source Of Injury Restrictions
The Plan will not limit coverage for Injuries or Illnesses resulting from 1) domestic violence, or 2) self-inflicted Injury or attempted suicide. Further, the Plan will not limit coverage for Injuries or Illnesses resulting from participation in any activity if such Illness or Injury is as a result of a covered physical or mental condition.

Wellness and Risk factors
The Plan will not charge Covered Persons who have adverse health factors, or who participate in certain adverse lifestyle activities, more than those similarly situated Covered Persons who do not have such factors or participate in such activities.* Further, the Plan will not provide rewards to Covered Persons who participate in, or meet the requirements of, positive lifestyle activities in excess of what is offered to those similarly situated Covered Persons who do not participate in, or meet the requirements of, such activities.*

* Except as such differential treatment is allowed through the incorporation of wellness program(s) meeting federally approved guidelines.

Family Medical Leave Act (FMLA)
The following only applies to companies with 50 or more employees:

If the Covered Person is entitled to, and elects to take, a family or medical leave solely under the terms of the Family and Medical Leave Act of 1993 (FMLA), the Covered Person and his covered Dependents shall continue to be covered under this Plan while the Covered Person is absent from work on an FMLA Leave as if there were no interruption of active employment. Provided the applicable premium is paid, such coverage will continue until the earlier of the expiration of such leave or the date notice is given to the Employer that the Covered Person does not intend to return to work at the end of the FMLA Leave.

The Covered Person may choose not to retain health coverage during the FMLA Leave. If he returns to active working status on or before the expiration of the leave, he is entitled to have coverage reinstated on the same basis as it would have been if the leave had not been taken. (Coverage will be reinstated without any additional qualification requirements imposed by this Plan. This Plan's provisions with

respect to Deductibles and percentage of payments will apply on the same basis as they did prior to the FMLA Leave.)

Military Leave (USERRA)

If You are absent from work due to military service, You may elect to continue coverage under the Plan (including coverage for enrolled Dependents) for up to 24 months from the first day of absence (or, if earlier, until the day after the date You are required to apply for or return to active employment with Your Employer under the Uniformed Services Employment and Reemployment Rights Act of 1994 (USERRA)). Your contributions for continued coverage will be the same as for a COBRA beneficiary, except that, if You are absent for 30 days or less, Your contribution will be the same as for similarly situated active Participants in the Plan.

Whether or not You continue coverage during military service, You may reinstate coverage under the Plan on Your return to employment under USERRA. The reinstatement will be without any Waiting Period otherwise required under the Plan, except to the extent that You had not fully completed any required Waiting Period prior to the start of military service.

Genetic Information

In accordance with the Genetic Information Nondiscrimination Act of 2008 (Public Law No. 110-233), which prohibits group health plans, issuers of individual health care policies, and employers from discriminating on the basis of Genetic Information, the Plan may not adjust premium or contribution amounts for those covered under the Plan based on Genetic Information. The Plan may also not request, require, or purchase Genetic Information for underwriting purposes (or in connection with any individual prior to such individual's enrollment under the Plan). The term "underwriting" covers rules relating to the determination of eligibility (including enrollment and continued eligibility) for Plan benefits or coverage, the computation of premium or contribution amounts and any activities relating to the creation, renewal, or replacement of the Plan.

This Plan is prohibited from requesting or requiring genetic testing on the part of an individual or his family members. Genetic tests include analysis of human DNA, RNA, chromosomes, proteins, or metabolites that detect genotypes, mutations, or chromosomal changes. The term "genetic test" does not mean an analysis of proteins or metabolites that does not detect genotypes, mutations, or chromosomal changes; or an analysis of proteins or metabolites that is directly related to a manifested disease, disorder, or pathological condition that could reasonably be detected by a health care professional with appropriate training and expertise in the field of medicine involved.

The Plan may obtain and use the results of a genetic test when making payment determinations (so long as only the minimum amount of information is utilized necessary for the determination).

A plan may request (but not require) that a Participant undergo a genetic test if 1) the plan clearly indicates that compliance is voluntary, and that noncompliance will have no effect on enrollment status or premium/contribution amounts, 2) no Genetic Information collected is used for underwriting purposes, and 3) the plan notify the applicable federal government agency that the plan is conducting activities pursuant to this exception and includes a description of the activities.

Women's Health And Cancer Rights Act

Effective October 21, 1998, the Federal Women's Health and Cancer Rights Act requires all health care plans that provide coverage for a Mastectomy must also provide coverage for the following Medical Care: reconstruction of the breast on which the Mastectomy has been performed; Surgery and reconstruction of the other breast to produce a symmetrical appearance; and Prostheses and physical complications at all stages of the Mastectomy, including lymphedemas, in a manner determined in

consultation with the attending Physician and the patient. Covered benefits are subject to all provisions described in Your Plan, including but not limited to: Deductible, Copayment, Coinsurance, exclusions, and limitations.

Consolidated Appropriations Act Of 2021 Notice - Your Rights and Protections Against Surprise Medical Bills

When you get emergency care or get treated by an In-Network Provider at an In-Network Hospital or Ambulatory Surgical Center, you are protected from surprise billing or balance billing.

What is "balance billing" (sometimes called "surprise billing")?
When you see a doctor or other health care Provider, you may owe certain Out-of-Pocket costs, such as a copayment, coinsurance, and/or a deductible. You may have other costs or have to pay the entire bill if you see a Provider or visit a health care facility that isn't in your health plan's Network.

"Out-of-Network" describes Providers and facilities that haven't signed a contract with your health plan. Out-of-Network Providers may be permitted to bill you for the difference between what your plan agreed to pay and the full amount charged for a service. This is called "**balance billing.**" This amount is likely more than In-Network costs for the same service and might not count toward your annual Out-of-Pocket limit.

"Surprise billing" is an unexpected balance bill. This can happen when you can't control who is involved in your care—like when you have an emergency or when you schedule a visit at an In-Network facility but are unexpectedly treated by an Out-of--Network Provider.

You are protected from balance billing for:

Emergency services
If you have an emergency medical condition and get emergency services from an In-Network Provider or facility, the most the Provider or facility may bill you is your plan's In-Network cost-sharing amount (such as Copayments and coinsurance). You **can't** be balance billed for these emergency services. This includes services you may get after you're in stable condition unless you give written consent and give up your protections not to be balanced billed for these post-stabilization services.

Certain services at an In-Network Hospital or Ambulatory Surgical Center
When you get services from an In-Network Hospital or Ambulatory Surgical Center, certain Providers there may be In-Network. In these cases, the most those Providers may bill you is your plan's In-Network cost-sharing amount. This applies to emergency medicine, anesthesia, pathology, radiology, laboratory, neonatology, assistant surgeon, hospitalist, or intensivist services. These Providers **can't** balance bill you and may **not** ask you to give up your protections not to be balance billed.

