SouthCoast Medical Group, LLC dba SouthCoast Health Employee Benefit Plan

Master Plan Document & Summary Plan Description

PPO Plan / HDHP Plan

Plan Revision Date: 01/01/24

Plan Effective Date: 01/01/13

Last Admendment Date: 01/01/25

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INTRODUCTION

This document is the Master Plan Document & Summary Plan Description (the "**SPD**") for the self-funded SouthCoast Medical Group, LLC dba SouthCoast Health Employee Benefit Plan (the "**Plan**"). The **Plan** is designed and maintained by SouthCoast Medical Group, LLC dba SouthCoast Health (referred to as "**Employer**" or "**Plan Sponsor**" or "**Plan Administrator**") to provide healthcare benefits in the event of **Injury** or **Illness** to covered **Employees** and covered **Dependents** (hereinafter collectively, "**Members**" or individually, a "**Member**"). Coverage under the **Plan** for **Members** will become effective when the **Members** satisfy the waiting period and all the eligibility requirements of the **Plan** outlined in Eligibility.

Words found in the body of this **SPD** (i.e., not in headings) which are Capitalized in **Bold** are further defined in Definitions. Underlined Phrases refer to particular sections in this **SPD** where additional information is found. Timeframes set forth in days shall be determined using calendar days unless the context or **Applicable Law** (hereinafter defined) clearly compels otherwise.

The **Plan** uses an **In-Network Provider** network. The **In-Network Provider** network is a group of **Providers** (**Physicians**, **Hospitals**, other healthcare professionals, and **Facilities**) contracted to offer healthcare services at reduced rates to **Members**. At any time, **Members** will be able to choose from the list of **In-Network Providers**, or they may obtain healthcare from an **Out-of-Network Provider**. When a **Member** uses an **In-Network Provider**, the **Plan** will pay a larger portion of the **Covered Healthcare Expenses**. As a result of the lower contracted rates, the higher benefit rate paid by the **Plan**, and the contractual agreement not to **Balance Bill**, the **Member** will save on healthcare expenses when using an **In-Network Provider**. However, the **Member** will always have the option to choose any healthcare **Provider**. If **Members** choose to use an **Out-of-Network Provider**, there is an increased risk of **Balance Billing**. In the event an **In-Network Provider** attempts to **Balance Bill** a **Member**, please contact the **Plan Supervisor** immediately.

Members should review this **SPD** carefully, especially the sections pertaining to Care Management Requirements 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 **Precertified** in order for the **Member** to receive the maximum benefit; if these services are not **Precertified**, benefits will be paid at a lower rate and a penalty may apply.

SouthCoast Medical Group, LLC dba 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 **Members** are limited to covered charges incurred before the modification, amendment, or termination. *See*, Plan Amendments and Termination in General Information. No benefit contained herein shall be considered vested, and benefits shall only be available during the time in which the **Member** is entitled to benefits under this **Plan**. The failure of SouthCoast Health to insist upon the strict observation or performance as set forth in this **SPD** or to exercise any right or remedy will not be construed as a waiver to insist upon the strict observation or performance of this **SPD** or impair or waive any available right or remedy.

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. If any provision, term, or condition (or the application thereof) of this **Plan** is found by a court of competent jurisdiction to be invalid under, inconsistent with, or in conflict with the provisions of any applicable statute, law, or decision of law, then such invalidity, conflict, or inconsistency shall be deemed modified by such statute, law, or decision of law so as to conform thereto, and such invalidity, conflict, or inconsistency shall not be deemed to affect, impair, invalidate, or nullify the remainder of this **Plan**, which shall remain in full force and effect.

PLAN INFORMATION

EMPLOYER ID NUMBER: 58-2194871

PLAN NUMBER: 501

PLAN EFFECTIVE DATE: 1/1/13

PLAN REVISION DATE: 1/1/24 (Added amend. 1.24 eff. 1/1/24: Added amend. 1.25 eff. 1/1/25)

EMPLOYEE GROUPS COVERED IN THIS SUMMARY.
This **SPD** applies to all eligible **Employees** of SouthCoast Medical Group, LLC dba SouthCoast Health and its participating subsidiaries. *See*, Eligibility.

EMPLOYER / PLAN SPONSOR / PLAN ADMINISTRATOR:

SouthCoast Medical Group, LLC dba 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
(980) 201-3020

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**, **Copayment**, and **Out-of-Pocket Limit** information is maintained on a calendar year basis. Instances where the word "year" is found in this **SPD** shall mean calendar year unless the context indicates otherwise. *See, e.g.,* **Deductible** and Schedule of Benefits.

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 services provided by 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**. The **Plan Supervisor's** ministerial processing of initial **Claims** is done within a framework of established policies, interpretations, rules, practices, and procedures. The **Plan Supervisor** does not accept fiduciary status, and no party shall appoint the **Plan Supervisor** as a fiduciary.

PLAN BENEFITS.
The **Plan** is an employee welfare benefits plan providing healthcare benefits pursuant to **ERISA**, as amended. The **Plan** provides benefits only for those **Covered Healthcare Expenses** specifically listed in this **SPD**. *See*, Schedule of Benefits and Covered Expenses. No benefit contained herein shall be considered vested, and benefits shall only be available during the time in which the **Member** is entitled to benefits under this **Plan**.

FUNDING.
The **Plan** is funded by contributions from the **Plan Sponsor** and **Members**. The **Plan Sponsor** determines the level of contributions required, if any, from each **Member** 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 Medical Group, LLC dba SouthCoast Health
Privacy Official
330 Benfield Drive
Savannah, Georgia 31406

GENERAL INFORMATION

PLAN AMENDMENTS AND TERMINATION.

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

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

ASSIGNMENT OF BENEFITS.

Benefits under the **Plan** may not be voluntarily or involuntarily assigned or alienated, provided that payment of benefits of a **Member** will be made directly to a **Physician**, **Hospital**, or other **Provider** furnishing services if: (i). the **Physician**, **Hospital**, or other **Provider** agrees to accept the payment directly as full reimbursement; or, (ii). the **Member** (or **Authorized Representative**) has executed a valid assignment of the right to receive payment of benefits due under the **Plan** to such **Physician**, **Hospital**, or other **Provider**. 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**. A valid assignment of the right to receive payment under the terms of the **Plan** shall not constitute a valid assignment of any other rights relating to this **Plan** including, but not limited to, the right to: file **Claim(s)**; request documents relating to a **Benefit Determination**; file an appeal; request an external review; or, enforce rights or institute litigation.

An assignment of benefits by a **Claimant** is generally limited to assignment of the **Claimant's** right to receive a benefit payment under the terms of the **Plan**. Typically, assignments are not a grant of authority to act on a **Claimant's** behalf as an **Authorized Representative** in pursuing and appealing a **Benefit Determination** under the **Plan**. In addition, the validity of a designation of an **Authorized Representative** will depend on whether the designation has been made in accordance with the procedures established by the **Plan**. *See*, Designating an Authorized Representative in Filing Claims.

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, 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:

1. Require that the **Member** or the person or entity that was paid return the amount of the overpayment; or,
2. Reduce any future benefit payments to the **Member** 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 **Plan** will allow credit toward the **Deductible** for any portion of the calendar-year **Deductible** that the **Member** satisfied under the prior plan. 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.

DEFINITIONS

Capitalized and **Bolded** terms that are used in the body of 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 or **ACCIDENTALLY INJURED**
Accidental Injury or **Accidentally Injured** is an immediate, unforeseen event caused by an external trauma to the body of a **Member**, which is unrelated either directly or indirectly to all other causes and which requires treatment by a **Physician**.

ADVERSE BENEFIT DETERMINATION - *see,* **Benefit Determinations** in Definitions.

AIRCRAFT
Aircraft means any contrivance now known, or hereafter invented, used or designed for navigation of or flight in the air.

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:

1. Is equipped and operated primarily for the purpose of performing surgical procedures;
2. Provides continuous service of **Physicians** and registered professional nurses whenever a patient is in the **Facility**; and,
3. 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.

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; or,
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 healthcare professional is an **In-Network Provider** and has concluded that the **Member's** participation in such trial would be appropriate; or,
2. The **Member** provides medical and scientific information establishing that the **Member's** participation in such trial would be appropriate.

AUTHORIZED REPRESENTATIVE
An **Authorized Representative** is an individual authorized to act on the **Claimant's** behalf in pursuing a **Claim** or appeal in accordance with procedures established by the **Plan**. For purposes of an **Urgent Care Claim**, a **Physician** or other health care professional licensed, accredited, or certified to perform specified health services consistent with State law with knowledge of the **Member's** condition shall be permitted to act as the **Authorized Representative** of the **Claimant**.

An assignment of benefits by a **Claimant** is generally limited to assignment of the **Claimant's** right to receive a benefit payment under the terms of the **Plan**. Typically, assignments are not a grant of authority to act on a **Claimant's** behalf in pursuing and appealing a **Benefit Determination** under the **Plan**. In addition, the validity of a designation of an **Authorized Representative** will depend on whether the designation has been made in

accordance with the procedures established by the Plan. *See*, Designating an Authorized Representative in Filing Claims.

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.

BENEFICIARY

Beneficiary means a person designated by a **Member**, or by the terms of the **Plan**, who is or may become entitled to a benefit thereunder.

BENEFIT DETERMINATION

A **Benefit Determination** is a determination for benefits, whether adverse or not, under the **Plan**. Specific **Benefit Determinations** include:

1. An **Adverse Benefit Determination** means a denial, reduction, or termination of, or a failure to provide or make payment (in whole or in part) for, a benefit, including any such **Member's** eligibility to participate in the **Plan**.
2. An **Initial Benefit Determination** is a **Benefit Determination** made on a **Claim**.
3. A **Level One Appeal Determination** is a **Benefit Determination** made on a Level One Appeal.
4. A **Level Two Appeal Determination** is a **Benefit Determination** made on a Level Two Appeal.
5. A **Final Internal Benefit Determination** is the final **Benefit Determination** made by the **Plan** using internal processes.

CHIPRA

CHIPRA stands for the Children's Health Insurance Program Reauthorization Act of 2009, as amended.

CLAIM

A **Claim** is any request for a **Plan** benefit, made by a **Claimant** or by an **Authorized Representative** of a **Claimant**, that complies with the **Plan's** procedures for making **Claims** for benefits. For purposes of an **Urgent Care Claim**, a **Physician** or other health care professional licensed, accredited, or certified to perform specified health services consistent with State law with knowledge of the **Member's** condition shall be permitted to act as the **Authorized Representative** of the **Claimant**. For purposes of this definition as it relates to non-**Urgent Care Claims**, a request for a **Plan** benefit made by a **Physician**, **Hospital**, or other **Provider** furnishing services to a **Member**, regardless of whether accompanied by an authorization, assignment, or other instrument purporting to assign benefits under the **Plan**, shall not constitute a **Claim** made by a **Claimant** or by an **Authorized Representative** of a **Claimant** without the written consent of the **Plan Sponsor**. In the event written consent is given, it shall only be effective as to the filing of said **Claim** and shall not amount to a waiver of any other provision(s) contained herein. **Claims** include, but are not limited to:

1. **Post-Service Claims** are any **Claims** filed for payment of benefits after medical care has been received.
2. **Pre-Service Claims** are **Claims** 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* Care Management Requirements.
3. **Concurrent Care Claim** - There are two (2) types of **Concurrent Care Claims**:
    a. A **Concurrent Care Claim** to extend coverage for a course of treatment beyond a previously approved period of time or number of treatments.
    b. A **Concurrent Care Claim** regarding reduction or termination of coverage by the **Plan** before the end of a previously approved period of time or number of treatments.
4. 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 **Member** or the ability

of the **Member** to regain maximum function, or, in the opinion of the attending or consulting **Physician**, would subject the **Member** 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 **Member'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.

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**.

CLAIMANT
A **Claimant** is any **Member** or **Beneficiary** making a **Claim** for benefits.

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

COBRA CONTINUATION COVERAGE
COBRA Continuation Coverage is health coverage that is required to be offered under **COBRA** in certain circumstances in which an employee or other individual covered under a health plan loses eligibility for coverage under that health plan (for example, because the employee terminates employment or has a reduction in hours).

COINSURANCE RATE or **COINSURANCE**
Coinsurance Rate or **Coinsurance** is the rate or percentage of costs of a **Covered Healthcare Expense** that a **Member** pays after the **Deductible** and/or **Copay** has been met, subject to any applicable maximums.

CONCURRENT CARE CLAIM - *see,* **Claim** in Definitions.

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.

CONTRACEPTIVES
Contraceptives are devices or drugs serving to prevent pregnancy. Coverage for **Contraceptives** is established by the **USPSTF** and includes, as prescribed by a health care **Provider** for women with reproductive capacity (excluding abortifacient drugs): **FDA**-approved **Contraceptive** methods, sterilization procedures, and patient education and counseling. This does not apply to health plans sponsored by certain exempt "religious employers".

COPAY or **COPAYMENT**
Copay or **Copayment** is the amount that the **Member** is required to pay directly to the **Physician**, **Hospital**, or other **Provider** each time the **Member** receives services. The **Copay** is separate from and does not accrue towards the **Deductible**.

