Effective Date: September 1, 2023

Please Note: The terms Preferred and Non-Preferred Provider are used throughout this document to describe a Medical Services Provider’s participation in the PPO Network. Also referred to as In-Network and Out-of-Network, the terms Preferred/Non-Preferred and In-Network/Out-of-Network are interchangeable.
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FACTS ABOUT THE PLAN

Name of Plan:
Mesquite ISD Employee Health Care Benefit Plan

Name, Address and Phone Number of Employer/Plan Sponsor:
Mesquite ISD
3819 Towne Crossing #204
Mesquite, Texas 75150
972-288-6411

Group Number:
MS00

Type of Plan:
Welfare Benefit Plan: Medical and Prescription benefits

Type of Administration:
Contract administration: The processing of claims for benefits under the terms of the Plan is provided through one or more companies contracted by the employer and shall hereinafter be referred to as the claims processor.

Name, Address and Phone Number of Plan Administrator, and Agent for Service of Legal Process:
Mesquite ISD
3819 Towne Crossing #204
Mesquite, Texas 75150
972-288-6411

Legal process may be served upon the plan administrator.

Eligibility Requirements:
For detailed information regarding a person's eligibility to participate in the Plan, refer to the following section:
Eligibility, Enrollment and Effective Date

For detailed information regarding a person being ineligible for benefits through reaching Essential Health Benefit/non-Essential Health Benefit maximum benefit levels, termination of coverage or Plan exclusions, refer to the following sections:
Schedule of Benefits
Termination of Coverage
Plan Exclusions

Source of Plan Contributions:
Contributions for Plan expenses are obtained from the employer and from covered employees. The employer evaluates the costs of the Plan based on projected Plan expenses and determines the amount to be contributed by the employer and the amount to be contributed by the covered employees. Contributions by the covered employees are deducted from their pay on a pre-tax basis as authorized by the employee on the enrollment form (whether paper or electronic) or other applicable forms.
Funding Method:

The employer pays Plan benefits and administration expenses directly from general assets. Contributions received from covered persons are used to cover Plan costs and are expended immediately.

Standards Relating to Benefits for Mothers and Newborns (Newborns’ and Mothers’ Health Protection Act of 1996):

If the Schedule of Benefits shows that you have coverage for pregnancy and newborn care, this Plan generally may not, under Federal law, restrict benefits for any hospital length of stay in connection with childbirth for the birth parent or newborn child to less than forty-eight (48) hours following a vaginal delivery, or less than ninety-six (96) hours following a caesarean section. However, Federal law generally does not prohibit the birth parent’s or newborn’s attending provider, after consultation with the birth parent, from discharging the birth parent or newborn earlier than forty-eight (48) hours (or ninety-six (96) hours as applicable). In any case, this Plan may not, under Federal law, require that a provider obtain authorization from the Plan for prescribing a length of stay not in excess of the above periods.

Preferred Provider Networks:

This Plan may contain a Preferred Provider Organization (PPO) network and pre-certification requirements. Refer to the Plan for detailed information concerning pre-certification and Preferred Provider requirements. For a listing of Preferred Providers, contact the PPO network listed on your identification card.

Procedures for Filing Claims:

For detailed information on how to submit a claim for benefits, or how to file an appeal on a processed claim, refer to the section entitled Claim Filing Procedure.

The designated claims processor for claims is:

Blue Cross Blue Shield of Illinois
300 E. Randolph St.
Chicago, Il 60601

Except as otherwise provided herein, the designated claims processor for prescription drug claims and benefits is:

For Claims and Appeals:

Blue Cross Blue Shield of Illinois
300 E. Randolph St.
Chicago, Il 60601

For Pharmacy Benefit Information:

Prime Therapeutics
www.myprime.com
855-649-9607

Consumer Assistance Information:

Covered persons may seek consumer assistance information by contacting 1-855-760-3135 or www.myBlueElementIl.com.
COBRA Continuation Coverage General Notice

Introduction

You are getting this notice because you recently gained coverage under this group health Plan. This notice has important information about your right to COBRA continuation coverage, which is a temporary extension of coverage under the Plan. This notice explains COBRA continuation coverage, when it may become available to you and your family, and what you need to do to protect your right to get it. When you become eligible for COBRA, you may also become eligible for other coverage options that may cost less than COBRA continuation coverage.

The right to COBRA continuation coverage was created by a federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA). COBRA continuation coverage can become available to you and other members of your family when group health coverage would otherwise end. For more information about your rights and obligations under this Plan and under federal law, you should contact the plan administrator.

You may have other options available to you when you lose group health coverage. For example, you may be eligible to buy an individual plan through the Health Insurance Marketplace. By enrolling in coverage through the Marketplace, you may qualify for lower costs on your monthly premiums and lower out-of-pocket costs. Additionally, you may qualify for a 30-day special enrollment period for another group health plan for which you are eligible (such as a spouse’s plan), even if that plan generally doesn’t accept late enrollees.