If you get other services at these In-Network facilities, In-Network Providers **can't** balance bill you, unless you give written consent and give up your protections.

You're <u>never</u> required to give up your protections from balance billing. You also aren't required to get care In-Network. You can choose a Provider or facility in your plan's Network.

When balance billing isn't allowed, you also have the following protections:

- You are only responsible for paying your share of the cost (like the copayments, coinsurance, and deductibles that you would pay if the Provider or facility was In-Network). Your health plan will pay In-Network Providers and facilities directly.

- Your health plan generally must:

    - Cover emergency services without requiring you to get approval for services in advance (precertification).

    - Cover emergency services by In-Network Providers.

    - Base what you owe the Provider or facility (cost-sharing) on what it would pay an In-Network Provider or facility and show that amount in your explanation of benefits.

    - Count any amount you pay for emergency services or In-Network services toward your deductible and Out-of-Pocket limit.

If you believe you've been wrongly billed, you may contact Health and Human Services (HHS") at (800) 985-3059.

Visit www.cms.gov/nosurprises/consumers for more information about your rights under federal law.

SECTION 12: ERISA RIGHTS

As a Plan Participant, You are entitled to certain rights and protection under the Employee Retirement Income Security Act of 1974 (ERISA). ERISA provides that all Plan Participants shall be entitled to:

RECEIVE INFORMATION ABOUT YOUR PLAN AND BENEFITS

Examine without charge, at the Plan Sponsor's office and at other specified locations, such as worksites and union halls, any documents governing the Plan, including insurance contracts, and collective bargaining agreements, and copies of any documents filed by the Plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Employee Benefits Services Administration (EBSA).

Obtain, upon written request to the Plan Sponsor, copies of documents governing the operation of the Plan, including insurance contracts, collective bargaining agreements, and updated Summary Plan Description. The Plan Sponsor may make a reasonable charge for the copies. If required, a copy of Form 5500 is available upon request.

Receive a summary of the Plan's annual financial report. The Plan Sponsor is required by law to furnish each Participant with a copy of this summary annual report.

CONTINUE GROUP HEALTH PLAN COVERAGE

Continue health care coverage for Yourself, Spouse or Dependents if there is a loss of coverage under the Plan as a result of a qualifying event. You or Your Dependents may have to pay for such coverage. Review this Summary Plan Description and the documents governing the Plan on the rules governing Your COBRA continuation coverage rights.

PRUDENT ACTIONS BY PLAN FIDUCIARIES

In addition to creating rights for Plan Participants, ERISA imposes duties upon the people who are responsible for the operation of the employee benefit Plan. The people who operate the Plan, called "fiduciaries" of the Plan, have a duty to do so prudently and in the interest of You and other Plan Participants and beneficiaries. No one, including Your employer, Your union, or any other person, may fire You or otherwise discriminate against You in any way to prevent You from obtaining a welfare benefit or exercising Your rights under ERISA.

ENFORCE YOUR RIGHTS

If Your claim for a welfare benefit is denied or ignored, in whole or in part, or if Your coverage was rescinded, You have a right to know why this was done, to obtain copies of documents relating to the decision, without charge, and to appeal any denial, all within certain time schedules.

Under ERISA, there are steps You can take to enforce the above rights. For instance, if You request a copy of Plan documents or the latest annual report from the Plan and do not receive them within 30 days, You may file suit in a Federal court. In such a case, the court may require the Plan Administrator to provide the materials and pay You up to $110 a day until You receive the materials, unless the materials were not sent because of reasons beyond the control of the administrator. If You have a claim for benefits which is denied or ignored, in whole or in part, or if Your coverage was rescinded, You may file suit in a state or Federal court, subject to the procedures discussed in the Section "APPEALS" under "GENERAL PROVISIONS." In addition, if You disagree with the Plan's decision or lack thereof concerning the qualified status of a Medical Child Support Order, You may file suit in Federal court. If it should happen that Plan fiduciaries misuse the Plan's money, or if You are discriminated against for asserting

Your rights, You may seek assistance from the U.S. Department of Labor, or You may file suit in a Federal court. The court will decide who should pay court costs and legal fees. If You are successful, the court may order the person You have sued to pay these costs and fees. If You lose, the court may order You to pay these costs and fees, for example, if it finds Your claim is frivolous.

ASSISTANCE WITH YOUR QUESTIONS

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

SECTION 13: THE HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT OF 1996, AS AMENDED ("HIPAA")

Standards For Privacy Of Individually Identifiable Health Information (The "Privacy Standards")

ISSUED PURSUANT TO: The Health Insurance Portability and Accountability Act of 1996, as amended ("HIPAA")

1. Disclosure of Summary Health Information to the Plan Sponsor

In accordance with the Privacy Standards, the Plan may disclose Summary Health Information to the Plan Sponsor if the Plan Sponsor requests the Summary Health Information for the purpose of (a) obtaining premium bids from health plans for providing health insurance coverage under this Plan or (b) modifying, amending or terminating the Plan.

"Summary Health Information" may be individually identifiable health information and it summarizes the claims history, claims expenses or the type of claims experienced by individuals in the Plan, but it excludes all identifiers that must be removed for the information to be de-identified, except that it may contain geographic information to the extent that it is aggregated by five-digit zip code.

2. Disclosure of Protected Health Information ("PHI") to the Plan Sponsor for Plan Administration Purposes

In order that the Plan Sponsor may receive and use PHI for Plan Administration purposes, the Plan Sponsor agrees to:

a. Not use or further disclose PHI other than as permitted or required by the Plan Documents or as required by law (as defined in the Privacy Standards);

b. Ensure that any agents, including a subcontractor, to whom the Plan Sponsor provides PHI received from the Plan agree to the same restrictions and conditions that apply to the Plan Sponsor with respect to such PHI;

c. Not use or disclose PHI for employment-related actions and decisions or in connection with any other benefit or employee benefit plan of the Plan Sponsor, except pursuant to an authorization which meets the requirements of the Privacy Standards;

d. Report to the Plan any PHI use or disclosure that is inconsistent with the uses or disclosures provided for of which the Plan Sponsor becomes aware;

e. Make available PHI in accordance with Section 164.524 of the Privacy Standards (45 CFR 164.524);

f. Make available PHI for amendment and incorporate any amendments to PHI in accordance with Section 164.526 of the Privacy Standards (45 CFR 164.526);

g. Make available the information required to provide an accounting of disclosures in accordance with Section 164.528 of the Privacy Standards (45 CFR 164.528);

h. Make its internal practices, books and records relating to the use and disclosure of PHI received from the Plan available to the Secretary of the U.S. Department of Health and Human Services ("HHS"), or any other officer or employee of HHS to whom the authority involved has been delegated, for purposes of determining compliance by the Plan with Part 164, Subpart E, of the Privacy Standards (45 CFR 164.500 et seq);

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

j. Ensure adequate separation between the Plan and the Plan Sponsor, as required in Section 164.504(f)(2)(iii) of the Privacy Standards (45 CFR 164.504(f)(2)(iii)).