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 HEALTHCARE EXPENSES

Covered Healthcare Expenses are expenses for healthcare provided to a **Member** of the **Plan** and for which coverage is available under the **Plan**. For listings, *see* Schedule of Benefits and Covered Expenses. Benefits for **Covered Healthcare Expenses** are subject to all the terms, conditions and limitations of the **Plan**. Depending on the benefits provided for under the **Plan**, **Covered Healthcare Expenses** may include:

1. **Covered Medical Expenses** are medical expenses provided to a **Member** of the **Plan** and for which coverage is available under the **Plan**. For listings, *see* Covered Medical Expenses in Covered Expenses, Medical Benefits in Schedule of Benefits, and Medical Exclusions; and,
2. **Covered Prescription Expenses** are prescription drug expenses provided to a **Member** of the **Plan** and for which coverage is available under the **Plan**. For listings, *see* Covered Prescription Drug Expenses in Covered Expenses, Prescription Drug Benefits in Schedule of Benefits, and Prescription Drug Exclusions.

CUSTODIAL CARE

Custodial Care refers to services and supplies, including room and board and other institutional services, which are provided to a **Member**, whether disabled or not, primarily to assist them 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 or **Individual Deductible** is the amount before **Coinsurance** that a **Member** must pay for certain **Covered Healthcare Expenses** during the year.[2] The **Deductible** is separate from **Copayments**. **Individual Deductible** and **Family Deductibles** apply under this **Plan**. Specific **Deductibles** include:

1. The **Family Deductible** is satisfied when the sum of all **Deductible** payments for covered family members meets the **Family Deductible** amount. Any **Covered Healthcare Expenses** incurred by any covered family member after the **Family Deductible** is satisfied will be paid at the **Coinsurance Rate** up to applicable **Plan** limits for the remainder of the year.[2]

[2] "year" as set forth in Plan Year / Calendar Year in Plan Information.

DENTAL SERVICES

Dental Services are procedures involving the teeth, gums, or supporting structures.

DEPENDENT

A **Dependent** is a child or relative of an **Employee** eligible to participate in the **Plan** who satisfies the requirements outlined in Eligibility. A "covered **Dependent**" is a **Dependent** who is covered under the **Plan**.

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 a **Member** is covered by the **Plan**.

ELIGIBILITY DATE

Eligibility Date is the date on which an **Employee** and/or **Dependent** becomes eligible to participate in the **Plan** by satisfying the requirements outlined in Eligibility.

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

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**.

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.

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.

1. An "eligible **Employee**" is an **Employee** who satisfies the requirements outlined in <u>Eligibility</u>.
2. A "covered **Employee**" is an **Employee** or former employee of the **Employer** who is covered under the **Plan**.

3. A "**Retired Employee**" is an **Employee** who satisfies one of the following factors for retirement, which begins on the first day on which retirement benefits become effective under any of the following:
   a. 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**;
   b. Any plan which the **Employer** sponsors;
   c. Any plan to which the **Employer** makes contributions or has made contributions; or,
   d. 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 a **Retired Employee**.

EMPLOYER
Employer is SouthCoast Medical Group, LLC dba 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**.

ERISA
ERISA means the Employee Retirement Income Security Act of 1974, as amended.

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 **Experimental or Investigational** if any of the following conditions are met:

1. The treatment is governed by the **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, or III clinical trials as defined by the National Institute of Health, National Cancer Institute or **FDA** and is not an **Approved Clinical Trial**; or,
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.

FAMILY DEDUCTIBLE - *see,* **Deductible** in Definitions.

FDA
FDA means the Food and Drug Administration.

FINAL INTERNAL BENEFIT DETERMINATION - *see,* **Benefit Determination** in Definitions.

FORMULARY DRUGS
Formulary Drugs mean the list of FDA-approved prescription drugs and supplies developed by the **PBM's** Pharmacy and Therapeutics Committee and which is selected and/or adopted by the **Plan** on behalf of its **Members**. The drugs and supplies included as **Formulary Drugs** will be modified by the **PBM** from time to time as a result of factors, including, but not limited to, medical appropriateness, manufacturer rebate arrangements, and patent expirations. Additions and/or deletions to the list of **Formulary Drugs** are hereby adopted by the **Plan**.

HIPAA
HIPAA means the Health Insurance Portability and Accountability Act of 1996, as amended.

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; and,
4. It has a full-time administrator and maintains written records of services provided to the patient.

HOSPITAL
A **Hospital** is an institution that fully meets all 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 R.N. services;
3. It is recognized as a hospital by the Joint Commission on Accreditation of Hospitals; and,
4. It charges fees for its services.

Neither the term **Hospital** nor 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.

INDIVIDUAL DEDUCTIBLE - *see,* **Deductible** in Definitions.

INITIAL BENEFIT DETERMINATION - *see,* **Benefit Determination** in Definitions.

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 **Member**.

IN-NETWORK BENEFITS
In-Network Benefits are benefits provided by **In-Network Providers**.

IN-NETWORK PROVIDERS - *see,* **Providers** in Definitions.

INPATIENT
Inpatient refers to medical care, treatment, services, or supplies received that requires admission to a **Hospital** or **Facility** for overnight stay.

LEGAL SEPARATION
Legal Separation includes, but is not limited to, spouses who:

1. Enter into a valid separation agreement; or,
2. Obtain any judicial decree whose ultimate purposes is to affect the legal status of the parties as spouses under the laws of any state.

LEVEL ONE APPEAL DETERMINATION - *see,* **Benefit Determination** in Definitions.

LEVEL TWO APPEAL DETERMINATION - *see,* **Benefit Determination** in Definitions.

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 or **MEDICAL NECESSITY**
Care and treatment is **Medically Necessary** (or is a **Medical Necessity**) 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 **Member's** medical record;
6. If an **Inpatient** procedure, it could not have been adequately performed in an **Outpatient Facility**; and,
7. It is not primarily for the convenience of the patient, **Physician** or other healthcare **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 the **Plan Supervisor**.

MEMBER
Member is an **Employee**, **Dependent**, or any other person who is eligible, satisfies the requirements outlined in Eligibility, and is enrolled in the **Plan**. No **Member** may be covered by the **Plan** prior to their **Effective Date** or after the date their coverage under the **Plan** ends.

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, 10th Revision, Clinical Modification (ICD-10-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.

MOTOR VEHICLE
A **Motor Vehicle** is any **Vehicle** that is self-propelled and every **Vehicle** designed to run upon the highways which is pulled by a self-propelled **Vehicle**, but does not include any **Vehicle**, locomotive, or car operated exclusively on a rail or rails, or a trolley bus operated by electric power derived from a fixed overhead wire furnishing local passenger transportation.

NMHPA
NMHPA means the Newborns' and Mothers' Health Protection Act of 1996, as amended.

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**.

NON-PARTICIPATING PROVIDERS - *see,* **Providers** in Definitions.

OUT-OF-AREA BENEFITS
Out-of-Area Benefits are paid at the in-network benefit level and 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 Services**. *See,* Out-Of-Area Benefits in Schedule of Benefits.

OUT-OF-NETWORK BENEFITS
Out-of-Network Benefits are benefits provided by **Out-of-Network Providers**.

OUT-OF-NETWORK PROVIDERS - *see,* **Providers** in Definitions.

OUT-OF-POCKET LIMIT
Except for expenses expressly disallowed, the **Out-of-Pocket Limit** is the maximum amount that a **Member** must pay for **Covered Healthcare Expenses** during the year.[2] The **Plan** has annual individual **Out-of-Pocket Limits** as well as annual family **Out-of-Pocket Limits**.

[2] "year" as set forth in Plan Year / Calendar Year in Plan Information.

OUTPATIENT
Outpatient refers to medical care, treatment, services, or supplies received without being admitted to a **Hospital** or **Facility** for overnight stay.

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 **Members**.

PARTICIPATING PROVIDERS - *see,* **Providers** in Definitions.

PBM
PBM stands for Pharmacy Benefit Manager.

PHYSICIAN
The term **Physician** means 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 CRNAs), 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 **Physicians**.

> A **Primary Care Physician** or **PCP** is a **Physician** specializing in general practice, family practice, pediatrics, obstetrics or gynecology, and internal medicine when performing primary care chosen by the **Member** 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**.

PLAN
The **Plan** is the SouthCoast Medical Group, LLC dba SouthCoast Health Employee Benefit Plan.

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
Plan Allowance shall be the lesser of:

1. Actual charge billed; or,
2. A percentage of Medicare as determined in the **Plan Administrator's** sole discretion.

Charges in excess of the **Plan Allowance** will not be considered **Covered Healthcare Expenses** under this **Plan**, and the **Plan Administrator** has the discretionary authority to decide whether a charge meets the **Plan Allowance**. A complete listing of the **Plan Allowance** charges is located at https://providers.healthgram.com/planallowance.cfm.

PLAN SPONSOR
Plan Sponsor means SouthCoast Medical Group, LLC dba SouthCoast Health, the **Employer** who established this **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 initial **Claims**. The services provided by 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**. The **Plan Supervisor's** ministerial processing of initial **Claims** is done within a framework of established policies, interpretations, rules, practices, and procedures.

PLAN YEAR
Plan Year shall mean the date range set forth in Plan Year / Calendar Year in Plan Information.

POST-SERVICE CLAIM - *see,* **Claim** in Definitions.

PRECERTIFICATION or **PRECERTIFIED** – *see*, Precertification in Schedule of Benefits.

PRE-SERVICE CLAIM - *see,* **Claim** in Definitions.

PREVENTIVE SERVICES
Preventive Services are those specified minimum preventive services required without cost sharing requirements under § 2713 of the Public Health Service Act, as added by the Affordable Care Act and incorporated into **ERISA**. For a list of covered **Preventive Services**, *see* https://www.healthcare.gov/coverage/preventive-care-benefits/. For additional information and limitations, *see* https://www.uspreventiveservicestaskforce.org/.

PRIMARY CARE PHYSICIAN - *see,* **Physician** in Definitions.

PRIMARY CARE SERVICES
The **Plan** encourages the selection of a **Primary Care Physician** at the time of enrollment in the **Plan**. The benefits listed in Primary Care Services (in Schedule of Benefits) apply only when provided in the office of a **Primary Care Physician**. **Plan Allowance** limitations may apply. *See*, Schedule of Benefits.

PROSTHETIC DEVICE
A **Prosthetic Device** is a device that is surgically inserted or physically attached to the body to restore a bodily function or replace a physical portion of the body.

PROSTHESIS
A **Prosthesis** is an artificial part that is worn to restore a bodily function or replace a physical portion of the body.

PROTECTED HEALTH INFORMATION (“PHI”)

Protected Health Information (“PHI”), as defined by **HIPAA**, means individually identifiable health information including demographic information collected from an individual, that:

1. Is created or received by a health care provider, health plan, employer, or health care clearinghouse; and,
2. Relates to the past, present, or future physical or mental health or condition of an individual; the provision of health care to an individual; or, the past, present, or future payment for the provision of health care to an individual; and,
   a. that identifies the individual; or,
   b. with respect to which there is a reasonable basis to believe the information can be used to identify the individual.

PROVIDERS

Providers are **Physicians** who are authorized to practice medicine or surgery (as appropriate) by the State in which the **Physician** practices, or any other person or entity determined by the **Plan** to be capable of providing health care services (including, but not limited to, **Physicians**, **Hospitals**, and other healthcare professionals and **Facilities**). Whether one is authorized to practice as used in this definition means that the **Provider** must be authorized to diagnose and treat physical or mental health conditions. For purposes of the **Plan**, **Providers** can be:

1. **In-Network Providers** or **Participating Providers** - An **In-Network Provider** or a **Participating 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**.
2. **Out-of-Network Providers** or **Non-Participating Providers** - As outlined in 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**.

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.

REFERENCE DIAGNOSTIC LAB CHARGES

Laboratory charges incurred from independent freestanding reference labs and/or laboratory charges incurred on an **Outpatient** basis from a **Hospital** and/or **Facility**.

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.

RETIRED EMPLOYEE – *see*, **Employee** in Definitions.

SICKNESS
A **Sickness** is an **Illness** or disease of a **Member** 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(ING) DISORDER
Sleep(ing) Disorders include, but are not limited to, sleep apnea, snoring, and narcolepsy.

SPD
SPD means the Master Plan Document & Summary Plan Description.

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 or **TMJ SYNDROME**
Temporomandibular Joint Syndrome or **TMJ Syndrome** is an abnormal condition characterized by facial pain and by mandibular dysfunction usually caused by a defective or dislocated temporomandibular joint.

TRANSPLANT - *see*, Organ/Tissue Transplant Program in Care Management Requirements.

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 nurses.

URGENT CARE CLAIM - *see,* **Claim** in Definitions.

USPSTF
USPSTF means the US Preventive Services Task Force.

UTILIZATION REVIEW – *see*, Utilization Review in Care Management Requirements.

VEHICLE
Vehicle means every device in, upon, or by which any person or property is or may be transported or drawn upon a highway, including, but not limited to, a **Motor Vehicle**, excepting devices moved by human power or used exclusively upon fixed rails or tracks; provided, that for purposes of this definition, bicycles and electric assisted bicycles shall be deemed **Vehicles**. **Vehicle** shall not include a device which is designed for and invented to be used as a means of transportation for a person with a mobility impairment, or who uses the

device for mobility impairment, is suitable for use both inside and outside a building, including on sidewalks, and is limited in design to fifteen (15) miles per hour when the device is being operated by a person with a mobility impairment or who uses the device for mobility enhancement.

VESSEL

Vessel means every description of watercraft or structure, other than a seaplane on the water, used or capable of being used as a means of transportation or habitation on the water.

WHCRA

WHCRA means the Women's Health and Cancer Rights Act of 1998, as amended.

