healthgram

SouthCoast HEALTH

# SouthCoast Health Employee Benefit Plan

## Master Plan Document & Summary Plan Description

Plan Revision Date: 1/1/13
Plan Effective Date: 1/1/13
Last Amendment Date: 1/1/23

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## INTRODUCTION

This document is the Summary Plan Description and Master Plan Document for the SouthCoast Health Employee Benefit Plan (the "Plan"). The Plan is designed and maintained by SouthCoast Health (referred to as "Employer" or "Plan Sponsor") to provide health care benefits in the event of injury or illness to covered employees and dependents.

Coverage under the Plan for an employee and the employee's designated dependents will become effective when the employee and such dependents satisfy the waiting period and all the eligibility requirements of the Plan. Covered employees and dependents are referred to as "members."

The Plan uses an In-Network Provider network. The network is a group of providers (physicians, hospitals, other health care professionals and facilities) contracted to offer health care services at reduced rates to Plan members. Members will be able to choose at any time from the list of In-Network Providers, or they may obtain health care from a non-network provider. When a member uses an In-Network Provider, the Plan will pay a larger portion of the covered medical expenses. As a result of the lower contracted rates and the higher benefit rate paid by the Plan, the member will save on health care expenses. However, the member will always have the option to choose any health care provider.

The members should review this booklet carefully, especially the sections pertaining to Care Management Services and Special Provisions. These sections describe certain steps that must be taken before receiving care in order to receive the maximum benefit available under the Plan. Certain services must be pre-approved in order for the member to receive the maximum benefit. If these services are not pre-approved, benefits will not be paid or will be paid at a lower rate and a penalty may apply.

SouthCoast Health intends to maintain this Plan indefinitely. However, it reserves the right to modify, amend or terminate the Plan at any time. If the Plan, or any benefit under the Plan, is modified, amended or terminated, the rights of covered persons are limited to covered charges incurred before the modification, amendment, or termination. (See "Amending and Terminating the Plan" in the General Information section).

The terms of the Plan will be construed and administered to meet the minimum requirements of all applicable laws (including, but not limited to, the WHCRA, MHPAEA, NMHPA, and the CAA) and to provide Beneficiaries legally enforceable rights under ERISA (hereinafter collectively, "Applicable Laws"). To the extent a Plan provision is contrary to or fails to address the minimum requirements of an applicable federal law, the Plan shall provide the coverage or benefit necessary to comply with such minimum requirements.

## PLAN INFORMATION

EMPLOYER ID NUMBER: 58-2194871

PLAN NUMBER: 501

PLAN EFFECTIVE DATE: 1/1/13

PLAN REVISION DATE: 1/1/13 (added. amend. #1.13 eff. 5/1/13; added amend. #3.13 eff. 1/1/13: Added amend. 1.14 eff. 1/1/14: Added amend. 2.14 eff. 6/1/14: Added amend. 1.15 eff. 1/1/15: Added amend. 2.15 eff. 1/1/15: Added amend. 1.16 eff. 1/1/16: Added amend. 2.16 eff. 7/1/16: Added amend. 1.17 eff. 1/1/17: Added amend. 1.18 eff. 1/1/18: Added amend. 1.19 eff. 1/1/19: Added amend. 1.20 eff. 1/1/20: Added amend. 2.20 eff. 4/1/20: Added amend. 3.20 eff. 3/23/20: Added amend. 1.21 eff. 1/1/21: Added amend. 1.22 eff. 1/1/22: Added amend. CAA-22 eff. 1/1/22: Added amend. 2.22 eff. 1/15/22: Added amend. 1.23 eff. 1/1/23)

**EMPLOYEE GROUPS COVERED IN THIS SUMMARY:**
This Summary Plan Description and Master Plan Document apply to all eligible employees of SouthCoast Health and its participating subsidiaries.

**EMPLOYER/PLAN SPONSOR/PLAN ADMINISTRATOR:**

SouthCoast Health
330 Benfield Drive
Savannah, Georgia 31406
(912) 303-3523

**AGENT FOR SERVICE OF LEGAL PROCESS:**
The Plan Administrator named above is the agent for service of legal process.

**PLAN SUPERVISOR:**

Healthgram, Inc.
P.O. Box 11088
Charlotte, NC 28220-1088
(704) 523-2758

**PLAN YEAR/CALENDAR YEAR:**
The financial records of the Plan are kept on a plan year basis. The plan year will begin each **January 1** and end on **December 31.** Deductible and co-insurance information is maintained on a calendar year basis.

**TYPE OF ADMINISTRATION:**
The Plan Administrator has complete power and discretionary authority to manage and administer the Plan. The Plan Administrator may delegate any assigned administrative duties to one or more designated persons or entities. Processing of initial claims has been delegated to the Plan Supervisor; however, the duties of the Plan Supervisor are merely ministerial in nature and no discretionary authority or responsibility for the Plan has been conferred on or delegated to the Plan Supervisor.

**Plan Benefits**
The Plan is an employee welfare benefits plan providing medical benefits. The Plan provides benefits only for those covered medical expenses specifically listed in this Summary Plan Description (See the Schedule of Benefits and Covered Medical Expenses sections.)

**Funding**
The Plan is funded by contributions from the Plan Sponsor and covered employees. The Plan Sponsor determines the level of contributions required, if any, from each participant and reserves the right to evaluate and modify the level of contributions from time to time. The application for enrollment and coverage authorizes the Plan Sponsor to make any required payroll deductions.

**HIPAA Privacy Official**
Questions about the Plan's privacy policies and procedures and privacy complaints must be directed to:

SouthCoast Health
Privacy Official
330 Benfield Drive
Savannah, Georgia 31406
(912) 303-3523

**High Deductible Health Plan**
This Plan is designed to meet the standards of a Qualifying High Deductible Health Plan under IRC Section
223.

## SCHEDULE OF BENEFITS

**Medical Benefits**
When injury or illness cause the member or the member's dependents, while covered under this Plan, to incur Covered Medical Expenses, the Plan will determine benefits according to the provisions described in this Summary Plan Description and Master Plan Document. Benefits for each Covered Medical Expense will be calculated as follows:

1. The lesser of the actual, negotiated or Plan Allowance fee will be determined.
2. The allowable charge will be reduced by any applicable deductible or co-pay and multiplied by the appropriate co-insurance rate, resulting in the benefit payable.
3. The benefit payable will be subject to all the terms, conditions and limitations of the Plan.

**Payment**
Covered expenses will only be paid if all of the following criteria are met:
1. The service is performed or provided on or after the member effective date.
2. The service is performed or provided prior to termination of coverage.
3. The service is provided by a provider within the scope of his or her license.
4. The Care Management Services requirements have been met.
5. The service is Medically Necessary.
6. The service is not subject to an Exclusion as provided in the Plan.

**Care Management Requirements**
Your Plan includes one or more features to help control the cost of medical care coverage. Some features will affect the amount of benefits payable for covered expenses. (See the Care Management Requirements section for details).

Please note that the Plan is not directly involved in treatment, but only provides benefits for services that are covered under the terms of the Plan. Therefore, the Plan has no liability for the quality of care you may receive. The member and health care provider(s) are responsible for making all decisions regarding your health care and will control the course of treatment followed.

**Pre-certification**
Hospital admissions, outpatient surgeries and other procedures require pre-certification. If pre-certification is not obtained, a penalty will apply and benefits will be reduced and/or denied. (See the Care Management Services section for details).

**In–Network Services**
The Plan uses In-Network Providers. "In-Network Providers" are contracted either directly by the Plan or through other provider networks that are supplementary to the Plan. An "Out-of-Network Provider" is one who has not elected to participate as an In-Network Provider in the Plan. A list of In-Network Providers is available on-line at www.Healthgram.com, or from the Plan Administrator.

Two different levels of benefits are provided under the Plan:

1. The "In-Network" benefit level will be payable for services rendered by a participating provider.
2. The "Out-of-Network" benefit level will be payable for services rendered by a provider who is not a participating provider.

**Out-of-Area Benefits**
Charges for Covered Medical Expenses rendered by a provider where a network arrangement does not exist will be considered as out-of-area charges.

**Emergency Services**
Charges for Emergency Services do not require pre-certification and are covered as In-Network (See Definitions).

**Calendar Year Deductible**
A covered person's deductible requirement will be met when Covered Medical Expenses paid by that person during each calendar year equal the deductible amount. The covered person is responsible for paying the calendar year deductible. The Plan will not reimburse the covered person for this expense. Co-pays, non-covered charges, hospital per occurrence deductibles, and hospital per admission deductibles do not accrue toward the calendar year deductible. When the Family deductible is satisfied, no further deductible will be applied for any covered Family member during the remainder of that calendar year. Non-covered charges do not accrue toward the calendar year deductible.

| | **In-Network** | **Out-of-Network** |
|---|---|---|
| Individual | $3,000 | $3,000 |
| Family | $6,000 | $6,000 |

*Deductible includes Prescription Drug Benefits

**Co-Insurance Rate**
Co-Insurance rate is the percentage of Covered Medical Expenses payable by the Plan after the deductible requirement is met. The co-insurance rate for each type of service is listed in the Schedule of Benefits.

**Standard Organ Transplant Benefit**
If a covered person does not meet all the requirements outlined in the Organ Transplant Program under Care Management Requirement, the co-insurance rate is 50% with a maximum benefit of $100,000.

**Oncology Management Program**
In order to receive benefits, the covered person must participate in the Oncology Management Program (see Care Management Requirement section for details).

**Out-of-Pocket Limit**
If the total amount of out-of-pocket expenses for deductibles, co-payments, and co-insurance meets the limit set forth below, then the Plan will pay 100% for any additional covered expenses incurred during the remainder of the calendar year. When an individual with family coverage has met the Individual Out-of-Pocket limit, all covered expenses for that individual are paid at 100%, even if the Family Out-of-Pocket limit has not been met.

If a covered person has health coverage from any other source where coordination of benefits is allowable, the out-of-pocket limit does not apply.

Non-covered charges, negotiated reduction in charges, benefit reduction for failure to comply with pre-certification and Care Management Service Requirements, and charges in excess of the Plan Allowance do not accrue toward the out-of-pocket limit for the year.

| Out-of-Pocket Limit | In-Network | | Out-of-Network |
|---|---|---|---|
| | **Medical** | **Rx** | |
| Individual | $3,000 | $2,000 | $10,000 |
| Family | $6,000 | $4,000 | $20,000 |

**PRIMARY CARE SERVICES**

| Services | In-Network | Out-of-Network (Subject to Plan Allowance) |
|---|---|---|
| 1. Charges of primary care physician for a visit to the office, including office surgery charges | Payable at 100% after deductible | Payable at 60% after deductible |

**PREVENTIVE AND WELLNESS SERVICES**

| Services | In-Network | Out-of-Network (Subject to Plan Allowance) |
|---|---|---|
| 1. Routine Physical exams, including office visits, x-rays, laboratory blood tests, immunizations/flu shots, and HPV vaccine | Payable at 100% | Payable at 60% after deductible |
| 2. Routine child care (up to age 6), including office visits, x-rays, laboratory blood tests, immunizations/flu shots | Payable at 100% | Payable at 60% after deductible |
| 3. Gynecological exams | Payable at 100% | Payable at 60% after deductible |
| 4. Mammogram* | Payable at 100% | Payable at 60% after deductible |
| 5. Prostate, PSA and rectal exams for men* | Payable at 100% | Payable at 60% after deductible |
| 6. Contraceptives | Payable at 100% | Payable at 60% after deductible |
| 7. Colonoscopies, including virtual colonoscopies* | Payable at 100% | Payable at 60% after deductible |
| 8. Preventive Services* | Payable at 100% | Payable at 60% after deductible |

*For a complete list of preventive services and frequency limitations please visit http://www.healthcare.gov/law/about/provisions/services/lists.html

| Covered Preventive Services for Adults | Covered Preventive Services for Women, Including Pregnant Women | Covered Preventive Services for Children |
|---|---|---|
| Screenings<br>• Abdominal Aortic Aneurysm<br>• Alcohol Misuse<br>• Blood Pressure<br>• Cholesterol<br>• Colorectal Cancer<br>• Depression<br>• Type 2 Diabetes<br>• HIV<br>• Obesity<br>• Tobacco Use<br>• Syphilis<br>• Hepatitis B<br>• Hepatitis C<br>• Lung Cancer<br>• Fecal Immunochemical | Screenings<br>• Anemia<br>• Bacteriuria<br>• Breast Cancer Mammography<br>• Breast Cancer Risk Reduction Medications<br>• Cervical Cancer<br>• Chlamydia Infection<br>• Domestic and Interpersonal Violence<br>• Gestational Diabetes<br>• Gonorrhea<br>• Hepatitis B | Screenings<br>• Alcohol and Drug Use<br>• Autism<br>• Behavioral Assessments<br>• Blood Pressure<br>• Cervical Dysplasia<br>• Congenital Hypothyroidism<br>• Depression<br>• Developmental<br>• Dyslipidemia<br>• Hearing<br>• Hematocrit or Hemoglobin<br>• Hemoglobinopathies<br>• HIV<br>• Lead<br>• Obesity |

| | | |
|---|---|---|
| testing (FIT) (yearly)<br>• CT colonography (every 5 years)<br>• FIT DNA (every 1-3 years)<br>• Flexible sigmoidoscopy with FIT (yearly & every 10 years)<br>• Statin preventive meds for CVD risk<br><br>Counseling (PCP Office Visit)<br>• Diet<br>• Sexually Transmitted Infection<br><br>Aspirin<br>Immunizations | • HIV<br>• Osteoporosis<br>• Rh Incompatibility<br>• Tobacco Use<br><br>Counseling (PCP Office Visit)<br>• BRCA<br>• Breast Cancer Chemoprevention<br>• Breastfeeding<br>• Sexually Transmitted Infection<br>Breastfeeding Rental Equipment<br>Contraceptives<br>Folic Acids<br>Human Papillomavirus DNA Test<br>Well-Woman Visits | • Oral Health<br>• Phenylketonuria (PKU)<br>• Sexually Transmitted Infection (STI)<br>• Vision<br>Fluoride Chemoprevention<br>Gonorrhea Preventive Medication<br>Height, Weight, and BMI<br>Immunizations<br>Iron Supplements<br>Tuberculin Testing |
| *For a complete list of preventive services and frequency limitations please visit http://www.healthcare.gov/law/about/provisions/services/lists.html | | |

**OTHER COVERED SERVICES**/*****

| Services | In-Network | Out-of-Network (Subject to Plan Allowance) |
|---|---|---|
| 1. Charges of a specialist for a visit to the office including surgical procedures | Payable at 100% after deductible | Payable at 60% after deductible |
| 2. All other services rendered by a physician | Payable at 100% after deductible | Payable at 60% after deductible |
| 3. Allergy tests and injections | Payable at 100% after deductible | Payable at 60% after deductible |
| 4. Charges for outpatient independent lab referred by physicians for illnesses not otherwise outlined in the Schedule of Benefits | Payable at 100% after deductible | Payable at 60% after deductible |
| 5. Charges for diagnostic testing, including x-rays and labs | Payable at 100% after deductible | Payable at 60% after deductible |
| 6. Charges of a hospital (facility) for outpatient treatment | Payable at 100% after deductible | Payable at 60% after deductible |
| 7. Charges of a hospital (facility) for inpatient treatment | Payable at 100% after deductible | Payable at 60% after deductible |
| 8. Charges of a hospital for emergency room care | Payable at 100% after deductible | Payable at 100% after In-Network deductible |
| 9. Charges of an emergency room physician* | Payable at 100% after deductible | Payable at 100% after In-Network deductible |
| 10. Charges of an ambulatory surgery center | Payable at 100% after deductible | Payable at 60% after deductible |
| 11. Charges of an urgent care center | Payable at 100% after deductible | Payable at 60% after deductible |
| 12. Charges for maternity services | Payable at 100% after deductible | Payable at 60% after deductible |

| | | |
|---|---|---|
| 13. Charges incurred which are considered out-of-area | Payable at 100% after in-network deductible | |
| 14. All other charges to include anesthesiologist, pathologist, radiologist* | Payable at 100% after deductible | Payable at 100% after In-Network deductible |
| 15. Charges for mental health (inpatient & outpatient) | Payable at 100% after deductible | Payable at 60% after deductible |
| 16. Charges for substance use disorder treatment (inpatient & outpatient) | Payable at 100% after deductible | Payable at 60% after deductible |
| 17. Durable Medical Equipment *Pre-certification required over $500* | Payable at 100% after deductible | Payable at 60% after deductible |
| 18. Home Health Care *Calendar year maximum 120 visits* | Payable at 100% after deductible | Payable at 60% after deductible |
| 19. Ambulance Service | Payable at 100% after deductible | Payable at 100% after In-Network deductible |
| 20. Extended Care Facility, Skilled Nursing Facility, or Rehabilitation Facility *Calendar year maximum 30 days* | Payable at 100% after deductible | Payable at 60% after deductible |
| 21. Hospice Care | Payable at 100% after deductible | Payable at 60% after deductible |
| 22. Physical, Speech, and Occupational Therapy *Calendar year maximum 20 visits each therapy* | Payable at 100% after deductible | Payable at 60% after deductible |
| 23. Cardiac Rehabilitation (Outpatient) | Payable at 100% after deductible | Payable at 60% after deductible |
| 24. Pain Therapy/Pain Management *Calendar year maximum 4 visits* | Payable at 100% after deductible | Payable at 60% after deductible |
| 25. Sleep Studies *Lifetime maximum $2,500* | Payable at 100% after deductible | Payable at 60% after deductible |
| 26. Temporomandibular Joint Dysfunction (TMJ) *Lifetime maximum $15,000* | Payable at 100% after deductible | Payable at 60% after deductible |
| 27. Vertebral Manipulation/Outpatient Skeletal Adjustment/Spinal Manipulation/Chiropractic Care *Calendar year maximum 20 visits* | Payable at 100% after deductible | Payable at 100% after In-Network deductible |
| 28. Artificial Limbs *Per limb limit $15,000* | Payable at 100% after deductible | Payable at 60% after deductible |
| 29. Autism Services / Applied Behavioral Therapy (ABA Therapy) *ABA Therapy Limited to calendar year maximum 20 visits* | Payable at 100% after deductible | Payable at 60% after deductible |
| 30. Residential Treatment *Limited to 30 days per calendar year* | Payable at 100% after deductible | Payable at 60% after deductible |
| 31. Respiratory Therapy *Calendar year maximum 30 visits* | Payable at 100% after deductible | Payable at 60% after deductible |
| 32. Prosthetics and Orthotics | Payable at 100% after deductible | Payable at 60% after deductible |
| 33. Endovenous Ablation Therapy Lifetime maximum $2,500 | Payable at 100% after deductible | Payable at 60% after deductible |
| 34. Genetic Testing | Payable at 100% after deductible | Payable at 60% after deductible |

| | | |
|---|---|---|
| 35. Genetic Counseling | Payable at 100% | Payable at 60% after deductible |
| 36. Dialysis Treatment – Outpatient *See,* Out-of-Network Dialysis Benefit Program, below | Not Covered**** | 0% after Deductible as set forth in and subject to the Out-of-Network Dialysis Benefit Program, below. |
| 37. Smoke Stoppers program through St. Joseph's/Candler | Payable at 100% | |
| 38. Charges of a Registered Dietitian performed at SouthCoast Health Only *Calendar year maximum 4 visits* | Payable at 100% after deductible | N/A |
| 39. Fees and/or charges relating to Telemedicine/Virtual Visits | 100% after deductible | 60% after deductible |

*May be Out-of-Network even though hospital is In-Network

**All services rendered at the following facilities will never be covered or reimbursed under any circumstances:

- East Georgia Regional Medical Center (Statesboro), *except for emergencies*
- The Doctor's Hospital of Tattnall, d/b/a Optim Medical Center-Tattnall (Reidsville)
- Exclude East GA Cancer Center (Statesboro) (TIN 270019844)

***All fees associated with the following Tax ID Numbers, including physicians and facility fees, for services rendered at the following facilities will never be covered or reimbursed, except for emergency services or services that cannot be performed at St. Josephs/Candler:

- Urology Center of Savannah (TIN: 582511751)
- The Doctor's Hospital of Tattnall, d/b/a Optim Medical Center-Tattnall (TIN: 300466706)
- De Renne Surgery Center (TIN: 300466706; same as above)
- Midtown Surgical Center (TIN: 203694906)
- Neurological Institute of Ambulatory Surgery Center (TIN: 141983013)
- Shanklin Plastic Surgery Center (TIN: 030475623)
- Savannah Plastic Surgery Center (TIN: 581687985)
- Schulze Surgery Center (TIN: 582264658)
- The Endoscopy Center (TIN: 582628189)
- The Plastic Surgery Center (TIN: 582203578)
- ENT Surgery Center (TIN: 582465247)
- Orthopedic Surgery Center (TIN: 582502026)
- East Georgia Regional (TIN: 582190713)
- East Georgia Cancer Center (TIN: 270019844)
- Jenkins County Hospital (TIN: 273100894)
- Screven County Hospital, d/b/a Optim Medical Center-Screven (TIN: 273100946)
- Appling Healthcare System (Baxley)
- Candler County Hospital (Metter)
- Effingham Hospital (Springfield) to include:
    - Effingham Hospital Medicare (Rincon)
    - Effingham Hospital MRI
    - Effingham Imaging Center
- Emanuel Medical Center (Swainsboro)
- Evans Memorial Hospital (Claxton)
- Hilton Head Regional Medical Center (Hilton Head Island)
- Liberty Regional Medical Center (Hinesville)
- Mayo Clinic Hospital (Jacksonville) to include:
    - Mayo Clinic Florida

- Mayo Clinic Outpatient Dialysis Center
- Mayo Clinic Providers (TIN: 590714831C)

- Nemours Children's Hospital (Jacksonville)
- Shepherd Spinal Center (Atlanta)

**** All Outpatient Dialysis services will be considered performed by Out-of-Network Providers.

**Pre-Certification Penalty**
Hospital admissions, outpatient surgeries and other procedures require pre-certification. Pre-certification is the responsibility of the member. If pre-certification is not obtained, benefits will be **reduced by 50%**. Co-insurance payments for services where pre-certification is not obtained do not accrue toward the co-insurance limits. **(See the Care Management Requirements for a list of services requiring pre-certification).**

This Schedule of Benefits may be revised as more information is made available regarding Healthcare Reform.

**CAA CONTINUITY OF CARE**
In accordance with the CAA, Members undergoing a course of treatment for a serious or complex medical condition, for institutional or inpatient care, who are pregnant or terminally ill, or scheduled for non-elective surgery (including post-operative care) are eligible for continuity of care. If there is a change in a Provider's network status, the Plan will notify the continuing care Member and inform them of their right to receive transitional care. The Plan provides an opportunity to request transitional care and allows for continued benefits (under the same terms and conditions as would have applied for an In-Network Provider). The continuing care Member will be able to access these services for the earliest to occur of: (1) up to ninety (90) days after the notice is provided; or, (2) until the Member no longer qualifies as a continuing care patient. Providers cannot Balance Bill these continuing care Members, but must instead accept in-network payments from the Plan (and cost-sharing amounts from the Member) as payment in full.