"Plan Administration" functions are activities that would meet the definitions of treatment, payment and health care operations. "Plan Administration" functions include, but are not limited to quality assurance, claims processing, auditing, monitoring, management, stop loss underwriting, stop loss claims filing, eligibility information requests, Medical Necessity reviews, certain appeal determinations, utilization review, case management and disease management. It does not include any employment-related functions or functions in connection with any other benefit or benefit plans.

The Plan shall disclose PHI to the Plan Sponsor only upon receipt of a certification by the Plan Sponsor that (a) the Plan Documents have been amended to incorporate the above provisions and (b) the Plan Sponsor agrees to comply with such provisions.

3. Disclosure of Certain Enrollment Information to the Plan Sponsor

Pursuant to Section 164.504(f)(1)(iii) of the Privacy Standards (45 CFR 164.504(f)(1)(iii)), the Plan may disclose to the Plan Sponsor information on whether an individual is participating in the Plan or is enrolled in or has disenrolled from a health insurance issuer or health maintenance organization offered by the Plan to the Plan Sponsor.

4. Other Disclosures and Uses of PHI

With respect to all other uses and disclosures of PHI, the Plan shall comply with the Privacy Standards.

Standards For Security Of Individually Identifiable Health Information (The "Security Standards")

1. DEFINITIONS

a. The term "Electronic Protected Health Information" ("EPHI") has the meaning set forth in Section 160.103 of the Security Standards (45 C.F.R. 160.103) and generally means individually identifiable health information that is transmitted or maintained in any electronic media.

b. The term "Security Incidents" has the meaning set forth in Section 164.304 of the Security Standards (45 C.F.R. 164.304) and generally means the attempted or successful unauthorized access, use, disclosure, modification, or destruction of information or interference with systems operations in an information system.

2. PLAN SPONSOR OBLIGATIONS

Where EPHI will be created, received, maintained, or transmitted to or by the Plan Sponsor on behalf of the Plan, the Plan Sponsor shall reasonably safeguard the EPHI as follows:

a. Plan Sponsor shall implement administrative, physical, and technical safeguards that reasonably and appropriately protect the confidentiality, integrity, and availability of EPHI that Plan Sponsor creates, receives, maintains, or transmits on behalf of the Plan;

b. Plan Sponsor shall ensure that the adequate separation that is required by Section 164.504 (f) (2) (iii) of the Security Standards (45 C.F.R. 164.504 (f) (2) (iii)) is supported by reasonable and appropriate security measures;

c. Plan Sponsor shall ensure that any agents, including a subcontractor, to whom it provides EPHI agrees to implement reasonable and appropriate security measures to protect such EPHI; and

d. Plan Sponsor shall report to the Plan any Security Incidents of which it becomes aware as described below:

   i.) Plan Sponsor shall report to the Plan within a reasonable time after the Plan Sponsor becomes aware of any Security Incident that results in unauthorized access, use, disclosure, modification, or destruction of the Plan's EPHI; and

   ii.) Plan Sponsor shall report to the Plan any other Security Incident on an aggregate basis every quarter, or more frequently upon the Plan's request.

e. Plan Sponsor shall make its internal practices, books, and records relating to its compliance with the Security Standards to the Secretary of the U.S. Department of Health and Human Services ("HHS"), or any other officer or employee of HHS to whom the authority involved has been delegated, for purposes of determining compliance by the Plan with the Security Standards.

Notice Of Privacy Practices

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT COVERED PERSONS MAY BE USED AND DISCLOSED AND HOW COVERED PERSONS CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

This Notice of Privacy Practices ("Notice") describes how protected health information may be used or disclosed by this Plan to carry out treatment, payment, health care operations and for other purposes that are permitted or required by law. This Notice also sets out this Plan's legal obligations concerning a Covered Person's protected health information and describes a Covered Person's rights to access, amend and manage that protected health information.

Protected health information ("PHI") is individually identifiable health information, including demographic information, collected from a Covered Person or created or received by a health care Provider, a health plan, an employer (when functioning on behalf of the group health plan), or a health care clearinghouse and that relates to: (1) a Covered Person's past, present or future physical or mental health or condition; (2) the provision of health care to a Covered Person; or (3) the past, present or future payment for the provision of health care to a Covered Person.

This Notice has been drafted to be consistent with what is known as the "HIPAA Privacy Rule," and any of the terms not defined in this Notice should have the same meaning as they have in the HIPAA Privacy Rule.

If You have any questions or want additional information about the Notice or the policies and procedures described in the Notice, please contact the person(s) or office identified under Plan Contact Information in the Key Information section at the beginning of this document:

THE PLAN'S RESPONSIBILITIES

The Plan is required by law to maintain the privacy of a Covered Person's PHI. The Plan is obligated to provide the Covered Person with a copy of this Notice of the Plan's legal duties and of its privacy practices with respect to the Covered Person's PHI, abide by the terms of the Notice that is currently in effect, and notify the Covered Person in the event of a breach of the Covered Person's unsecured PHI. The Plan reserves the right to change the provisions of this Notice and make the new provisions effective for all PHI that is maintained. If the Plan makes a material change to this Notice, a revised Notice will be mailed to the address that the Plan has on record.

When using or disclosing PHI or when requesting PHI from another covered entity, the Plan will make reasonable efforts not to use, disclose or request more than the minimum amount of PHI necessary to accomplish the intended purpose of the use, disclosure or request, taking into consideration practical and technological limitations.

Genetic information shall be treated as health information pursuant to the Health Insurance Portability and Accountability Act. The use or disclosure by the Plan of protected health information that is Genetic Information about an individual for underwriting purposes under the Plan shall not be a permitted use or disclosure.

However, the minimum necessary standard will not apply in the following situations:

- disclosures to or requests by a health care Provider for treatment;
- uses or disclosures made to the individual;
- disclosures made to the Secretary of the U.S. Department of Health and Human Services;
- uses or disclosures that are required by law;
- uses or disclosures that are required for compliance with the HIPAA Privacy Rule; and
- uses or disclosures made pursuant to an authorization.