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.

SCHEDULE OF BENEFITS – PPO PLAN

MEDICAL BENEFITS

When **Injury** or **Illness** cause the **Member**, while covered under this **Plan**, to incur **Covered Medical Expenses**, the **Plan** will determine benefits according to the provisions described in this **SPD**. 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**, **Copay** or **Coinsurance** resulting in the payable benefit.
3. The benefit payable will be subject to all the terms, conditions, and limitations of the **Plan**.

PAYMENT.
Covered Medical 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's 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 Requirements have been met;
5. The service is **Medically Necessary**; and,
6. The service is not subject to an Exclusion as provided in the **Plan**.

CARE MANAGEMENT.
The **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 Medical Expenses**. *See*, Care Management Requirements.

Please note that the **Plan** is not directly involved in treatment; it 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 received. The **Member** and healthcare **Provider(s)** are responsible for making all healthcare decisions and will control the course of treatment followed.

PRECERTIFICATION.
Hospital admissions, **Outpatient** surgeries and other procedures require **Precertification**. If **Precertification** is not obtained, a penalty will apply and benefits will be reduced. *See*, Care Management Requirements and Special Provisions.

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 https://members.healthgram.com/third_party_ppopage.cfm, 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 **Non-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 Benefits** and paid at the **In-Network Benefit** level.

EMERGENCY SERVICES.
Charges for **Emergency Services** do not require **Precertification** and are covered as **In-Network Benefits**.

DEDUCTIBLE.
A **Member's Deductible** requirement will be met when **Covered Medical Expenses** paid by that **Member** during each year[2] equal the **Deductible** amount. The **Member** is responsible for paying the **Deductible**. The **Plan** will not reimburse the **Member** for this expense. **Copays**, non-covered charges, **Balance Billing** payments do not accrue toward the **Deductible**.

Deductibles	In-Network	Out-of-Network
Individual Deductible	$1,500	$3,000
Family Deductible	$3,000	$6,000

[2] "year" as set forth in Plan Year / Calendar Year in Plan Information.

COINSURANCE RATE.
Coinsurance Rate is the percentage of **Covered Medical Expenses** payable by the **Member** after the **Deductible** requirement is met. The **Coinsurance Rate** for each type of service is listed in Schedule of Benefits.

OUT-OF-POCKET LIMIT.
If the total amount of out-of-pocket expenses for **Deductibles**, **Copayments**, and **Coinsurance** meets the limit set forth below, then the **Plan** will pay one-hundred percent (100%) for any additional covered expenses incurred during the remainder of the year.[2] When an individual with family coverage has met the Individual **Out-of-Pocket Limit**, all covered expenses for that individual are paid at one-hundred percent (100%), even if the Family **Out-of-Pocket Limit** has not been met.

If a **Member** has health coverage from any other source where coordination of benefits is allowable, amounts payable by the **Member** do not accrue toward the **Out-of-Pocket Limit**.

Non-covered charges, negotiated reduction in charges, benefit reduction for failure to comply with **Precertification** and Care Management Service Requirements, **Balance Billing** amounts, and charges in excess of **Plan Allowance** do not accrue toward the **Out-of-Pocket Limit** for the year.[2]

Out-of-Pocket Limit	In-Network	Out-of-Network
Individual	$5,000	$10,000
Family	$10,000	$20,000

[2] "year" as set forth in Plan Year / Calendar Year in Plan Information.

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.

PRIMARY CARE SERVICES.

Covered Medical Expense	Payable by Member	
	In-Network	Out-of-Network (Plan Allowance May Apply)
Office visit (**PCP** Non-**Preventive Services**)	$30 **Copay** per visit	50% after **Deductible**
Office surgical procedures (PCP)	20% after **Deductible**	50% after **Deductible**

WELLNESS AND PREVENTIVE SERVICES.

Covered Medical Expense	Payable by Member	
	In-Network	Out-of-Network (Plan Allowance May Apply)
Well baby / Child care **Preventive Services*** / [1] - CDC: www.cdc.gov/vaccines/schedules/index.html	0% no **Deductible**	50% after **Deductible**
Well Adult Care **Preventive Services*** / [1] - CDC: www.cdc.gov/vaccines/schedules/index.html	0% no **Deductible**	50% after **Deductible**
Women's **Preventive Services*** / [1]	0% no **Deductible**	50% after **Deductible**
Contraceptives	0% no **Deductible**	50% after **Deductible**

* For a list of covered **Preventive Services**, *see* https://www.healthcare.gov/coverage/preventive-care-benefits/. For additional information and limitations, *see* https://www.uspreventiveservicestaskforce.org/.
[1] For additional information, *see* Special Provisions.

OTHER COVERED SERVICES. ** / ***

Covered Medical Expense	Payable by Member	
	In-Network	**Out-of-Network (Plan Allowance May Apply)**
All other services rendered by a **Physician** outside an office setting	20% after **Deductible**	50% after **Deductible**
Medically Necessary professional Ambulance service to the nearest **Hospital****	20% after **Deductible**	20% after **Deductible**
Ambulatory Surgery Center	20% after **Deductible**	50% after **Deductible**
Applied Behavioral Therapy (ABA Therapy) *Limited to 20 visits per year*[2]	20% after **Deductible**	50% after **Deductible**
Outpatient Dialysis (Hemodialysis and Peritoneal) *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.
Durable Medical Equipment For the purchase of or rental up to purchase price	20% after **Deductible**	50% after **Deductible**
Emergency Room (**Facility**)* / **	$500 **Copay** per visit	$500 **Copay** per visit
Emergency Room (**Physician**)***	20% after **Deductible**	20% after **In-Network Deductible**
Endovenous Ablation Therapy *Lifetime maximum $2,500*	20% after **Deductible**	50% after **Deductible**
Extended Care **Facility**, Skilled Nursing **Facility**, or Rehabilitation **Facility**[1] *Limited to 30 days per year*[2]	20% after **Deductible**	50% after **Deductible**
Genetic Testing/Counseling	20% after **Deductible**	50% after **Deductible**
High-tech Diagnostic Radiology scans including, but not limited to: computed tomography (“CT”); magnetic resonance imaging (“MRI”); magnetic resonance angiography (“MRA”); and, positron emission tomography (“PET”)	20% after **Deductible**	50% after **Deductible**
Home Health Care[1] *Limited to 120 visits per year*[2]	20% after **Deductible**	50% after **Deductible**
Hospice Care[1]	20% after **Deductible**	50% after **Deductible**
Hospital (Facility) Inpatient treatment	20% after **Deductible**	50% after **Deductible**
Hospital (**Facility**) **Outpatient** treatment	20% after **Deductible**	50% after **Deductible**
Reference Diagnostic Lab Charges referred by **Physicians** for **Illnesses** not otherwise outlined in Schedule of Benefits	20% no **Deductible**	50% after **Deductible**
Maternity[1] Services	20% after **Deductible**	50% after **Deductible**
Mental Health Disorders (**Inpatient** & **Outpatient**)[1]	20% after **Deductible**	50% after **Deductible**
Mental Health Disorders (Office visit)[1]	$30 **Copay** per visit	50% after **Deductible**
Newborn Care[1]	0% after **Deductible**	50% after **Deductible**
Nutritional Counseling (all diagnoses)	20% after **Deductible**	50% after **Deductible**

Office Visit (Specialist Non-**Preventive Services**)	$50 **Copay** per visit	50% after **Deductible**
Office Surgery (Specialist)	20% after **Deductible**	50% after **Deductible**
Oral Surgery including, but not limited to, removal of impacted teeth[1]	20% after **Deductible**	50% after **Deductible**
Other **Covered Healthcare Expenses** including, but not limited to, anesthesiologist; pathologist; radiologist; or, hospitalist	20% after **Deductible**	20% after **In-Network Deductible**
Pain Therapy / Pain Management *Limited to 4 visits per year*[2]	20% after **Deductible**	50% after **Deductible**
Physical, Speech, and Occupational Therapy[1] *Autism / Non-Autism: Limited to 20 combined visits per year*[2]	20% after **Deductible**	50% after **Deductible**
Prosthesis *Per limb limit $15,000*	20% after **Deductible**	50% after **Deductible**
Residential Treatment *Limited to 30 days per year*[2]	20% after **Deductible**	50% after **Deductible**
Sleep Studies *Lifetime maximum $2,500*	20% after **Deductible**	50% after **Deductible**
Substance Use Disorder treatment (**Inpatient** & **Outpatient**)[1]	20% after **Deductible**	50% after **Deductible**
Substance Use Disorder treatment (Office visit) [1]	$30 **Copay** per visit	50% after **Deductible**
Telemedicine / Virtual Health Visit(s)	Payable where performed	
TMJ Syndrome *Lifetime maximum $15,000*	20% after **Deductible**	50% after **Deductible**
Therapy Services: • Chemotherapy / radiation • Respiratory • Cardiac rehabilitation (**Outpatient**)	20% after **Deductible**	50% after **Deductible**
Urgent Care Center	$50 **Copay** per visit	50% after **Deductible**
Vertebral Manipulation / **Outpatient Skeletal Adjustment**[1] *Limited to 20 visits per year*[2]	20% after **Deductible**	20% after **In-Network Deductible**
Smoke Stopper program through St. Joseph's/Candler	0% no **Deductible**	N/A
Charges of a Registered Dietitian performed at SouthCoast Health Only *Limited to 4 visits per year*[2]	20% after **Deductible**	N/A

* **Copay** waived if admitted.
** In-network **Deductible** / **Out-of-Pocket Limit** also applies.
*** May be out-of-network even though **Hospital** is in-network
[1] For additional information, *see* Special Provisions.
[2] "year" as set forth in Plan Year / Calendar Year in Plan Information.

**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)
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- The Plastic Surgery Center (TIN: 582203578)
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- Jenkins County Hospital (TIN: 273100894)
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- 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**.

PRECERTIFICATION PENALTY.
Hospital admissions, **Outpatient** surgeries and other procedures require **Precertification**. **Precertification** is the responsibility of the **Member**. If **Precertification** is not obtained, benefits will be reduced by fifty percent (50%). **Coinsurance** payments for services where **Precertification** is not obtained do not accrue toward the **Out-of-Pocket Limits**. For a list of services requiring **Precertification**, *see* Care Management Requirements.

PRESCRIPTION DRUG BENEFITS - PPO PLAN

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 **Pla**n 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 **Member** choose a Brand Name Drug rather than the Generic equivalent when the **Physician** allowed a Generic Drug to be dispensed, the **Member** 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 **Member's** share of the Prescription Drug cost does not apply toward the **Plan's Deductible** or **Out-of-Pocket Limit** maximum and the **Member** is responsible for the cost difference even after the **Out-of-Pocket Limit** 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 in Schedule of Benefits for prescription drug **Out-of-Pocket Limit**.

Prescription Drug Card	
Prescription Drug Type	**Payable by Member**
Generic Drug	$15 **Copay**; *max 30 day supply*
Formulary Drug	$35 **Copay**; *max 30 day supply*
Non-Formulary Brand	$75 **Copay**; *max 30 day supply*
Specialty Drugs	**Member** pays 25% up to $350; *max 30 day supply*
Affordable Care Act Medications	$0 **Copay**; *max 30 day supply*
Prescription Drug Mail Service	
Prescription Drug Type	**Payable by Member**
Generic Drug	$37.50 **Copay**; *max 31-90 supply*
Formulary Drug	$87.50 **Copay**; *max 31-90 supply*
Non-Formulary Brand	$187.50 **Copay**; *max 31-90 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.

The **Plan** includes a policy that requires the generic medication when a chemically equivalent generic is available. The **Member** will pay the applicable **Copay** plus the cost difference between the brand and generic medication unless the **Physician** requests the brand and signs the prescription "dispense as written." Only the applicable **Copay** will apply.

SCHEDULE OF BENEFITS – HDHP PLAN

MEDICAL BENEFITS

When **Injury** or **Illness** cause the **Member**, while covered under this **Plan**, to incur **Covered Medical Expenses**, the **Plan** will determine benefits according to the provisions described in this **SPD**. 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**, **Copay** or **Coinsurance** resulting in the payable benefit.
3. The benefit payable will be subject to all the terms, conditions, and limitations of the **Plan**.

PAYMENT.

Covered Medical 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's 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 Requirements have been met;
5. The service is **Medically Necessary**; and,
6. The service is not subject to an Exclusion as provided in the **Plan**.

CARE MANAGEMENT.

The **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 Medical Expenses**. *See*, Care Management Requirements.

Please note that the **Plan** is not directly involved in treatment; it 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 received. The **Member** and healthcare **Provider(s)** are responsible for making all healthcare decisions and will control the course of treatment followed.

Hospital admissions, **Outpatient** surgeries and other procedures require **Precertification**. If **Precertification** is not obtained, a penalty will apply and benefits will be reduced. *See*, Care Management Requirements and Special Provisions.

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 https://members.healthgram.com/third_party_ppopage.cfm, 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 **Non-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 Benefits** and paid at the **In-Network Benefit** level.

EMERGENCY SERVICES.
Charges for **Emergency Services** do not require **Precertification** and are covered as **In-Network Benefits**.

DEDUCTIBLE.
A **Member's Deductible** requirement will be met when **Covered Medical Expenses** paid by that **Member** during each year[2] equal the **Deductible** amount. The **Member** is responsible for paying the **Deductible**. The **Plan** will not reimburse the **Member** for this expense. **Copays**, non-covered charges, **Balance Billing** payments do not accrue toward the **Deductible**. When the family **Plan** is selected, no benefits will be payable for a family **Member** until the individual in a family **Deductible** amount has been met.