**CAA NSA CLAIMS**
Out-of-Network Covered Medical Expenses subject to the NSA shall be calculated the same as In-Network Covered Medical Expenses, applied to the lesser of a Provider's billed amount or QPA. Any cost-sharing payments for Out-of-Network Covered Medical Expenses subject to the NSA shall be counted towards any In-Network Deductible or Out-of-Pocket Maximum, in the same manner as if furnished by an In-Network Provider or Facility.
Examples of Out-of-Network Covered Medical Expenses subject to the NSA include, but are not limited to:

1. Air Ambulance Claims;
2. Emergency Medical Conditions; and,
3. Ancillary non-Emergency Services performed at an In-Network Facility including, but not limited to:
    - **a.** Anesthesiologists;
    - **b.** Pathologists;
    - **c.** Radiologists;
    - **d.** Neonatologists;
    - **e.** Assistant surgeons;
    - **f.** Hospitalists;
    - **g.** Intensivists;
    - **h.** Diagnostic testing service providers (including radiology and laboratory services); and,
    - **i.** Those provided by an Out-of-Network Provider when there is no In-Network Provider who can furnish such item or service at such Facility.

For more information about Balance Billing (also called “Surprise Billing”), *see* Your Rights and Protections Against Surprise Medical Bills, below.

## PRESCRIPTION DRUG BENEFITS

The Plan includes a prescription drug benefit program, which uses an ID card and a network of participating pharmacies **provided by CVS/Caremark**. Participating pharmacies will accept the required payment and file the claim directly.

**Dispense as Written**

The Plan requires retail pharmacies dispense Generic Drugs when available unless the Physician specifically prescribes a Brand Name Drug and marks the script "Dispense as Written" (DAW). Should a Covered Person choose a Brand Name Drug rather than the Generic equivalent when the Physician allowed a Generic Drug to be dispensed, the Covered Person will be responsible for the cost difference between the Generic and Brand Name drug in addition to the Brand Name Drug deductible and coinsurance. The Covered Person's share of the Prescription Drug cost does not apply toward the Plan's deductible or out-of-pocket maximum and the Covered Person is responsible for the cost difference even after the out-of-pocket maximum has been reached.

The Plan includes a mail order prescription drug benefit program **administered by CVS/Caremark**. Refer to the member packet for complete instructions on how to use this program or call Caremark Customer service at 1-800-552-8159.

**Caremark** also offers online tools to manage prescription needs. To get detailed information via the web and learn about the Express Scripts programs and services, visit www.caremark.com.

NOTE**:** See Out-of-Pocket Limit section in the Schedule of Benefits for prescription drug out-of-pocket limit.

| **Prescription Drug Card** | |
|---|---|
| Generic, Formulary Brand, Non-Formulary Brand, and Specialty medications | Member pays 15% after medical deductible up to $150 per prescription; *maximum 30-day supply* |
| Generic Contraceptives & Immunizations | Members pays 0%; *maximum 30-day supply* |

| **Prescription Drug Mail Service** | |
|---|---|
| Generic, Formulary Brand and Non-Formulary Brand | Member pays 15% after medical deductible up to $450 per prescription; *maximum 90-day supply* |

**Please Note: Maintenance medications are available for a 90 day supply and must be filled at either CVS/Caremark mail order or at any retail CVS or Target pharmacy after the 2nd fill**.

## COVERED PRESCRIPTION DRUG EXPENSES.

The following are **Covered Prescription Drug Expenses**:

1. Federal legend drugs.
2. Syringes and needles used only to inject insulin.
3. Insulin.
4. Specialty Drugs, subject to precertification.
5. Sexual Dysfunction.
6. Smoking cessation products.
7. Testosterone, topical and injections, prior authorization required.
8. Over the counter COVID tests through CVS Caremark, limited to 8 test kits per month.

The following **Covered Prescription Drug Expenses** are payable at one-hundred percent (100%):

1. Contraceptives.
2. Generic breast cancer risk reduction medications.
3. Aspirin to prevent Cardiovascular Disease ("CVD") for men ages forty-five (45) to seventy-nine (79) and women ages fifty-five (55) to seventy-nine (79).
4. Oral fluoride supplementation for children from birth through age five (5).
5. Iron supplementation for children from birth to twelve (12) months of age.
6. Folic acid supplementation for women ages eighteen (18) to forty-five (45).
7. Immunizations (**USPSTF**).

## PRESCRIPTION DRUG EXCLUSIONS

No benefits will be paid for the following charges:

1. Appetite Suppressants, medications for anorexiants may be covered, prior authorization required.
2. Experimental or Investigational drugs, including compounded medications for non-FDA approved use.
3. Fertility medications.
4. Ostomy supplies (covered through the Plan).
5. Growth hormones.
6. Retin-A and tretinoin, which may be covered with a letter of medical necessity, prior authorization required.
7. Therapeutic devices or appliances, support garments, and other non-medical substances.
8. Gene therapy.
9. Over-the –counter medications and equivalents, with prior authorization.
10. Vitamins, except prenatal.
11. Rogaine.
12. Prescriptions designated as newly launched products are evaluated through a New to Market block strategy. Prescriptions under this designation are evaluated on an ongoing basis, not part of the formulary and omitted from coverage under the prescription plan benefit.

**Caremark Specialty Pharmacy** is a program that was designed to provide patient support, clinical management, physician involvement, and convenient, priority delivery of the product to customers. A Patient Care Coordinator handles case management activities and schedules the appropriate follow up with Nurses, Clinical Pharmacists and Social Workers. Proactive counseling, compliance management, education and support are available 7 days a week, 24 hours a day. For all other Specialty questions, members must be referred to the Specialty Pharmacy at 1-800-237-2767.

**Step Therapy**
For certain medical conditions, a physician must first prescribe a "first-step" drug (generic or low cost brand name). Coverage of more expensive brand name "second-step" drugs will be provided if "first step" drug have been tried. If the pharmacy claims processing system has history of the member taking a "first step" or "second-step" drug within the previous 130 days from the date of service, the member would not need to try a "first-step" drug and the claim for the "second-step" drug would process.

## COVERED MEDICAL EXPENSES

The following expenses are covered by the Plan provided they are incurred for such care, services and supplies as prescribed by an attending physician while the person is covered under this Plan:

1. Charges for medically necessary professional **ambulance service** to or from a hospital, or charges by regularly scheduled airline, railroad or air ambulance to the nearest hospital qualified to give the required treatment.
2. Charges for an **ambulatory surgery center**.
3. Charges by a physician or professional anesthetist for **anesthesia** and its administration.
4. Charges for the placement of **artificial limbs or eyes.**
5. When an **assistant surgeon** is required to render technical assistance during an operation, the covered expense for such services shall be limited to 20% of the approved charge for the primary surgeon.
6. Charges for Autism Spectrum Disorder, to include Applied Behavioral Therapy.
7. Charges for behavioral disorders or learning disabilities.
8. Charges for **blood or blood plasma** and its administration, excluding any charges for blood or blood plasma which has been replaced by a donor.
9. Charges for the initial purchase of an external **breast prosthesis** or post mastectomy bra (up to two per year), prescribed in connection with a mastectomy for which the person is receiving benefits under the Plan (however, replacement of the initial breast prosthesis is not covered).
10. Charges for the **circumcision** of a newborn.
11. Routine charges for services furnished in connection with participation in an **Approved Clinical Trial.**
12. Charges for initial contact lenses or glasses following cataract surgery.
13. Charges for **dental care** or treatment performed by a dentist or physician for the following:
    a. Removal of malignant tumors and cysts.
    b. Treatment of injury to sound natural teeth incurred as a result of a traumatic injury (other than an injury as a result of eating or chewing), including fixed bridgework and full or partial dentures and crowns, and rendered within twelve (12) months of the traumatic injury.
    c. Treatment for osteomyelitis as confirmed through pathology.
    d. Surgical removal of fully impacted wisdom teeth.
14. Charges for **diabetic supplies** to include insulin, syringes with or without needles, needles, alcohol swabs, blood glucose test strips, ketone test strips and tablets, lancets, and devices.
15. Charges for rental of **durable medical equipment** at home, including but not limited to mechanical equipment for the treatment of respiratory paralysis, wheelchairs, and hospital beds; however if the purchase price would be less than the rental cost for long-term usage, the Plan will pay for the purchase of such equipment upon approval from the Plan Supervisor, but not for any repair.
16. Medically necessary patient **education programs** for diabetic and ostomy care.
17. Charges for **genetic testing** including diagnostic testing of genetic information and counseling when medically appropriate, limited as outlined in the Schedule of Benefits.
18. Charges by a **home health** care agency.
19. Charges for **Hospice care**.
20. **Hospital room and board** charges, up to a daily maximum of the prevailing semi-private room rate.
21. Charges care and supplies for diagnostic services for **infertility** diagnosis only.
22. Hospital charges for **intensive care**, cardiac care or other similar necessary accommodations.
23. Charges for **medically** necessary supplies such as **casts, splints or surgical dressings, trusses, braces (except dental) or crutches**.
24. Charges for medical care or treatment of **mental health disorders (including ADD and ADHD).**

25. **Miscellaneous hospital** charges (other than room and board) **required for** medical or surgical care or treatment.
26. Hospital charges for routine **newborn nursery care** and for the initial examination by a pediatrician at birth to determine the health of the infant.
27. Charges for medically necessary **nursing care** rendered by a registered nurse (R.N.) or, if none is available as certified by the attending physician, for services rendered by a Licensed Practical Nurse (L.P.N.), but only for nursing duties excluding custodial care and care by members of immediate family.
28. Charges for approved **off-label** anticancer chemotherapy drug indications supported in the American Hospital Formulary Service-Drug Information or in the US Pharmacopoeia-Drug Information compendia.
29. Charges for an **organ transplant incurred by** recipient and the organ donor if the recipient is covered under this Plan (See Organ Transplant Program for details).
30. Charges for **oxygen** and rental of equipment for its administration.
31. Charges for **pain therapy** including, but not limited to, pain clinics and/or labs, epidural steroid injections for the treatment of pain, and all testing and therapies related to the treatment of pain or pain management.
32. Charges for **physical therapy and occupational therapy**, when services are provided by licensed therapists.
33. Charges by a **physician** for medical care and treatment.
34. **Charges** incurred by the covered female employee or spouse due to **pregnancy, childbirth and related conditions** on the same basis as for illness (see Schedule of Benefits).
35. Charges for **prescription drugs** (including insulin) that are (i) ordered for the patient in writing by a physician and (ii) dispensed by a licensed pharmacist or a physician.
36. Charges for **pulmonary rehabilitation**.
37. Charges for **rehabilitative care**, but only for necessary medical care (as prescribed by a physician) which is rendered in a rehabilitation facility or hospital, excluding custodial care or occupational training.
38. Charges relating to **Residential Treatment.**
39. Charges for **routine physical examinations**.
40. Charges for **sex counseling/treatment** for or related to sexual dysfunction or inadequacies caused by an organic disease or accidental injury with an approved treatment plan for Covered Persons age 18 and over. Drug therapy is covered under the Prescription Drug Benefits.
41. Charges for treatment received in a **skilled nursing facility or extended care facility**.
42. Charges for sleep studies and treatment include diagnosis, testing, surgery and all charges associated with **sleeping disorders.**
43. Charges for **speech therapy** by a qualified speech therapist required because of an **Injury** or **Illness**. If therapy is required because of a congenital abnormality, the person must have had corrective surgery before therapy.
    For more information, *see* Physical, Speech, and Occupational Therapy in Special Provisions.
44. Charges for **sterilization** procedures, but not for the reversal of sterilization procedures.
45. Charges for medical care or treatment **of substance use disorders.**
46. Charges made by a physician for **surgical procedures** performed on an inpatient or outpatient basis. In the case of multiple surgical procedures performed through the same incision or separate incisions during the same operative session, the eligible expense for the surgeon will be the Plan Allowance charge or the contractual rate with the provider for the primary procedure, and 50% of the Plan Allowance charge or the contractual rate with the provider for the secondary procedure, and 50% of the Plan Allowance charge or the contractual rate with the provider for the third procedure.
47. Charges for outpatient **skeletal adjustment**, **adjunctive therapy**, **vertebral manipulation, spinal manipulation, and chiropractic services** and services for the care or treatment of dislocations or subluxations of the vertebrae.
48. Charges for **attempted suicide or intentionally self-inflicted Injury**, while sane or insane.

49. Charges for **Temporomandibular Joint Dysfunction**, not to include: orthodontics, crowns, inlays or any appliance that is attached to or rests on the teeth.
50. Charges for **well baby care** services.
51. Charges limited to one (1) **wig** every 12 months as a result of chemotherapy or radiation treatment.
52. Charges for diagnostic **x-ray or laboratory** examinations and their interpretation.

## SPECIAL PROVISIONS

### DENTAL SERVICES / ORTHODONTICS / ORAL SURGERY

Expenses for dental services and oral surgery are Covered Medical Expenses only if they are for the prompt repair of natural teeth, bone, or other body tissue needed as a result of a traumatic injury or malignancy. Treatment for cleft lip or cleft palate is covered as any other major medical expense.

### DIALYSIS

*See*, Out-of-Network Dialysis Benefit Program, below

### EXTENDED CARE, REHABILITATION AND SKILLED NURSING FACILITIES

Charges for services and supplies from qualified extended care, rehabilitation and skilled nursing facilities are Covered Medical Expenses. Services must be furnished to a covered person while confined to convalesce from an illness or injury and must occur during a convalescent period. The convalescent period is defined as the first day a covered person is admitted to a facility, if all of the following requirements are met:

1. The person was previously admitted to a hospital for at least three (3) days of inpatient treatment for an illness or injury.
2. The person is admitted to the extended care or rehabilitation facility within thirty (30) days after discharge from the hospital.
3. The person is admitted to the extended care or rehabilitation facility for services needed to convalesce from the condition that caused the hospital stay.

These covered services include skilled nursing and physical restorative care. Covered extended care or rehabilitation Facility expenses do not include treatment for Substance Use Disorder, chronic brain syndrome, alcoholism, senility, intellectual disability, or any other Mental Health Disorder.

**Pre-certification and Utilization Review are required.**

### HOME HEALTH CARE

Covered Home Health Care Expenses include:

1. Part-time or intermittent care by an R.N., or by an L.P.N. if an R.N. is not available.
2. Part-time or intermittent home health services including private duty nursing provided by a licensed nurse.
3. Physical, occupation and speech therapy.
4. Medical supplies, medications or lab services ordered by a physician, which require nursing administration.

**Pre-certification and Utilization Review are required.**

### HOSPICE CARE

Hospice care with an approved Hospice Care Program, whether inpatient or outpatient, is a covered benefit. An approved “Hospice Care Program” is a written plan of the care to be provided for the palliation and management of a person’s terminal illness developed by or under the supervision of the attending physician. “Palliative care” is a course of treatment that is primarily directed at lessening or controlling pain while maximizing comfort and does not attempt to cure the person’s terminal illness.

**Pre-certification and Utilization Review are required.**

**HOSPITAL CARE**
Intensive care charges in a hospital are Covered Medical Expenses. Private room charges are not Covered Medical Expenses unless certified as medically necessary by the attending physician and pre-certified by Healthgram, Inc.

**Pre-certification and Utilization Review are required.**

**MASTECTOMY-BREAST RECONSTRUCTION**
Any covered person who is receiving benefits under the Plan in connection with a mastectomy and elects breast reconstruction shall be eligible for coverage of the following, to be provided in a manner determined in consultation with the attending physician and the patient:

1. Reconstruction of the breast on which the mastectomy was performed;
2. Surgical reconstruction of the other breast to produce a symmetrical appearance; and
3. Prostheses and treatment of physical complications of mastectomy, including lymphedemas.

All of the benefits outlined above are subject to the Plan's deductibles, co-pay, co-insurance, Plan Allowance charge limitations and Care Management Requirements. For more information, please contact the Plan Supervisor.

**Pre-certification and Utilization Review are required.**

**MATERNITY HOSPITALIZATIONS**
Under federal law, the Plan may not restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than forty-eight (48) hours following a normal vaginal delivery, or less than ninety-six (96) hours following a Cesarean section, or require that a provider obtain authorization from a plan for prescribing a length of stay not in excess of the above period. However, federal law does not prohibit the attending physician, after consultation with the mother, from discharging the mother or newborn before these periods have expired.

**MENTAL HEALTH**
Charges for treatment of **Mental Health Disorders** (*see* Definitions) are **Covered Medical Expenses**. Prescription drugs used for these conditions are covered as any other prescription drugs, whether prescribed by a psychiatrist or medical doctor.

**Pre-certification and Utilization Review are required for inpatient.**

**NEWBORN CARE**
Routine newborn care includes hospital charges for room and board, services, supplies, and professional fees during the initial hospital confinement for in-hospital visits but only while the mother or infant is confined for delivery or post-delivery complications. Also included are charges for circumcision. (See Maternity Hospitalizations). (See Eligibility Requirements.)

**ORGAN TRANSPLANTATION**
See "Organ TransplantProgram" in the **CARE MANAGEMENT REQUIREMENTS** section.

**Pre-certification and Utilization Review are required.**

**PHYSICAL, SPEECH AND OCCUPATIONAL THERAPY**
Charges of a doctor or facility for physical, speech and occupational therapy that are covered expenses may be limited. The limitation applies for treatment received while the patient is not confined to the hospital as a bed patient (outpatient services). The limitation for treatment applies to

the number of days that treatment may be received from the initial date of the accident, injury, or illness. A new period may begin 180 days after the last date of treatment for a given injury or illness.

**PREVENTIVE SERVICES**
Recommended Preventive Services are payable at 100% if services rendered are performed by an In-Network Provider. If a recommended preventive service is billed separately from an office visit or if the recommended preventive service is not the primary purpose of the office visit, copays, deductibles, and co-insurance still apply to the office visit.

For a complete list of covered preventive services go to http://www.healthcare.gov/law/about/provisions/services/lists.html or visit your Human Resources department

**ROOM AND BOARD CHARGES**
Charges by an institution for room and board and other necessary services and supplies must be regularly made at a daily or weekly rate. The semi-private rate is the charge that an institution applies to the beds in a semi-private room with two (2) or more beds. If a facility has private rooms only, it will be paid the same as the semi-private room charge.

**SKELETAL ADJUSTMENT**
Charges for the treatment of the skeletal system performed by external manipulation including, but not limited to, vertebral manipulation and associated adjunctive therapy are Covered Medical Expenses when medically necessary and when performed by physical therapists, chiropractors, osteopaths, and/or physicians.

**SPEECH THERAPY**
See Physical, Speech and Occupational Therapy.

**SUBSTANCE USE DISORDERS**
Charges for the treatment of substance use disorders are Covered Medical Expenses if all of the following requirements are met:
1. The treatment must be prescribed and supervised by a physician.
2. The treatment must have a follow-up therapy program directed by a physician on at least a monthly basis or include meetings at least twice a month with approved organizations devoted to the treatment of substance use disorders such as Alcoholics Anonymous or Narcotics Anonymous.

If a person is confined as an inpatient in a hospital, the covered charges include treatment of the medical complications of substance abuse/substance use. No room and board charges in excess of the semi-private room rate are covered.

If a person is confined as an inpatient in a non-hospital treatment facility, the covered charges include room and board charges equal to the semiprivate room rate. Charges are covered only for facilities that are recognized by the Joint Commission on Accreditation of Hospitals and licensed by the state. No room and board charges in excess of the semi-private room rate are covered.

**Pre-certification and Utilization Review are required for inpatient treatment.**

**VERTEBRAL MANIPULATION**
See Skeletal Adjustment.

**WELLNESS PROGRAM**

The Plan offers a Wellness Program that is designed to educate members in order to promote healthy lifestyles and informed healthcare consumption. Requirements, eligibility, and services may change from time to time. For Wellness Program materials and more information, please contact Human Resources or the Plan Supervisor at (980) 201-3020.

## EXCLUSIONS

No benefits shall be payable under this Plan for any charges resulting from:

1. Charges for services performed more than twelve (**12) months prior** to receipt of the corresponding claim by the Plan Supervisor.
2. Charges for **abortions**, unless
    a. It is medically determined that the life or well being of the mother would be threatened by carrying the child to term.
    b. The pregnancy is the product of rape or incest.
    c. The fetus has a severe birth defect.
3. Illness or injury resulting from **acts of war**, insurrections, or atomic explosions.
4. Charges for **acupuncture, biofeedback** or **hypnosis**.
5. Charges for treatment of any injury or illness resulting from: a commission of or an attempt to commit an **assault** or **felony**. Charges resulting from these activities are excluded whether the covered person was sane, insane, or under the influence of drugs or another impairing substance at the time of the activity. This exclusion does not apply if the injury resulted from an act of domestic violence or a medical (including both physical and mental health) condition.
6. Charges for treatment of an Injury resulting from a Vehicle, Aircraft, or Vessel accident in which a Member was the driver / operator of the Vehicle, Aircraft, or Vessel and:
    a. has a blood alcohol concentration equal to or in excess of the level established by the laws of the state in which the accident occurred for driving while impaired; or,
    b. the Member has pled guilty or was convicted for violating those laws pertaining to driving while impaired or driving while intoxicated for that state.

    Charges resulting from these activities are excluded whether the Member was sane, insane, or under the influence of drugs or another impairing substance at the time of the activity. For purposes of this exclusion, a Vehicle, Aircraft, or Vessel accident includes, but is not limited to, any event that results in Injury or property damage attributable directly to the motion of a Vehicle, an Aircraft, a Vessel, or Motor Vehicle or its load. For purposes of this exclusion, a Vehicle, Aircraft, or Vessel accident does *not* include an occurrence involving only boarding and alighting from a stationary Vehicle, Aircraft, or Vessel or an occurrence involving only the loading or unloading of cargo. For purposes of this exclusion, a driver / operator is a person in actual physical control of a Vehicle, Aircraft, or Vessel which is in motion or which has the engine running. This exclusion does not apply if the injury resulted from an act of domestic violence or a medical (including both physical and mental health) condition.
7. Charges for an **Injury** resulting from an act of aggression or battery initiated by the **Member**. This exclusion does not apply if the injury resulted from an act of domestic violence or a medical (including both physical and mental health) condition.
8. Expenses incurred **before coverage begins** or **after coverage ends**.
9. Charges resulting from the following **care, treatment or supplies for the feet**, unless needed in treatment of diabetes and/or blood circulation problems:
    a. orthopedic shoes.
    b. orthopedic prescription devices to be attached to or placed in shoes.
    c. treatment of weak, strained, flat, unstable or unbalanced feet.
    d. treatment for metatarsalgia.
    e. treatment for bunions except for surgical treatments.
    f. treatment for infected, ingrown toenails, except for surgical procedures in office setting.
    g. treatment for corns, calluses or toenails.
10. Charges billed by a **certified surgical assistant or technician** (CSA, CST, LSA OR LST).
11. **Charges in excess** of Plan Allowance charges, where a contractual arrangement with the provider does not exist, including but not limited to physicians, hospitals, facilities, and providers of medical equipment and supplies.