This Notice does not apply to information that has been de-identified. De-identified information is health information that does not identify an individual and with respect to which there is no reasonable basis to believe that the information can be used to identify an individual. It is not individually identifiable health information.

PERMISSIBLE USES AND DISCLOSURES OF PHI

The following is a description of how the Plan is most likely to use and/or disclose a Covered Person's PHI.

TREATMENT, PAYMENT AND HEALTH CARE OPERATIONS

The Plan has the right to use and disclose a Covered Person's PHI for all activities that are included within the definitions of "treatment, payment and health care operations" as described in the HIPAA Privacy Rule.

TREATMENT

The Plan will use or disclose PHI so that a Covered Person may seek treatment. Treatment is the provision, coordination or management of health care and related services. It also includes but is not limited to consultations and referrals between one or more of a Covered Person's Providers. For example, the Plan may disclose to a treating Specialist Physician the name of a Covered Person's Primary Care Physician so that the Specialist Physician may request medical records from that Primary Care Physician.

PAYMENT

The Plan will use or disclose PHI to pay claims for services provided to a Covered Person and to obtain stop-loss reimbursements, if applicable, or to otherwise fulfill the Plan's responsibilities for coverage and providing benefits. For example, the Plan may disclose PHI when a Provider requests information regarding a Covered Person's eligibility for coverage under this Plan, or the Plan may use PHI to determine if a treatment that was received was Medically Necessary.

HEALTH CARE OPERATIONS

The Plan will use or disclose PHI to support its business functions. These functions include, but are not limited to quality assessment and improvement, reviewing Provider performance, licensing, stop-loss underwriting, business planning and business development. For example, the Plan may use or disclose PHI: (1) to provide a Covered Person with information about a disease management program; (2) to respond to a customer service inquiry from a Covered Person or (3) in connection with fraud and abuse detection and compliance programs.

POTENTIAL IMPACT OF STATE LAW

The HIPAA Privacy Regulations generally do not "preempt" (or take precedence over) state privacy or other applicable laws that provide individuals greater privacy protections. As a result, to the extent state law applies, the privacy laws of a particular state, or other federal laws, rather than the HIPAA Privacy Regulations, might impose a privacy standard under which the Plan will be required to operate. For example, where such laws have been enacted, the Plan will follow more stringent state privacy laws that relate to uses and disclosures of PHI concerning HIV or AIDS, mental health, substance abuse/chemical dependency, genetic testing, reproductive rights, etc.

OTHER PERMISSIBLE USES AND DISCLOSURES OF PHI

The following is a description of other possible ways in which the Plan may (and is permitted to) use and/or disclose PHI.

REQUIRED BY LAW

The Plan may use or disclose PHI to the extent the law requires the use or disclosure. When used in this Notice, "required by law" is defined as it is in the HIPAA Privacy Rule. For example, the Plan may disclose PHI when required by national security laws or public health disclosure laws.

PUBLIC HEALTH ACTIVITIES

The Plan may use or disclose PHI for public health activities that are permitted or required by law. For example, the Plan may use or disclose information for the purpose of preventing or controlling disease, injury, or disability, or it may disclose such information to a public health authority authorized to receive reports of child abuse or neglect. The Plan also may disclose PHI, if directed by a public health authority, to a foreign government agency that is collaborating with the public health authority.

HEALTH OVERSIGHT ACTIVITIES

The Plan may disclose PHI to a health oversight agency for activities authorized by law, such as: audits; investigations; inspections; licensure or disciplinary actions; or civil, administrative, or criminal proceedings or actions. Oversight agencies seeking this information include government agencies that oversee: (1) the health care system; (2) government benefit programs; (3) other government regulatory programs and (4) compliance with civil rights laws.

ABUSE OR NEGLECT

The Plan may disclose PHI to a government authority that is authorized by law to receive reports of abuse, neglect or domestic violence. Additionally, as required by law, the Plan may disclose to a governmental entity, authorized to receive such information, a Covered Person's PHI if there is reason to believe that the Covered Person has been a victim of abuse, neglect, or domestic violence.

LEGAL PROCEEDINGS

The Plan may disclose PHI: (1) in the course of any judicial or administrative proceeding; (2) in response to an order of a court or administrative tribunal (to the extent such disclosure is expressly authorized) and (3) in response to a subpoena, a discovery request, or other lawful process, once the Plan has met all administrative requirements of the HIPAA Privacy Rule. For example, the Plan may disclose PHI in response to a subpoena for such information, but only after first meeting certain conditions required by the HIPAA Privacy Rule.

LAW ENFORCEMENT

Under certain conditions, the Plan also may disclose PHI to law enforcement officials. For example, some of the reasons for such a disclosure may include, but not be limited to: (1) it is required by law or some other legal process; (2) it is necessary to locate or identify a suspect, fugitive, material witness, or missing person or (3) it is necessary to provide evidence of a crime.

CORONERS, MEDICAL EXAMINERS, FUNERAL DIRECTORS, AND ORGAN DONATION ORGANIZATIONS

The Plan may disclose PHI to a coroner or medical examiner for purposes of identifying a deceased person, determining a cause of death or for the coroner or medical examiner to perform other duties authorized by law. The Plan also may disclose, as authorized by law,

information to funeral directors so that they may carry out their duties. Further, the Plan may disclose PHI to organizations that handle organ, eye or tissue donation and transplantation.

RESEARCH

The Plan may disclose PHI to researchers when an institutional review board or privacy board has: (1) reviewed the research proposal and established protocols to ensure the privacy of the information and (2) approved the research.

TO PREVENT A SERIOUS THREAT TO HEALTH OR SAFETY

Consistent with applicable federal and state laws, the Plan may disclose PHI if there is reason to believe that the disclosure is necessary to prevent or lessen a serious and imminent threat to the health or safety of a person or the public. The Plan also may disclose PHI if it is necessary for law enforcement authorities to identify or apprehend an individual.

MILITARY ACTIVITY AND NATIONAL SECURITY, PROTECTIVE SERVICES

Under certain conditions, the Plan may disclose PHI if Covered Persons are, or were, Armed Forces personnel for activities deemed necessary by appropriate military command authorities. If Covered Persons are members of foreign military service, the Plan may disclose, in certain circumstances, PHI to the foreign military authority. The Plan also may disclose PHI to authorized federal officials for conducting national security and intelligence activities, and for the protection of the President, other authorized persons, or heads of state.

INMATES

If a Covered Person is an inmate of a correctional institution, the Plan may disclose PHI to the correctional institution or to a law enforcement official for: (1) the institution to provide health care to the Covered Person; (2) the Covered Person’s health and safety and the health and safety of others or (3) the safety and security of the correctional institution.