Deductibles	In-Network	Out-of-Network
Individual Deductible	$3,000	$3,000
Individual in a Family Deductible	$3,300	$3,300
Family Deductible	$6,000	$6,000

[2] "year" as set forth in Plan Year / Calendar Year in Plan Information.

COINSURANCE RATE.
Coinsurance Rate is the percentage of **Covered Medical Expenses** payable by the **Member** after the **Deductible** requirement is met. The **Coinsurance Rate** for each type of service is listed in Schedule of Benefits.

HIGH DEDUCTIBLE HEALTH PLAN
This Plan is designed to meet the standards of a Qualifying High Deductible Health Plan under IRC Section 223.

OUT-OF-POCKET LIMIT.
If the total amount of out-of-pocket expenses for **Deductibles**, **Copayments**, and **Coinsurance** meets the limit set forth below, then the **Plan** will pay one-hundred percent (100%) for any additional covered expenses incurred during the remainder of the year.[2] When an individual with family coverage has met the Individual **Out-of-Pocket Limit**, all covered expenses for that individual are paid at one-hundred percent (100%), even if the Family **Out-of-Pocket Limit** has not been met.

If a **Member** has health coverage from any other source where coordination of benefits is allowable, amounts payable by the **Member** do not accrue toward the **Out-of-Pocket Limit**.

Non-covered charges, negotiated reduction in charges, benefit reduction for failure to comply with **Precertification** and Care Management Service Requirements, **Balance Billing** amounts, and charges in excess of **Plan Allowance** do not accrue toward the **Out-of-Pocket Limit** for the year.[2]

Out-of-Pocket Limit	In-Network	Out-of-Network
Individual	$5,000	$10,000
Family	$10,000	$20,000

[2] "year" as set forth in Plan Year / Calendar Year in Plan Information.

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.

PRIMARY CARE SERVICES.

Covered Medical Expense	Payable by Member	
	In-Network	Out-of-Network (Plan Allowance May Apply)
Office visit (**PCP** Non-**Preventive Services**) including surgical procedures	0% after **Deductible**	40% after **Deductible**

WELLNESS AND PREVENTIVE SERVICES.

Covered Medical Expense	Payable by Member	
	In-Network	Out-of-Network (Plan Allowance May Apply)
Well baby / Child care **Preventive Services*** / [1] - CDC: www.cdc.gov/vaccines/schedules/index.html	0% no **Deductible**	40% after **Deductible**
Well Adult Care **Preventive Services*** / [1] - CDC: www.cdc.gov/vaccines/schedules/index.html	0% no **Deductible**	40% after **Deductible**
Women's **Preventive Services*** / [1]	0% no **Deductible**	40% after **Deductible**
Contraceptives	0% no **Deductible**	40% after **Deductible**

* For a list of covered **Preventive Services**, *see* https://www.healthcare.gov/coverage/preventive-care-benefits/. For additional information and limitations, *see* https://www.uspreventiveservicestaskforce.org/.

[1] For additional information, *see* Special Provisions.

OTHER COVERED SERVICES. ** / ***

Covered Medical Expense	Payable by Member	
	In-Network	**Out-of-Network (Plan Allowance May Apply)**
All other services rendered by a **Physician** outside an office setting	0% after **Deductible**	40% after **Deductible**
Medically Necessary professional Ambulance service to the nearest **Hospital****	0% after **Deductible**	0% after **Deductible**
Ambulatory Surgery Center	0% after **Deductible**	40% after **Deductible**
Applied Behavioral Therapy (ABA Therapy) *Limited to 20 visits per year*[2]	0% after **Deductible**	40% after **Deductible**
Outpatient Dialysis (Hemodialysis and Peritoneal) *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.
Durable Medical Equipment For the purchase of or rental up to purchase price	0% after **Deductible**	40% after **Deductible**
Emergency Room (**Facility**)* / **	0% after **Deductible**	0% after **Deductible**
Emergency Room (**Physician**)***	0% after **Deductible**	0% after **Deductible**
Endovenous Ablation Therapy *Lifetime maximum $2,500*	0% after **Deductible**	40% after **Deductible**
Extended Care **Facility**, Skilled Nursing **Facility**, or Rehabilitation **Facility**[1] *Limited to 30 days per year*[2]	0% after **Deductible**	40% after **Deductible**
Genetic Testing/Counseling	0% after **Deductible**	40% after **Deductible**
High-tech Diagnostic Radiology scans including, but not limited to: computed tomography ("CT"); magnetic resonance imaging ("MRI"); magnetic resonance angiography ("MRA"); and, positron emission tomography ("PET")	0% after **Deductible**	40% after **Deductible**
Home Health Care[1] *Limited to 120 visits per year*[2]	0% after **Deductible**	40% after **Deductible**
Hospice Care[1]	0% after **Deductible**	40% after **Deductible**
Hospital (Facility) Inpatient treatment	0% after **Deductible**	40% after **Deductible**
Hospital (**Facility**) **Outpatient** treatment	0% after **Deductible**	40% after **Deductible**
Reference Diagnostic Lab Charges referred by **Physicians** for **Illnesses** not otherwise outlined in Schedule of Benefits	0% after **Deductible**	40% after **Deductible**
Maternity[1] Services	0% after **Deductible**	40% after **Deductible**
Mental Health Disorders (**Inpatient** & **Outpatient**)[1]	0% after **Deductible**	40% after **Deductible**
Mental Health Disorders (Office visit)[1]	0% after **Deductible**	40% after **Deductible**
Newborn Care[1]	0% after **Deductible**	40% after **Deductible**
Nutritional Counseling (all diagnoses)	0% after **Deductible**	40% after **Deductible**
Office Visit (Specialist Non-**Preventive Services**)) including surgical procedures	0% after **Deductible**	40% after **Deductible**

Oral Surgery including, but not limited to, removal of impacted teeth[1]	0% after **Deductible**	40% after **Deductible**
Other **Covered Healthcare Expenses** including, but not limited to, anesthesiologist; pathologist; radiologist; or, hospitalist	0% after **Deductible**	0% after **In-Network Deductible**
Pain Therapy / Pain Management *Limited to 4 visits per year*[2]	0% after **Deductible**	40% after **Deductible**
Physical, Speech, and Occupational Therapy[1] *Autism / Non-Autism: Limited to 20 combined visits per year*[2]	0% after **Deductible**	40% after **Deductible**
Prosthesis *Per limb limit $15,000*	0% after **Deductible**	40% after **Deductible**
Residential Treatment *Limited to 30 days per year*[2]	0% after **Deductible**	40% after **Deductible**
Sleep Studies *Lifetime maximum $2,500*	0% after **Deductible**	40% after **Deductible**
Substance Use Disorder treatment (**Inpatient** & **Outpatient**)[1]	0% after **Deductible**	40% after **Deductible**
Substance Use Disorder treatment (Office visit) [1]	0% after **Deductible**	40% after **Deductible**
Telemedicine / Virtual Health Visit(s)	Payable where performed	
TMJ Syndrome *Lifetime maximum $15,000*	0% after **Deductible**	40% after **Deductible**
Therapy Services: • Chemotherapy / radiation • Respiratory • Cardiac rehabilitation (**Outpatient**)	0% after **Deductible**	40% after **Deductible**
Urgent Care Center	0% after **Deductible**	40% after **Deductible**
Vertebral Manipulation / **Outpatient Skeletal Adjustment**[1] *Limited to 20 visits per year*[2]	0% after **Deductible**	0% after **In-Network Deductible**
Smoke Stopper program through St. Joseph's/Candler	0% no **Deductible**	N/A
Charges of a Registered Dietitian performed at SouthCoast Health Only *Limited to 4 visits per year*[2]	0% after **Deductible**	N/A

* **Copay** waived if admitted.
** In-network **Deductible** / **Out-of-Pocket Limit** also applies.
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    - Effingham Imaging Center
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- 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)
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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 **Pla**n 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 **Member** choose a Brand Name Drug rather than the Generic equivalent when the **Physician** allowed a Generic Drug to be dispensed, the **Member** 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 **Member's** share of the Prescription Drug cost does not apply toward the **Plan's Deductible** or **Out-of-Pocket Limit** maximum and the **Member** is responsible for the cost difference even after the **Out-of-Pocket Limit** 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 in Schedule of Benefits for prescription drug **Out-of-Pocket Limit**.

Prescription Drug Card	
Prescription Drug Type	**Payable by Member**
Generic Drug	**Member** pays 15% after **Deductible** up to $150; *max 30 day supply*
Formulary Drug	**Member** pays 15% after **Deductible** up to $150; *max 30 day supply*
Non-Formulary Brand	**Member** pays 15% after **Deductible** up to $150; *max 30 day supply*
Specialty Drugs	**Member** pays 15% after **Deductible** up to $150; *max 30 day supply*
Affordable Care Act Medications	$0 **Copay**; *max 30 day supply*
Prescription Drug Mail Service	
Prescription Drug Type	**Payable by Member**
Generic Drug	**Member** pays 15% after **Deductible** up to $450; *max 31-90 supply*
Formulary Drug	**Member** pays 15% after **Deductible** up to $450; *max 31-90 supply*
Non-Formulary Brand	**Member** pays 15% after **Deductible** up to $450; *max 31-90 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.

The **Plan** includes a policy that requires the generic medication when a chemically equivalent generic is available. The **Member** will pay the applicable **Copay** plus the cost difference between the brand and generic medication unless the **Physician** requests the brand and signs the prescription "dispense as written." Only the applicable **Copay** will apply.

COVERED EXPENSES

COVERED MEDICAL EXPENSES

The following expenses, unless otherwise excluded, are covered by the **Plan** provided they are incurred for such care, services, and supplies as prescribed by an attending **Physician** while the **Member** is covered under this **Plan**:

1. Charges for **Medically Necessary** abortions to the extent allowed by applicable law in the state where the services were rendered, where:
    a. the life of the mother is endangered if the pregnancy were to be carried to term;
    b. in the case of rape or incest; or,
    c. the fetus has a severe birth defect.
2. Charges for allergy testing and treatment.
3. 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.
4. Charges relating to ambulatory surgery.
5. Charges by a **Physician** or professional anesthetist for anesthesia and its administration.
6. Routine charges for services furnished in connection with participation in an **Approved Clinical Trial**.
7. Charges for attempted suicide or intentionally self-inflicted **Injury**, while sane or insane.
8. Charges for Autism Spectrum Disorder, to include Applied Behavioral Analysis.
9. Charges for the placement of **Prosthesis** or **Prosthetic Devices**.
10. When an assistant surgeon is required to render technical assistance during an operation, the **Covered Medical Expense** for such services shall be limited to twenty percent (20%) of the approved charge for the primary surgeon.
11. Charges for behavioral disorders or learning disabilities.
12. Charges for blood or blood plasma and its administration, excluding any charges for blood or blood plasma which has been replaced by a donor.
13. Charges for the initial purchase of an external breast **Prosthesis** or post mastectomy bra (up to two (2) per year[2]), prescribed in connection with a mastectomy for which the **Member** is receiving benefits under the **Plan**. However, replacement of the initial breast **Prosthesis** is not covered.

    For more information, *see* Mastectomy / Breast Reconstruction in Special Provisions.

    [2] "year" as set forth in Plan Year / Calendar Year in Plan Information.
14. Charges for the circumcision of a newborn.
15. Charges for initial contact lenses or glasses following cataract surgery.
16. Charges for **Contraceptives** per **USPSTF**.
17. 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.

    For more information, see Dental Services / Orthodontics / Oral Surgery in Special Provisions.
18. 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.
19. 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**.
20. **Medically Necessary** patient education programs for diabetic and ostomy care.

21. Charges for **genetic testing** including diagnostic testing of genetic information and counseling when medically appropriate, limited as outlined in the Schedule of Benefits.
22. Charges for implants and devices to include cochlear implants and pre-anchored hearing implants for **Members** under the age of twenty-one (21).
23. Charges by a **Home Health Care** agency.

    For more information, *see* Home Health Care in Special Provisions.
24. Charges for **Hospice** care.

    For more information, *see* Hospice Care in Special Provisions.
25. **Hospital** room and board charges.

    For more information, *see* Room and Board Charges in Special Provisions.
26. Charges for diagnostic testing for the purposes of diagnosing the underlying cause(s) of infertility.
27. **Hospital** charges for intensive care, cardiac care or other similar necessary accommodations.
28. Charges for **Medically Necessary** supplies such as casts, splints or surgical dressings, trusses, braces (except dental), or crutches.
29. Charges for medical care or treatment of **Mental Health Disorders** (including Attention Deficit Disorder and Attention Deficit Hyperactivity Disorder).

    For more information, *see* Mental Health in Special Provisions.
30. Miscellaneous **Hospital** charges (other than room and board) required for medical or surgical care or treatment.
31. **Hospital** charges for routine newborn nursery care and for the initial examination by a pediatrician at birth to determine the health of the infant.

    For more information, *see* Newborn Care in Special Provisions.
32. Charges for **Medically Necessary** nursing care rendered by a 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.
33. Charges for Nutritional Counseling (all diagnoses).
34. 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.
35. Charges for an organ **Transplant** incurred by recipient and the organ donor if the recipient is covered under this **Plan**.