12. Charges incurred as a result of **complications** arising from a service or procedure that is not a Covered Medical Expense, except for abortions.
13. Charges for treatment of **Injury** resulting from the voluntary taking of or being under the influence of any controlled substance, drug, hallucinogenic, or narcotic not administered on the advice of a Physician or not taken as prescribed by a Physician (except for charges related to treatment for Substance Use Disorder**).**
14. **Cosmetic**, elective, plastic, reconstructive, or restorative surgery, except following illness or injury as specifically provided for in this Plan, including, but not limited to, rhinoplasty, abdominoplasty, lipectomy, liposuction, breast augmentation, face lifts, and complications arising from such services.
15. Any expenses for treatment, services, or supplies, while in the custody of local, state, or federal **correctional** authorities.
16. Charges for admissions or portions thereof for **custodial care or long-term care**, including:
    a. Rest Care.
    b. Care to assist a Member in the performance of activities of daily living (including, but not limited to: walking, movement, bathing, dressing, feeding, toileting, continence, eating, food preparation, and taking medication).
    c. Care in a sanitarium.
    d. Custodial Care or long-term care.
    e. Wilderness Therapy, therapeutic schools; therapeutic boarding homes; half-way houses; therapeutic group homes, and/or wilderness boot camps where services are not provided by a Facility and licensed Provider.
17. Treatment of injuries that result from participation in the following **dangerous leisure activities**:
    a. Pilot or co-pilot of an ultralight.
    b. Racing **including, but not limited to**, competition in an automobile, motorcycle, balloon, hydroplane, powerboat, or ATV.
    c. Participation in soaring, parachuting, skydiving, or bungee jumping.
    d. Professional sports of any type.

    This exclusion does not apply if the injury resulted from an act of domestic violence or a medical (including both physical and mental health) condition.
18. Charges for a service, procedure, or substance when the charge for a service, procedure, or substance that is known to be less expensive and would achieve the same or similar results with no additional medical risk.
19. Repair or replacement of **Durable Medical Equipment** and **artificial limbs**, due to abuse or desire for new equipment.
20. All **exercise programs** or exercise equipment for treatment of any condition, outside of prescribed rehabilitation program.
21. **Any Experimental or Investigational treatment**, procedure, facility, equipment, service, device, substance, or drug (see the Definitions section), except for routine charges for services furnished in connection with participation in an Approved Clinical Trial.
22. Charges for **gene therapy**.
23. Any expenses for treatment, services, supplies, and facilities provided by or in a hospital owned or operated by any **government or agency thereof** where such care is provided at government expense under a plan or program established pursuant to the laws or regulations of any government or under a plan or program under which any government participates other than as an employer. The term “any government” includes the federal, veteran, state, provincial, municipal, or local government or, any political subdivision thereof, of the United States or of any other country. The Plan shall not exclude benefits for a covered person who received billable medical care at any of the above facilities.
24. **Hearing aids**, devices, and implants used to improve hearing.
25. Any expense or charge for the treatment of **infertility** in men or women including:
    a. Reversals of surgical sterilization including reconstruction of vasectomy or reconstruction of tubal ligation.

b. Direct attempts to cause pregnancy by hormone therapy, artificial insemination, in vitro fertilization and embryo transfer.
c. Supervision of pregnancy by infertility specialists who do not practice obstetrics.

26. **Marital counseling, recreational, educational, or social therapy or training services** or any form of non-medical self care or self help training and any related diagnostic testing, except for medically necessary patient education programs for diabetic and ostomy care.
27. Services and supplies that are **not Medically Necessary** except for covered wellness benefits.
28. Conditions arising out of or as a result of **military service**.
29. Medical services or supplies for which **no charge** was made or for which no payment would be required if the covered individual was not covered under this Plan.
30. Charges for services and supplies that are **non-covered expenses**.
31. **Nutritional supplements**, special foods, or vitamins which are either not prescribed by a physician or which are capable of being purchased over the counter (such as hypoallergenic infant formula).
32. Any treatment of obesity or weight reduction, whether surgical or medical. Medications for anorexiants will be covered, prior authorization required. This exclusion does not apply to Preventive Services.
33. Professional services performed by the covered person or a person who **ordinarily resides in the covered person's home** or is related to the covered person as a spouse, parent, child, brother, or sister, whether the relationship is by blood or exists in law.
34. Any artificial, mechanical or cross-species **organ or tissue transplant**.
35. Charges for **orthoptic** training (eye muscle exercises). Training by an optometrist does not have to be prescribed by a physician. Training by an orthoptic technician must be prescribed by a physician.
36. Charges for treatment **outside of the United States**. This exclusion does not apply to a resident of the United States traveling for business or pleasure that requires emergency medical treatment.
37. Charges for over-the-counter (OTC) COVID tests.
38. **Personal comfort items** such as television, telephones, extra food trays, etc.
39. Charges for **pregnancy** including delivery and complications **for covered dependents** other than the spouse of the covered employee. This exclusion does not apply to Preventive Services.
40. **Replacement** braces for the leg, arm, back, neck.
41. Charges for **shock wave therapy** for orthopedic procedures, including but not limited to the treatment of Plantar Fasciitis, Patellar Tendonitis, Shoulder Tendonitis and Medial Epicondylitis.
42. Except as outlined in the Schedule of Benefits, charges for telephone consultations, missed appointments, and/or fees added for filling out a **Claim** form**.**
43. Charges related to hospital precertification, concurrent review, utilization review, quality assurance, hospital-related case management, or third-party related case management.
44. Expenses incurred after **termination of coverage** under this Plan.
45. Charges for routine examinations, periodic physical examinations, childhood checkups, examinations or services required or requested by any **third party**, including, but not limited to, such services for employment, license, insurance, school, or recreational purposes. This includes hospital charges to the extent they are allocable to scholastic **education, vocational training,** or for confinements resulting from a local or state mandate (court ordered).
46. Charges for which a **third party may be liable** (See "Third Party Recovery" section) or charges for which the covered person is **not legally required to pay**.
47. **Travel**, except for covered ambulance charges.
48. Charges incurred for any operation or **treatment for realignment of teeth or jaw or any other dental services not specifically provided for under Covered Medical Expenses**. Charges not covered include, but are not limited to: **oral care** or supplies for treatment of nerves connected to teeth, charges for treatment of atrophy of the lower jaw, occlusion, maxillofacial surgery, retrognathia, and related hospital and facility charges. The above charges are excluded unless otherwise provided in the Schedule of Benefits, or provided under DENTAL

CARE/ORTHODONTICS/ORAL SURGERY (See the Special Provisions section). This exclusion shall not be construed to deny otherwise eligible expenses for the treatment of the teeth or jaws when such treatment is necessitated by traumatic injury that occurs within one year prior to the treatment.

49. **Vision care** including but not limited to eyeglasses, contact lenses, refractions, radial keratotomy, LASIK surgery and any surgery which involves corneal tissue for the purpose of altering, modifying, or correcting myopia, hyperopia, or stigmatic error, unless covered by a vision benefit in the Plan.
50. Charges resulting from illness or injury covered by the **Worker's Compensation Act** or similar law (See Workers Compensation Section).
51. Charges resulting from an accidental injury or illness arising out of, in connection with, or in the course of, **working for wages or profit** (past or present).

## WORKERS' COMPENSATION

This policy does not provide benefits for diagnosis, treatment or other service for any injury or illness that is sustained by a member that arises out of, in connection with, or as the result of, any work for wage or profit when coverage under any Workers' Compensation Act or similar law is required or is otherwise available for the member.

If the Plan pays benefits for an injury or illness and the Plan determines the member also received Workers' Compensation benefits by means of a settlement, judgment, or other payment for the same injury or illness, member shall reimburse the Plan in full all benefits paid by the Plan relating to the injury or illness.

The Plan's right of recovery will be applied even if: the Workers' Compensation benefits are in dispute or are made by means of a compromised, doubtful and disputed, clincher or other settlement; no final determination is made that the injury or illness was sustained in the course of or resulted from the member's employment; the amount of Workers' Compensation benefits due to medical or health care is not agreed upon or defined by the member or the Workers' Compensation carrier; or, the medical or health care benefits are specifically excluded from the Workers' Compensation settlement or compromise.

## ELIGIBILITY

### ELIGIBILITY REQUIREMENTS

**Requirements for Employee Coverage:** A person is eligible for employee coverage as of the date that all of the following requirements are met:

1. The person is a full-time employee of the Employer. An employee is full-time under the medical plan if regularly expected to work at least **thirty (30)** hours per week **or** determined during the 12-month measurement period to have worked on average at least **thirty (30)** hours per week and on the regular payroll of the Employer. The person is in a class eligible for coverage under the Plan.
2. The waiting period for Employee coverage:
    a. Physicians. No waiting period.
    b. Employees of an acquisition. Must complete the waiting period of **60 days** actively-at-work, full-time Employee but will receive credit toward waiting period for the accrual of days as a full-time Employee with the acquired entity.
    c. All other eligible Employees. Must complete the waiting period of **60 days** actively-at-work, full-time Employee.
3. When the enrollment requirements are met, an eligible Employee's coverage is effective:
    a. Physician - on the first day actively-at-work, full-time employment
    b. Employees of an acquisition - on the **first day of the month following the waiting period** (minus the number of days accrued as a full-time employee with the acquired entity)
    c. All other eligible Employees - on the first day of the month following the waiting period.

The Employer has established safe harbor measurement and stability periods to determine full-time status and eligibility for coverage in accordance with applicable law.

If an employee is considered a variable hour employee, the employer will use a twelve initial month look-back measurement period from the employee's date of hire to evaluate if the employee would qualify as a fulltime employee after the measurement period. An employee is considered variable hour if the employer cannot determine if the employee is reasonably expected to average 30 hours of service per week because their hours vary or are otherwise uncertain.

If a variable hour employee is found to have averaged 30 hours of service during the measurement period, the employee will be considered fulltime and offered enrollment into the medical plan in accordance with applicable law.

The employee will continually be tested for fulltime status in the employer's standard measurement period. Coverage in the medical plan will continue to be offered at the end of the stability period as the variable hour employee qualifies in accordance with applicable law.

**Requirements for Dependent Coverage:** A family member of an employee will become eligible for dependent coverage on the first day that the employee is eligible for employee coverage and the family member satisfies the requirements for dependent coverage.

Dependents eligible for coverage include:

1. The employee's spouse, of the same or opposite sex, legally married under the laws of any state;
2. The employee's child (ren) under or until the end of the month in which he or she turns the age of twenty-six (26), including:
    a. A natural born child.

b. A stepchild.
c. An adopted child or a child lawfully placed with the employee for legal adoption by the employee. A "child lawfully placed with an employee for legal adoption" refers to a child whom the employee intends to adopt, whether or not the adoption has become final, provided that the child has not attained the age of eighteen (18) as of the date of placement for adoption. The child must be available for adoption, and the legal process must have commenced and be documented.
d. An eligible foster child. An eligible foster child is an individual who is placed with the employee by an authorized placement agency or by judgment, decree, or other order of any court of competent jurisdiction.

3. An employee's unmarried child over the age of twenty-six (26) who is mentally or physically incapable of earning his or her own living due to permanent, chronic, and total disability. The child may obtain continued coverage if, within thirty (30) days after the date coverage would otherwise terminate, the employee submits proof of the child's incapacity (See Eligibility for Disabled Children); and
4. A minor for whom the **Employee** has legal guardianship and who is primarily dependent upon the **Employee** for support and resides with the **Employee**.

**Note:** The phrase "primarily dependent upon" shall mean dependent upon the covered employee for support and maintenance as defined by the Internal Revenue Code, and the covered employee must declare the dependent for purposes of taking an income tax exemption. The Plan Administrator may require documentation proving dependency, including birth certificates, tax records, or initiation of legal proceedings severing parental rights.

At any time, the Plan Administrator may require documentation proving that a spouse or a child qualifies or continues to qualify as a dependent as defined by this Plan, including but not limited to marriage licenses, birth certificates, and/or a court order establishing a relationship of parent and child. If both husband and wife are employees, their children will be covered as dependents of the husband or wife, but not of both.

Any child of a Plan participant who is an alternate recipient under a Qualified Medical Child Support Order (QMCSO) shall be considered as having a right to dependent coverage under this Plan. A participant of the Plan may obtain from the Plan Administrator, without charge, a copy of the procedures governing QMCSO determinations.

**Eligibility for Disabled Children:** In order for a disabled child to be eligible for coverage under the Plan beyond the end of the month of the child's twenty-sixth (26$^{th}$) birthday, the child:

1. Must be enrolled in the Plan prior to the age of twenty-six (26).
2. Must be incapable of self-support because of intellectual disability or permanent, chronic, and total disability which commenced prior to the age of twenty-six (26).
3. Must be primarily dependent upon the employee.
4. Must be continuously disabled and covered thereafter.
5. Must be considered disabled by the Social Security Administration.

If you believe a covered dependent meets the disability criteria above you may obtain a determination of disability from the Social Security Administration. This information must be submitted to the Plan Administrator within thirty-one (31) days after the date coverage would otherwise terminate due to the covered dependent reaching the age of twenty-six (26). You may be required to submit additional information necessary for completion of the eligibility determination.

If such eligibility is approved, you may be further required (usually not more frequently than once a year) to furnish satisfactory evidence to substantiate the continued eligibility of the covered dependent under the Plan.

**Persons Excluded as Non-Dependents:** The term “dependent” excludes:

1. Any individuals living in the covered employee’s home that do not satisfy the eligibility requirements for dependents as defined by the Plan.
2. The legally separated or divorced former spouse of the employee.
3. Any person who is on active duty in any military service of any country.
4. Any person who is covered under the Plan as an employee.

If a person covered under this Plan changes his or her status from employee to dependent or dependent to employee, and the person is covered continuously under this Plan before, during, and after the change in status, credit will be given for deductibles and all amounts applied to benefit maximums.

## ENROLLMENT REQUIREMENTS

### Enrollment

An eligible employee must enroll for coverage by filling out and signing an enrollment application. The covered employee is also required to enroll for dependent coverage, if dependent coverage is desired.

Under the Plan, members are classified as "timely," "late" or "special" enrollees depending on when the completed enrollment form is received by the Plan Administrator.

### Timely Enrollment

Enrollment is "timely" if the completed enrollment form is received by the Plan Administrator no later than thirty-one (31) days after the person first becomes eligible for coverage, either initially or under a special enrollment period. If the enrollment form is not submitted within this deadline, the person will be a "late enrollee" and will have to wait until the next annual open enrollment period to enroll, unless that person experiences an event permitting mid-year enrollment (See Mid-Year Enrollment Changes).

### Open Enrollment

The Plan includes an annual Open Enrollment period. Eligible employees failing to enroll when initially eligible can enroll as "late enrollees" during Open Enrollment without having to satisfy the special enrollment requirements. In addition, members may elect to make changes in their benefit selections during the Open Enrollment period. Changes in enrollment elections will become effective as of the first day of the plan year following the Open Enrollment period. Enrollment elections will remain in effect for the entire plan year and cannot be changed unless the employee experiences certain events that permit mid-year changes (See Mid-Year Enrollment Changes).

### Late Enrollment

An enrollment is "late" if it is not "timely" that is, if the enrollment is not completed within thirty-one (31) days after the person first becomes eligible to enroll or during a special enrollment period. Generally, late enrollees may enroll in the Plan only during Open Enrollment (See Open Enrollment above).

### Special Enrollment

If an employee or the employee's dependents are eligible but not already enrolled in the Plan, the employee may request "special enrollment" in the Plan upon either (1) the loss of other health plan coverage or (2) the addition of a new dependent as provided below:

1. **Loss of Other Health Plan Coverage:** An employee or a dependent who is eligible, but not enrolled in this Plan, may enroll if all of the following conditions are met:
    a. The employee or dependent was covered under another group health plan or had health insurance coverage at the time the individual first became eligible for coverage under this Plan.
    b. The employee stated in writing at the time Plan coverage was initially offered that the other health coverage was the reason for declining enrollment in this Plan, or the employee provided sufficient documentation of coverage under another plan at the time the initial decision to decline coverage was made.
    c. The other coverage of the employee or dependent ended because:
        - The other coverage was COBRA continuation coverage that was exhausted. COBRA continuation coverage is considered exhausted when it ceases for any reason other than the person's failure to pay premiums on a timely basis or for improper or illegal acts (such as making a fraudulent claim or an intentional misrepresentation).

- The other health coverage was not COBRA continuation and was terminated due either to loss of eligibility for the coverage (due to legal separation, divorce, death, termination of employment, or reduction in number of hours of employment) or because employer contributions for the other coverage were terminated. An individual will not have special enrollment rights if the other coverage ended due to the individual's failure to pay premiums on a timely basis or for cause (such as making fraudulent claims or intentional misrepresentations).
- The employee or dependent incurs a claim that will meet or exceed the overall annual maximum on all benefits. This right continues until at least thirty (30) days after the earliest date that a claim is denied due to the annual maximum.
- The employee or dependent is in a class of coverage that is no longer eligible under the terms of the other Plan.

d. The employee submits a request for special enrollment in writing to the Plan Administrator no later than thirty-one (31) days after the date the other coverage terminates. Coverage will be effective no later than the first day of the month following the date the special enrollment request is received.

The above list is not an all-inclusive list of situations when an Employee or dependent loses eligibility. For situations other than those listed above see the Employer.

2. **Newly-Acquired Dependents:** An employee's newly-acquired dependents may enroll in this Plan if:
   a. The employee is a participant under this Plan or, if not a participant at the time, the employee has met the waiting period applicable to becoming a participant and is eligible to be enrolled under this Plan; and
   b. The person becomes a dependent of the employee through marriage, birth, adoption, or placement for adoption.

If the employee is not yet a participant, the employee must enroll during the Special Enrollment Period in order for the newly acquired dependent to be eligible for coverage. In the case of birth or adoption of a child, the spouse of the covered employee may be enrolled as a dependent of the covered employee if the spouse is eligible for coverage.

The Special Enrollment Period is a period of not more than thirty-one (31) days that begins on the date of the marriage, birth, adoption, or placement for adoption.

The coverage of the employee or dependent enrolled during the Special Enrollment Period will be effective:

1. In the case of marriage, not later than the first day of the first month following the date that the completed request for enrollment is received by the Plan Administrator.
2. In the case of a dependent's birth, as of the date of birth.
3. In the case of a dependent's adoption or placement for adoption, the date of the adoption or placement for adoption.

The "enrollment date" for anyone who enrolls under a Special Enrollment Period is the first date of coverage.

**Mid-Year Enrollment Changes**

Once enrollment elections are made, either during the initial or Special Enrollment periods or during an annual Open Enrollment period, those elections may not be changed and will remain in effect for the entire plan year. However, there are some important exceptions:

1. **Change in Status**
   Employees may revoke or modify their enrollment elections mid-year only if they experience a Change in Status that affects their eligibility or the eligibility of their dependents under this Plan. A "Change in Status" is one of the following events:

   a. **Change in legal marital status,** including marriage, death of spouse, divorce, legal separation or annulment.

   b. **Change in number of dependents,** including birth, adoption, placement for adoption, and death of a spouse or other dependent.

   c. **A dependent satisfying or ceasing to satisfy the requirements for coverage.**

   d. **Change in employment status** of the employee, the employee's spouse or other dependent, including termination or commencement of employment, taking or returning from an unpaid leave of absence, change in work site, change in full-time or part-time status, change in hourly or salaried status, change in dependent's eligibility for other employer-based coverage.

   e. **Change in residence** by the employee, the spouse or dependent.

   f. **Reduction in hours of service** during stability period from full-time to part-time status.

   An election change will be approved only if it is consistent with the Change in Status. An election change is "consistent with" a Change in Status if the change is both the result of and corresponds with the Change in Status. For example, if a child ceases to be eligible for coverage because of age, it would be consistent with the Change in Status to drop coverage for the child. However, it would <u>not</u> be consistent with the Change in Status to drop coverage for the employee. As another example, if a spouse is covered under the medical plan of the spouse's employer, and the spouse loses coverage under that plan because of a change from full-time to part-time employment, it would be consistent with the Change in Status for the employee to elect to add the spouse under this Plan.

2. **Change in Cost or Coverage**
   If the cost of benefits increases or decreases during a benefit period, the Plan Sponsor may automatically change employee premium contributions. When the change in cost is significant, employees will be given the opportunity to either increase their contributions or elect a less-costly option (if available).

   If there is a significant overall reduction in the Plan's coverage, employees may elect another benefit option (if available). If a new benefit option is added under the Plan, employees will have the right to change their election to the new benefit option.

3. **Qualified Medical Child Support Order ("QMCSO")**
   A QMCSO is a judgment, decree or order resulting from a divorce, legal separation, annulment or change in custody that requires health coverage for an employee's child. An employee may change his or her Plan enrollment elections if the employee becomes subject to a QMCSO that requires the employee to provide (or cancel) health care coverage for a child.

4. **Entitlement to Medicare**
   An employee may change his or her elections for Plan coverage if the employee or any dependent becomes entitled to or loses Medicare coverage.

5. **Entitlement to Medicaid or Children's Health Insurance Coverage Reauthorization Act (CHIPRA)**
   An employee may change his or her elections for Plan coverage if the employee or any dependent becomes entitled to or loses Medicaid or CHIPRA**.**

Eligible employees enrolled in Medicaid or CHIPRA may enroll in the Plan by submitting a completed Enrollment Change form to the Plan Administrator within 60 days of loss of coverage.

**How to Make Mid-Year Enrollment Changes**
If an employee experiences an event that allows the employee to make a mid-year enrollment change, the employee must submit a completed Enrollment Change Form to the Plan Administrator no later than thirty-one (31) days after the event occurs. If the employee does not request the coverage change within the specified time limit, the employee will lose the right to make a change allowed by that event.

**How to Make Mid-Year Enrollment Changes for Medicaid or CHIPRA**
If an employee experiences an event that allows the employee to make a mid-year enrollment change, the employee must submit a completed Enrollment Change Form to the Plan Administrator no later than sixty (60) days after the event occurs. If the employee does not request the coverage change within the specified time limit, the employee will lose the right to make a change allowed by that event.

**Effective Date**
If approved, the employee's enrollment change(s) will take effect:

1. On the date of the event, in the case of a birth, adoption or placement for adoption.
2. No later than the first day of the month following the date the Plan Administrator receives the employee's completed Enrollment Change Form, in the case of all other enrollment changes.