WORKERS' COMPENSATION

The Plan may disclose PHI to comply with workers' compensation laws and other similar programs that provide benefits for work-related injuries or Illnesses.

EMERGENCY SITUATIONS

The Plan may disclose PHI of a Covered Person in an Emergency situation, or if the Covered Person is incapacitated or not present, to a family member, close personal friend, authorized disaster relief agency, or any other person previously identified by the Covered Person. The Plan will use professional judgment and experience to determine if the disclosure is in the best interests of the Covered Person. If the disclosure is in the best interest of the Covered Person, the Plan will disclose only the PHI that is directly relevant to the person's involvement in the care of the Covered Person.

FUNDRAISING ACTIVITIES

The Plan may use or disclose the PHI of a Covered Person for fundraising activities, such as raising money for a charitable foundation or similar entity to help finance its activities. If the Plan does contact the Covered Person for fundraising activities, the Plan will give the Covered Person the opportunity to opt-out, or stop, receiving such communications in the future.

GROUP HEALTH PLAN DISCLOSURES

The Plan may disclose the PHI of a Covered Person to a sponsor of the group health plan – such as an employer or other entity – that is providing a health care program to the Covered Person.

The Plan can disclose the PHI of the Covered Person to that entity if that entity has contracted with the Plan to administer the Covered Person's health care program on its behalf.

UNDERWRITING PURPOSES

The Plan may use or disclose the PHI of a Covered Person for underwriting purposes, such as to make a determination about a coverage application or request. If the Plan does use or disclose the PHI of the Covered Person for underwriting purposes, the Plan is prohibited from using or disclosing in the underwriting process the PHI of the Covered Person that is Genetic Information.

OTHERS INVOLVED IN YOUR HEALTH CARE

Using its best judgment, the Plan may make PHI known to a family member, other relative, close personal friend or other personal representative that the Covered Person identifies. Such use will be based on how involved the person is in the Covered Person's care or in the payment that relates to that care. The Plan may release information to parents or guardians, if allowed by law.

If a Covered Person is not present or able to agree to these disclosures of PHI, then, using its professional judgment, the Plan may determine whether the disclosure is in the Covered Person's best interest.

REQUIRED DISCLOSURES OF PHI

The following is a description of disclosures that the Plan is required by law to make.

DISCLOSURES TO THE SECRETARY OF THE U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES

The Plan is required to disclose PHI to the Secretary of the U.S. Department of Health and Human Services when the Secretary is investigating or determining the Plan's compliance with the HIPAA Privacy Rule.

DISCLOSURES TO COVERED PERSONS

The Plan is required to disclose to a Covered Person most of the PHI in a "designated record set" when that Covered Person requests access to this information. Generally, a designated record set contains medical and billing records, as well as other records that are used to make decisions about a Covered Person's health care benefits. The Plan also is required to provide, upon the Covered Person's request, an accounting of most disclosures of his PHI that are for reasons other than treatment, payment and health care operations and are not disclosed through a signed authorization.

The Plan will disclose a Covered Person's PHI to an individual who has been designated by that Covered Person as his personal representative and who has qualified for such designation in accordance with relevant state law. However, before the Plan will disclose PHI to such a person, the Covered Person must submit a written notice of his designation, along with the documentation that supports his qualification (such as a power of attorney).

Even if the Covered Person designates a personal representative, the HIPAA Privacy Rule permits the Plan to elect not to treat that individual as the Covered Person's personal representative if a reasonable belief exists that: (1) the Covered Person has been, or may be, subjected to domestic violence, abuse or neglect by such person; (2) treating such person as his personal representative could endanger the Covered Person, or (3) the Plan determines, in the exercise of its professional judgment, that it is not in its best interest to treat that individual as the Covered Person's personal representative.

BUSINESS ASSOCIATES

The Plan contracts with individuals and entities (Business Associates) to perform various functions on its behalf or to provide certain types of services. To perform these functions or to provide the services, the Plan's Business Associates will receive, create, maintain, use or disclose PHI, but only after the Plan requires the Business Associates to agree in writing to contract terms designed to appropriately safeguard PHI. For example, the Plan may disclose PHI to a Business Associate to administer claims or to provide service support, utilization management, subrogation, or pharmacy benefit management. Examples of the Plan's Business Associates would be its Third-Party Administrator, broker, Preferred Provider Organization and utilization review vendor.

OTHER COVERED ENTITIES

The Plan may use or disclose PHI to assist health care Providers in connection with their treatment or payment activities or to assist other covered entities in connection with payment activities and certain health care operations. For example, the Plan may disclose PHI to a health care Provider when needed by the Provider to render treatment to a Covered Person, and the Plan may disclose PHI to another covered entity to conduct health care operations in the areas of fraud and abuse detection or compliance, quality assurance and improvement activities or accreditation, certification, licensing, or credentialing. This also means that the Plan may disclose or share PHI with other insurance carriers in order to coordinate benefits, if a Covered Person has coverage through another carrier.

PLAN SPONSOR

The Plan may disclose PHI to the Plan Sponsor of the group health plan for purposes of plan administration or pursuant to an authorization request signed by the Covered Person. Also, the Plan may use or disclose "summary health information" to the Plan Sponsor for obtaining premium bids or modifying, amending or terminating the group health plan. Summary health information summarizes the claims history, claims expenses or types of claims experienced by individuals for whom a Plan Sponsor has provided health benefits under a group health plan and from which identifying information has been deleted in accordance with the HIPAA Privacy Rule.

USES AND DISCLOSURES OF PHI THAT REQUIRE A COVERED PERSON'S AUTHORIZATION

SALE OF PHI

The Plan will request the written authorization of a Covered Person before the Plan makes any disclosure that is deemed a sale of the Covered Person's PHI, meaning that the Plan is receiving compensation for disclosing the PHI in this manner.

MARKETING

The Plan will request the written authorization of a Covered Person to use or disclose the Covered Person's PHI for marketing purposes with limited exceptions, such as when the Plan has face-to-face marketing communications with the Covered Person or when the Plan provides promotional gifts of nominal value.

PSYCHOTHERAPY NOTES

The Plan will request the written authorization of a Covered Person to use or disclose any of the Covered Person's psychotherapy notes that the Plan may have on file with limited exception, such as for certain treatment, payment or health care operation functions.

Other uses and disclosures of PHI that are not described previously will be made only with a Covered Person's written authorization. If the Covered Person provides the Plan with such an authorization, he/she may revoke the authorization in writing, and this revocation will be

effective for future uses and disclosures of PHI. However, the revocation will not be effective for information that has already been used or disclosed, relying on the authorization.