What is COBRA continuation coverage?

COBRA continuation coverage is a continuation of Plan coverage when it would otherwise end because of a life event. This is also called a “qualifying event.” Specific qualifying events are listed later in this notice. After a qualifying event, COBRA continuation coverage must be offered to each person who is a “qualified beneficiary.” You, your spouse, and your dependent children could become qualified beneficiaries if coverage under this Plan is lost because of the qualifying event. Under this Plan, qualified beneficiaries who elect COBRA continuation coverage must pay for COBRA continuation coverage.

If you’re an employee, you’ll become a qualified beneficiary if you lose your coverage under this Plan because of the following qualifying events:

• Your hours of employment are reduced, or
• Your employment ends for any reason other than your gross misconduct.

If you’re the spouse of an employee, you’ll become a qualified beneficiary if you lose your coverage under this Plan because of the following qualifying events:

• Your spouse dies;
• Your spouse’s hours of employment are reduced;
• Your spouse’s employment ends for any reason other than gross misconduct;
• Your spouse becomes entitled to Medicare benefits (under Part A, Part B, or both); or
• You become divorced or legally separated from your spouse.

Your dependent children will become qualified beneficiaries if they lose coverage under this Plan because of the following qualifying events:

• The parent-employee dies;
• The parent-employee’s hours of employment are reduced;
• The parent-employee’s employment ends for any reason other than gross misconduct;
• The parent-employee becomes entitled to Medicare benefits (Part A, Part B, or both); or
• The parents become divorced or legally separated; or
• The child stops being eligible for coverage under this Plan as a “dependent child.”
When is COBRA continuation coverage available?

This Plan will offer COBRA continuation coverage to qualified beneficiaries only after the plan administrator has been notified that a qualifying event has occurred. The employer must notify the plan administrator of the following qualifying events:

- The end of employment or reduction of hours of employment;
- Death of the employee; or
- The employee’s becoming entitled to Medicare benefits (under Part A, Part B, or both).

For all other qualifying events (divorce or legal separation of the employee and spouse or a dependent child’s losing eligibility for coverage as a dependent child), you must notify the plan administrator within 60 days after the qualifying event occurs. You must provide this notice to the plan administrator (or its designee).

How is COBRA continuation coverage provided?

Once the plan administrator receives notice that a qualifying event has occurred, COBRA continuation coverage will be offered to each of the qualified beneficiaries. Each qualified beneficiary will have an independent right to elect COBRA continuation coverage. Covered employees may elect COBRA continuation coverage on behalf of their spouses, and parents may elect COBRA continuation coverage on behalf of their children.

COBRA continuation coverage is a temporary continuation of coverage that generally lasts for 18 months due to employment termination or reduction of hours of work. Certain qualifying events, or a second qualifying event during the initial period of coverage, may permit a beneficiary to receive a maximum of 36 months of coverage.

There are also ways in which this 18-month period of COBRA continuation coverage can be extended:

Disability extension of 18-month period of COBRA continuation coverage

If you or anyone in your family covered under this Plan is determined by Social Security to be disabled and you notify the plan administrator in a timely fashion, you and your entire family may be entitled to get up to an additional 11 months of COBRA continuation coverage, for a maximum of 29 months. The disability would have to have started at some time before the 60th day of COBRA continuation coverage and must last at least until the end of the 18-month period of COBRA continuation coverage. The disabled person (or the disabled person’s representative) must submit written proof of the Social Security Administration's disability determination to the plan administrator (or its designee) within the initial eighteen (18) month period of continuation coverage and no later than sixty (60) days after the latest of:

(i.) The date of the disability determination by the Social Security Administration;
(ii.) The date of the 18-Month Qualifying Event;
(iii.) The date on which the person loses (or would lose) coverage under this Plan as a result of the 18-Month Qualifying Event; or
(iv.) The date on which the person is furnished with a copy of this Plan Document.

Second qualifying event extension of 18-month period of continuation coverage

If your family experiences another qualifying event during the 18 months of COBRA continuation coverage, the spouse and dependent children in your family can get up to 18 additional months of COBRA continuation coverage, for a maximum of 36 months, if this Plan is properly notified about the second qualifying event. This extension may be available to the spouse and any dependent children getting COBRA continuation coverage if the employee or former employee dies; becomes entitled to Medicare benefits (under Part A, Part B, or both); gets divorced or legally separated; or if the dependent child stops being eligible under this Plan as a dependent child. This extension is only available if the second qualifying event would have caused the spouse or dependent child to lose coverage under this Plan had the first qualifying event not occurred.
Are there other coverage options besides COBRA Continuation Coverage?