## TERMINATION OF COVERAGE

**Rescission:** Fraud and intentional misrepresentation of a material fact by employees or covered persons are prohibited. The Plan shall have the right to rescind coverage if a covered person performs an act, practice or omission that constitutes fraud or makes an intentional misrepresentation of a material fact relating to health care or coverage. Thirty (30) days advance written notice will be provided to the person for whom coverage is being rescinded. An employee has the right to appeal a rescission of coverage (See Appeals section). A rescission is a cancellation or discontinuance of coverage that has a retroactive effect.

**Employee Coverage Termination:** Employee coverage will terminate on the earliest of the following dates:

1. The date following the last day for which premiums were paid when the covered employee terminates employment.
2. The date on which the covered employee ceases to be in a class eligible for coverage.
3. The date on which this Plan is terminated; or in case of any benefit under this Plan, the date of termination of the specific benefit.
4. The date the covered employee dies.
5. The date the covered employee enters the military service of any country or international organization on a full-time active duty basis other than scheduled drills or other training not exceeding one (1) month in any calendar year.
6. The date the covered employee fails to make any required contribution for coverage
7. The date on which a cancellation or discontinuance of coverage due to rescission is effective retroactively, as provided above.

A covered employee may be eligible for COBRA continuation coverage. For a complete explanation of COBRA availability, see the section entitled COBRA Continuation Coverage.

**Coverage Continuation During Periods of Furlough:**
A person may remain eligible for a limited time if active, full-time work ceases due to furlough.

1. This continuation will end at the end of the three (3) calendar month period immediately following the month the **Employee** was actively-at-work.
2. The employee must continue to pay their premiums during this period to employer.
3. Premiums are due within 30 days of the date the premium would have been withheld from payroll. If payment is not received within 30 days, active coverage will be terminated.
4. If an employee is in a waiting period at the time of their furlough, the furlough period will not count towards the waiting period.

**Personal Leave**
SouthCoast Health will grant Unpaid Personal Leave to accommodate personal needs that can only be satisfied through a temporary absence from work. Full Time and Part Time Employees are eligible once the employee has successfully completed the ninety- (90) day Initial Employment Period.

A Personal Leave of Absence may be granted for reasons such as family illness, employee illness or surgery, involvement in legal matters, settling family estates, household disasters, family crises, extended jury duty, extended bereavement, etc. to employees who have successfully completed the ninety (90) day Initial Employment Period but are not eligible for Family Medical Leave Act (FMLA).

Unpaid Personal Leave of Absence may not be used for purposes of seeking or engaging in other employment.

Requests for Unpaid Personal Leave of Absence will be considered on an individual basis; taking into consideration the reason for the request, the urgency of the request, the ability of the department/practice to provide coverage for the absence, and the employee's length of service and work record. Military leave of absence will be granted in accordance with federal/state regulations. SouthCoast reserves the right to deny any or all requests for Unpaid Personal Leave of Absence based upon the needs of the business.

*Unpaid Personal Leave of Absence will be granted once in a rolling twelve (12) month period measured backward from the date employee uses any unpaid leave with a maximum of 30 days.

*Leave is unpaid:* Personal Leave of Absence is an unpaid leave. However, in the event that you have any accrued paid time off, SouthCoast will require the employee to use any accrued paid time off during this leave. The use of accrued paid time off for unpaid leave time will not extend the thirty (30) day leave period.

*Other Benefits:* The employee will be asked to make a written election concerning contributory benefits during an unpaid leave. If employee chooses to continue benefits, which require an employee contribution, he/she may be asked to prepay any required premiums within thirty (30) days of the date the payment would normally be due.

Employees granted a Personal Leave of Absence do not suffer a loss of service time as a result of the leave. During the unpaid portion of a Personal Leave of Absence, vacation time will not accrue, and there will be no pay for holidays, jury duty, or bereavement leave.

*Employee's Written Request for Leave:* The request for a Personal Leave of Absence must be submitted in writing and must be approved by the employee's supervisor and is subject to final approval by the Human Resources Department. The request must state the reason for the leave, the commencement date and expected date of return. A minimum of thirty (30) days of advance written notice of intent to take Unpaid Personal Leave of Absence shall be presented to the supervisor when possible.

*Return From Unpaid Personal Leave:* Management will make an effort to provide an opportunity for the employee to return to the same position or one of like status and pay, assuming that the employee returns to work on or before the specified date of expiration of the leave, that such a position is available, and that the employee is qualified. There is no guarantee of job restoration unless on Military Leave or FMLA leave. Failure to return from personal leave of absence on the specified date will be considered a voluntary resignation.

*Medical Benefits:* During an approved Personal Leave of Absence, SouthCoast will maintain the employee's company sponsored health/dental benefits, as if the employee continued to be actively employed. If paid leave is substituted for an unpaid personal leave of absence, SouthCoast will deduct the employee's portion of the health/dental plan premium as a regular payroll deduction. If the employee's leave is unpaid, the employee must pay his/her portion of the premium to the Human Resource Department on or before the 26$^{th}$ day of the month prior to the month the premium will cover. The employee's failure to pay his/her portion of the premium in a timely manner may result in termination of coverage.

If an employee does not return to work at the end of the leave period, and SouthCoast paid premiums to maintain his/her group health/dental benefits during the unpaid leave, the employee will be responsible for reimbursing the total cost of the paid premium(s) to SouthCoast.

**Coverage Continuation During Family and Medical Leave:** Regardless of the leave policies described elsewhere in this Plan, this Plan will at all times comply with the Family and Medical Leave Act of 1993 and applicable regulations issued by the Department of Labor.

An eligible employee who is the spouse, son, daughter, parent or "next to kin" (defined as the nearest blood relative) of a injured US Armed Services member who is recovering from a serious illness or injury sustained in the line of duty on active duty is entitled to a total of 26 work weeks of leave during a 12-month period to care for the service member. (In compliance with the Family and Medical Leave Act of 1993 and applicable regulations issued by the Department of Labor).

During any leave taken under the Family and Medical Leave Act (FMLA), the employer will maintain coverage under this Plan under the same terms and conditions as coverage which would have been provided if the covered employee had been continuously employed during the entire leave period. The employee will continue paying any required contributions during the leave.

If Plan coverage is discontinued during the FMLA leave (either upon the employee's election or for failure to pay required contributions during the leave), coverage will be reinstated for the employee and his or her covered dependents if the employee returns to work in accordance with the terms of the FMLA leave. Coverage will be reinstated only if the person had coverage under this Plan when the FMLA leave started and will be reinstated to the same extent as the coverage that was in force when coverage was discontinued. For example, waiting periods will not be imposed unless they were in effect for the employee and/or the employee's dependents when Plan coverage was discontinued for the period of leave.

**Rehiring a Terminated Employee:** A terminated employee who is rehired will be treated as a new hire and be required to satisfy all eligibility and enrollment requirements.

**Employees on Military Leave:** Employees entering into or returning from military service will have the rights mandated by the Uniformed Services Employment and Reemployment Rights Act ("USERRA"). These rights include up to twenty-four (24) months of extended health care coverage upon payment of the entire cost of coverage plus a reasonable administration fee, and immediate coverage upon return from military service. These rights apply only to employees and their dependents covered under the Plan before active military service begins.

Plan exclusions and waiting periods may be imposed for any sickness or injury determined by the Secretary of Veterans Affairs to have been incurred in, or aggravated during, military service.

**Termination of Dependent Coverage:** A dependent's coverage will terminate on the earliest of these dates:

1. The date on which the covered dependent ceases to be an eligible dependent.
2. The date the covered employee's coverage under this Plan terminates.
3. The date on which the covered employee ceases to be in a class eligible for dependent coverage.
4. The date this Plan is terminated; in the case of any covered dependent's benefit under this Plan, the date of termination of such benefit.
5. The date the covered dependent enters the military service of any country or international organization on a full-time active duty basis other than scheduled drills or other training not exceeding one month in any calendar year.
6. The date the covered employee fails to make any required contribution for dependent coverage.

A covered dependent may be eligible for COBRA continuation coverage. For a complete explanation of COBRA availability, see the section entitled COBRA Continuation Coverage.

## DEFINITIONS

Capitalized terms that are used in this Plan shall have the following defined meanings. The inclusion of any phrase or word below does not imply that coverage for the service or supply is provided under the Plan.

**ACCIDENTAL INJURY**
Accidental injury is an immediate, unforeseen event caused by an external trauma to the body of a covered person, which is unrelated either directly or indirectly to all other causes and which requires treatment by a physician.

**APPROVED CLINICAL TRIAL**
An Approved Clinical Trial is a phase I, phase II, phase III or phase IV clinical trial for a qualifying individual that is conducted in relation to the prevention, detection, or treatment of cancer or other life-threatening disease or condition and is one of the following:

1. A federally-funded or approved trial.
2. A clinical trial conducted under an FDA investigational new drug application.
3. A drug trial that is exempt from the requirement of an FDA investigational new drug application.

For purposes of Approved Clinical Trials, a qualifying individual is a member who is eligible to participate in an approved clinical trial according to the trial protocol with respect to the treatment of cancer or other life-threatening disease or condition; and either of the following applies:

1. The referring health care professional is an in-network provider and has concluded that the individual's participation in such trial would be appropriate.
2. The member provides medical and scientific information establishing that the individual's participation in such trial would be appropriate.

**AMBULATORY SURGICAL CENTER**
An ambulatory surgical center is any licensed public or private establishment with an organized medical staff of physicians with permanent facilities that (i) is equipped and operated primarily for the purpose of performing surgical procedures; (ii) provides continuous service of physicians and registered professional nurses whenever a patient is in the facility, and (iii) which does not provide services or other accommodations for patients to stay overnight. Charges are covered only for facilities that are approved by the Joint Commission on Accreditation of Hospitals.

**BALANCE BILLING or BALANCE BILL**
**Balance Billing** or **Balance Bill** describes the practice where a **Non-Participating Provider**, **Physician**, or **Hospital** directly bills a patient the difference between the total amount charged by the **Non-Participating Provider**, **Physician**, or **Hospital** and the total amount paid by the **Plan**. For more information about Balance Billing (also called "Surprise Billing"), *see* Your Rights and Protections Against Surprise Medical Bills, below.

**CLAIM**
A claim is any request for a Plan benefit, made by a claimant or by a representative of a claimant that complies with the Plan's procedures for making benefit claims.

**CLEAN CLAIM**
A Clean Claim is a Claim that can be processed without obtaining additional information from the Provider of the service or from a third party. It includes a Claim with errors originating in a State's claims system. It does not include a Claim from a Provider who is under investigation for fraud or abuse, or a Claim under review for Medical Necessity**.**

**COBRA**
"COBRA" stands for the Consolidated Omnibus Budget Reconciliation Act of 1985, as amended, and any applicable regulations.

**CO-INSURANCE RATE**
Co-insurance rate is the rate or percentage that the Plan pays for Covered Medical Expenses after the calendar year deductible and/or co-pay has been met, subject to any applicable maximums.

**CONCURRENT CARE CLAIM**
There are two types of Concurrent Care Claims:
1. A claim to extend coverage for a course of treatment beyond a previously approved period of time or number of treatments.
2. A claim regarding reduction or termination of coverage by the Plan before the end of a previously approved period of time or number of treatments.

**CONSOLIDATED APPROPRIATIONS ACT**
**Consolidated Appropriations Act** or **CAA** means the Consolidated Appropriations Act of 2021, as amended, signed into law on 27 December 2020. The **CAA** further established an Independent Dispute Resolution process to resolve disputes in situations where:

**1.** No All-Payer Model Agreement applies;
**2.** No applicable state law applies; and,
**3.** The **Plan** and the **Provider** or **Facility** are unable to agree on a payment amount.

**CO-PAY OR CO-PAYMENT**
Co-pay is the amount that the covered person is required to pay directly to the Provider each time the covered person receives services. The co-pay is separate from and does not accrue towards the deductible or co-insurance limits. Co-payments are required for certain Covered Expenses even if the deductible requirements have been met or the co-insurance limit has been reached.

**COSMETIC SURGERY**
Cosmetic surgery is a procedure performed primarily to preserve or improve appearance rather than to restore the anatomy and/or functions of the body that are lost or impaired due to an illness or injury.

**COVERED MEDICAL EXPENSES**
Covered medical expenses are expenses for medical care provided to an individual while covered under the Plan and for which coverage is available under the Plan (see the Schedule of Benefits and Covered Medical Expenses sections for listings). Benefits for Covered Medical Expenses are subject to all the terms, conditions and limitations of the Plan.

**CUSTODIAL CARE**
Custodial care refers to services and supplies, including room and board and other institutional services, which are provided to an individual, whether disabled or not, primarily to assist him in the activities of daily living. These services and supplies are classified as custodial care regardless of the practitioner or provider who prescribes, performs or recommends the services.

**DEDUCTIBLE**
Deductible is the "out-of-pocket" amount before co-insurance that a covered person must pay for certain Covered Expenses. The deductible is separate from co-payments. Individual and family deductibles apply under this plan.

**Family Deductible** – The family deductible is satisfied when the sum of all deductible payments for covered family members meets the calendar year family deductible amount. Any covered charges incurred by any covered family member after the family deductible is satisfied will be paid at the co-insurance rate up to applicable plan limits for the remainder of the calendar year.

**DENTAL SERVICES**
Dental services are procedures involving the teeth, gums or supporting structures.

**DURABLE MEDICAL EQUIPMENT**
Durable medical equipment is a device that is able to withstand repeated use, is primarily and customarily used to serve a medical purpose, is generally not useful to a person in the absence of an illness or injury, and is prescribed by a physician and appropriate for use in the home.

**EFFECTIVE DATE**
Effective date is the date on which an employee or dependent is covered by the Plan.

**ELIGIBILITY DATE**
Eligibility date is the date on which an employee or dependent becomes eligible to participate in the Plan.

**EMERGENCY MEDICAL CONDITION**
Emergency Medical Condition(s), as defined by the CAA, 45 C.F.R. § 149.110(c)(1), is a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) that a prudent layperson, possessing an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in a condition described in the Emergency Medical Treatment and Labor Act, including:

1. Placing the health of the Member (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.

Emergency Medical Condition includes mental health conditions and substance use disorders. Emergency Medical Condition also includes any additional items and services covered by the Plan furnished by an Out-of-Network Provider or emergency Facility (regardless of the department of the hospital in which such items and services are furnished) after a Member is stabilized and as part of Outpatient observation or an Inpatient or Outpatient stay with respect to the visit in which the other emergency services are furnished unless all of the following conditions are met:

1. The attending emergency Physician or treating Provider has determined that the Member is able to travel using nonmedical transportation or nonemergency transportation to an available In-Network Provider or Facility located within a reasonable travel distance, taking into consideration the individual's medical condition;
2. The Provider or Facility furnishing the post-stabilization services has satisfied the notice and consent criteria required by applicable law with respect to such items and services;
3. The Member (or, the Member's Authorized Representative) is in a condition to receive the information in the notice and consent criteria and to provide informed consent under such section, in accordance with applicable state law; and,

The Provider or Facility has satisfied any additional requirements or prohibitions as may be imposed under applicable state law.

**EMERGENCY SERVICES**
Emergency Services, with respect to an Emergency Medical Condition, includes:

1. a medical screening examination 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 to stabilize the patient.

**EMERGENCY ROOM PHYSICIANS**
Emergency room physicians are physicians who provide emergency services located in hospitals or in minor emergency centers. Care by emergency room physicians is not given on an on-going basis, and emergency room physicians do not admit and follow patients when hospitalized. For the purposes of this Plan, emergency room physicians are not considered to be primary care physicians.

**EMPLOYEE**
Employee is any person who is employed by the Employer, excluding any leased employees, independent contractors, or contract employees. Individuals classified by the Employer as leased employees, independent contractors or contract employees shall be excluded from Plan participation even if they are subsequently determined to be common law employees by any court or government agency.

**EMPLOYER**
Employer is **SouthCoast Health** and any affiliates that participate in the Plan for the benefit of eligible employees.

**ENROLLMENT DATE**
Enrollment date is the first day of coverage or, if the Plan has a waiting period, the first day of the waiting period. The enrollment date for a late enrollee or any person who enrolls during a special enrollment period is considered to be the first date of coverage under this Plan.

**ESSENTIAL HEALTH BENEFITS** or **EHBs**
Essential Health Benefits are the core package of health care services required by section 2707(a) of the Public Health Service Act, as amended, as added by the Patient Protection and Affordable Care Act, to be covered by all non-grandfathered health plans in the individual and small group markets to cover essential health benefits (EHB), which include items and services in the following ten benefit categories:

1. ambulatory patient services;
2. emergency services;
3. hospitalization;
4. maternity and newborn care;
5. mental health and substance use disorder services including behavioral health treatment;
6. prescription drugs;
7. rehabilitative and habilitative services and devices;
8. laboratory services;
9. preventive and wellness services and chronic disease management; and,
10. pediatric services, including oral and vision care.

Regulations from the Department of Health and Human Services (45 CFR 156.100, *et seq.*) define EHB's based on State-specific EHB-benchmark plans. This SPD uses Utah as its benchmark plan, *available at* https://www.cms.gov/CCIIO/Resources/Data-Resources/ehb.

**EXPERIMENTAL OR INVESTIGATIONAL**
A treatment (other than covered off-label drug use) will be considered to be experimental or investigational if any of the following conditions are met:

1. The treatment is governed by the Food and Drug Administration (FDA) and the FDA has not approved the treatment for the particular condition at the time the treatment is provided.
2. The treatment is the subject of on-going Phase I, II, III, or IV clinical trials as defined by the National Institute of Health, National Cancer Institute or FDA and is not an Approved Clinical Trial (see Definitions).
3. There is documentation in published U.S. peer-reviewed medical literature stating that further research, studies, or clinical trials are necessary in order to determine the safety, toxicity or efficacy of the treatment.

**FACILITY**
A Facility is a healthcare institution which meets all applicable state or local licensure requirements, and which includes, but is not limited to the following: hospitals, skilled nursing facilities, intermediate care facilities, ambulatory surgical centers, free standing dialysis facilities or lithotripter centers.

**FORMULARY DRUGS**
Formulary drugs are specified alternative prescription drugs for specific brand name drugs.
Formulary drugs have been reviewed for safety, quality, effectiveness, and cost. A list of the Plan's formulary drugs is included in the member information packet. The formulary drug list is periodically reviewed and modified by a panel of physicians and pharmacists.

**GENERIC DRUGS**
"Generic drugs" is a term used for prescription drugs identified by their chemical name. When the patent has expired on a brand name drug, the FDA permits manufacturers other than the original developer to create a bioequivalent of the brand name drug and make it available to the public. Generally, more than one manufacturer will create the generic version, although in many cases the same pharmaceutical firm that produces the brand name drug also makes the generic version. This prompts competitive pricing of the generic version and usually results in a less expensive drug.

**HOME HEALTH CARE**
Home Health care is a formal program of care and treatment that is performed in the home of a person, is prescribed by a physician, and is prescribed in lieu of treatment in a hospital or skilled nursing facility or results in a shorter hospital or skilled nursing facility stay. The home health care program must be organized, administered, and supervised by a hospital or qualified licensed personnel under the medical direction of a physician.

**HOSPICE**
Hospice is an agency that provides counseling and medical services and may provide room and board for a terminally ill individual. Covered Hospice services must meet all of the following requirements:

1. It is licensed and has obtained any required state or governmental Certificate of Need approval.
2. It is under the direct supervision of a physician, has a nurse coordinator who is a registered nurse (R.N.) and provides service twenty-four (24) hours a day, seven (7) days a week.
3. It is an agency that has as its primary purpose the provision of hospice services.
4. It has a full-time administrator and maintains written records of services provided to the patient.

**HOSPITAL**
An institution is considered to be a hospital if it fully meets each of the following requirements:

1. It maintains on the premises, on an inpatient basis, diagnostic and therapeutic facilities for surgical and medical diagnosis and treatment of sick and injured persons, by or under the supervision of a staff of duly qualified physicians.

2. It continually provides on the premises twenty-four (24) hours a day registered nurse (R.N.) services.
3. It is recognized as a hospital by the Joint Commission on Accreditation of Hospitals.
4. It charges fees for its services.

The term "hospital" will not include, nor will the term "covered charges" include charges incurred in connection with confinement in any institution or part thereof used principally as a rest or nursing facility or a facility for custodial care. Facilities for the treatment of mental health disorders and substance use disorders must be licensed by the State Board of Health and approved by the Joint Commission on Accreditation of Hospitals.

**ILLNESS**
An Illness is a mental or physical disease or infirmity, including pregnancy or pregnancy-related conditions.

**INJURY**
An Injury is the accidental bodily harm to a covered employee or covered dependent.

**IN-NETWORK PROVIDERS**
An In-Network Provider is one who has elected to participate directly in the Plan or through a network supplementary to the Plan. A directory of In-Network Providers is available from the Plan Administrator. This Plan may reimburse differently based on whether the hospital/facility, physician, or other medical service provider participates directly in the Plan or through a network supplementary to the Plan.

**MEDICAL RECORD REVIEW**
A Medical Record Review involves review of Member's medical records and other pertinent documents for various reasons including, but not limited to, analysis of the condition, treatment, and claims for health care purposes and operations.

**MEDICALLY NECESSARY**
Care and treatment is "medically necessary" if the Plan Administrator or its delegate determines that the care and treatment meets all of the following conditions:

1. It is recommended and provided by a licensed physician, dentist or other medical practitioner who is practicing within the scope of his or her licenses.
2. It is appropriate for the symptoms and is consistent with the diagnosis, if any. "Appropriate" means that the type, level and length of services and setting are needed to provide safe and adequate care and treatment.
3. It is generally accepted as the standard of medical practice and care for the diagnosis and treatment of the particular condition.
4. It is specifically allowed by the licensing statutes which apply to the provider who renders the service.
5. It is ordered and documented in a timely fashion in the covered person's medical record.
6. If an inpatient procedure, it could not have been adequately performed in an outpatient facility.
7. It is not primarily for the convenience of the patient, physician or other health care provider and not more costly than an alternative service or sequence of services at least as likely to produce equivalent therapeutic or diagnostic results as to the diagnosis or treatment of that patient's illness, injury or disease.

The fact that a physician may prescribe, recommend, approve or view a service or supply, as medically necessary does not make that service or supply medically necessary under the Plan. The Plan Administrator has sole and complete discretionary authority to determine whether the service or

supply is medically necessary as defined under the Plan and may seek assistance or guidance for its determination from the Medical Department of Healthgram, Inc.

**MEMBER**
Member is an employee or dependent that satisfies the requirements outlined in the Eligibility section and is enrolled in the Plan.

**MENTAL HEALTH DISORDERS**
A mental health disorder is a disease or condition, except those related to a substance use disorder, that is classified as a mental or nervous disorder in the current edition of Internal Classification of Diseases, 9th Revision, Clinical Modification (ICD-9-CM), U.S. Department of Health and Human Services Publication No. (PHS) 89-1260, or in any subsequent revision of the International Classification of Diseases published by the U.S. Government Printing Office.