A COVERED PERSON'S RIGHTS

The following is a description of a Covered Person's rights with respect to PHI:

RIGHT TO REQUEST A RESTRICTION

A Covered Person has the right to request a restriction on the PHI the Plan uses or discloses about him/her for treatment, payment, or health care operations. The Plan is not required to agree to any restriction that a Covered Person may request. If the Plan does agree to the restriction, it will comply with the restriction unless the information is needed to provide Emergency treatment.

A Covered Person may request a restriction by contacting the person(s) or office identified under Plan Contact Information in the Key Information section at the beginning of this document. It is important that the Covered Person directs his request for restriction to this individual or office so that the Plan can begin to process Your request. Requests sent to individuals or offices other than the one indicated might delay processing the request.

The Plan will want to receive this information in writing and will instruct the Covered Person where to send the request when the Covered Person's call is received. In this request, it is important that the Covered Person states: (1) the information whose disclosure he/she wants to limit and (2) how he/she wants to limit the Plan's use and/or disclosure of the information.

RIGHT TO REQUEST CONFIDENTIAL COMMUNICATIONS

If a Covered Person believes that a disclosure of all or part of his PHI may endanger him/her, that Covered Person may request that the Plan communicates with him/her regarding PHI in an alternative manner or at an alternative location. For example, the Covered Person may ask that the Plan only contact the Covered Person at a work address or via the Covered Person's work e-mail.

The Covered Person may request a restriction by contacting the person(s) or office identified under Plan Contact Information in the Key Information section at the beginning of this document. It is important that the request for confidential communications is addressed to this individual or office so that the Plan can begin to process the request. Requests sent to individuals or offices other than the one indicated might delay processing the request.

The Plan will want to receive this information in writing and will instruct the Covered Person where to send a written request upon receiving a call. This written request should inform the Plan: (1) that he/she wants the Plan to communicate his PHI in an alternative manner or at an alternative location and (2) that the disclosure of all or part of this PHI in a manner inconsistent with these instructions would put the Covered Person in danger.

The Plan will accommodate a request for confidential communications that is reasonable and that states that the disclosure of all or part of a Covered Person's PHI could endanger that Covered Person. As permitted by the HIPAA Privacy Rule, "reasonableness" will (and is permitted to) include, when appropriate, making alternate arrangements regarding payment.

Accordingly, as a condition of granting a Covered Person's request, he/she will be required to provide the Plan information concerning how payment will be handled. For example, if the Covered Person submits a claim for payment, state or federal law (or the Plan's own contractual obligations) may require that the Plan disclose certain financial claim information to the Plan Participant under whose coverage a Covered Person may receive benefits (e.g., an Explanation

of Benefits "EOB"). Unless the Covered Person has made other payment arrangements, the EOB (in which a Covered Person's PHI might be included) will be released to the Plan Participant.

Once the Plan receives all the information for such a request (along with the instructions for handling future communications), the request will be processed usually within 2 business days or as soon as reasonably possible.

Prior to receiving the information necessary for this request, or during the time it takes to process it, PHI may be disclosed (such as through an EOB). Therefore, it is extremely important that the Covered Person contact the person(s) or office identified under Plan Contact Information in the Key Information section at the beginning of this document as soon as the Covered Person determines the need to restrict disclosures of his PHI.

If the Covered Person terminates his request for confidential communications, the restriction will be removed for all of the Covered Person's PHI that the Plan holds, including PHI that was previously protected. Therefore, a Covered Person should not terminate a request for confidential communications if that person remains concerned that disclosure of PHI will endanger him/her.

RIGHT TO INSPECT AND COPY

A Covered Person has the right to inspect and copy PHI that is contained in a "designated record set." Generally, a designated record set contains medical and billing records, as well as other records that are used to make decisions about a Covered Person's health care benefits. However, the Covered Person may not inspect or copy psychotherapy notes or certain other information that may be contained in a designated record set.

To inspect and copy PHI that is contained in a designated record set, the Covered Person must submit a request by contacting the person(s) or office identified under Plan Contact Information in the Key Information section at the beginning of this document. It is important that the Covered Person contact this individual or office to request an inspection and copying so that the Plan can begin to process the request. Requests sent to individuals or offices other than the one indicated might delay the processing of the request. If the Covered Person requests a copy of the information, the Plan may charge a fee for the costs of copying, mailing or other supplies associated with that request.

The Plan may deny a Covered Person's request to inspect and copy PHI in certain limited circumstances. If a Covered Person is denied access to information, he/she may request that the denial be reviewed. To request a review, the Covered Person must contact the person(s) or office identified under Plan Contact Information in the Key Information section at the beginning of this document. A licensed health care professional chosen by the Plan will review the Covered Person's request and the denial. The person performing this review will not be the same one who denied the Covered Person's initial request. Under certain conditions, the Plan's denial will not be reviewable. If this event occurs, the Plan will inform the Covered Person through the denial that the decision is not reviewable.

RIGHT TO AMEND

If a Covered Person believes that his PHI is incorrect or incomplete, he/she may request that the Plan amend that information. The Covered Person may request that the Plan amend such information by contacting the person(s) or office identified under Plan Contact Information in the Key Information section at the beginning of this document. Additionally, this request should include the reason the amendment is necessary. It is important that the Covered Person direct this request for amendment to this individual or office so that the Plan can begin to process the

request. Requests sent to individuals or offices other than the one indicated might delay processing the request.

In certain cases, the Plan may deny the Covered Person's request for an amendment. For example, the Plan may deny the request if the information the Covered Person wants to amend is not maintained by the Plan, but by another entity. If the Plan denies the request, the Covered Person has the right to file a statement of disagreement with the Plan. This statement of disagreement will be linked with the disputed information and all future disclosures of the disputed information will include this statement.

RIGHT OF AN ACCOUNTING

The Covered Person has a right to an accounting of certain disclosures of PHI that are for reasons other than treatment, payment or health care operations. No accounting of disclosures is required for disclosures made pursuant to a signed authorization by the Covered Person or his personal representative. The Covered Person should know that most disclosures of PHI will be for purposes of payment or health care operations, and, therefore, will not be subject to this right. There also are other exceptions to this right.

An accounting will include the date(s) of the disclosure, to whom the Plan made the disclosure, a brief description of the information disclosed and the purpose for the disclosure.

A Covered Person may request an accounting by submitting a request in writing to the person(s) or office identified under Plan Contact Information in the Key Information section at the beginning of this document. It is important that the Covered Person direct the request for an accounting to this individual or office so that the Plan can begin to process the request. Requests sent to individuals or offices other than the one indicated might delay processing the request.