    For more information, *see* Organ / Tissue Transplant Program in Care Management Requirements.
36. Charges for orthoptic training (eye muscle exercises). Training by an optometrist does not have to be prescribed by a **Physician**, but training by an orthoptic technician must be prescribed by a **Physician**.
37. Charges for oxygen and rental of equipment for its administration.
38. Charges for **Pain Therapy / Pain Management** 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.
39. Charges for physical therapy and occupational therapy, when services are provided by licensed therapists.

    For more information, *see* Physical, Speech, and Occupational Therapy in Special Provisions.
40. Charges by a **Physician** for medical care and treatment.
41. Unless arising from or relating to home-birth or surrogacy, charges incurred by the covered female **Employee or** spouse due to pregnancy, childbirth, and related conditions on the same basis as for **Illness**.

    For more information, *see* Schedule of Benefits and Exclusions.
42. Charges for prescription drugs (including insulin) that are:
    - **a.** ordered for the patient in writing by a **Physician**; and,
    - **b.** dispensed by a licensed pharmacist or a **Physician**.

43. Charges for rehabilitative care, but only for **Medically Necessary** care (as prescribed by a **Physician**) which is rendered in a rehabilitation **Facility** or **Hospital**, excluding **Custodial Care** or occupational training.

    For more information, *see* Extended Care, Rehabilitation and Skilled Nursing Facilities in Special Provisions.

44. Charges relating to **Residential Treatment**.
45. Charges for routine physical examinations.
46. Charges for treatment received in a skilled nursing **Facility** or extended care **Facility**.

    For more information, *see* Extended Care, Rehabilitation and Skilled Nursing Facilities in Special Provisions.

47. Charges for sleep studies and treatment including diagnosis, testing, surgery, and all charges associated with **Sleeping Disorders**.
48. 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 **Member** must have had corrective surgery before therapy.

    For more information, *see* Physical, Speech, and Occupational Therapy in Special Provisions.

49. Charges for sterilization procedures, but not for the reversal of sterilization procedures.
50. Charges for medical care or treatment of **Substance Use Disorders**.

    For more information, *see* Substance Use Disorders in Special Provisions.

51. 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 fifty percent (50%) of the **Plan Allowance** charge or the contractual rate with the **Provider** for the secondary procedure, and fifty percent (50%) of the **Plan Allowance** charge or the contractual rate with the **Provider** for the third procedure.
52. Charges for **Outpatient Skeletal Adjustment**, adjunctive therapy, vertebral manipulation, and services for the care or treatment of dislocations or subluxations of the vertebrae.

    For more information, *see* Skeletal Adjustment and Vertebral Manipulation in Special Provisions.

53. Charges for **Telemedicine** services.
54. Charges for **TMJ**, not to include: orthodontics, crowns, inlays, or any appliance that is attached to or rests on the teeth.
55. Charges for well baby care services.
56. Charges for one (1) wig per lifetime as a result of, chemotherapy or radiation treatment.
57. Charges for diagnostic x-ray or laboratory examinations and their interpretation.

COVERED PRESCRIPTION DRUG EXPENSES

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 eight (8) test kits per month.

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

1. Generic **Contraceptives** (**USPSTF**).
2. **Contraceptive** injectables, subject to **Precertification**.
3. Generic breast cancer chemoprevention.
4. 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).
5. Oral fluoride supplementation for children from birth through age five (5).
6. Iron supplementation for children from birth to twelve (12) months of age.
7. Folic acid supplementation for women ages eighteen (18) to forty-five (45).
8. Immunizations (**USPSTF**).

For more information, *see,* Prescription Drug Benefits in Schedule of Benefits, above.

SPECIAL PROVISIONS

DENTAL SERVICES / ORTHODONTICS / ORAL SURGERY.
Expenses for **Dental Services** and oral surgery are **Covered Healthcare 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.

OUTPATIENT 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 Healthcare Expenses**. Services must be furnished to a **Member** 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 **Member** is admitted to a **Facility** if all of the following requirements are met:

1. The **Member** was previously admitted to a **Hospital** for at least three (3) days of **Inpatient** treatment for an **Illness** or **Injury**;
2. The **Member** is admitted to the extended care or rehabilitation **Facility** within thirty (30) days after discharge from the **Hospital**; and,
3. The **Member** 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**.

Precertification 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 Care** services including private duty nursing provided by a licensed nurse.
3. Physical, occupational, and speech therapy.
4. Medical supplies, medications or lab services ordered by a **Physician**, which require nursing administration.

Precertification 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 **Member'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 **Member's** terminal **Illness**.

Precertification and **Utilization Review** are required.

MASTECTOMY / BREAST RECONSTRUCTION.
Any **Member** 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 **Deductibles**, **Copay**, **Coinsurance**, **Plan Allowance** charge limitations, and Care Management Requirements. For more information, please contact the **Plan Supervisor**.

Precertification and **Utilization Review** are required.

MATERNITY HOSPITALIZATIONS / STATEMENT OF RIGHTS UNDER THE NMHPA.
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. However, federal law does not prohibit the attending **Physician**, after consultation with the mother, from discharging the mother or newborn earlier.

Also, under federal law, the **Plan** may not set the level of benefits or out-of-pocket costs so that any later portion of the forty-eight (48) (or ninety-six (96)) hour stay is treated in a manner less favorable to the mother or newborn than any earlier portion of the stay.

In addition, the **Plan** may not, under federal law, require that a **Physician** or other health care **Provider** obtain authorization from a **Plan** for prescribing a length of stay of up to forty-eight (48) (or ninety-six (96)) hours. However, to use certain **Providers** or **Facilities**, or to reduce out-of-pocket costs, a **Member** may be required to obtain **Precertification**. For more information on **Precertification**, contact the **Plan Administrator**.

MENTAL HEALTH.
Charges for treatment of **Mental Health Disorders** are **Covered Healthcare Expenses**. Charges for treatment of behavioral or learning disabilities are not covered. Prescription drugs used for these conditions are covered as any other prescription, whether prescribed by a psychiatrist or **Physician**.

Precertification 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 / Statement of Rights Under the NMHPA and Medical Eligibility Requirements.

ORGAN TRANSPLANTATION.
See, Organ / Tissue Transplant Program in Care Management Requirements.

Precertification 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).

PREVENTIVE SERVICES.
Recommended **Preventive Services** are payable at one-hundred percent (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 **Coinsurance** still apply to the office visit.

For a complete description of covered **Preventive Services** go to www.healthcare.gov/coverage/preventive-care-benefits or visit the **Employer's** 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. Daily room and board charges in a **Hospital** will be paid at either an ICU rate or a regular room rate.

SKELETAL ADJUSTMENT.
Charges for **Skeletal Adjustment** are **Covered Healthcare Expenses** when **Medically Necessary** and when performed by physical therapists, chiropractors, osteopaths, and/or **Physicians**.

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

SUBSTANCE USE DISORDERS.
Charges for the treatment of **Substance Use Disorders** are **Covered Healthcare Expenses** if all of the following requirements are met:

1. The treatment must be prescribed and supervised by a **Physician**; and,
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 **Member** is confined as an **Inpatient** in a **Hospital**, the covered charges include treatment of the medical complications of **Substance Use Disorders**.

Charges are covered only for **Facilities** that are recognized by the Joint Commission on Accreditation of Hospitals and licensed by the state.

Precertification and **Utilization Review** are required for **Inpatient** treatment.

VERTEBRAL MANIPULATION.
See, Skeletal Adjustment, above.

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

MEDICAL EXCLUSIONS

Unless the **Injury** or **Illness** resulted from an act of domestic violence or a medical (including both physical and mental health) condition, no benefits shall be payable under this **Plan** for any charges resulting from the following:

1. Charges for services performed more than twelve (12) months prior to actual receipt of the corresponding **Claim** by the **Plan Supervisor**.
2. Charges for abortions, unless, to the extent allowed by applicable law in the state where the services were rendered:
   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; or,
   c. The fetus has a severe birth defect.
3. **Illness** or **Injury** resulting from a **Member's** participation in acts of war, riots, or insurrections.
4. Charges for acupuncture, biofeedback, or hypnosis.
5. Charges for treatment of any **Injury** resulting from a **Member's** commission of, or attempt to commit, an assault or felony. 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.
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.

7. Charges for an **Injury** resulting from an act of aggression or battery initiated by the **Member**.
8. Expenses incurred before the **Effective Date** or after the termination date.
9. Unless needed in treatment of diabetes and/or blood circulation problems, charges resulting from treatment or supplies for the feet or the following care:
   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; or,
   g. treatment for corns, calluses or toenails.
10. Charges billed by a certified surgical assistant or technician (CSA, CST, LSA, LST, LFSA, or similar designation).
11. Charges in excess of **Plan Allowance** 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. Any service or treatment for complications resulting from any non-covered procedures.
13. Charges incurred as a result of complications that occur because a **Member** did not complete treatment and/or did not follow the course of treatment prescribed by a **Provider**, including complications that occur because a **Member** left a **Hospital** against medical advice.
14. 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**).
15. Any expenses for treatment, services, or supplies, while in the custody of local, state, or federal **correctional** authorities.
16. **Cosmetic Surgery** and elective, plastic, reconstructive, or restorative surgeries, 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.
17. 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**.
18. Charges for gene therapy.
19. Treatment of **Injuries** or **Illnesses** that result from or relate to participation in the following dangerous leisure activities:
    a. Pilot or co-pilot of an ultralight **Aircraft**.
    b. Racing in any **Vehicle**, self-propelled automobile, **Motor Vehicle**, **Vessel**, watercraft, **Aircraft**, balloon or hydroplane including, but not limited to, when done in competition.
    c. Participation in extremely hazardous activities or sports. This exclusion includes, but is not limited to: soaring; parachuting; skydiving; hang gliding; paragliding; bungee jumping; rodeo participation; base jumping; cliff diving; and, similar activities. This exclusion also includes participation in any organized competitive extreme sports at any level of competition, such as acrobatic skiing, skateboarding, snowboarding, or similar sports. It is suggested that those who participate in extremely hazardous activities or sports purchase insurance that specifically covers their pursuits.
    d. Professional sports of any type. This exclusion is not intended to exclude common: 1). organized school sports; 2). pre-collegiate sports; or, 3). community sponsored sports. For purposes of this exclusion, a “sport” is any contest or game in which an individual or team engages in certain activities requiring skill or prowess according to a specific set of rules including, but not limited to, those which are primarily: physical, mind, motorized, coordination, and/or animal-supported.
20. 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.
21. Repair or replacement of **Durable Medical Equipment** and artificial limbs, due to abuse or desire for new equipment.
22. All exercise programs or exercise equipment for treatment of any condition, outside of prescribed rehabilitation program.
23. **Illness** or **Injury** resulting from or related to the keeping of exotic or wild animal. An exotic or wild animal is an animal that would be ordinarily confined to a zoo, or one that is not indigenous to the United States, or one that would be ordinarily found in the wilderness of this or any other country, or

would likely cause a reasonable person to be fearful of significant destruction of property or of bodily harm. An exotic or wild animal includes, but is not limited to: poisonous reptiles; members of the crocodile family; nonhuman primates weighing greater than eight (8) pounds; any member of the cat family not customarily domesticated by man or any hybrids thereof; and, any member of the Canid dog family not customarily domesticated by man or any hybrids thereof, including wolf hybrids that are a cross between a wolf and a domestic dog. Exotic or wild animals do not include: domestic cats; domestic dogs; foreign rodents such as guinea pigs; small lizards; turtles; frogs; fish; or Vietnamese pot-bellied pigs.

24. Except for routine charges for services furnished in connection with participation in an **Approved Clinical Trial**, any **Experimental or Investigational** treatment, procedure, **Facility**, equipment, service, device, substance, or drug.

25. Charges for genetic counseling and testing that are not needed for diagnosis or treatment of genetic abnormalities.

26. 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 **Member** who received **Covered Medical Expenses** at any of the above **Facilities**.

27. Charges for implants and devices to include cochlear implants and pre-anchored hearing implants for **Members** over the age of twenty-one (21). If implant received prior to age twenty-one (21), ongoing coverage will apply.

28. Charges for hearing aids.

29. Any expense or charge for the diagnosis or treatment of infertility in men or women including:

- **a.** Fertility studies or tests.
- **b.** Reversals of surgical sterilization including reconstruction of vasectomy or reconstruction of tubal ligation.
- **c.** Direct attempts to cause pregnancy by hormone therapy, artificial insemination, in vitro fertilization, and embryo transfer.
- **d.** Supervision of pregnancy by infertility specialists who do not practice obstetrics.

30. 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.

31. Except for covered wellness benefits, services and supplies that are not **Medically Necessary**.

32. Conditions arising out of or as a result of military service.

33. Medical services or supplies for which no charge was made or for which no payment would be required if the **Member** was not covered under this **Plan**.

34. Charges for services and supplies that are not **Covered Medical Expenses**.

35. 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).

36. 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.

37. Professional services performed by the **Member** or a person who ordinarily resides in the **Member's** home or is related to the **Member** as a spouse, parent, child, brother, or sister, whether the relationship is by blood or exists in law.

38. Charges for any care, services, drugs, or supplies incurred outside the United States if the **Member** traveled to such a location for the purpose of obtaining the care, services, drugs, or supplies.

39. 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.