**MHPAEA**
**MHPAEA** means the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008, as amended by the Patient Protection and Affordable Care Act, as amended by the Health Care and Education Reconciliation Act of 2010. Members, Beneficiaries, or their Authorized Representative may obtain copies of information concerning the Plan's treatment limitations related to coverage for Mental Health Disorders and Substance Use Disorder benefits, generally or for specific treatment relating to a condition or disorder by making a written request to the Plan Sponsor at the address listed in the Plan Information section, above.

**NO SURPRISES ACT**
No Surprises Act or NSA is a portion of the CAA relating to services furnished by nonparticipating emergency facilities (including air ambulance services) and Non-Participating Providers at participating Facilities**.**

**OUT-OF-AREA BENEFITS**
Out-of-area benefits apply to members who reside in a location that does not offer access to a sufficient number or specialty of In-network Providers. The Plan Administrator determines which members are covered through the out-of-area provision. Out-of-area benefits also apply to emergency care.

**OUT-OF-NETWORK PROVIDER**
As outlined in the Schedule of Benefits, this Plan may reimburse differently based on whether the hospital, facility, physician or other medical service provider is contracted as a participating provider with the Plan or through an In-Network Provider network supplementary to the Plan. An "Out-of-Network Provider" is one who has not elected to participate in the Plan or through an In-Network Provider network supplementary to the Plan. All charges by an Out-of-Network Provider are subject to the Plan's definition of Plan Allowance.

**OUT-OF-POCKET LIMIT**
Except for expenses expressly disallowed, the Out-of-Pocket Limit is the maximum amount that a covered person must pay for covered expenses during the calendar year. The Plan has individual as well as family annual out-of-pocket limits.

**OUTPATIENT/REFERENCE DIAGNOSTIC LAB CHARGES**
Charges incurred from independent freestanding reference labs and/or charges incurred on an outpatient basis from a hospital and/or facility.

**PAIN THERAPY / PAIN MANAGEMENT**
Pain therapy/pain management treatment includes but is not limited to epidural steroid injections, nerve blocks, pain center (facility) fees, and all other related professional services. This does not include services received as a result of malignancy.

**PARTICIPATING PHARMACY**
Participating pharmacy is any pharmacy licensed to dispense prescription drugs that is included as a participant in the program offering pre-paid benefits to eligible Plan participants.

**PHYSICIAN**
The term physician is a doctor of medicine (M.D.) or a doctor of osteopathy (D.O.) who is legally qualified and licensed without limitation to practice medicine, surgery or obstetrics at the time and place service is rendered. For services covered by this Plan and for no other purpose, doctors of dental surgery, doctors of dental medicine, doctors of podiatry or surgical chiropody, chiropractors, optometrists, licensed psychologists, physical therapists, occupational therapists, speech therapists, physician assistants, nurse practitioners, licensed medical social workers, and midwives are deemed to be physicians when acting within the scope of their state licenses. Except as otherwise provided by state law, physician assistants, nurse practitioners (including Certified Registered Nurse Anesthetist also known as CRNA's), and midwives must practice under the direct supervision of a physician (M.D. or D.O.). Physical, occupational and speech therapy must be prescribed by a physician (M.D. or D.O.). PhDs in psychology are also considered covered providers.

**PLAN ADMINISTRATOR**
Plan Administrator is the Plan Sponsor or the person or committee appointed by the Plan Sponsor to carry out the administration and management of the Plan. The Plan Administrator has sole and complete discretionary authority to interpret the Plan, including those provisions relating to eligibility and benefits due under the Plan, and to make all determinations, including factual determinations, arising under the Plan.

**PLAN ALLOWANCE**
The Plan allowance is the amount that the Plan Administrator in its sole discretion, has determined to be the maximum amount payable for an Out-of-Network Provider covered service. Charges in excess of the Plan allowance will not be considered Covered Medical Expenses under this Plan. The Plan will reimburse the actual charge billed if it is less than the Plan allowance. A complete listing of the Plan Allowance charges is located at www.Healthgram.com/providers.The Plan allowance only applies to Out-of-Network Providers (see Schedule of Benefits). This provision does not apply to Dental benefits. The Plan Administrator has the discretionary authority to decide whether a charge meets the Plan allowance.

**PLAN PARTICIPANT**
Plan participant is an employee of the Employer who is covered under the Plan.

**PLAN SUPERVISOR**
Plan Supervisor is the person or firm employed by the Plan Sponsor to provide administrative services to the Plan including the processing and payment of claims.

**POST -SERVICE CLAIM**
Post-Service Claims are any claims filed for payment of benefits after medical care has been received.

**PRE-SERVICE CLAIM**
Pre-Service Claim is a claim for a benefit under this Plan when the Plan conditions receipt of the benefit, in whole or in part, on approval in advance of obtaining medical care. For more information, see the Care Management Requirements section.

**PRIMARY CARE PHYSICIAN (PCP)**
A PCP is a physician specializing in internal medicine, general practice, family practice, pediatrics, and/or obstetrics or gynecology chosen by the covered person to manage the continuity of his or her medical care. Certified Physician's Assistants (PAC's) and Certified Nurse Practitioners (CNP's) supervised by the primary care physician may also be considered PCP's under the Plan as long as they practice in the same location as the PCP.

**PRIMARY CARE SERVICES**
The Plan encourages the selection of a primary care physician at the time of enrollment in the Plan. **A primary care physician is a general internist, pediatrician, family physician or a gynecologist**. The benefits listed in the Primary Care Services section apply only when provided in the office of a primary care physician. Plan Allowance limitations may apply. (See Schedule of Benefits)

**QUALIFYING PAYMENT AMOUNT**
Qualifying Payment Amount or QPA as set forth in, 45 C.F.R. § 149.140(a)(16), is the cost-sharing amount for services subject to the CAA's NSA provisions furnished by nonparticipating emergency facilities (including air ambulance services) and Non-Participating Providers at participating facilities where there is no applicable: (1) All-Payer Model Agreement under section 1115A of the Social Security Act; or, (2) amount determined by a specific state law. QPA is the lesser of the billed charge or the Plan Supervisor's median contracted rate for the item or services in the geographic region. QPA is indexed annually for general inflation, and contracted rate refers only to the rate negotiated with Participating Providers that are contracted to participate in any of the networks of the Plan under generally applicable terms of this SPD. For more information about QPA, please see the Requirements Related to Surprise Billing; Part I, *available at* https://www.govinfo.gov/content/pkg/FR-2021-07-13/pdf/2021-14379.pdf

**RESIDENTIAL TREATMENT**
**Residential Treatment** covers **Medically Necessary** charges or services while in a live-in **Facility** whose stated intention is to provide therapy for **Substance Use Disorders**, **Mental Health Disorders**, or other behavioral problems.

**RETIREMENT**
Retirement begins on the first day on which retirement benefits become effective under:

1. Any plan of a federal, state, county, municipal or association retirement system for which the employee is eligible as a result of employment with the Employer.
2. Any plan which the Employer sponsors.
3. Any plan to which the Employer makes contributions or has made contributions.
4. The United States Social Security Act or any similar plan or act. If the employee is in active employment and is receiving disability benefits under the United States Social Security Act or any similar plan or act, the employee will not be considered retired.

**SICKNESS**
An illness or disease of a covered employee or covered dependent including congenital defects or birth abnormalities.

**SKELETAL ADJUSTMENT**
Skeletal Adjustment is the treatment of the skeletal system performed by external manipulation including, but not limited to, vertebral manipulation and associated adjunctive therapy.

**SLEEP DISORDER**
Sleep Disorders include but are not limited to sleep apnea, snoring, and narcolepsy.

**SUBSTANCE USE DISORDER**
A substance use disorder is the continued use or abuse of, and/or dependence on, legal or illegal substance(s), despite significant consequences or marked problems associated with the use as defined, described, or classified in the most current version of Diagnostic and Statistical Manual of Mental Disorders published by the American Psychiatric Association.

**TELEMEDICINE**
Telemedicine is any two-way, real time interactive communication between the patient, and the Physician or practitioner at the distant site. For purposes of this definition, distant site is the telehealth site where the Provider or specialist is seeing the patient at a distance or consulting with the patient's Provider. Other common names for this term include hub site, specialty site, provider/physician site, referral site, or consulting site.

**TEMPOROMANDIBULAR JOINT SYNDROME (TMJ)**
TMJ is an abnormal condition characterized by facial pain and by mandibular dysfunction usually caused by a defective or dislocated temporomandibular joint.

**TRANSPLANT**
See Organ Transplant Program under the Care Management Requirements section.

**URGENT CARE CENTERS**
An urgent care center is a public or private establishment that is equipped and operated primarily for the purpose of providing emergency treatment or performing surgical procedures and which does not provide services or other accommodations for patients to stay overnight. An urgent care center must be staffed by physicians and registered nurses.

**URGENT CARE CLAIM**
An Urgent Care Claim is any claim for medical care or treatment where using the timetable for a non-urgent care determination could seriously jeopardize the life or health of the claimant or the ability of the claimant to regain maximum function, or, in the opinion of the attending or consulting physician, would subject the claimant to severe pain that could not be adequately managed without the care or treatment that is the subject of the claim. A physician with knowledge of the claimant's medical condition may determine if a claim is one involving urgent care. If there is no such physician, an individual acting on behalf of the Plan applying the judgment of a prudent layperson possessing an average knowledge of health and medicine may make the determination.

**WILDERNESS THERAPY**
Wilderness Therapy, sometimes referred to as outdoor behavioral healthcare, is a mental health treatment strategy for adolescents with maladaptive behaviors, Substance Use Disorders, and/or Mental Health Disorders that combines therapy with challenging experiences in an outdoor wilderness environment.

## CARE MANAGEMENT REQUIREMENTS

The Plan features certain care management services designed to help ensure that all covered persons receive necessary and appropriate health care while avoiding unnecessary expenses when a hospital confinement, a surgical procedure or certain other care is proposed. Covered persons **must** use the services and follow all necessary steps as required. **Failure to comply with these requirements will result in a 50% reduction of benefits and a penalty may apply**.

Please note that the Plan is not directly involved in treatment, but only provides benefits for services that are covered under the terms of the Plan. Therefore, the Plan has no liability for the quality of care the member may receive. The member and health care provider(s) are responsible for making all decisions regarding health care and will control the course of treatment followed.

### 1. PRE-CERTIFICATION PROCESS

**In order to receive full benefits for the services listed below, the covered person must obtain** pre-certification prior to receiving the services or treatment. Pre-certification is the responsibility of the member. If the member is unsure whether pre-certification has been made, he or she should call to verify.

**7 day advance notice is required for any non-emergency admission from the pre-certification list below:**

**Services To Be Pre-Certified**
Pre-certification is required for: emergency hospital admissions, non-emergency hospital admissions (including observation), ambulatory surgery (outpatient surgery), dialysis, inpatient care in substance treatment centers, inpatient care in mental health treatment centers, inpatient care in extended care facilities, inpatient care in skilled nursing facilities, hospice care, inpatient rehabilitation services, chemotherapy/radiation therapy, durable medical equipment over $500 (rental or purchase), prosthetics, pain therapy (outpatient), home health care, botox, and sclerotherapy.

**FOR PRE-CERTIFICATION CALL:**
(980) 201-3020
**8:30am—5:00pm EST**
**Monday through Friday**

**Hospital Admissions**
For Emergency Admission: The covered person or an authorized representative of the family or the admitting office must call within forty-eight (48) hours or by the end of the first business day after admission.

For Non-Emergency Admission: The covered person or an authorized representative of the family or the admitting office must have the hospital/facility days certified by calling Healthgram's Medical Department when planning a future admission for the covered person. This must be done at least seven (7) days before the scheduled date of admission.

Pre-certification is the ultimate responsibility of the covered person. If the member is unsure whether pre-certification has been made, he or she should call to verify.

**Pre-Certification Penalty**
See Schedule of Benefits.
If pre-certification is not obtained, benefits are reduced by 50% of the applicable rate.

**Pre-Admission Certification is not a guarantee of either payment of benefits or the amount of benefits. Eligibility for and payment of benefits are subject to the terms of this Plan. If pre-certification is not obtained due to special circumstances and the member notifies the Plan Supervisor promptly of those circumstances, the applicable benefit reductions and penalties may be waived. Waivers will be applied in a consistent, nondiscriminatory manner to all similarly situated persons.**

## 2. UTILIZATION REVIEW

When a hospital admission or other admission requiring pre-certification is recommended, the Plan Supervisor's Medical Department must be contacted for utilization review.

**Information Needed for Review.** The following information will be needed for a review:

1. Employee name and member number.
2. Employer's name.
3. Patient's name and date of birth.
4. Name, address, and phone number of admitting/attending physician.
5. Date of hospital/facility admission.
6. Hospital/facility name, address, and phone number.

**Physician Contact.** Healthgram's Medical Department will contact the attending physician as part of the pre-certification process to:

1. Discuss the admitting diagnosis and the procedure(s) to be performed.
2. Determine if an outpatient option applies and if the procedure(s) can/should be performed on an outpatient basis.
3. Document any change in diagnosis or treatment.
4. Agree upon the number of days in the hospital/facility for the specific procedure(s).

**Hospital/Facility Contact.** During the covered person's inpatient stay, Healthgram's Medical Department will contact the hospital/facility as part of the pre-certification process in order to determine that:

1. The admission takes place upon the determined date and the prescribed care is being administered.
2. The patient is actually receiving the treatment outlined by the physician.
3. The patient is released from the hospital/facility when inpatient care is no longer needed.

**Inpatient Extension Process.** If, in the opinion of the patient's physician, it becomes necessary to extend the stay, then the physician or the hospital/facility may request an extension of the certification by calling Healthgram's Medical Department. This must be done no later than on the last day that has already been certified.

**Treatment Disagreements.** When there is a disagreement between the Healthgram's medical review coordinator and the attending physician as to the length of stay, course of treatment, or any other medical need, the physician may proceed as he sees fit, although covered benefits could be affected. The attending physician always has control of all treatment issues once the patient is admitted to the hospital/facility. The role of the Plan Administrator and of the Healthgram Medical Department in the utilization review process pertains solely to coverage under the terms of this Plan.

**Pre-Admission Certification is not a guarantee of either payment of benefits or the amount of benefits. Eligibility for and payment of benefits are subject to the terms of this Plan. If pre-certification is not obtained due to special circumstances and the member notifies the Plan Supervisor promptly of those circumstances, the applicable benefit reductions and penalties**

**may be waived. Waivers will be applied in a consistent, nondiscriminatory manner to all similarly situated persons.**

## 3. CASE MANAGEMENT

If a covered person suffers an injury or illness for which health care needs are likely to be very complex and/or costs extremely high, the case may be referred for case management by Healthgram**.** After reviewing the case, the case manager may decide that an alternative plan of treatment is available. If an alternative plan of treatment is approved, benefits other than those described in this Summary Plan Description as Covered Medical Expenses may be payable if recommended by the case manager. Recommendations are made only on a prospective basis and only if the treatment is agreed to by the patient, the attending physician, and case management on behalf of the Plan. The Plan reserves the right to pay In-Network benefits to any provider willing to enter into a negotiated arrangement through the case management program.

## 4. ORGAN/TISSUE TRANSPLANT PROGRAM

The Plan covers certain organ transplant procedures when a covered person is the recipient of the organ. The co-insurance limit will not apply for the transplant procedure unless (a) the procedure is arranged through case management and (b) the procedure is performed at an approved facility or hospital.

1. Eligible charges incurred by the covered person will be paid for the following donor expenses directly related to the procurement of a living or cadaver human organ for any covered transplant procedure:
    a. Testing to identify a suitable donor.
    b. Transportation of a donor to and from the site of the transplant procedure.
    c. Life support of a donor to and from the site of the transplant procedure.
    d. Hospital, medical and surgical charges related to the removal of the donated organ(s).
    e. Storage and transportation of donated organ(s).

2. Charges incurred for organ transplant surgery will be paid for the following organ transplant categories to allow for reasonable and medically necessary care and treatment. All other organ transplants not specifically mentioned here will be excluded and no benefits will be paid for any charges associated with them. **Covered organ transplant categories** are:
    a. bone marrow
    b. heart
    c. lung
    d. kidney
    e. pancreas
    f. liver
    g. peripheral stem cell

3. Covered Medical Expenses will include:
    a. Use of temporary life-support equipment, pending the acquisition of “matched” human organs.
    b. Multiple transplants during one operative session.
    c. Replacement(s) or subsequent transplant(s).
    d. Follow-up expenses for covered services (including immuno-suppressant therapy).

4. Non-covered expenses will include:
    a. Any financial consideration to a donor other than expenses directly related to the performance of the surgery.
    b. Any animal organ or mechanical organ.
    c. Anything excluded or limited as stated in the Plan.

**Additional Covered Benefits.** In addition to the standard organ transplant benefit, the following benefits may be available when a covered person participates in the Plan's Organ Transplant Program. This Organ Transplant Program is an enhancement to the standard organ transplant benefit and participation in the program is voluntary. Additional covered benefits include:

1. Access to over forty (40) "Transplant Centers of Excellence" across the United States, as well as outpatient peripheral stem cell facilities and transplant facilities in Great Britain.
2. Reimbursement for travel and lodging expenses incurred during the transplant procedure immediately prior to and after the transplant up to a $10,000 maximum for the covered person and a companion. Travel and lodging discounts are also available with select airlines and hotels.
3. Waiver of the covered person's deductible and out-of-pocket expenses up to a maximum of $1,500.
4. Services of a transplant facilitator who will coordinate the entire transplant process.

The services listed above are only available when a covered person fully participates in the Organ Transplant Program and meets all of the following requirements:

1. Pre-certification of the proposed organ transplant must be made by the covered person or the physician as soon as the covered person is identified as a potential transplant candidate. **Pre-certification is made by calling Healthgram at** (980) 201-3020; and
2. All organ transplant services must be rendered at a "Transplant Center of Excellence" facility in the Transplant Program Network. Healthgram will coordinate selection of the facility with the patient and physician.

**If these requirements are not met, Organ Transplant Program benefits may be reduced.**

Once enrolled in the program, a transplant facilitator will be assigned. This facilitator will coordinate the entire organ transplant process with the patient and physician, from hospital selection to travel arrangements to prescription drug options. Information regarding the network hospitals and other relevant information will be forwarded to the covered person and the physician. The transplant facilitator will work with the covered person, the physician, and the Plan Supervisor to assure quality and continuity of care throughout the process, pre-transplant to post-transplant, including organ harvest.

## 5. ONCOLOGY PHARMACEUTICAL AND CLINICAL MANAGEMENT PROGRAM

In order to receive benefits, the covered person receiving outpatient chemotherapy treatment for cancer, and related oncology pharmaceuticals must participate in the Oncology Management Program. The covered person or provider must submit the treatment plan for review and approval. The Healthgram Medical Department will assist the covered person and supervise the course of treatment.

## COORDINATION OF BENEFITS

**Coordination of Benefits.** When two (2) or more plans cover the incurred expenses, coordination of benefit rules will apply to determine the order in which those plans pay for covered charges. When a covered person is covered by this Plan and another plan, the plans will coordinate benefits when a claim is received.

The plan that pays first according to the coordination rules is the primary plan. When this Plan is secondary, the Plan will pay the lesser of the patient liability under the primary plan or the allowable charges the Plan would pay if primary.

**Generally, unless a specific rule applies, where a claim is submitted for payment under this Plan of Benefits and one or more other Plans, this Plan of Benefits is the Secondary Plan.**

**BENEFIT PLAN.**
The **Plan** will coordinate medical and dental benefits provided under another benefit plan. The term "benefit plan" is any of the following that provides benefits or services for medical or dental care or treatment. If separate contracts are used to provide coordinated coverage for Members of a group, the separate contracts are considered parts of the same benefit plan and there is no coordination of benefits among those separate contracts.

1. Benefit plan(s) include: group contracts, health maintenance organization (HMO) contracts, or other forms of group or group-type coverage (whether insured or uninsured); medical care components of long-term care contracts, such as skilled nursing care; medical benefits under group or individual automobile contracts (including, but not limited to, no fault auto insurance, by whatever name it is called, when not prohibited by law); plans required or provided by law; and Medicare or any other federal governmental plan, as permitted by law.
2. Benefit plan(s) do not include: hospital indemnity coverage or other fixed indemnity coverage; accident only coverage; specified disease or specified accident coverage; limited benefit health coverage, as defined by state law; school accident type coverage; benefits for non-medical components of long-term care policies; Medicare supplement polices; Medicaid policies; or coverage under other federal governmental plans unless permitted by law.

**Allowable Charges.** For a charge to be allowable it must be a Plan Allowance charge (see Definitions) and at least part of it must be covered under this Plan.

In the case of health maintenance organization (HMO) plans, this Plan will not consider any charges in excess of what an HMO provider has agreed to accept as payment in full. In addition, when an HMO pays its benefits first, this Plan will not consider as an allowable charge any charge that would have been covered by the HMO had the covered person used the service of an HMO provider.

In the case of service type plans, where services are provided as benefits, the reasonable cash value of each service will be the allowable charge.

**When coverage of medical expenses is available under an automobile insurance policy**, **coverage under** this Plan is **limited** to covered expenses in excess of those available under the automobile insurance policy, without reimbursement for any deductibles under the automobile insurance policy. This Plan always shall be the secondary plan regardless of the individual's election under PIP (personal injury protection) coverage with the automobile insurance carrier.

**BENEFIT PLAN PAYMENT ORDER.**
When two (2) or more benefit plans provide benefits for the same allowable charge, benefit payment will follow these rules:

1. The primary benefit plan pays or provides its benefits according to its terms of coverage and without regard to the benefits under any other plan**.**
    a. Except as provided in Paragraph (b), a plan that does not contain a coordination of benefits provision that is consistent with NAIC regulation is always primary unless provisions of both plans state that the complying plan is primary.
    b. Coverage that is obtained by virtue of membership in a group that is designed to supplement a part of a basic package of benefits and provides that this supplementary coverage shall be excess of any other parts of the plan provided by the contract holder.
2. Each plan determines its order of benefits using the first of the following rules that apply:
    a. Non-dependent or dependent. The plan that covers the person other than as a dependent for example as an employee, member, policyholder, subscriber, or retiree is the primary plan and the plan that covers the person as a dependent is the secondary plan. However, if the person is a Medicare beneficiary and, as a result of federal law, Medicare is secondary to the plan covering the person as a dependent and primary to the plan covering the person as other than a dependent (e.g., a retired employee), then the order of benefits between the two (2) plans is reversed so that the plan covering the person as an employee, member, policyholder, subscriber, or retiree is the secondary plan and the other plan is the primary plan.
    b. Dependent child covered under more than one plan. Unless there is a court decree stating otherwise, when a dependent child is covered by more than one plan the order of benefits is determined as follows:
        i. For a dependent child whose parents are married or are living together, whether or not they have ever been married:
            1. The plan of the parent whose birthday falls earlier in the calendar year is the primary plan; or,
            2. If both parents have the same birthday, the plan that has covered the parent the longest is the primary plan.
        ii. For a dependent child whose parents are divorced or separated or not living together, whether or not they have ever been married:
            1. If a court decree states that one of the parents is responsible for the dependent child's health care expenses or health care coverage and the plan of that parent has actual knowledge of those terms, that plan is primary. This rule applies to plan years commencing after the plan is given notice of the court decree;
            2. If a court decree states that both parents are responsible for the dependent child's health care expenses or health care coverage, the provisions of Subparagraph (i) above shall determine the order of benefits;
            3. If a court decree states that the parents have joint custody without specifying that one parent has responsibility for the health care expenses or health care coverage of the dependent child, the provisions of Subparagraph (i) above shall determine the order of benefits; or
            4. If there is no court decree allocating responsibility for the dependent child's health care expenses or health care coverage, the order of benefits for the child are as follows:
                a. The plan covering the custodial parent;
                b. The plan covering the spouse of the custodial parent;

**c.** The plan covering the non-custodial parent; and then,

**d.** The plan covering the spouse of the non-custodial parent.

**iii.** For a dependent child covered under more than one (1) plan of individuals who are the parents of the child, the provisions of Subparagraph (i) or (ii) above shall determine the order of benefits as if those individuals were the parents of the child.