A Covered Person's request may be for disclosures made up to 6 years before the date of the request, but not for disclosures made before April 14, 2004. The first list requested within a 12-month period will be free. For additional lists, the Plan may charge for the costs of providing the list. The Plan will notify the Covered Person of the cost involved and he/she may choose to withdraw or modify the request before any costs are incurred.

RIGHT TO A COPY OF THIS NOTICE

The Covered Person has the right to request a copy of this Notice at any time by contacting the person(s) or office identified under Plan Contact Information in the Key Information section at the beginning of this document. If You receive this Notice on the Plan's website or by electronic mail, You also are entitled to request a paper copy of this Notice.

COMPLAINTS

A Covered Person may complain to the Plan if he/she believes that the Plan has violated these privacy rights. The Covered Person may file a complaint with the Plan by contacting the person(s) or office identified under Plan Contact Information in the Key Information section at the beginning of this document. A copy of a complaint form is available from this contact office.

A Covered Person also may file a complaint with the Secretary of the U.S. Department of Health and Human Services. Complaints filed directly with the Secretary must: (1) be in writing; (2) contain the name of the entity against which the complaint is lodged; (3) describe the relevant problems and (4) be filed within 180 days of the time the Covered Person became or should have become aware of the problem.

The Plan will not penalize or in any other way retaliate against a Covered Person for filing a complaint with the Secretary or with the Plan.

SECTION 14: COBRA CONTINUATION RIGHTS

INTRODUCTION

This notice contains important information about Your rights to COBRA continuation coverage, which is a temporary extension of coverage under the Plan. **This notice generally explains COBRA continuation coverage, when it may become available to You and Your family, and what You need to do to protect the right to receive it.**

The right to COBRA continuation coverage was created by a federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA). COBRA continuation coverage can become available to You and other members of Your family when group health coverage would otherwise end. For more information about Your rights and obligations under the Plan and under federal law, You should review the Plan's Summary Plan Description or contact the Plan Administrator.

You may have other options available to You when You lose group health coverage. For example, You may be eligible to buy an individual plan through the Health Insurance Marketplace. By enrolling in coverage through the Marketplace, You may qualify for lower costs on Your monthly premiums and lower Out-of-Pocket costs. Additionally, You may qualify for a 30-day Special Enrollment period for another group health plan for which You are eligible (such as a Spouse's plan), even if that plan generally doesn't accept Late Enrollees.

WHAT IS COBRA CONTINUATION COVERAGE?

COBRA continuation coverage is a continuation of Plan coverage when coverage would otherwise end because of a life event. This is also called a “qualifying event”. Specific qualifying events are listed later in this notice. After a qualifying event, COBRA continuation coverage must be offered to each person who is a “qualified beneficiary.” You, Your Spouse, and Your Dependent Child(ren) could become qualified beneficiaries if coverage under the Plan is lost because of the qualifying event. Under the Plan, qualified beneficiaries who elect COBRA continuation coverage must pay for COBRA continuation coverage.

If You're an Employee, You'll become a qualified beneficiary if You lose Your coverage under the Plan because of the following qualifying events:

- Your hours of employment are reduced, or
- Your employment ends for any reason other than Your gross misconduct.

If You're the Spouse of an Employee, You will become a qualified beneficiary if You lose Your coverage under the Plan because of the following qualifying events:

- Your Spouse dies;
- Your Spouse's hours of employment are reduced;
- Your Spouse's employment ends for any reason other than his or her gross misconduct;
- Your Spouse becomes entitled to Medicare benefits (under Part A, Part B, or both); or
- You become divorced or legally separated from Your Spouse.

Your Dependent Child(ren) will become qualified beneficiaries if they lose coverage under the Plan because any of the following qualifying events:

- The parent-Employee dies;
- The parent-Employee's hours of employment are reduced;
- The parent-Employee's employment ends for any reason other than his or her gross misconduct;
- The parent-Employee becomes entitled to Medicare benefits (Part A, Part B, or both);
- The parents become divorced or legally separated; or

- The Child stops being eligible for coverage under the plan as a “Dependent Child.”

Sometimes, filing a proceeding in bankruptcy under title 11 of the United States Code can be a qualifying event. If a proceeding in bankruptcy is filed with respect to Your employer, and that bankruptcy results in the loss of coverage of any retired employee covered under the Plan, the retired employee will become a qualified beneficiary with respect to the bankruptcy. The retired employee's Spouse, surviving Spouse, and Dependent Child(ren) will also become qualified beneficiaries if bankruptcy results in the loss of their coverage under the Plan.

WHEN IS COBRA COVERAGE AVAILABLE?

The Plan will offer COBRA continuation coverage to qualified beneficiaries only after the Plan Sponsor has been notified that a qualifying event has occurred. When the qualifying event is the end of employment or reduction of hours of employment, death of the Employee, commencement of a proceeding in bankruptcy with respect to the Employer (if the Plan provides retiree coverage), or the Employee's becoming entitled to Medicare benefits (under Part A, Part B, or both), the Employer must notify the Plan Sponsor of the qualifying event.

For all other qualifying events (divorce or legal separation of the Employee and Spouse or a Dependent Child's losing eligibility for coverage as a Dependent Child), You must notify the Plan Administrator within 60 days after the qualifying event occurs. You must send this notice in writing to the Plan Administrator. IF YOU, YOUR SPOUSE OR YOUR DEPENDENT FAIL TO PROVIDE TIMELY WRITTEN NOTICE TO THE PLAN ADMINISTRATOR AFTER A DIVORCE, LEGAL SEPARATION OR LOSS OF DEPENDENT CHILD ELIGIBILITY, THE RIGHT TO ELECT TO PURCHASE COBRA CONTINUATION COVERAGE IS WAIVED.

HOW IS COBRA COVERAGE PROVIDED?

Once the Plan Sponsor receives notice that a qualifying event has occurred, COBRA continuation coverage will be offered to each of the qualified beneficiaries. Each qualified beneficiary will have an independent right to elect COBRA continuation coverage. Covered Employees may elect COBRA continuation coverage on behalf of their Spouses, and parents may elect COBRA continuation coverage on behalf of their Child(ren).

COBRA continuation coverage is a temporary continuation of coverage that generally lasts for 18 months due to employment termination or reduction of hours of work. Certain qualifying events, or a second qualifying event during the initial period of coverage, may permit a beneficiary to receive a maximum of 36 months of coverage.

There are also ways in which this 18-month period of COBRA continuation coverage can be extended.