40. Personal comfort items such as television, telephones, extra food trays, etc.

41. 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**.
42. Charges relating to planned home-births (including, but not limited to, charges relating to midwives, **Physicians**, or other medical personnel) and/or surrogacy pregnancies. For purposes of this exclusion, surrogacy pregnancy shall be designed as implantation of a fertilized egg for the purpose of carrying the fetus to term for another. This exclusion does not apply to **Preventive Services**.
43. Replacement braces for the leg, arm, back, neck.
44. Services or supplies related to sexual dysfunctions or inadequacies including penile **Prosthesis**, implants, and all procedures and equipment developed for male impotency.
45. 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.
46. Except as outlined in the Schedule of Benefits, charges for telephone consultations, missed appointments, and/or fees added for filling out a **Claim** form.
47. Charges related to **Hospital Precertification**, concurrent review, **Utilization Review**, quality assurance, **Hospital**-related Case Management, or third-party related Case Management.
48. Expenses incurred after termination of coverage under this **Plan**.
49. 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).
50. Charges for which a third party may be liable (*see*, Third Party Recovery) or charges for which the **Member** is not legally required to pay.
51. Care, services, or treatment for transsexualism, gender dysphoria, or sexual reassignment or change, including medications, implants, hormone therapy, surgery, medical or psychiatric treatment.
52. Travel, except for covered ambulance charges.
53. Charges incurred for any operation or treatment for realignment of teeth or jaw or any other **Dental Services** not specifically provided for under Covered 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, **TMJ Syndrome**, retrognathia, and related **Hospital** and **Facility** charges. The above charges are excluded unless otherwise provided in Schedule of Benefits or under Dental Services / Orthodontics / Oral Surgery in Special Provisions. 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 (1) year prior to the treatment.
54. 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**.
55. Charges resulting from **Illness** or **Injury** covered by the Worker's Compensation Act or similar law. *See,* Workers Compensation.
56. 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).
57. Any and all charges, expenses, services, supplies, and care of or relating in any way to a **Claim** or benefit where a **Member** commits fraud, intentional misrepresentation of a material fact, and/or omission or concealment of a material fact. The aforementioned exclusion shall include, but not be limited to, actions justifying or supporting rescission. *See*, Rescission.

PRESCRIPTION DRUG EXCLUSIONS

No benefits will be paid for the following charges:

1. Appetite Suppressants and anti-obesity medications; notwithstanding the foregoing, medications for anorexiants may be covered, prior authorization required.
2. Charges for prescriptions that are not **FDA** approved and/or **Experimental or Investigational** drugs, including, but not limited to, 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. Medications for hair regrowth including, but not limited to, 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.
13. Charges for over-the-counter COVID tests.
14. Drugs for cosmetic purposes.
15. Homeopathic medications, inhaler devices, fluoride, and/or anabolic steroids.

<u>WORKERS' COMPENSATION</u>

This **Plan** 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**, the **Member** shall reimburse the **Plan** in full all benefits paid by the **Plan** relating to the **Injury** or **Illness**. The amount to be reimbursed to the **Plan** will equal the payments advanced by the **Plan**, without any adjustment for the **Member'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. *See*, <u>Third Party Recovery</u>.

Among other things, it shall be fraud, intentional misrepresentation of a material fact, and/or omission of a material fact if: 1). the **Member** and/or their attorney, if one is obtained, receives funds and does not promptly reimburse the **Plan**; 2). the **Member** and/or their attorney, if one is obtained, indicates an intent not to reimburse the Plan upon receipt of funds; or, 3). the **Member** and/or their attorney, if one is obtained, fail to complete a Reimbursement & Subrogation Agreement to reimburse the **Plan** one-hundred percent (100%) before or after payments are advanced. In the event any of the foregoing occurs, the **Plan** expressly reserves any and all remedies available, including, but not limited to: the reduction of future benefits to cover the amount of payments advanced by the **Plan**; suspension or termination of payments advanced by the **Plan**; seeking the return of any payments advanced directly from the **Provider(s)**; and/or, taking legal and/or equitable action against the parties engaging in said activity. *See*, <u>Rescission</u>.

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 healthcare is not agreed upon or defined by the **Member** or the Workers' Compensation carrier; or, the medical or healthcare benefits are specifically excluded from the Workers' Compensation settlement or compromise.

ELIGIBILITY

MEDICAL ELIGIBILITY REQUIREMENTS.

REQUIREMENTS FOR EMPLOYEE COVERAGE.

A person's **Eligibility Date** is 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 if:
    - **a.** regularly scheduled to work at least thirty (30) hours per week or determined during the twelve (12)-month measurement period to have worked on average at least thirty (30) hours per week; and,
    - **b.** on the regular payroll of the **Employer**;
2. The person is in a class eligible for coverage under the **Plan**; and,
3. The person has completed the following waiting period. A "waiting period" is the time between the first day of employment and the first day of coverage under the **Plan**. Absences
    - **a.** Physicians: no waiting period.
    - **b.** Employees of an acquisition: must complete the waiting period of sixty (60) days actively-at-work as a full-time **Employee**, but will receive credit towards the waiting period for the accrual of days as a full-time **Employee** with the acquired entity.
    - **c.** All other Employees: must complete the waiting period of sixty (60) days active-at-work as a full-time **Employee**.

    Absences due to health reasons will be disregarded in determining whether the waiting period is satisfied. When the eligibility requirements are met, an eligible **Employee's** coverage is effective:

    - **a.** Physicians: on the first day actively-at-work as a full-time **Employee**.
    - **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 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 (12) initial month look-back measurement period from the **Employee's** date of hire to evaluate if the **Employee** would qualify as a full-time employee after the measurement period. An **Employee** is considered variable hour if the **Employer** cannot determine if the **Employee** is reasonably expected to average thirty (30) hours of service per week because their hours vary or are otherwise uncertain.

If a variable hour employee is found to have averaged thirty (30) hours of service during the measurement period, the **Employee** will be considered full-time and offered enrollment into the **Plan** in accordance with **Applicable Law**.

The **Employee** will continually be tested for full-time status in the **Employer's** standard measurement period. Coverage in the **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** legally married spouse licensed under the laws of any state.

2. The **Employee's** child(ren) 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 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, below; 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 **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 or terminating 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 spouses are **Employees**, their children will be covered as **Dependents** of one spouse, but not of both.

Any child of a covered **Employee** 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 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. A **Member** 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 (26th) birthday, the child:

1. Must be enrolled in the **Plan** prior to the age of twenty-six (26);
2. Must be unmarried;
3. 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);
4. Must be primarily dependent upon the **Employee**;
5. Must be continuously disabled and covered thereafter; and,
6. Must be considered disabled by the Social Security Administration.

If a covered **Employee** believes a covered **Dependent** meets the disability criteria above they 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). The **Employee** may be required to submit additional information necessary for completion of the eligibility determination.

If such eligibility is approved, the **Employee** 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 the following:

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 **Employee** or **Dependent** first becomes eligible for coverage, either initially or under a Special Enrollment Period. If the enrollment form is not submitted within this deadline, the **Employee** or **Dependent** will be a "late enrollee" and will have to wait until the next annual Open Enrollment Period to enroll, unless that **Employee** or **Dependent** experiences an event permitting mid-year enrollment. *See*, Mid-Year Enrollment Changes, below.

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, below. **Members** who fail to make an election during Open Enrollment will automatically retain their present benefit elections. Elections made during Open Enrollment are effective as of January 1st.

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 the loss of other health plan coverage or 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:
        - **i.** 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);
        - **ii.** The other health coverage was not **COBRA Continuation Coverage** 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); or,
        - **iii.** 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 covered **Employee**, 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; or,
    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, legally terminated parental rights, 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 **Employee's** 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 not 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 **Member** premium contributions. When the change in cost is significant, **Members** 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, **Members** may elect another benefit option (if available). If a new benefit option is added under the **Plan**, **Members** will have the right to change their election to the new benefit option.
3. **QMCSO:** 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) healthcare 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 CHIPRA Coverage:** 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**.

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 event relates to entitlement to Medicaid or **CHIPRA** coverage, 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.

A rescission is a cancellation or discontinuance of coverage that has a retroactive effect, regardless of whether it has an adverse effect on any particular benefit at the time it is made. Fraud, intentional misrepresentation of a material fact, and/or omission or concealment of a material fact by **Members** are prohibited. The **Plan** shall have the right to rescind coverage if a **Member** performs an act, practice, or omission that constitutes fraud or makes an intentional misrepresentation of a material fact relating to healthcare or coverage. For purposes of this section, a failure to notify the **Plan** regarding **Legal Separation**, divorce, or a **Dependent** child's loss of eligibility within sixty (60) days of the qualifying event shall constitute omission of a material fact. Thirty (30) days advance written notice will be provided to the **Member** to whom the rescission applies. A **Member** has the right to appeal a rescission of coverage. *See*, Appeals.

In the event fraud, intentional misrepresentation of a material fact, and/or omission of a material fact result in benefits being conferred by the **Plan** and the **Member** does not promptly reimburse the **Plan** or agree to promptly reimburse the **Plan**, the **Plan** expressly reserves any and all remedies available including, but not limited to: the reduction of future benefits to cover the amount of payments advanced by the **Plan**; suspension or termination of payments advanced by the **Plan**; and/or, seeking the return of any payment advanced directly from the **Provider(s)**.

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* COBRA Continuation Coverage.

COVERAGE CONTINUATION DURING PERIODS OF FURLOUGH.

Subject to any **Employer** guidelines (including, but not limited to, Human Resources Policies and Employee Handbooks), an **Employee** may remain eligible for a limited time beyond the date they were last actively-at-work if the **Employee's**, full-time work ceases due to furlough. This continuation will end at the end of the three (3) calendar month period immediately following the month the **Employee** was actively-at-work.

The continued **Employee** must continue to pay their premiums during this continuation period to the Employer. Premiums are due within thirty (30) days of the date the premium would have been withheld from payroll. If payment is not received within thirty (30) days, active coverage will be terminated. If an employee is in a waiting period at the time of their furlough, the furlough period will not count towards the waiting period.

While continued, coverage will remain the same as the coverage in effect on the **Employee's** last day actively-at-work. However, if benefits are modified or reduced for others in the **Employee's** class, benefits will also be modified or reduced for the continued person.

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 are not eligible for Family Medical Leave Act (**FMLA**) but who have successfully completed the ninety (90) day Initial Employment Period.

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:

1. the reason for the request;
2. the urgency of the request;
3. the ability of the department/practice to provide coverage for the absence; and,
4. the **Employee's** length of service and work record.

Military leave of absence will be granted in accordance with **Applicable Law**. SouthCoast Health 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 thirty (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 Health 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 or 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 Health 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 Health 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 or her portion of the premium to the Human Resource Department

on or before the 26th day of the month prior to the month the premium will cover. The **Employee's** failure to pay his or 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 Health paid premiums to maintain his or 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 Health.

COVERAGE CONTINUATION DURING FAMILY AND MEDICAL LEAVE.
Regardless of the policies described elsewhere in this **Plan**, this **Plan** will at all times comply with the Family and Medical Leave Act of 1993 ("FMLA") 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 an 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 twenty-six (26) work weeks of leave during a twelve (12)-month period to care for the service member (in compliance with the FMLA and applicable regulations issued by the Department of Labor).

During any leave taken under the 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 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. Where an **Employee** experiences a break-in-service of at least thirteen (13) weeks, they may be treated as newly-hired upon their return.

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. These rights include up to twenty-four (24) months of extended healthcare coverage upon payment of the entire cost of coverage plus a reasonable administration fee, and immediate coverage with no pre-existing condition exclusions applied 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 (1) 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* COBRA Continuation Coverage.

CARE MANAGEMENT REQUIREMENTS

The **Plan** features certain care management services designed to help ensure that all **Members** receive necessary and appropriate healthcare while avoiding unnecessary expenses when a **Hospital** confinement, surgical procedure, or certain other care is proposed. **Members** must use the services and follow all necessary steps as required. **Note:** Failure to comply with these requirements will result in a fifty percent (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 Healthcare Expenses** under the terms of the **Plan**. Therefore, the **Plan** has no liability for the quality of care the **Member** may receive. The **Member** and healthcare **Provider(s)** are responsible for making all decisions regarding healthcare and will control the course of treatment followed.

PRECERTIFICATION PROCESS.

In order to receive full benefits for the services listed below, the **Member** must obtain **Precertification** prior to receiving the services or treatment. **Precertification** is the responsibility of the **Member**. If the **Member** is unsure whether **Precertification** has been made, he or she should call to verify.

A seven (7)-day advance notice for **Precertification** is required for the following:

- Ambulatory Surgery
- Botox Injections
- Chemotherapy/Radiation Therapy
- Dialysis
- **Durable Medical Equipment** (rental or purchase) five-hundred dollars ($500) or more
- High-tech diagnostic radiology (CT, MRI, MRA, PET scans)
- **Home Health Care**
- **Hospice**
- **Inpatient** Care in Extended Care **Facilities**
- **Inpatient** Care in Mental Health & Substance Use Treatment Centers
- **Inpatient** Rehabilitation Services
- **Inpatient** Care in Skilled Nursing **Facilities**
- Non-Emergency Room admissions including observation
- **Outpatient** Surgery
- **Pain Therapy / Pain Management**
- **Prosthesis** or **Prosthetic Device**
- Sclerotherapy

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

HOSPITAL ADMISSIONS.

1. **For Emergency Admission:** The **Member** 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.
2. **For Non-Emergency Admission:** The **Member** or an authorized representative of the family or the admitting office must have the **Hospital**/**Facility** days certified by calling the **Plan Supervisor's** Medical Department when planning a future admission for the **Member**. This must be completed at least forty-eight (48) hours before the scheduled date of admission.