**c.** Active Employee or Retired or Laid-off Employee. The plan that covers a person as an active employee, that is, an employee who is neither laid off nor retired, is the primary plan. The plan covering that same person as a retired or laid-off employee is the secondary plan. The same would hold true if a person is a dependent of an active employee and that same person is a dependent of a retired or laid-off employee. This rule does not apply if the rule labeled 3(a) can determine the order of benefits.

**d.** **COBRA** or State Continuation Coverage. If a person whose coverage is provided pursuant to **COBRA** or under a right of continuation provided by state or other federal law is covered under another plan, the plan covering the person as an employee, member, subscriber or retiree or covering the person as a dependent of an employee, member, subscriber or retiree is the primary plan and the **COBRA** or state or other federal continuation coverage is the secondary plan. This rule does not apply if the rule labeled 3(a) can determine the order of benefits.

**e.** Longer or Shorter Length of Coverage. The plan that covered the person as an employee, member, policyholder, subscriber, or retiree longer is the primary plan and the plan that covered the person the shorter period of time is the secondary plan.

**f.** If the preceding rules do not determine the order of benefits, the allowable expenses shall be shared equally between the plans meeting the definition of plan. In addition, this **Plan** will not pay more than it would have paid had it been the primary plan.

**Right to Receive or Release Necessary Information.** This Plan may give or obtain needed information from another insurer or any other organization or person for purposes of coordinating benefits. This information may be given or obtained without the authorization of or notice to the person that is the subject of the information. When a claim for benefits is filed, information must be provided regarding any other plans which also cover those claims.

**Facility of Payment.** This Plan may repay other plans for benefits paid by the other plans that the Plan Administrator determines should have paid by this Plan. That repayment will count as a valid payment under this Plan.

**Right of Recovery.** This Plan may pay benefits that should be paid by another benefit plan. In this case, this Plan may recover the amount paid from the other benefit plan or from the covered person. That repayment will count as a valid payment under the other benefit plan. In addition, this Plan may pay benefits that are later determined to be greater than the allowable charge. In this case, this Plan may recover the amount of the overpayment from the source to which it was paid.

**PLEASE NOTE:** If other health coverage is available from any other source that provides for coordination, including Medicare, Medicaid, TRICARE coverage and **CHIPRA**, amounts paid by the Plan do not accrue toward the co-insurance limit.

## COBRA CONTINUATION COVERAGE

Federal law gives certain persons the right to continue Plan coverage beyond the date it would otherwise terminate. The entire cost (plus an administration fee allowed by law) must be paid by the continuing person. Continuation coverage will end if the covered individual fails to make timely payment of the required contribution or premium. This law is referred to as "COBRA," which stands for the Consolidated Omnibus Budget Reconciliation Act of 1985.

**What COBRA Provides**
COBRA coverage is available to the member and covered dependents, if coverage under the Plan would otherwise end because:

1. The member's employment ends for any reason other than gross misconduct.
2. The member's regularly scheduled work hours are reduced so that the Plan's eligibility requirements are no longer met.

In addition, COBRA coverage is available to the member's covered dependents if the dependent's coverage would otherwise end because of:

1. The member's death, divorce, legal separation.
2. The member's entitlement to Medicare.
3. The dependent child ceased to be eligible for Plan coverage (for example, due to age).

The Employer filing a proceeding in bankruptcy under title 11 of the United States Code is a qualifying event for retired employees and their dependents covered under the Plan if the bankruptcy results in loss of coverage under the Plan.

Under COBRA, "qualified beneficiaries" – the member and the member's eligible covered dependents – may continue the same coverage in effect before the COBRA qualifying event. If coverage for similarly situated active employees or their dependents is modified, COBRA coverage will be modified in the same manner.

A newly-acquired dependent during the period of COBRA continuation coverage will be entitled to receive coverage under the Plan for the duration of the COBRA coverage period. The child must be enrolled within 30 days of the birth, adoption or placement for adoption, otherwise the member will have to wait until the next annual open enrollment period to enroll the child.

**Maximum COBRA Continuation Period**
If elected, COBRA coverage begins as of the date Plan coverage would otherwise end. The maximum duration of COBRA continuation varies depending on the reason the member or the member's covered dependents are eligible for COBRA.

**For Up to 18 months**. Coverage may continue for the member and covered dependents for **up to 18 months** if coverage under the Plan would otherwise end because of a reduction in work hours or termination of employment for reasons other than gross misconduct, fraud, or intentional misrepresentation of a material fact.

**For Up to 29 months**. If the Social Security Administration determines that a member or a covered dependent is disabled within 60 days of the date coverage ends due to a reduction in hours or termination of employment, COBRA coverage for the disabled individual and non-disabled family members entitled to COBRA may be continued for **up to 29 months** from the date of the qualifying COBRA event. The Plan Administrator must be notified in writing of the disability within 60 days after the latest of: (a) the Social Security's determination of disability, (b)

the date on which the qualifying event occurs, or (c) the date on which notification is received of the requirement to provide the notice of disability. The Plan Administrator must also be notified within 30 days if Social Security Administration determines that the disabled individual is no longer disabled. Notices about disability must be provided to the Plan Administrator in writing at the address listed in the Plan Information section.

**For Up to 36 Months**. COBRA coverage may continue for covered dependents for **up to 36 months** if their coverage would otherwise end because of (1) the member's death, divorce or legal separation, (2) the member's entitlement to Medicare, or (3) the member's dependent child ceases to be eligible for Plan coverage. If any of these qualifying events occurs while the dependents are covered under COBRA due to an event resulting in 18 months of COBRA coverage (see above), coverage may continue for a total of 36 months from the date of the first COBRA qualifying event, but only if the second qualifying event would have caused the covered dependent to lose coverage had the first qualifying event not occurred. The Plan Administrator must be notified within 60 days of the second qualifying event, as described below, to extend coverage.

**Notice of Some Qualifying Events**

The Plan will offer COBRA continuation coverage to qualified beneficiaries only after the Plan Administrator has been notified that a qualifying event has occurred. If the qualifying event is termination of employment, reduction in hours, death, or entitlement to Medicare, the Employer must notify the Plan Supervisor within 30 days of such event.

However, for other qualifying events (divorce, legal separation, or a dependent child's loss of eligibility), the member or the member's dependents must notify the Plan Administrator within 60 days of the qualifying event or the date coverage would terminate due to that event, whichever is later. If notice is not provided within this time limit, COBRA continuation coverage will not be available to dependents. The Plan Supervisor will provide notification in writing if COBRA continuation is not available after one of these qualifying events.

In addition, if while covered under COBRA for 18 months, a covered spouse or dependents experience a second qualifying event that allows extension of COBRA coverage to 36 months, the Plan Administrator must be notified in writing within 60 days of the second qualifying event. Failure to provide timely notice will result in loss of eligibility for the extension on account of the second qualifying event.

Required notices of qualifying events must be provided to the Employer and/or the Plan Administrator in writing at the address listed in the "Plan Information" section.

**How to Elect COBRA Coverage**

Once notified that a qualifying event has occurred, the Plan Supervisor will notify qualified beneficiaries in writing that they have the right to elect COBRA and will send the appropriate election forms. Each qualified beneficiary will have an independent right to elect COBRA. Covered employees may elect COBRA on behalf of their spouses, and parents may elect COBRA on behalf of their children.

Qualified beneficiaries must elect COBRA within 60 days after the date coverage would otherwise end or, if later, within 60 days of the date they receive the COBRA notice from the Plan Supervisor.

**Paying for COBRA Coverage**

Qualified beneficiaries who elect to continue coverage under COBRA are required to pay 102% of the full cost of coverage. If COBRA continuation coverage is extended due to disability, COBRA

payments will equal 150% of the full cost of coverage beginning on the 19th month of COBRA coverage.

The first payment for COBRA coverage must be made within 45 days after the date of the COBRA election and must be retroactive to the date regular coverage ended. Thereafter, COBRA payments are due on the first day of each calendar month and must be received within 30 days of the due date. If payments are not timely received, COBRA coverage will be terminated retroactive to the last day for which payment was received.

**Special COBRA Rules for TAA-Eligible Employees**
The Trade Act of 2002 created a new tax credit for employees who become eligible for trade adjustment assistance ("TAA") because their employment is adversely affected by international trade. Under these new provisions, TAA-eligible individuals can either take a tax credit or get advance payment of 72.5% of the premiums for COBRA coverage.

To assist TAA-eligible individuals in taking advantage of this tax credit or advance payments, the Trade Act provides them a special second COBRA election period. Therefore, if a member loses Plan coverage as a result of a TAA-related event and does not enroll in COBRA at the time, once the IRS makes a determination of TAA-eligibility, a second COBRA election period will be available to the member and covered dependents. This second election period begins on the first day of the month in which the member is determined to be TAA-eligible, provided the election is made no later than six months after the date coverage is lost as a result of the TAA-related event. COBRA coverage elected during this second election period will be effective as of the first day of the election period, not the date as of which the coverage first lapsed. The cost will be the same as described above for other COBRA coverage.

For questions about TAA eligibility, call the Department of Labor Employment and Training Administration toll-free at 1-877-US-2JOBS. For questions about the health coverage tax credit, call the Health Coverage Tax Credit Customer Contact Center toll-free at 1-866-628-4282.

**Termination of COBRA Coverage**
COBRA continuation coverage will terminate before the end of the maximum period on the earliest of the following:

1. The date that the Employer ceases to provide a group health plan to any of its employees.
2. The date after the COBRA election date that the qualified beneficiary first becomes:
   a. Entitled to benefits under Medicare; or
   b. Covered under any other group health plan as an employee or otherwise.
3. The date the qualified beneficiary fails to pay the cost of COBRA coverage by the due date (including the applicable grace periods).
4. For a qualified beneficiary who has extended COBRA coverage of 29 months due to disability, COBRA coverage will end as of the month that begins at least 30 days after a final determination has been made by the Social Security Administration that the disabled individual is no longer disabled.

The Plan Supervisor will notify qualified beneficiaries in writing in the event COBRA coverage is terminated before the end of the applicable maximum continuation period.

**Keep Plan Informed of Address Changes**
In order to protect family COBRA rights, the Plan Administrator must be kept informed of any changes in the addresses of covered family members.

**Other Coverage Options**
Health coverage may be purchased through the Health Insurance Marketplace, and purchasers may qualify for subsidized lower premium costs and lower out-of-pocket costs. Additionally, an individual may qualify for a 30-day special enrollment period for another group health plan for which he or she is eligible (such as a spouse's plan), even if that plan doesn't accept late enrollees. See *www.healthcare.gov* for more information about these options.

**Questions About COBRA**
For questions about COBRA continuation coverage, please contact the Plan Supervisor at (980) 201-3020.

## THIRD PARTY RECOVERY

### Rights of Reimbursement and Subrogation

The Plan does not cover expenses for which another part(ies) may be responsible as a result of liability for causing or contributing to the injury or illness of you and your Dependent(s). While such expenses are not covered under this Plan, the Plan may advance payments for such expenses. As a condition to the Plan advancing payments for any condition or injury for which another party may be responsible, the covered person shall agree to reimburse the Plan in full, and in first priority, from any funds recovered from any responsible party, (which may be an individual, a company or an insurer).

The amount to be reimbursed to the Plan will equal the payments advanced by the Plan, without any adjustment for the covered person's attorney fees and costs to obtain payment from the responsible party, but will not exceed the amount received from the responsible party. The Plan's rights shall not be subject to reduction under any common fund or similar claims or theories.

The Plan shall automatically have a first priority lien upon the proceeds of any recovery from a third party as the result of a judgment, settlement, or otherwise, by or on behalf of a covered person. Such proceeds shall be deemed to be held in trust for the benefit of the Plan until reimbursement, to the extent of the payments advanced by the Plan. Any funds recovered from the third party shall be applied first to reimburse the Plan for any and all payments made under the Plan for that covered person, regardless of the following:

1. The amount of damages claimed by the covered person against the third party or whether the covered person has been made whole for such damages.
2. Any characterization of the payments by the third party with respect to the covered person's damages, such as personal injuries, future education or training or, pain and suffering.
3. The covered person recovering the funds or property being a minor.

If the covered person receives funds from the third party and does not promptly reimburse the Plan, future benefits may be reduced to cover the amount of payments advanced by the Plan.

In addition to the right to reimbursement, if the Plan advances payments for a condition or injury that another party is responsible for paying, the Plan will be subrogated to the covered person's right to recover from the third party. This means that the Plan may assume the rights of the covered person to file a lawsuit or make a claim against the party whose acts or omissions caused the condition or injury.

The Plan Administrator may in its sole and complete discretion determine whether or not to pursue the Plan's right of subrogation.

The Plan's right of full recovery may be from the third party, and liability or other insurance covering the third party, malpractice insurance; the Member's own uninsured motorist insurance, underinsured motorist insurance, any medical payment (Med-Pay), no fault, personal injury protection (PIP); or, any other first or third-party insurance coverages which are paid or payable. The Plan's right of recovery shall not be subject to reduction under any common fund or similar claim or theories.

### Pursuing Reimbursement and Subrogation

These rights of reimbursement and subrogation are reserved whether the liability of a third party arises in tort, contract or otherwise. As a condition to receiving payments from the Plan, covered persons shall agree to fully assist and cooperate with the Plan Administrator in protecting and obtaining the Plan's reimbursement and subrogation rights, including, but not limited to, promptly

furnishing the Plan Administrator with information concerning the person's right of recovery from any third party, and, if requested, executing and returning any reimbursement or subrogation-related documents. The covered person shall further agree not to allow the Plan's reimbursement and subrogation rights to be limited or prejudiced by any acts or omissions by the covered person. In the event of any such acts or omissions by the covered person, the Plan Administrator shall be authorized in its sole discretion to suspend or terminate the payment or provision of any further benefits to or for the benefit of the covered person.

**Please Note: If an attorney is obtained, the Plan may require him/her to complete a subrogation agreement to reimburse the Plan 100% before payments are advanced.**

## FILING CLAIMS

### CLAIM FILING PROCEDURE

It is the responsibility of the covered person to see that doctor bills, medical bills, and hospital charges are submitted to the Plan Supervisor. Claim forms may be obtained from the Human Resources Office at your location. Claim forms must be filled out completely. Claims must be submitted to the Plan Supervisor at:

Healthgram, Inc.
Attention: Claims Department
PO Box 11088
Charlotte, North Carolina 28220-1088
(704) 523-2758

Benefits are paid to the employee/covered person unless the provider agrees to accept the payment directly or there is a valid assignment of the right to receive payment permitted under the terms of the Plan. The following items are important and should be submitted with each claim.

1. If a provider has not completed a billing statement form, the covered person must obtain a claim form from the Human Resources Office for completion.
2. All provider bills must include the following:
    a. Name of patient.
    b. Date, description and charge for each service.
    c. A complete and accurate diagnosis.
    d. Current Procedural Terminology (CPT) code(s).
    e. Provider's Federal ID Number or social security number.
    f. Complete current address of physician, including zip code and telephone number.
3. Claims for medication or drug expenses must include the following:
    a. Name of person for whom drug was prescribed.
    b. Prescription number and name of drug.
    c. Cost of medication and date of purchase (cash receipts, canceled checks, or credit card receipts cannot be accepted for consideration).
    d. Name of physician prescribing drug.
    e. For generic drugs, the prescription receipt marked GENERIC by pharmacist.
4. Copies of all other covered charges, such as for registered nurses and supply houses, must include the following:
    a. Name of patient.
    b. Date and charge for visit(s).
    c. Nature of treatment or services rendered.
    d. Federal ID Number or social security number of provider.
    e. Complete diagnosis.

**Report claims promptly**. The deadline for filing a claim for any benefit is twelve (12) months after the date that the expense is incurred. If the covered person fails to file a claim within this time period, the claimed expenses will not be covered under the Plan. **If a claim or part of a claim is denied for additional information, the claim must be re-submitted before the timely filing period expires.**

## INITIAL CLAIMS PROCESSING

Following is a description of how the Plan processes claims for benefits. A claim is defined as any request for a Plan benefit, made by a claimant or by a representative of a claimant that complies with the Plan's procedure for making benefit claims, as described here.

There are different kinds of claims and each one has a specific timetable for approval, payment, denial, or request for further information. For questions regarding the claims procedure, please contact the Plan Supervisor.

### Post-Service Claims

Post-Service Claims are those filed for payment of benefits after medical care has been received. If a Post-Service Claim is denied, the Plan Supervisor will provide written notification not later than thirty (30) days after receipt of the claim, if all needed information was provided with the claim. Sometimes additional time is necessary to process a claim due to circumstances beyond the control of the Plan. If an extension is necessary, the Plan Supervisor will provide written notification within the thirty (30) day period of the reasons for the extension and the date by which it expects to render a decision. The extension generally will be no longer than fifteen (15) days, unless additional information is needed.

If the extension is necessary because the claimant failed to provide all needed information, the notice of extension will describe the additional information required. The additional information must be provided within forty-five days. If all the needed information is received within that time limit and the claim is denied, the Plan Supervisor will provide notification the denial within fifteen (15) days after the information is received. If the needed information is not received within the forty-five (45) day period, the Plan Supervisor may decide the claim without that information.

A notification of denial will include:

1. The date of service, the health care provider, and the claim amount (if applicable).
2. The specific reason (s) for the denial, including the denial code and its corresponding meaning, and a description of the Plan's standard, if any used in denying the claim.
3. A statement that diagnosis and treatment codes and their corresponding meanings will be provided upon request and free of charge.
4. Reference to the specific Plan provisions on which the determination is based.
5. A description of any additional material or information necessary to perfect the Claim and an explanation of why such material or information is necessary.
6. A description of the Plan's appeal procedures, including the right to request an external review, and a statement of the right to bring a civil action under federal law following the denial of an appeal. A civil action against the Plan must be filed by December 31 of the second year after the year in which the disputed services, drugs, or supplies were received or from the year in which precertification was denied.
7. A statement disclosing any internal rule, guideline, protocol, or similar criterion referenced in making the adverse benefit determination (or a statement that such information will be provided free of charge upon request).
8. If the denial is based on a medical necessity or experimental treatment or similar exclusion, an explanation of the scientific or clinical judgment for the adverse benefits determination (or a statement that such explanation will be provided free of charge upon request).
9. A statement regarding the availability of language assistance, as applicable.
10. Contact information for consumer assistance for the EBSA and state agencies.

### Pre-Service Claims

Pre-Service Claims are those claims that require notification or approval prior to receiving medical care (for example, non emergency hospitalizations and surgery). If a Pre-Service Claim is submitted

properly with all needed information, the Plan Supervisor will send notification of the benefit determination, whether adverse or not, no later than fifteen (15) days from receipt of the claim.

If a Pre-Service Claim is not filed in accordance with the Plan's procedures, the Plan Supervisor will send notification of the improper filing, and how to correct it, within five (5) days after the improper claim is received.

If an extension is necessary to process your Pre-Service Claim, the Plan Supervisor will send written notification within the initial fifteen (15) day response period, and may request a one-time extension of up to fifteen (15) days. If the extension is necessary because additional information is needed, the notice of extension will describe the additional information required. The additional information must be provided within forty-five (45) days. If all the needed information is received within that time limit, the Plan Supervisor will provide written notification of the determination within fifteen (15) days after the information is received. If the needed information is not provided within the forty-five (45) day period, the Plan Supervisor may decide the claim without that information.

A denial notification will include the information listed here for Post-Service Claim details.

**Urgent Care Claims**
Urgent Care Claims are those that require pre-certification prior to receiving medical care, and where a delay:

1. Could seriously jeopardize life or health or the ability to regain maximum function.
2. In the opinion of the attending physician with knowledge of the member's medical condition, could cause severe pain.

If an Urgent Care Claim is filed in accordance with the Plan's procedures and include all needed information, the Plan Supervisor will provide notice of the determination, whether adverse or not, as soon as possible, but no later than seventy-two (72) hours after receipt of the Urgent Care Claim. If, however, the Plan's procedures are not followed; the Plan Supervisor will provide notice of the improper filing and how to correct it within twenty-four (24) hours of receipt of the improper claim. This notification may be oral, unless the member requests a written notification.

If the claimant fails to provide all the information required to decide the claim, the Plan Supervisor will provide notice of the additional information needed within twenty-four (24) hours after receipt of the claim. The requested information must be provided within forty-eight (48) hours. The Plan Supervisor will provide notice of the determination on the claim no more than forty- eight (48) hours after the earlier of the following:

1. The Plan Supervisor's receipt of the requested information.
2. The end of the forty-eight (48) hours given to provide the requested information.

A denial of an Urgent Care Claim will include the information listed here for Post-Service Claim denials. Notifications regarding Urgent Care Claim determinations may be oral, with written or electronic confirmation to follow within three (3) days.

**Concurrent Care Claims**
There are two types of Concurrent Care Claims:

1. A claim to extend coverage for a course of treatment beyond a previously approved period of time or number of treatments.
2. A claim regarding reduction or termination of coverage by the Plan before the end of a previously approved period of time or number of treatments.

A request to extend an ongoing course of treatment must be submitted at least twenty-four (24) hours before the end of the previously approved limit. If a request for extension is made timely and involves Urgent Care, the Plan Supervisor will provide notification of the determination, whether adverse or not, within twenty-four (24) hours after the claim is received. If the claim is not made at least twenty-four (24) hours prior to the end of the previously approved limit, the request will be treated as an Urgent Care Claim (not a Concurrent Care Claim) and decided according to the timeframes described here for Urgent Care Claims. A request to extend coverage that does not involve urgent care will be considered a new claim and will be decided according to the Post-Service or Pre-Service timeframes described here, as applicable.