DISABILITY EXTENSION OF 18-MONTH PERIOD OF CONTINUATION COVERAGE

If You or anyone in Your family covered under the Plan is determined by the Social Security Administration to be disabled and You notify the Plan Sponsor in a timely fashion, You and Your entire family may be entitled to receive up to an additional 11 months of COBRA continuation coverage, for a total maximum of 29 months. The disability would have to have started at some time before the 60th day of COBRA continuation coverage and must last at least until the end of the 18-month period of continuation coverage. A copy of the determination of disability by the Social Security Administration must be sent to the Plan Sponsor within 60 days after the date the determination is issued and before the end of the 18-month maximum coverage period that applies to the qualifying event. Any individual who is either the Employee, a qualified beneficiary with respect to the qualifying event, or any representative acting on behalf of the Employee or qualified beneficiary, may send the written notice to

the Plan Sponsor. Such individual(s) must further notify the Plan Sponsor in writing within 30 days after a determination has been made that the person is no longer disabled. The Plan may require the payment of an amount that is up to 150 percent of the applicable premium for the period of extended coverage as long as the disabled individual is included in the extended coverage period.

SECOND QUALIFYING EVENT EXTENSION OF 18-MONTH PERIOD OF CONTINUATION COVERAGE

If Your family experiences another qualifying event while receiving 18 months of COBRA continuation coverage, the Spouse and Dependent Child(ren) in Your family can get up to 18 additional months of COBRA continuation coverage, for a maximum of 36 months, if the Plan is properly notified about the second qualifying event. This extension may be available to the Spouse and any Dependent Child(ren) receiving continuation coverage if the Employee or former Employee dies, becomes entitled to Medicare benefits (under Part A, Part B, or both), or gets divorced or legally separated, or if the Dependent Child stops being eligible under the Plan as a Dependent Child, but only if the event would have caused the Spouse or Dependent Child to lose coverage under the Plan had the first qualifying event not occurred.

ARE THERE OTHER COVERAGE OPTIONS BESIDES COBRA CONTINUATION COVERAGE?

Yes, instead of enrolling in COBRA continuation coverage, there may be other coverage options for You and Your family through the Health Insurance Marketplace, Medicaid, or other group health plan coverage options (such as a Spouse's plan) through what is called a "Special Enrollment period." Some of these options may cost less than COBRA continuation coverage. You can learn more about these options at www.HealthCare.gov.

You should compare Your other coverage options with COBRA continuation coverage and choose the coverage that is best for You. For example, if You move to other coverage, You may pay more out of pocket than You would under COBRA because the new coverage may impose a new deductible.

When You lose job-based health coverage, it's important that You choose carefully between COBRA continuation coverage and other coverage options, because once You've made Your choice, it can be difficult or impossible to switch to another coverage option.

WHAT IS THE HEALTH INSURANCE MARKETPLACE?

The Marketplace allows You to find and compare private health insurance options. In the Marketplace, You could be eligible for a new kind of tax credit that lowers Your monthly premiums and cost-sharing reductions (amounts that lower Your Out-of-Pocket costs for deductibles, coinsurance, and copayments) right away, and You can see what Your premium, deductibles, and Out-of-Pocket costs will be before You make a decision to enroll. Through the Marketplace You'll also learn if You qualify for free or low-cost coverage from Medicaid or the Children's Health Insurance Program (CHIP). You can access the Marketplace for Your state at www.HealthCare.gov.

Coverage through the Health Insurance Marketplace may cost less than COBRA continuation coverage.

WHEN CAN I ENROLL IN MARKETPLACE COVERAGE?

You always have 60 days from the time You lose Your job-based coverage to enroll in the Marketplace. That is because losing Your job-based health coverage is a "Special Enrollment" event. **After 60 days Your Special Enrollment period will end and You may not be able to enroll, so You should take action right away.** In addition, during what is called an "open enrollment" period, anyone can enroll in Marketplace coverage.

To find out more about enrolling in the Marketplace, such as when the next open enrollment period will be and what You need to know about qualifying events and Special Enrollment periods, visit www.HealthCare.gov.

IF I SIGN UP FOR COBRA CONTINUATION COVERAGE, CAN I SWITCH TO COVERAGE IN THE MARKETPLACE? WHAT ABOUT IF I CHOOSE MARKETPLACE COVERAGE AND WANT TO SWITCH BACK TO COBRA CONTINUATION COVERAGE?

If You sign up for COBRA continuation coverage, You can switch to a Marketplace plan during a Marketplace open enrollment period. You can also end Your COBRA continuation coverage early and switch to a Marketplace plan if You have another qualifying event such as marriage or birth of a child through something called a "Special Enrollment period." But be careful though - if You terminate Your COBRA continuation coverage early without another qualifying event, You'll have to wait to enroll in Marketplace coverage until the next open enrollment period and could end up without any health coverage in the interim.

Once You've exhausted Your COBRA continuation coverage and the coverage expires, You'll be eligible to enroll in Marketplace coverage through a Special Enrollment period, even if Marketplace open enrollment has ended.

If You sign up for Marketplace coverage instead of COBRA continuation coverage, You cannot switch to COBRA continuation coverage under any circumstances.

WHAT FACTORS SHOULD I CONSIDER WHEN CHOOSING COVERAGE OPTIONS?

When considering Your options for health coverage, You may want to think about:

- Premiums: Your previous plan can charge up to 102% of total plan premiums for COBRA coverage. Other options, like coverage on a Spouse's plan or through the Marketplace, may be less expensive.
- Provider Networks: If You're currently getting care or treatment for a condition, a change in Your health coverage may affect Your access to a particular health care Provider. You may want to check to see if Your current health care Providers participate in a Network as You consider options for health coverage.
- Drug Formularies: If You're currently taking medication, a change in Your health coverage may affect Your costs for medication – and in some cases, Your medication may not be covered by another plan. You may want to check to see if Your current medications are listed in Drug formularies for other health coverage.
- Severance payments: If You lost Your job and got a severance package from Your former employer, Your former employer may have offered to pay some or all of Your COBRA payments for a period of time. In this scenario, You may want to contact the Department of Labor at 1-866-444-3272 to discuss Your options.
- Service Areas: Some plans limit their benefits to specific service or coverage areas – so if You move to another area of the country, You may not be able to use Your benefits. You may want to see if Your plan has a service or coverage area, or other similar limitations.
- Other Cost-Sharing: In addition to premiums or contributions for health coverage, You probably pay copayments, deductibles, coinsurance, or other amounts as You use Your benefits. You may want to check to see what the cost-sharing requirements are for other health coverage options. For example, one option may have much lower monthly premiums, but a much higher deductible and higher copayments.

IF YOU HAVE QUESTIONS