Precertification is the ultimate responsibility of the **Member**. If the **Member** is unsure whether **Precertification** has been made, he or she should call to verify.

PRECERTIFICATION PENALTY.
If **Precertification** is not obtained, benefits are reduced by fifty percent (50%) of the applicable rate. **Coinsurance** payments for services where **Precertification** is not obtained do not accrue toward the **Out-of-Pocket Limits**.

Precertification 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 **Precertification** 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.

UTILIZATION REVIEW.

When a **Hospital** admission or other admission requiring **Precertification** is recommended, **Utilization Review** is required. 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; and,
6. **Hospital/Facility** name, address, and phone number.

PHYSICIAN CONTACT.
The attending **Physician** will be contacted as part of the **Precertification** 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 **Member's Inpatient** stay, the **Hospital**/**Facility** will be contacted as part of the **Precertification** 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 the **Plan Supervisor**. 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 **Utilization 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 the **Utilization Review** process pertains solely to coverage under the terms of this **Plan**.

Precertification 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 **Precertification** 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.

CASE MANAGEMENT.

If a **Member** suffers an **Injury** or **Illness** for which healthcare needs are likely to be very complex and/or costs extremely high, the case may be referred for Case Management by the **Plan Supervisor**. 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 **SPD** as **Covered Healthcare 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.

ORGAN/TISSUE TRANSPLANT PROGRAM.

The **Plan** covers certain organ transplant procedures when a **Member** is the recipient of the organ. In order to receive full benefits, the following requirements must be met:

1. The procedure must be **Precertified** and arranged through Case Management by calling the **Plan Supervisor** at (980) 201-3020.
2. The procedure must be performed at an approved **Facility** or **Hospital**.

Eligible charges incurred by the **Member** will be paid for donor expenses directly related to the procurement of a living or cadaver human organ for any covered transplant procedure.

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 bone marrow, heart, lung, kidney, pancreas, liver, peripheral stem cell.

Covered Healthcare Expenses will include use of temporary life-support equipment pending the acquisition of “matched” human organs, multiple transplants during one operative session, replacement(s) or subsequent transplant(s), follow-up expenses for covered services (including immuno-suppressant therapy). Non-covered expenses will include any financial consideration to a donor other than expenses directly related to the performance of the surgery, any animal organ or mechanical organ, anything excluded or limited as stated in the **Plan**.

Additional covered benefits include:

1. Access to “Transplant Centers of Excellence” across the United States.
2. Reimbursement for travel and lodging expenses incurred during the transplant procedure immediately prior to and after the transplant up to a ten-thousand dollar ($10,000) maximum for the **Member** and a companion. Travel and lodging discounts are also available with select airlines and hotels.

COORDINATION OF BENEFITS

COORDINATION OF BENEFITS.
When two (2) or more benefit 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 **Member** 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** and one or more other plans, this **Plan** 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 and non-group insurance 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 reasonable, subject to **Plan Allowance** if applicable, 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 **Member** 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 healthcare 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**.**

2. As follows:
   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.
3. 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 **Member**. 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.

COBRA CONTINUATION COVERAGE

Federal law gives certain **Members** 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**.

WHAT COBRA PROVIDES.
COBRA coverage is available to the covered **Employee** and covered **Dependents**, if coverage under the **Plan** would otherwise end because:

1. The covered **Employee's** employment ends for any reason other than gross misconduct; or,
2. The covered **Employee'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 covered **Employee's** covered **Dependents** if the **Dependent's** coverage would otherwise end because of:

1. The covered **Employee's** death, divorce, or legal separation;
2. The covered **Employee's** entitlement to Medicare; or,
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 covered **Employee** and 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 thirty (30) days of the birth, adoption or placement for adoption; otherwise, the covered **Employee** will have to wait until the next annual Open Enrollment Period to enroll the child.

MAXIMUM COBRA CONTINUATION PERIOD.
If elected, **COBRA Continuation Coverage** begins as of the date **Plan** coverage would otherwise end. The maximum duration of **COBRA Continuation Coverage** varies depending on the reason the covered **Employee** or covered **Dependents** are eligible for **COBRA**.

1. **For up to 18 months.**
   Coverage may continue for the covered **Employee** and covered **Dependents** for up to eighteen (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.
2. **For up to 29 months.**
   If the Social Security Administration determines that a covered **Employee** or a covered **Dependent** is disabled within sixty (60) days of the loss of coverage due to a **COBRA** qualifying event, **COBRA** coverage for the disabled individual and non-disabled family members entitled to **COBRA** may be continued for up to twenty-nine (29) months from the date of the qualifying **COBRA** event. The **Plan Administrator** must be notified in writing of the disability within sixty (60) days after the latest of:
   a. The Social Security's determination of disability; or,
   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 thirty (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 Plan Information.

3. **For up to 36 Months.**
   COBRA coverage may continue for covered **Dependents** for up to thirty-six (36) months if their coverage would otherwise end because of:
   - **a.** The covered **Employee's** death, divorce, or legal separation; or,
   - **b.** The covered **Employee's** entitlement to Medicare; or,
   - **c.** The covered **Employee'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 eighteen (18) months of **COBRA** coverage (*see*, above), coverage may continue for a total of thirty-six (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 sixty (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 thirty (30) days of such event.

However, for other **COBRA** qualifying events (divorce, legal separation, or a **Dependent** child's loss of eligibility), the covered **Employee** or the covered **Dependents** must notify the **Plan Administrator** within sixty (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 Coverage** is not available after one of these qualifying events.

In addition, if while covered under **COBRA** for eighteen (18) months, a covered spouse or covered **Dependents** experience a second qualifying event that allows extension of **COBRA** coverage to thirty-six (36) months, the **Plan Administrator** must be notified in writing within sixty (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 notice of qualifying events must be provided to the **Employer** and/or the **Plan Administrator** in writing at the address listed in Plan Information.

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 sixty (60) days after the date coverage would otherwise end or, if later, within sixty (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 one-hundred two percent (102%) of the full cost of coverage. If **COBRA Continuation Coverage** is extended due to disability, **COBRA** payments will equal one-hundred fifty percent (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 forty-five (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 thirty (30) days of the due date. If payments are not timely received, **COBRA Continuation Coverage** will be terminated retroactive to the last day for which payment was received. Notwithstanding the foregoing, in the event a check is returned for insufficient funds ("NSF") you will be given a one-time extension of fifteen (15) days to remit premiums. This one-time extension will only be given for the first payment which is returned NSF, and no additional extensions will be granted for any subsequent NSF payments. Unless the thirty (30) day grace period is extended in the **Plan's** sole and complete discretion, if payments are not timely received, **COBRA Continuation Coverage** will be terminated retroactive to the last day for which payment was received.

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 that the **Employer** ceases to employ any **Employee**.
3. 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.
4. The date the qualified beneficiary fails to pay the cost of **COBRA** coverage by the due date (including the applicable grace periods).
5. For a qualified beneficiary who has extended **COBRA** coverage of twenty-nine (29) months due to disability, **COBRA** coverage will end as of the month that begins at least thirty (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 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 thirty (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 REGARDING 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 party(ies) may be responsible as a result of liability for causing or contributing to the **Injury** or **Illness** of the **Member**. Although such expenses are excluded, the **Plan**, in its sole and complete discretion, 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 **Member** shall agree to reimburse the **Plan** in full, and in first priority, from any funds recovered from any responsible party (which may be, among other things, 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 **Member'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 **Member**. 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**. The **Member** agrees that if they receive any payment from any third party contemplated herein, they will serve as a constructive trustee over the funds that constitutes such payment, and failure to hold such funds in trust shall be deemed a breach of the **Member's** duties to 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 **Member**, regardless of the following:

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

Amounts that have been recovered by a **Member** from a third party are assets of the **Plan**, and are not distributable to any person or entity without the **Plan's** prior written release of its subrogation interest. The **Member** and/or their agent or attorney shall notify the **Plan** and obtain its written consent prior to settling any and all third-party claims contemplated herein.

If the **Member** 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**. Among other things, it shall be fraud, intentional misrepresentation of a material fact, and/or omission of a material fact if: 1). the **Member** and/or their attorney, if one is obtained, receives funds from the third party and does not promptly reimburse the **Plan**; 2). the **Member** and/or their attorney, if one is obtained, indicates an intent not to reimburse the Plan upon receipt of funds from the third party; or, 3). the **Member** and/or their attorney, if one is obtained, fail to complete a Reimbursement & Subrogation Agreement to reimburse the **Plan** one-hundred percent (100%) before or after payments are advanced. In the event any of the foregoing occurs, the **Plan** expressly reserves any and all remedies available, including, but not limited to: the reduction of future benefits to cover the amount of payments advanced by the **Plan**; suspension or termination of payments advanced by the **Plan**; seeking the return of any payments advanced directly from the **Provider(s)**; and/or, taking legal and/or equitable action against the parties engaging in said activity. *See*, Rescission.

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 **Member's** right to recover from the third party. This means that the **Plan** may assume the rights of the **Member** 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 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**, **Members** 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 **Member** 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 **Member**. In the event of any such acts or omissions by the **Member**, 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 **Member**.

PLEASE NOTE: If an attorney is obtained by a **Member**, the **Plan** may require him/her to complete a subrogation agreement to reimburse the **Plan** one-hundred percent (100%) before payments are advanced.

FILING CLAIMS

CLAIM FILING PROCEDURE.

It is the responsibility of the **Member** 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, or they can be found online *via* Healthgram's Member Portal at https://members.healthgram.com. **Claim** forms must be filled out completely. **Claims** must be submitted to the **Plan Supervisor** at the address listed on the back of the ID Card.

An assignment of benefits by a **Claimant** is generally limited to assignment of the **Claimant's** right to receive a benefit payment under the terms of the **Plan**. Typically, assignments are not a grant of authority to act on a **Claimant's** behalf in pursuing and appealing a **Benefit Determination** under the **Plan**. In addition, the validity of a designation of an **Authorized Representative** will depend on whether the designation has been made in accordance with the procedures established by the Plan. *See*, Designating an Authorized Representative, below.

Benefits are paid to the **Member** unless: (i). the **Provider** agrees to accept the payment directly as full reimbursement; or, (ii). there is a valid assignment of the right to receive payment permitted under the terms of the **Plan**. A valid assignment of the right to receive payment under the terms of the **Plan** shall not constitute a valid assignment of any other rights relating to this **Plan** including, but not limited to, the right to: file a **Claim(s)**; request documents relating to an **Adverse Benefit Determination**; file an appeal; request an external review; and/or, enforce rights or institute litigation.

The following items are important and should be submitted with each **Claim**.

1. If a **Provider** has not completed a billing statement form, the **Member** 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 **Member** 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.**

DESIGNATING AN AUTHORIZED REPRESENTATIVE.
The **Member** has a right to designate an individual as **Authorized Representative** using the Designation of Authorized Representative Form approved by the **Plan**. To request a copy of the required Designation of Authorized Representative Form, the **Member** may: 1). call into the Customer Service number on the back of the card; 2). contact the **Plan Supervisor**; or, 3). Visit Healthgram's Member Portal at https://members.healthgram.com. No authorization shall be binding on the **Plan** unless the **Plan's** requirements for designating an **Authorized Representative** are fully complied with.

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 an **Authorized Representative** of a **Claimant** that complies with the **Plan's** procedure for making benefit **Claims**, as described herein.

There are different kinds of **Claims** (including **Post-Service Claims**; **Pre-Service Claims**; **Urgent Care Claims**; and, **Concurrent Care Claims**), and each one has a specific timetable for approval, payment, denial, or request for further information. For further questions regarding the **Claims** procedure(s), 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** results in an **Adverse Benefit Determination**, the **Plan Supervisor** will provide written notification no later than thirty (30) days after actual 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 (45) days. If all the needed information is not received within the forty-five (45)-day period, the **Plan Supervisor** may decide the **Claim** without that information. If all the needed information is received within that time limit and the **Claim** results in an **Adverse Benefit Determination**, the **Plan Supervisor** will provide notification of the **Adverse Benefit Determination** within fifteen (15) days after the information is received.

A notification of **Adverse Benefit Determination** will include:

1. The date of service, the healthcare **Provider**, and the **Claim** amount (if applicable).
2. The specific reason(s) for the **Adverse Benefit Determination**, 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 **Adverse Benefit 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. For example, if a **Member** received services on January 1, 2023, they must file a civil action against the **Plan** on or before December 31, 2025. If a **Member** received services on December 1, 2023, they must also file a civil action against the **Plan** on or before December 31, 2025. Nothing herein shall extend the time to file a suit.

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 **Adverse Benefit Determination** is based on a **Medical Necessity** or **Experimental or Investigational** treatment or similar exclusion, an explanation of the scientific or clinical judgment for the **Adverse Benefit 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 **Initial Benefit Determination** no later than fifteen (15) days from actual 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. Notification may be oral unless written notification is requested.

If an extension is necessary to process a **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 not provided within the forty-five (45)-day period, the **Plan Supervisor** may decide the **Claim** without that information. If all the needed information is received within that time limit, the **Plan Supervisor** will provide written notification of the **Initial Benefit Determination** within fifteen (15) days after the information is received.

An **Adverse Benefit Determination** notification will include the information listed above for <u>Post-Service Claim</u> details.