If an ongoing course of treatment previously approved by the Plan is denied for continued coverage, the Plan Supervisor will provide notice sufficiently in advance to allow for an appeal.

Notices regarding denials of Concurrent Care Claims will include the information listed for Post-Service Claim denials.

**Questions About Claim Determinations**

Questions or concerns about a determination on your claim, contact the Plan Supervisor to inquire about it. This often clears up questions about benefit determinations, what the Plan covers, or what services were actually provided. The Plan Supervisor can be reached by calling the telephone number on the ID card or by writing to the address indicated above. A representative of the Plan Supervisor's Claims Department will be available to answer questions about the claim. If the Plan Supervisor cannot resolve the issue satisfactorily, a formal appeal may be made as described below. Remember that a member is not required to contact the Plan Supervisor informally. If the claimant is not satisfied with a benefit determination, it may be appealed immediately.

Legal action cannot be taken against the Plan after December 31 of the second year after the year in which the disputed services, drugs, or supplies were received, or from the year in which precertification was denied. This deadline may not be extended. Legal action may be taken only after the appeals process has been completed. See, Appeals.

Further, Federal law governs your lawsuit, benefits, and payment of benefits. The Federal court will base its review on the record that was before the Plan Sponsor when the Plan Sponsor decided to uphold or overturn the initial determination. You may recover only the amount of benefits in dispute.

## APPEALS

This Plan offers a two-level appeals procedure.

**NOTE:** To appeal an Urgent Care Claim denial, please refer to the Urgent Care Appeals section below and call the Plan Supervisor immediately at the number indicated on the ID card.

### How to File a Level One Appeal

A Level One Appeal is made to the Plan Supervisor in order to verify that the Claim was processed properly and free of mechanical or factual error. Except for appeals involving Urgent Care Claims (*see*, Urgent Care Claims Appeals, below), to appeal a Claim that resulted in an Adverse Benefit Determination, a request for Level One Appeal must be submitted either *via* Healthgram's Member Portal at www.members.healthgram.com or in writing to the Plan Supervisor at the address indicated below:

Healthgram, Inc.
Post Office Box 11088
Charlotte, NC 28220

A level one appeal must be filed within one hundred eighty (180) days of receipt of the notice of denial. Comments, documents, and other information may be submitted in support of the claim. A member may review the claim file and present evidence and testimony. The review on appeal will consider any information submitted, even if it was not submitted for or considered as part of the initial determination. Also, upon request and free of charge, reasonable access to and copies of all documents, records, and information that are relevant to the claim will be provided. Any new or additional evidence considered, relied upon, or generated by the Plan, and any new rationale relied upon by the Plan, will be provided within a time frame sufficient to allow claimant to respond.

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

1. Was relied upon in making the benefit determination.
2. Was submitted, considered, or generated in the course of making the benefit determination.
3. Demonstrates compliance with the administrative processes and safeguards designed to ensure and to verify that benefit determinations are made in accordance with Plan documents and Plan provisions have been applied consistently with respect to all claimants.
4. Constitutes a statement of policy or guidance with respect to the Plan concerning the denied treatment option or benefit.

#### Determinations on a Level One Appeal

The review on appeal will afford no deference to the initial benefit determination. Someone other than the individual involved in the initial benefit determination, not a subordinate of that individual, will be appointed to decide the appeal.

If the claim was denied based on a medical judgment (such as whether a service or supply is Medically Necessary, Experimental or Investigational), the Plan Supervisor will consult with a health professional with appropriate training and experience. The health care professional consulted for the appeal will not be a professional (if any) consulted during the initial determination or a subordinate of that professional. The Plan Supervisor also will identify medical or vocational experts whose advice was obtained on behalf of the Plan in connection with the adverse benefit determination, even if the advice was not relied upon in making the benefit determination.

The Plan Supervisor will provide written or electronic notification of the determination on appeal as follows:

1. *For level one appeals of Pre-Service Claims*, not later than fifteen (15) days after receipt of the appeal.

2. *For level one appeals of Post-Service Claims*, not later than thirty (30) days after receipt of the appeal.

If the appeal is denied, the notification will include:

1. The date of service, the health care provider and the claim amount (if applicable).
2. The specific reason(s) for the denial, including the denial code and its corresponding meaning and a description of the Plan's standard, if any, used in denying the claim.
3. Reference to the specific Plan provisions on which the determination is based.
4. A statement that the member entitled to receive, upon request and free of charge, reasonable access to or copies of all documents, records, or other information relevant to the claim, including the diagnosis and treatment codes and their corresponding meanings.
5. A statement of the appeals procedures offered by the Plan, including the right to request an external review, and a statement of the right to bring civil action under Federal law. A civil action against the Plan must be filed by December 31 of the second year after the year in which the disputed services, drugs, or supplies were received or from the year in which precertification was denied.
6. A statement disclosing any internal rule, guideline, protocol, or similar criterion referenced in making the adverse determination (or a statement that such information will be provided free of charge upon request).
7. If the denial on appeal is based on a medical necessity or experimental treatment or similar exclusion, an explanation of the scientific or clinical judgment for the adverse benefits determination (or a statement that such explanation will be provided free of charge).
8. A statement regarding the availability of language assistance, as applicable.
9. Contact information for consumer assistance for EBSA and state agencies.

**How to File a Level Two Appeal**

Except for appeals involving Urgent Care Claims (*see*, Urgent Care Claims Appeals, below), a Level Two Appeal must be submitted either *via* Healthgram's Member Portal at www.members.healthgram.com or in writing to the Plan Supervisor at the address indicated below:

c/o Healthgram, Inc.
Post Office Box 11088
Charlotte, NC 28220

A level two appeal must be filed within ninety (90) days of the receipt of the level one appeal denial. Comments, documents, and other information may be submitted in support of the claim. A member may review the claim file and present evidence and testimony. The review of the level two appeal will consider any information submitted, even if it was not submitted for or considered as part of the initial determination or level one appeal. Also, upon request and free of charge, reasonable access to and copies of all documents, records, and information that are relevant to the claim and level one appeal will be provided. Any new or additional evidence considered, relied upon, or generated by the Plan, and any new rationale relied on by the Plan, will be provided within a time frame sufficient to allow claimant to respond.

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

1. Was relied upon in making the benefit determination.
2. Was submitted, considered, or generated in the course of making the benefit determination.
3. Demonstrates compliance with the administrative processes and safeguards designed to ensure and to verify that benefit determinations are made in accordance with Plan documents and Plan provisions have been applied consistently with respect to all claimants.
4. Constitutes a statement of policy or guidance with respect to the Plan concerning the denied treatment option or benefit.

**Determinations on a Level Two Appeal**
The review on the level two appeal will be made by the Plan Administrator, and will afford no deference to the initial benefit determination and level one appeal. Someone other than the individual involved in the initial benefit determination and level one appeal, not a subordinate of either individual, will be appointed by the Plan Administrator to decide the appeal.

If the claim and appeal was denied based on a medical judgment (such as whether a service or supply is Medically Necessary, Experimental or Investigational), the Plan Administrator will consult with a health professional with appropriate training and experience. The health care professional consulted for the appeal will not be a professional (if any) consulted during the initial determination and the level one appeal or a subordinate of that professional. The Plan Administrator also will identify any medical or vocational expert whose advice was obtained on behalf of the Plan in connection with the adverse benefit determination, even if the advice was not relied upon in making the benefit determination.

The Plan Administrator will provide written or electronic notification of the determination on appeal as follows:
1. *For level two appeals of Pre-Service Claims*, not later than fifteen (15) days after receipt of the appeal.
2. *For level two appeals of Post-Service Claims*, not later than thirty (30) days after receipt of the appeal.

If the level two appeal is denied, the notification will include:
1. The date of service, the health care provider and the claim amount (if applicable).
2. The specific reason(s) for the denial, including the denial code and its corresponding meaning and a description of the Plan's standard, if any, used in denying the claim, and a discussion of the decision.
3. Reference to the specific Plan provisions on which the determination is based.
4. A statement that the member is entitled to receive, upon request and free of charge, reasonable access to or copies of all documents, records, or other information relevant to the claim, including diagnosis and treatment codes and their corresponding meanings.
5. A statement of the appeal procedures offered by the Plan, including the right to request an external review and a statement of the right to bring civil action under Federal law. A civil action against the Plan must be filed by December 31 of the second year after the year in which the disputed services, drugs, or supplies were received or from the year in which precertification was denied.
6. A statement disclosing any internal rule, guideline, protocol, or similar criterion referenced in making the adverse determination (or a statement that such information will be provided free of charge upon request).
7. If the denial on appeal is based on a medical necessity or experimental treatment or similar exclusion, an explanation of the scientific or clinical judgment for the adverse benefits determination (or a statement that such explanation will be provided free of charge).
8. A statement regarding the availability of language assistance, as applicable.
9. Contact information for consumer assistance for EBSA and state agencies.

**Urgent Care Appeals**
An appeal involves Urgent Care and requires immediate action if a delay could significantly increase the risk to the member's health or impair the ability to regain maximum function or, in the opinion of a physician with knowledge of the member's condition, could cause severe pain.

If an appeal involves Urgent Care, the appeal does not need to be submitted in writing. The member or physician should call the Plan Supervisor immediately at the number indicated on the ID card. The Plan Supervisor will provide notice of the determination on the appeal as soon as possible, but not

later twenty-four (24) hours after receipt of the appeal. The notification may be written or electronic and will include the information described here for other appeal denials.

**Voluntary Level of Appeal**
The Plan offers a voluntary level of appeal that may include mediation or arbitration. Claimants may submit a benefit dispute to this voluntary appeal only after exhaustion of the appeals process described in the Appeals section.

If the claimant elects the voluntary level of appeal, any statute of limitations or other defense based on timeliness will be tolled during the time the voluntary appeal is pending. In addition, the Plan shall not assert that a claimant has failed to exhaust administrative remedies by not electing to submit the benefit dispute to the voluntary appeal provided by the Plan.

The Plan will provide to the claimant, upon request and at no cost, sufficient information about the voluntary appeal process to enable the claimant to make an informed judgment on whether or not to submit a benefit dispute to the voluntary level of appeal. This information will include a statement that the decision will have no effect on the claimant's rights to any other benefits under the Plan, will list the rules of the appeal, will state the claimant's right to representation, will enumerate the process for selecting the decision maker, and will give circumstances, if any, that may affect the impartiality of the decision maker.

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

**How to Request an External Review**
External review is not available to resolve disputes about eligibility other than those disputes that are related to rescissions.

1. Request for external review. A claimant or authorized representative ("claimant") may file a written request for an external review after receipt of notice of a final internal adverse benefit determination. The request for review must be submitted in writing to the Plan Administrator at the address indicated below:

   c/o Healthgram, Inc.
   Post Office Box 11088
   Charlotte, NC 28220

The request must be filed within four (4) months after the date of receipt of a notice of a final internal adverse benefit determination. If there is no corresponding date four months after the date of receipt of such a notice, then the request must be filed by the first day of the fifth month following the receipt of the notice.

2. Within five (5) business days following the date of actual receipt of the external review request, the **Plan** will complete a preliminary review of the request to determine whether all of the following conditions are met:
   a. The claimant is or was covered under the plan at the time the health care item or service was requested or, in the case of a retrospective review, was covered under the plan at the time the health care item or service was provided
   a. The **Final Internal Benefit Determination** involves: (1) medical judgment, as determined by the external reviewer; (2) a rescission of coverage; or, (3) an issue related to compliance with the surprise billing and cost-sharing protections under the NSA.

Examples of determinations that are eligible under the NSA for external review include, but are not limited to, determinations of:

i. whether a claim is for treatment for Emergency Services that involves medical judgment or consideration of compliance with the cost-sharing and surprise billing protections under the NSA;
ii. whether a claim for items and services furnished by an Out-of-Network Provider at an In-Network Facility is subject to the NSA;
iii. whether an individual was in a condition to receive a notice about the availability of the protections under the NSA and give informed consent to waive those protections;
iv. whether a claim for items and services is coded correctly, consistent with the treatment an individual actually received; and,
v. whether cost-sharing was appropriately calculated for claims for ancillary services provided by an Out-of-Network Provider at an In-Network Facility.

b. The claimant has exhausted the plan's internal appeal process.
c. The claimant has provided all the information and forms required to process an external review.

Within one (1) business day after completion of the preliminary review, the Plan will issue a notification in writing to the claimant. If the request is complete but not eligible for external review, such notification must include the reasons for ineligibility and contact information for the Employee Benefits Security Administration (EBSA) (toll-free number 866-444-3272). If the request is not complete, the claimant must submit the additional information within the four-month filing period or within the 48 hour period following receipt of the notification, whichever is later.

3. Referral to Independent Review Organization. The Plan will assign an independent review organization (IRO) that is accredited by URAC or by similar nationally-recognized accrediting organization to conduct the external review.

4. Review by IRO.
    a. The IRO will utilize legal experts where appropriate to make coverage determinations under the plan.
    b. The IRO will timely notify the claimant in writing of the request's eligibility and acceptance for external review. Within ten business days following the date of receipt of such notice, the claimant may submit in writing additional information that the IRO must consider.
    c. Within five business days after the date of assignment of the IRO, the Plan will provide to the IRO the documents and any information considered in making the adverse benefit determination or final internal adverse benefit determination.
    d. Upon receipt of any information submitted by the claimant, the IRO will, within one (1) business day, forward the information to the Plan. The Plan may reverse its prior decision upon consideration of the additional information. The Plan will provide notice of such reversal to the IRO and the claimant, and the IRO will terminate the external review upon receipt of such notice.
    e. The IRO will consider the following in reaching a decision:
        i. The claimant's medical records.
        ii. The attending health care professional's recommendation
        iii. Reports from appropriate health care professionals and other documents submitted by the Plan, claim or the claimant's treating provider.
        iv. The terms of the Master Plan Document and SPD.
        v. Appropriate practice guidelines.
        vi. Any applicable clinical review criteria developed and used by the Plan.
        vii. The opinion of the IRO's clinical reviewer.

5. Notice of Final External Review Decision.
    a. The IRO will provide written notice to the Plan and claimant of the final external review decision within 45 days after receipt of the request for external review.
    b. The IRO decision notice will contain:
        i. A general description of the claim, including the date of service, the health care provider, the claim amount, the diagnosis code and its corresponding meaning, the treatment code and its corresponding meaning, and the reason for the previous denial.
        ii. The date the IRO received the assignment to conduct the review and the date of the IRO decision.
        iii. Reference to the evidence or documentation considered in reaching its decision.
        iv. A discussion of the principle reason(s) for its decision.
        v. A statement that the determination is binding except to the extent that other remedies may be available under state or federal law to either the Plan or to the claimant.
        vi. A statement that judicial review may be available to the claimant.
        vii. Current contact information for the EBSA (1-866-444-3272).

**How to file an Expedited External Review**

1. Request for expedited external review. A Claimant may make a request for an expedited external review at the time the claimant receives either of the following:
    a. An adverse benefit determination that involves a medical condition of the claimant for which the timeframe for completion of an expedited internal appeal would seriously jeopardize the life or health of the claimant or the ability to regain maximum function and the claimant has filed a request for an expedited internal appeal.
    b. A final internal adverse benefit determination, if the claimant has a medical condition where the timeframe for completion of an external review would seriously jeopardize the life or health of the claimant or the ability to regain maximum function, or if the final internal adverse benefit determination concerns an admission, availability of care, continued stay, or health care item or service for which the claimant received emergency services, but has not been discharged from a facility.

2. Preliminary Review. Using the standards set forth above for external review, the Plan will, immediately upon receipt of the request for expedited external review, determine whether the request meets the reviewability requirements and will immediately provide notice of its determination to the claimant.

3. Referral to IRO. Using the standards and procedures set forth above for external review, the Plan will assign an IRO and transmit all necessary documents and information by any available expeditious method. Using the standards and procedures set forth above for external review, the IRO will review the claim and reach a decision.

Notice of final external review decision. Using the standards and procedures set forth above for external review, the IRO will provide notice of the final external review decision as expeditiously as the claimant's medical condition or circumstances require, but in no event more than seventy-two (72) hours after receipt of the request for a expedited external review. If the notice is not in writing, the IRO will provide written confirmation of the decision in writing within forty-eight (48) hours after the date of providing that notice.

## RESPONSIBILITIES FOR PLAN ADMINISTRATION

**Plan Administrator.** The Plan Sponsor may appoint an individual or a committee to serve as Plan Administrator of the Plan. If the Plan Administrator resigns, dies, or is otherwise removed from the position, the Plan Sponsor shall appoint a new Plan Administrator as soon as reasonably possible.

If the Plan Sponsor does not otherwise appoint a Plan Administrator, the Plan Sponsor shall be the Plan Administrator.

The Plan Administrator is required to administer this Plan in accordance with its terms and has the authority to establish policies and procedures for the management and operation of the Plan. It is the express intent of this Plan that the Plan Administrator shall have sole and complete discretionary authority to construe and interpret the terms and provisions of the Plan, to decide issues regarding eligibility and benefits due under the Plan, and to make all determinations, including factual determinations, arising under the Plan. Except as otherwise required by law, the decisions of the Plan Administrator will be final and binding for all interested parties.

**Duties of the Plan Administrator.** The Plan Administrator's duties include:

1. To administer the Plan in accordance with its terms.
2. To interpret the Plan, including the right to remedy possible ambiguities, inconsistencies, or omissions.
3. To settle disputes which may arise relative to a participant's or beneficiary's rights.
4. To prescribe procedures for filing claims for benefits and to review claim denials.
5. To keep and maintain the Plan documents and all other records pertaining to the Plan.
6. To appoint a claims administrator to process and pay claims.
7. To perform all necessary reporting as required by ERISA.
8. To establish and communicate procedures to determine whether a medical child support order is qualified under ERISA Section 609.
9. To delegate to any person or entity such powers, duties, and responsibilities, as it deems appropriate.

**Plan Administrator Compensation.** Unless otherwise determined by the Plan Sponsor and permitted by law, any plan administrator that is also an Employee of the Plan Sponsor shall serve without compensation for services rendered in such capacity, but all reasonable expenses incurred in the performance of their duties shall be paid by the Plan Sponsor.

**Fiduciary.** A fiduciary is anyone who (i) exercises discretionary authority or control over the management of the Plan or the management and disposition of Plan assets; (ii) renders investment advice to the Plan; or (iii) has discretionary authority or responsibility in the administration of the Plan.

**Fiduciary Duties.** A fiduciary must carry out his or her duties and responsibilities solely in the interest of participants and beneficiaries as follows:

1. For the exclusive purpose of providing benefits to employees and their dependents and defraying reasonable expenses of administering the Plan.
2. With the care, skill, prudence, and diligence under the given circumstances that a prudent person, acting in a like capacity and familiar with such matters, would use in a similar situation.
3. In accordance with the Plan documents to the extent that they are consistent with ERISA.

**The Named Fiduciary.** A "named fiduciary" is the Plan Administrator. The named fiduciary can appoint others to carry out fiduciary responsibilities other than as Plan trustees. These other

persons become fiduciaries themselves and have fiduciary responsibility for their acts under the Plan. To the extent that the named fiduciary allocates fiduciary responsibilities to other persons, the named fiduciary shall not be liable for any act or omission of those persons unless:

1. The appointment was imprudent or the named fiduciary fails to monitor the conduct and performance of the appointee; or
2. The named fiduciary breached his or her fiduciary responsibility under Section 405(a) of ERISA.

**Plan Supervisor Is Not a Fiduciary.** The Plan Supervisor is not a fiduciary under the Plan by virtue of processing and paying claims in accordance with the Plan's rules as established and interpreted by the Plan Administrator.

A participant or beneficiary shall not rely on any oral statement from any employee or customer representative of the Plan Supervisor to:

1. Modify or otherwise amend the benefits, limitations and exclusions or other provisions of this Plan.
2. Increase, reduce, waive or void any coverage or benefits under this Plan.

Any statement by the Plan Supervisor should not be interpreted as a guarantee of coverage or payment for any services rendered or otherwise provided to a participant or beneficiary.

# YOUR RIGHTS AND PROTECTIONS AGAINST SURPRISE MEDICAL BILLS

When you get emergency care or are treated by an out-of-network provider at an in-network hospital or ambulatory surgical center, you are protected from balance billing. In these cases, you shouldn't be charged more than your plan's copayments, coinsurance and/or deductible.

**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, like a copayment, coinsurance, or deductible. You may have additional 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" means providers and facilities that haven't signed a contract with your health plan to provide services. Out-of-network providers may be allowed to bill you for the difference between what your plan pays 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 plan's deductible or 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. Surprise medical bills could cost thousands of dollars depending on the procedure or service.

**You are protected from balance billing for:**

**Emergency services:** If you have an emergency medical condition and get emergency services from an out-of-network provider or facility, the most they can bill you is your plan's in-network cost-sharing amount (such as copayments, coinsurance, and deductibles). 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 out-of-network. In these cases, the most those providers can 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 types of services at these in-network facilities, out-of-network providers can't balance bill you, unless you give written consent and give up your protections.

**You're never required to give up your protections from balance billing. You also aren't required to get out-of-network care. You can choose a provider or facility in your plan's network.**

**When balance billing isn't allowed, you also have these protections:**

- You're only responsible for paying your share of the cost (like the copayments, coinsurance, and deductible that you would pay if the provider or facility was in-network). Your health plan will pay any additional costs to out-of-network providers and facilities directly.
- Generally, your health plan must:
    - Cover emergency services without requiring you to get approval for services in advance (also known as "prior authorization").
    - Cover emergency services by out-of-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 out-of-network services toward your in-network deductible and out-of-pocket limit.

**If you think you've been wrongly billed**, contact the Plan Administrator, Plan Supervisor, or the Department of Health and Human Services' No Surprises Help Desk at 1-800-985-3059, or visit https://www.cms.gov/nosurprises. Visit https://members.healthgram.com/nsa.cfm for state Department of Insurance contact information.

Visit https://www.cms.gov/nosurprises for more information about your rights under federal law.

## GENERAL INFORMATION

### PLAN AMENDMENTS AND TERMINATION

The Plan Sponsor reserves the right to modify, amend or terminate the Plan completely or in part. The Plan may be amended or terminated by formal action of the board of directors of the Plan Sponsor or by appropriate action of any person(s) authorized to act on behalf of the board of directors of the Plan Sponsor.

If the Plan, or any benefit offered under the Plan, is amended, modified or terminated, the rights of covered persons are limited to covered charges incurred before the effective date of that amendment, modification or termination. Covered persons will be informed of any changes that affect their coverage.

### ASSIGNMENTS

Benefits under the Plan may not be voluntarily or involuntarily assigned or alienated, provided, that payment of benefits of a covered person will be made directly to a physician, hospital or other provider furnishing services to the extent that the covered person has authorized such physician, hospital or other provider to receive direct payment of benefits due under the Plan. Assignment of benefits for any purpose other than direct payment to providers shall not be permitted and shall not be binding on the Plan, the Plan Administrator or the Employer.