URGENT CARE CLAIMS.
Urgent Care Claims are those that require **Precertification** prior to receiving medical care, and where a delay:

1. Could seriously jeopardize life, health, or the ability to regain maximum function; or,
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 includes all needed information, the **Plan Supervisor** will provide notice of the **Initial Benefit Determination** as soon as possible, but no later than seventy-two (72) hours after actual 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 actual receipt of the improper **Claim**. This notification may be oral, unless written notification is requested.

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 actual receipt of the **Claim**. The requested information must be provided within forty-eight (48) hours. The **Plan Supervisor** will provide notice of the **Initial Benefit Determination** on the **Claim** no more than forty-eight (48) hours after the earlier of the following:

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

An **Adverse Benefit Determination** of an **Urgent Care Claim** will include the information listed above for Post-Service Claim **Adverse Benefit Determinations**. 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 (2) 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 **Initial Benefit Determination** 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 Claim or Pre-Service Claim timeframes described hereinabove, as applicable.

If an ongoing course of treatment previously approved by the **Plan** results in an **Adverse Benefit Determination** for continued coverage, the **Plan Supervisor** will provide notice sufficiently in advance to allow for an appeal.

Notices regarding **Adverse Benefit Determinations** of **Concurrent Care Claims** will include the information listed above for Post-Service Claim **Adverse Benefit Determinations**.

QUESTIONS REGARDING CLAIMS DETERMINATIONS.

Contact the **Plan Supervisor** to inquire about questions or concerns about a **Benefit Determination** on a **Claim**. 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. For example, if a **Member** received services on January 1, 2023, they must file a civil action against the **Plan** on or before December 31, 2025. If a **Member** received services on December 1, 2023, they must also file a civil action against the **Plan** on or before December 31, 2025. Legal action may be taken only after exhausting the **Plan's** administrative procedures including, but not limited to, completing the appeals process. *See*, Appeals. Nothing herein shall extend the time to file a suit.

Further, Federal law governs any 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 **Benefit Determination**. A **Member** may recover only the amount of benefits in dispute.

APPEALS

This **Plan** offers a two (2) level appeals procedure.

NOTE: To appeal an **Adverse Benefit Determination** of an **Urgent Care Claim**, please refer to Urgent Care Claims Appeals, 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 https://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 One Appeal must be filed within one hundred eighty-three (183) days of the date of the notice of **Initial Benefit Determination**. Comments, documents, and other information may be submitted in support of the Level One Appeal. A **Member** may review the **Claim** file and present evidence and testimony. The Level One Appeal review will consider any information submitted, even if it was not submitted for or considered as part of the **Initial Benefit 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 **Initial Benefit Determination**.
2. Was submitted, considered, or generated in the course of making the **Initial 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 Level One Appeal review 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 Level One Appeal.

If the **Claim** was denied based on a medical judgment (such as whether a service or supply is **Medically Necessary** or **Experimental or Investigational**), the **Plan Supervisor** will consult with a health professional with appropriate training and experience. The healthcare professional consulted for the Level One Appeal will not be a professional (if any) consulted during the **Initial Benefit 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 **Initial Benefit Determination**, even if the advice was not relied upon in making the **Initial Benefit Determination**.

The **Plan Supervisor** will provide written or electronic notification of the **Level One Appeal Determination** as follows:

1. For Level One Appeals of **Pre-Service Claims**, no later than fifteen (15) days after actual receipt of the Level One Appeal.

2. For Level One Appeals of **Post-Service Claims**, no later than thirty (30) days after actual receipt of the Level One Appeal.

If the Level One Appeal results in an **Adverse Benefit Determination**, the notification will include:

1. The date of service, the healthcare **Provider**, and the **Claim** amount (if applicable).
2. The specific reason(s) for the **Level One Appeal Determination**, 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 **Level One Appeal 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. For example, if a **Member** received services on January 1, 2023, they must file a civil action against the **Plan** on or before December 31, 2025. If a **Member** received services on December 1, 2023, they must also file a civil action against the **Plan** on or before December 31, 2025. Nothing herein shall extend the time to file a suit.
6. A statement disclosing any internal rule, guideline, protocol, or similar criterion referenced in making the **Level One Appeal Determination** (or a statement that such information will be provided free of charge upon request).
7. If the **Level One Appeal Determination** is based on **Medical Necessity** or **Experimental or Investigational** treatment or similar exclusion, an explanation of the scientific or clinical judgment for the **Level One Appeal 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 https://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-three (93) days of the date of the notice of **Level One Appeal Determination**. 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 Benefit Determination** or **Level One Appeal 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** 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 **Initial Benefit Determination** or **Level One Appeal Determination**.
2. Was submitted, considered, or generated in the course of making the **Initial Benefit Determination** or **Level One Appeal 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** or **Level One Appeal Determination**. Someone other than the individual involved in the **Initial Benefit Determination** or **Level One Appeal Determination**, not a subordinate of either individual, will be appointed by the **Plan Administrator** to decide the Level Two Appeal.

If the **Claim** and appeal was denied based on a medical judgment (such as whether a service or supply is **Medically Necessary** or **Experimental or Investigational**), the **Plan Administrator** will consult with a health professional with appropriate training and experience. The healthcare professional consulted for the Level Two Appeal will not be a professional (if any) consulted during the **Initial Benefit Determination** or **Level One Appeal Determination** 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 Level Two Appeal, even if the advice was not relied upon in making the **Level Two Appeal Determination**.

The **Plan Administrator** will provide written or electronic notification of the **Level Two Appeal Determination** as follows:

1. For Level Two Appeals of **Pre-Service Claims**, no later than fifteen (15) days after actual receipt of the Level Two Appeal.
2. For Level Two Appeals of **Post-Service Claims**, no later than thirty (30) days after actual receipt of the Level Two Appeal.

If the Level Two Appeal results in an **Adverse Benefit Determination**, the notification will include:

1. The date of service, the healthcare **Provider** and the **Claim** amount (if applicable).
2. The specific reason(s) for the **Level Two Appeal Determination**, 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 **Level Two Appeal 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. For example, if a **Member** received services on January 1, 2023, they must file a civil action against the **Plan** on or before December 31, 2025. If a **Member** received services on December 1, 2023, they must also file a civil action against the **Plan** on or before December 31, 2025. Nothing herein shall extend the time to file a suit.
6. A statement disclosing any internal rule, guideline, protocol, or similar criterion referenced in making the **Level Two Appeal Determination** (or a statement that such information will be provided free of charge upon request).
7. If the **Level Two Appeal Determination** is based on **Medical Necessity** or **Experimental or Investigational** treatment or similar exclusion, an explanation of the scientific or clinical judgment for the **Level Two Appeal 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 CLAIMS APPEALS.
An appeal involves an **Urgent Care Claim** 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 an **Urgent Care Claim**, 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 seventy-two (72) hours after actual receipt of the appeal. The notification may be written or electronic and will include the information described here for other appeal **Adverse Benefit Determinations**.

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 Appeals.

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** will 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 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** may file a written request for an external review after receipt of notice of a **Final Internal 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 Benefit Determination**. If there is no corresponding date four (4) 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. For purposes of this section, receipt shall be presumed to occur three (3) days after the date of the notice of **Final Internal Benefit Determination**.
2. **Preliminary review.**
   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 healthcare item or service was requested or, in the case of a retrospective review, was covered under the **Plan** at the time the healthcare item or service was provided.

b. 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**.
c. The **Claimant** has exhausted the **Plan's** internal appeal process.
d. 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 (4)-month filing period or within forty-eight (48)-hours following receipt of the notification, whichever is later. For purposes of this section, receipt shall be presumed to occur three (3) days after the date of the notification.

3. **Referral to Independent Review Organization.**
   The **Plan** will assign an independent review organization ("IRO") that is accredited by the Utilization Review Accreditation Commission 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 (10) business days following the date of receipt of such notice, the **Claimant** may submit in writing additional information that the IRO must consider. For purposes of this section, receipt shall be presumed to occur three (3) days after the date of the notice.
   c. Within five (5) 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 **Final Internal 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 healthcare professional's recommendation.
      iii. Reports from appropriate healthcare professionals and other documents submitted by the **Plan**, **Claim**, or the **Claimant's** treating **Provider**.
      iv. The terms of the **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 forty-five (45) days after actual 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 healthcare **Provider**, the **Claim** amount, the diagnosis code and its corresponding meaning, the treatment code and its corresponding meaning, and the reason for the previous **Adverse Benefit Determinations**.
      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; or,
   b. A **Final Internal 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 Benefit Determination** concerns an admission, availability of care, continued stay, or healthcare 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 actual 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 actual receipt of the request for an 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 **Member** or **Beneficiary's** rights.
4. To prescribe procedures for filing **Claims** for benefits and to review **Claim Adverse Benefit Determinations**.
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 a **QMCSO** under **ERISA** § 609.
9. To delegate to any person or entity such powers, duties, and responsibilities, as it deems appropriate.

PLAN ADMINISTRATOR COMPENSATION.
The **Plan Administrator** serves without compensation from the **Plan Sponsor**. However, all administrative expenses of the **Plan**, including compensation for services contracted from third parties in connection with the **Plan**, will be paid by the **Plan Sponsor**.

FIDUCIARY.
A fiduciary is anyone who:

1. Exercises discretionary authority or control over the management of the **Plan** or the management and disposition of **Plan** assets;
2. Renders investment advice to the **Plan**; or,
3. 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 **Members** 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 **ERISA** § 405(a).

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 **Member** 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**; or,
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 **Member** 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.

PRIVACY AND SECURITY RIGHTS UNDER HIPAA

HIPAA requires that the **Plan** protect the confidentiality of private health information. A description of the **Member**'s 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.

This **Plan** will not use or disclose individually identifiable health information protected by **HIPAA** ("**PHI**") except as necessary for treatment, payment, and other healthcare 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 and security requirements.

The **Plan** also may use or disclose **PHI** about individuals covered under the **Plan** in communications with family members involved in the care or payment of healthcare of that individual, if relevant to such involvement. In addition, the **Plan** may disclose **PHI** 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 OF PHI TO PLAN SPONSOR.

The **Employer**, as **Plan Sponsor**, hereby agrees to comply with **HIPAA** requirements to the same extent as the **Plan** is required to comply. The **Employer** will limit access of **PHI** to certain classifications of employees and only for certain permitted purposes (as described below), will report any violations of **HIPAA** privacy requirements of which it becomes aware, and has implemented procedures for handling noncompliance.

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 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 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 the **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 the **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** 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 availability 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**.

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**. **PHI** 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**, including, **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 **PHI** to accomplish the intended **Plan** administration purpose. **Plan Sponsor** has implemented procedures for handling non-compliance.

RIGHTS UNDER ERISA

Participants in this **Plan** are entitled to certain rights and protections under **ERISA**. **ERISA** specifies that all **Members** shall be entitled to the following:

1. **Receive Information about the Plan and Benefits.**
   a. 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.
   b. 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.
   c. Receive a summary of the **Plan's** Annual Financial report. The **Plan Administrator** is required by law to furnish each covered **Employee** with a copy of this summary annual report.
2. **Continue Plan Coverage.**
   Continue health care coverage for an **Employee**, spouse, or **Dependents** if there is a loss of coverage under the **Plan** as a result of a qualifying event. **Members** (including the **Employee** and any **Dependents**) will have to pay for such coverage.
3. **Prudent Actions by Plan Fiduciaries.**
   In addition to creating rights for 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 **Members** and their **Beneficiaries**. No one, including the **Employer** or any other person, may fire a **Member** or otherwise discriminate against a **Member** in any way to prevent that **Member** from obtaining benefits under the **Plan** or from exercising his or her rights under **ERISA**.
4. **Enforcement of Rights.**
   If a **Member** has a **Claim** for a benefit which results in an **Adverse Benefit Determination** or is ignored, in whole or in part, the **Member** has the right to know why this was done, to obtain copies of documents relating to the decision without charge, and to appeal any **Adverse Benefit Determination**, all within certain time schedules.

   Under **ERISA** there are steps that can be taken to enforce these rights. For instance, if a copy of the **Plan** Document or the latest Annual Report from the **Plan** is requested, but is not received within thirty (30) days, the **Member** may sue in federal court. In that event, the court may require the **Plan Administrator** to provide the materials and to pay the **Member** up to one-hundred ten dollars ($110) a day until the materials are received, unless the materials were not sent because of reasons beyond the control of the **Plan Administrator**. If a **Member** has a **Claim** for benefits, which is denied or ignored, in whole or in part, the **Member** may file suit in a court of proper jurisdiction after exhausting the administrative procedures set forth herein.

   In addition, if the **Member** disagrees with the **Plan's** decision or lack thereof concerning the qualified status of a medical child support order, the **Member** may file suit in a Federal court.

   In the event that the **Plan** fiduciaries misuse the **Plan's** money, or if a **Member** 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 **Member** is successful, the court may order the person sued to pay the costs and fees. If the **Member** 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 QUESTIONS.
For questions about the **Plan**, contact the **Plan Administrator**. For questions about this statement, rights under **ERISA**, or for assistance in obtaining documents from the **Plan Administrator**, 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. **Members** may also obtain certain publications about rights and responsibilities under **ERISA** by calling the publications hotline of the Employee Benefits Security Administration.

IN WITNESS WHEREOF, this **SPD** is hereby executed this 27 day of December, 2023

SOUTHCOAST MEDICAL GROUP, LLC DBA SOUTHCOAST HEALTH

By: ______________________

Authorized Representative of SouthCoast Medical Group, LLC dba SouthCoast Health

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. <u>Secondary Coverage</u>. 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. <u>Exclusions and Limitations</u>. 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.