### CLERICAL ERROR & MISSTATEMENTS

Any clerical error by the Plan Administrator or an agent of the Plan Administrator in keeping pertinent records or a delay in making any changes will not invalidate coverage otherwise validly in force or continue coverage validly terminated. An equitable adjustment of contributions will be made when the error or delay is discovered. If any relevant information as to the amount of coverage shall have been misstated, the facts will determine whether or not, and how much, coverage is in force.

### OVER PAYMENTS

If a member or any other person or entity receives a benefit payment that exceeds the amount of benefits payable under the Plan, the Plan has the right to either (i) require that the member or the person or entity that was paid return the amount of the overpayment or (ii) reduce any future benefit payments to the member or his/her dependents by the amount of the overpayment. This right does not affect any other right of recovery concerning the overpayment.

### PLAN IS NOT AN EMPLOYMENT CONTRACT

The Plan is not a contract of employment, and participation in the Plan does not guarantee any person's employment with the Employer.

### PRIOR COVERAGE PROVISION

This provision applies only to a person who was covered on the date this Plan first became effective and who was covered under the prior plan, which this Plan replaced.

1. **Pre-existing Conditions.** Benefits for pre-existing conditions will be equal to the lesser of:
   a. benefits payable under the prior plan had it remained in effect; or
   b. benefits payable under this Plan.

   If any person is eligible for continuation of coverage under the prior plan, benefits under this Plan will be limited to only those eligible expenses not eligible for payment under continuation of coverage under the prior plan.
2. **Deductible.** This Plan will allow credit toward the deductible for any portion of the calendar year deductible that the covered person satisfied under the prior plan.

## PRIVACY RIGHTS UNDER HIPAA

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) requires that the Plan protect the confidentiality of your private health information. A description of your privacy rights under HIPAA can be found in the Plan's Notice of Privacy Practices provided upon enrollment.

**Uses and Disclosures of Protected Health Information (PHI)**
This Plan will not use or disclose your individually identifiable health information protected by HIPAA ("protected health information") except as necessary for treatment, payment, and other health care operations, or as permitted or required by law. The Plan also requires all of its business associates (as that term is defined by HIPAA) to observe HIPAA's privacy requirements.

The Plan also may use or disclose protected health information about individuals covered under the Plan in communications with family members involved in the care or payment of health care of that individual, if relevant to such involvement. In addition, the Plan may disclose protected health information if required by law or for certain public health and national priority purposes, including: (1) as authorized and necessary to comply with workers' compensation laws, (2) in response to a subpoena or other valid legal process, (3) to health oversight agencies and public health authorities, and (4) to authorized government officials for intelligence and national security activities authorized by law.

**Disclosure Protected Health Information ("PHI") to Plan Sponsor**
The Plan will disclose (or require the Plan Supervisor to disclose) PHI to the Plan Sponsor only to permit the Plan Sponsor to carry out plan administration functions for the Plan not inconsistent with the requirements of HIPAA. Any disclosure to and use by the Plan Sponsor will be subject to and consistent with the restrictions set forth below.

**Restrictions on Plan Sponsor's Use and Disclosure of ("PHI")**
1. The plan sponsor will neither use nor further disclose Member's PHI, except as permitted or required by the Plan Documents, as amended or required by law.
2. The Plan Sponsor will ensure that any agent, including any subcontractor, to whom it provides Member PHI agrees to the restrictions and conditions of the Plan, with respect to Member's PHI.
3. The Plan sponsor will not use or disclose Member PHI for employment-related actions or decisions or in connection with any other benefit or Employee benefit plan of the Plan Sponsor.
4. The Plan Sponsor will report to the Plan any use or disclosure of Member PHI that is inconsistent with the uses and disclosures allowed under this section promptly upon learning of such inconsistent use or disclosure.
5. The Plan Sponsor will make PHI available to the Member who is the subject of the information in accordance with HIPAA.
6. The Plan Sponsor will make Member PHI available for amendment, and will on notice amend Member PHI, in accordance with HIPAA.
7. The Plan Sponsor will track disclosures it may make of Member PHI so that it can make available the information required for the Plan to provide an accounting of disclosures in accordance with HIPAA.
8. The Plan Sponsor will make its internal practices, books, and records, relating to its use and disclosure of Member PHI, to the Plan and to the U.S. Department of Health and Human Services to determine compliance with HIPAA.
9. The Plan Sponsor will, if feasible, return or destroy all Member PHI, in whatever form or medium (including in any electronic medium under the Plan Sponsor's custody or control), received from the Plan, including all copies of and any data or compilations derived from and allowing identification of any Member who is the subject of the PHI, when the Member's PHI is no longer needed for the plan administration functions for which the disclosure was made. If it is not feasible to return or destroy all Member PHI, the Plan Sponsor will limit the use or disclosure of

any Member PHI it cannot feasibly return or destroy to those purposes that make the return or destruction of the information infeasible.

10. The Plan Sponsor will implement administrative, physical, and technical safeguards that reasonably and appropriately protect the confidentiality, integrity, and availability of the electronic PHI that Plan Sponsor creates, receives, maintains, or transmits on behalf of the Plan.
11. The Plan Sponsor will ensure that any agent, including a subcontractor, to whom Plan Sponsor provides electronic PHI (that Plan Sponsor creates, receives, maintains or transmits on behalf of the Plan), agrees to implement reasonable and appropriate security measures to protect this information.
12. The Plan Sponsor shall report any security incident of which it becomes aware to the Plan as provided below:
    a. In determining how and how often the Plan Sponsor shall report security incidents to the Plan, both Plan Sponsor and Plan agree that unsuccessful attempts at unauthorized access or system interference occur frequently and that there is no significant benefit for data security from requiring the documentation and reporting of such unsuccessful intrusion attempts. In addition, both parties agree that the cost of documenting and reporting such unsuccessful attempts as they occur outweigh any potential benefit gained from reporting them. Consequently, both Plan Sponsor and Plan agree that this Agreement shall constitute the documentation, notice and written report of any such unsuccessful attempts at unauthorized access or system interference as required above and by 45 CFR Part 164, Subpart C and that no further notice or report of such attempts will be required.
    b. Plan Sponsor shall, however, separately report to the Plan (i) any successful unauthorized access, use, disclosure, modification or destruction of the Plan's electronic PHI of which Plan Sponsor becomes aware if such security incident either results in a breach of confidentiality, results in a breach of integrity but only if such breach results in a significant, unauthorized alteration or destruction of the Plan's electronic PHI, or results in a breach of available of the Plan's electronic PHI, but only if said breach results in a significant interruption to normal business operations. Such reports will be provided in writing within ten (10) business days after Plan Sponsor becomes aware of the impact of such security incident upon the Plan's electronic PHI.
13. Adequate separation between the Plan Sponsor and the Plan will be achieved by giving access to Member PHI to certain classes of employees under the control of the Plan Sponsor. Protected health information may be disclosed to and used by human resources, benefits, finance/accounting and information technology employees of the Employer who are responsible for carrying out administrative functions for the Plan – for example, benefit determinations, benefit payments, and claims audits. However, these employees will only have access to the information on a "need to know" basis and will use and disclose only the minimum necessary protected health information to accomplish the intended Plan administration purpose. Plan Sponsor has implemented procedures for handling non-compliance.

## YOUR RIGHTS UNDER ERISA

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

**Receive Information about Your Plan and Benefits**

- Examine, without charge, at the Plan Administrator's office, all documents governing the Plan, including insurance contracts, and a copy of the latest Annual Report (form 5500 series) filed by the Plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Pension and Welfare Benefits Administration.

- Obtain, upon written request to the Plan Administrator, copies of all documents governing the operation of the Plan, including insurance contracts, and copies of the latest Annual Report (form 5500 series) and updated summary plan description. The Plan Administrator may make a reasonable charge for the copies.

- Receive a summary of the Plan's Annual Financial report. The Plan Administrator is required by law to furnish each participant with a copy of this summary annual report.

**Continue Plan Coverage**

- Continue health care coverage for yourself, your spouse, or dependents if there is a loss of coverage under the Plan as a result of a qualifying event. You or your dependents will have to pay for such coverage.

**Prudent Actions by Plan Fiduciaries**

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

**Enforce Your Rights**

If your claim for a benefit is denied or ignored, in whole or in part, you have the 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 that you can take to enforce your rights. For instance, if you request a copy of the Plan Document or the latest Annual Report from the Plan and do not receive them within 30 days, you may sue in federal court. In that event, the court may require the Plan Administrator to provide the materials and to 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 Plan Administrator. If you have a claim for benefits, which is denied or ignored, in whole or in part, you may file suit in a state or federal court.

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 a federal court.

In the event that the Plan fiduciaries misuse the Plan's money, or if a plan participant is discriminated against for asserting his or her rights, he or she may seek assistance from U.S. Department of Labor or may file suit in a federal court. The court will decide who should pay court costs and legal fees. If the plan participant is successful, the court may order the person sued to pay the costs and fees. If the plan

participant loses the suit, the court may order him or her to pay the costs and fees (for example, if the court finds the claim or suit to be frivolous).

**Assistance with Your Questions**

If you have any questions about the Plan, you should contact the Plan Administrator. If you have any questions about this statement or your rights under ERISA, or if you need assistance in obtaining documents from the Plan Administrator, you should contact either the nearest area office of the Pension and Welfare Benefits Administration of the U.S. Department of Labor listed in the telephone directory or the Division of Technical Assistance and Inquires of the Pension and Welfare Benefits Administration, U.S. Department of Labor, 200 Constitution Avenue, NW, Washington, DC 20210. You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefits Security Administration.

**OUT-OF-NETWORK DIALYSIS BENEFIT PROGRAM**

A. Purpose. Effective on and after the Amendment Effective Date set forth in the Adoption Agreement, the Out-of-Network Dialysis Benefit Program ("Dialysis Benefit Program") shall be the exclusive terms and means for administering the Dialysis Benefit Program and shall replace and supersede any conflicting Plan provisions or conflicting provisions in the Medical Booklets and/or ASAs; provided, however, that the cost-sharing terms (such as deductibles and coinsurance requirements), medical necessity terms and other noncontradictory terms of the Plan and the Medical Booklets shall continue to apply to out-of-network, outpatient dialysis-related claims as designated by the Plan Administrator and set forth in the Plan and Medical Booklets. Specifically, the Plan does not provide in-network benefits for outpatient dialysis charges and there are no in-network providers of outpatient dialysis treatment. Such outpatient dialysis charges or treatment will be covered only as out-of-network benefits by an out-ot-network provider and the Dialysis Benefit Program shall apply to all out-of-network, outpatient dialysis-related claims received by the Plan, or its Third-Party Administrator as filed by, or on behalf of, Plan participants, regardless of:

1. the condition causing the need for dialysis;

2. the type of dialysis services or supplies provided, including but not limited to hemodialysis or peritoneal dialysis;

3. the location where dialysis treatments are provided; or

4. when the expenses related to such out-of-network, outpatient dialysis-related claims were incurred or whether previous out-of-network, outpatient dialysis-related claims for such services or supplies were received by the Plan or Third-Party Administrator with respect to the Plan participant, provided the expense was incurred on or after the effective date of this Amendment.

For purposes of this Amendment, the term Plan participants shall include eligible employees and their eligible spouses and dependents enrolled in group medical and prescription drug coverage under the Plan.

This Dialysis Benefit Program section of the Plan, however, does not apply to inpatient dialysis-related services and supplies or to in-network dialysis-related claims that are subject to a valid network, preferred provider or other similar contracted rate agreement adopted by the Plan. Any inpatient or in-network dialysis-related services and supplies shall continue to be governed by the other terms of the Plan and Medical Booklets applicable to inpatient and in-network services as administered by the Third-Party Administrator.

B. Reasonable Value Payment. Payment under the Plan, through its Third-Party Administrator, for out-of-network, outpatient dialysis-related claims shall be limited to the "Reasonable Value Payment" amount as determined in the sole discretion of the Plan Administrator through the assistance of its Third-Party Administrator, which amount and the payment to a dialysis provider will be based on and subject to the requirements and methodology set forth in this section.

1. *Dialysis Provider and Billing*. The Plan participant's out-of-network dialysis provider, including his or her dialysis treatment clinic, must contact the Third-Party Administrator before any new out-of-network, outpatient dialysis treatments are rendered on and after the Amendment Effective Date. Payment to a dialysis provider from the Plan for all out-of-network, outpatient dialysis-related claims will be strictly limited to the Reasonable Value Payment, after subtracting any amounts payable to the dialysis provider by the Plan participant as Plan deductibles, coinsurance, copayments or similar cost-sharing requirements set forth in the Plan and the Medical Booklets; provided, however, that such cost-sharing requirements shall be computed based on the Reasonable Value Payment amount. All out-of-network, outpatient dialysis-related claims must be billed by the dialysis provider in accordance with generally accepted industry standards, applicable laws and Plan terms.

2. *Reasonable Value Payment Determination*. With respect to all out-of-network, outpatient dialysis-related claims received by the Plan for expenses incurred after the effective date of this Amendment, the Plan Administrator, in consultation with the Third-Party Administrator, shall determine the Reasonable Value Payment for such out-of- network, outpatient dialysis-related services or supplies based upon reasonably available data regarding the average payment made to or received by the same or other dialysis providers for reasonably comparable services or supplies during a preceding valuation period as determined by the Plan Administrator, in consultation with the Third-Party Administrator, regardless of whether the payor was a governmental payor, commercial insurance plan, self-funded health plan or other type of payor and regardless of whether the payment was pursuant to a network, preferred provider or other similar contracted rate. The Plan Administrator, in consultation with the Third-Party Administrator, may increase or decrease the Reasonable Value Payment to take into consideration applicable factors concerning the nature and severity of the condition being treated or adjust the Reasonable Value Payment based on other relevant factors.

3. *Appeal/Additional Information Related to the Reasonable Value Payment for Dialysis-Related Services and Supplies*. With respect to a timely and valid appeal for the reduction or denial of a dialysis-related claim, the Plan participant (or his/her validly designated representative, or assignee for receipt of payment, delegated in accordance with the terms of this Plan Document) may provide additional credible information from identified sources to the Third-Party Administrator with respect to the Reasonable Value Payment of the supplies or services for which reimbursement or payment is claimed or sought. In the event that the Plan Administrator, in consultation with the Third-Party Administrator, determines that such information demonstrates with reasonable probability that the payment for the dialysis-related claim or claims did not reflect the Reasonable Value Payment, the Plan shall increase or decrease the payments (as applicable) to the amount of the Reasonable Value Payment, as determined by the Plan Administrator, in consultation with the Third-Party Administrator, based upon such credible information from identified sources. In addition to such credible information provided by or on behalf of the Plan participant, the Plan may, but is

not required to, independently obtain, review and consider additional credible information from identified third-party sources in determining any such appeal.

In the event of an adverse benefit determination regarding Reasonable Value Payment Determinations, a claimant will be entitled to receive other relevant information. Solely for the Dialysis Benefit Program and notwithstanding anything to the contrary, proprietary information of the Third-Party Administrator shall not be considered relevant information unless required by a court order to be produced with respect to an adverse benefit determination or a non-disclosure agreement is entered between the Plan Administrator, or, to the extent delegated under the ASA, the Third-Party Administrator, (collectively referred to as "Claims Administrator") and the Plan participant (or his/her validly designated representative delegated in accordance with the terms of this Amendment, the Plan or Medical Booklets) receiving the proprietary information.

4. *Payment to Dialysis Provider*. A dialysis provider that accepts a Reasonable Value Payment from the Plan for the out-of-network, outpatient dialysis-related claim shall be deemed to consent and agree that: (i) such Reasonable Value Payment shall be for the full amount due for the provision of out-of-network, outpatient dialysis-related services and supplies to a Plan participant; (ii) the dialysis provider shall not "balance bill" or seek any additional payment from a Plan participant for any amount billed but not paid by the Plan; (iii) such Reasonable Value Payment may be made directly to the dialysis provider pursuant a Plan participant's valid assignment of payment to such provider; and (iv) the dialysis provider understands that the Plan's anti-assignment provision prohibits the Plan participant from assigning any right, demand, claim or cause of action under federal or state law, including any derivative claim under ERISA or other federal or state law, to a provider, including a dialysis provider, against the Plan, Plan Sponsor, Plan Administrator, fiduciary or Third-Party Administrator.

5. *Single Patient Agreements*. Under appropriate circumstances as determined within the sole discretion of the Plan Administrator, in consultation with the Third-Party Administrator, and when both the dialysis provider and the Plan participant agree or consent to the dialysis treatment, the Plan Administrator, on behalf of the Plan, may enter into a Single Patient Agreement with the dialysis provider establishing the rates payable for out-of-network, outpatient dialysis services or supplies; provided, however, that such Single Patient Agreement must expressly identify this Dialysis Benefit Program under the Plan and clearly state that such Single Patient Agreement is intended to supersede this Dialysis Benefit Program.

C. Administration of the Dialysis Benefit Program. The Employer and Plan have entered into an administrative service agreement (ASA) with the Third-Party Administrator for purposes of administering the health benefit and claims in accordance with the terms of the Plan and this Amendment, including, but not limited to, the Third-Party Administrator adjudicating, approving Reasonable Value Payments and managing, authorizing, utilization reviewing and other services for out-of-network, outpatient dialysis-related services and treatments.

The Plan Administrator, or, to the extent delegated under the ASA, the Third-Party Administrator (collectively referred to as "Claims Administrator"), shall have full, binding and final authority and discretion to construe, interpret, administer, enforce and apply this Amendment to out-of-network, outpatient dialysis-related claims. Specifically, the Claims Administrator shall have maximum legal discretionary authority to construe, interpret, administer, enforce and apply the terms and provisions of the Dialysis Benefit Program, to make determinations regarding issues that relate to eligibility for benefits, to decide disputes or appeals which may arise relative to a Plan participant's rights, to decide questions of interpretation and those of fact relating to the Dialysis Benefit Program, and to decide the Reasonable Value Payment amount for all out-of-network, outpatient dialysis-related claims. Benefits under this Dialysis Benefit Program shall be paid only if the Claims Administrator decides in its sole discretion that a Plan participant is entitled to such benefits. The Plan participant, and any dialysis provider that has an assignment of the right to receive payment, specifically acknowledge and agree that the Plan has a fiduciary right to bring an equitable reimbursement recovery action or restitution action under Section 502(a)(3) of ERISA should the Plan participant or dialysis provider be paid or obtain payment in an amount determined to be in excess of the Reasonable Value Payment for out-of-network, outpatient dialysis-related claims. In connection with such action, the Plan participant and dialysis provider specifically acknowledge and agree that the Plan shall have an equitable lien on any amount determined to be in excess of the Reasonable Value Payment for out-of-network, outpatient dialysis-related claims. This equitable lien shall apply to and attach to all property and any other tangible and intangible assets of the Plan participant or dialysis provider. The Plan participant and dialysis provider further acknowledge and agree that the Plan has the right to obtain injunctive relief prohibiting the Plan participant or any dialysis provider from obtaining payment for or retaining payment of an amount in excess of the Reasonable Value Payment for out-of-network, outpatient dialysis-related claims. As a condition of receiving benefits or payments from the Plan, the Plan participant and any dialysis provider consent to such injunctive relief.

D. Anti-Assignment Provisions. Notwithstanding anything to the contrary in the Plan document, Medical Booklets and ASAs, no right or benefit provided for under this Dialysis Benefit Program or any of the Plan provisions will be subject in any manner to anticipation, alienation, sale, transfer, assignment, pledge, encumbrance or charge and any attempt to do so will be void. Specifically, a Plan participant may **not** assign any right, demand, claim or cause of action under federal or state law, including any derivative claim under ERISA or other federal or state law, to a provider, including a dialysis provider, against the Plan, Employer, Plan Sponsor, Plan Administrator, fiduciary or Third-Party Administrator.

However, this anti-assignment provision does not and will not be construed to restrict or forfeit any subrogation rights of the Employer under the Plan. If authorized in writing by a Plan participant, the Plan reserves the right to pay benefits, in its sole discretion, directly to a provider of services, instead of to the Plan participant, as a convenience to the Plan participant. In such event, the Employer shall be relieved of all further responsibility with respect to that particular expense. A Claims Administrator's review, under the Plan's claims review and appeal procedures, of a dialysis-related claim directly with a dialysis provider, as the designated representative of the Plan participant, is not intended, and shall not be construed as a waiver of these anti-assignment provisions.

E. Secondary Coverage. Plan participants who are eligible for secondary coverage from or by any other health plan are encouraged to obtain such coverage. Failure to obtain secondary coverage may result in the Plan participant incurring costs that are not covered by the Plan and that would otherwise be covered by the secondary coverage. The Plan will not pay for any costs which would have been payable by such secondary coverage, except to the extent that such costs are payable in any event by the Plan.

If a Plan participant becomes eligible for Medicare based solely on End Stage Renal Disease ("ESRD"), the Plan will pay as primary for the Medicare three-month waiting period and 30-month coordination period beginning with the month in which the Plan participant could have been enrolled in Medicare had timely application for Medicare been made ("Medicare coordination period").

After the Medicare coordination period has ended, Medicare shall become the primary payer and this Plan will be the secondary payer, for as long as the Plan participant retains eligibility based on ESRD, even if the Plan participant also becomes eligible for Disability or Working Aged Medicare. If the ESRD-based eligibility ends, then the Disability or Working Aged Medicare rules apply as set forth in the Plan document (i.e., the Plan will pay as primary with Medicare paying as secondary when ESRD-based Medicare terminates, and the Plan participant is still working for the Employer with Disability or Working-Aged Medicare).

The following special coordination rule applies after the Medicare coordination period has ended:

The Plan will pay as secondary payer and Medicare will pay as primary payer for dialysis-related services or claims of a Plan participant who has actually enrolled in Medicare. If a Plan participant is not enrolled in Medicare, the Plan will continue to pay as primary payer, subject to Plan terms, for such dialysis-related services or claims until such time as the Plan participant actually enrolls in any Medicare option.

Notwithstanding anything to the contrary, the Dialysis Benefit Program and other Plan terms are intended to and are administered to comply with the Medicare Secondary Payer Act. Specifically, the terms of the Dialysis Benefit Program adopted by the Plan does not and is not intended to take into account that a Plan participant is eligible for or entitled to Medicare benefits on the basis of ESRD during the Medicare coordination period, and does not and is not intended to differentiate in Plan benefits between Plan participants who have ESRD and Plan participants who need dialysis but do not have ESRD (i.e., Plan participants with ESRD are treated the same during the Medicare coordination period under the Dialysis Benefit Program as other Plan participants who do not have ESRD, but are receiving Plan benefits under the Dialysis Benefit Program).

F. Exclusions and Limitations. The general exclusions and limitations section of the Plan and Medical Booklets are hereby amended to provide that no benefit shall be payable with respect to out-of-network, outpatient dialysis-related services or claims other than as covered or provided under the Dialysis Benefit Program described in this Amendment