Yes. Instead of enrolling in COBRA continuation coverage, there may be other coverage options for you and your family through the Health Insurance Marketplace, Medicare, Medicaid, Children’s Health Insurance Program (CHIP) or other group health plan coverage options (such as a spouse’s plan) through what is called a “special enrollment period.” Some of these options may cost less than COBRA continuation coverage. You can learn more about many of these options at www.healthcare.gov.

Can I enroll in Medicare instead of COBRA Continuation Coverage after my group health plan coverage ends?

In general, if you don’t enroll in Medicare Part A or B when you are first eligible because you are still employed, after the Medicare initial enrollment period, you have an 8-month special enrollment period to sign up for Medicare Part A or B, beginning on the earlier of

- The month after your employment ends;
- The month after group health plan coverage based on current employment ends.

If you don’t enroll in Medicare and elect COBRA continuation coverage instead, you may have to pay a Part B late enrollment penalty and you may have a gap in coverage if you decide you want Part B later. If you elect COBRA continuation coverage and later enroll in Medicare Part A or B, beginning on the earlier of the COBRA election, COBRA coverage may not be discontinued on account of Medicare entitlement, even if you enroll in the other part of Medicare after the date of the election of COBRA coverage.

If you are enrolled in both COBRA continuation coverage and Medicare, Medicare will generally pay first (primary payer) and COBRA continuation coverage will pay second. Certain plans may pay as if secondary to Medicare, even if you are not enrolled in Medicare.

For more information visit https://www.medicare.gov/medicare-and-you.

If you have questions

Questions concerning this Plan or your COBRA continuation coverage rights should be addressed to the contact or contacts identified below. For more information about your rights under the Employee Retirement Income Security Act (ERISA), including COBRA, the Patient Protection and Affordable Care Act, and other laws affecting group health plans, contact the nearest Regional or District Office of the U.S. Department of Labor’s Employee Benefits Security Administration (EBSA) in your area or visit www.dol.gov/ebsa. (Addresses and phone numbers of Regional and District EBSA Offices are available through EBSA’s website.) For more information about the Marketplace, visit www.HealthCare.gov.

Keep your Plan informed of address changes

To protect your family's rights, let the plan administrator (or its designee) know about any changes in the addresses of family members. You should also keep a copy, for your records, of any notices you send to the plan administrator (or its designee).

Plan contact information

Mesquite ISD
3819 Towne Crossing #204
Mesquite, Texas 75150
972-288-6411
MEDICAL SCHEDULE OF BENEFITS
PPOA PLAN

Benefit Period: September 1 through August 31

<table>
<thead>
<tr>
<th>MEDICAL BENEFITS - PPOA PLAN</th>
<th>PREFERRED PROVIDER</th>
<th>NONPREFERRED PROVIDER</th>
</tr>
</thead>
<tbody>
<tr>
<td>Deductible per benefit period</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Individual</td>
<td>$1,000</td>
<td>$2,000</td>
</tr>
<tr>
<td>Family (embedded)</td>
<td>$3,000</td>
<td>$6,000</td>
</tr>
</tbody>
</table>

Deductible does not share between preferred and nonpreferred

Generally, each covered person must pay all of the costs from providers up to the deductible amount before the Plan begins to pay.

Embedded family deductible: Any number of covered family members may help to satisfy the family deductible, but no family member will incur more than the individual deductible amount.

<table>
<thead>
<tr>
<th>Out-of-Pocket Expense Limit per benefit period (includes deductible, coinsurance, copays, and prescription drug cost-share)</th>
<th>PREFERRED PROVIDER</th>
<th>NONPREFERRED PROVIDER</th>
</tr>
</thead>
<tbody>
<tr>
<td>Individual</td>
<td>$7,900</td>
<td>$23,700</td>
</tr>
<tr>
<td>Family (embedded)</td>
<td>$15,800</td>
<td>$47,400</td>
</tr>
</tbody>
</table>

Out-of-pocket expense limit does not share between preferred and nonpreferred

The out-of-pocket expense limit is the most the covered person could pay in a year for covered expenses.

The Plan will pay the designated percentage of covered expenses until the out-of-pocket expense limits are reached, at which time the Plan will pay 100% of the remainder of covered expenses for the rest of the benefit period unless stated otherwise.

Embedded family out-of-pocket expense limit: Any number of covered family members may help to satisfy the family out-of-pocket expense limit, but no family member will incur more than the individual out-of-pocket expense limit.

The following charges do not apply to the out-of-pocket expense limit and are never paid at 100%:

- expenses not covered by the Plan
- expenses in excess of amounts covered by the Plan
- expenses in excess of customary and reasonable amount
- expenses incurred as a result of failure to obtain pre-certification

<table>
<thead>
<tr>
<th>Standard coinsurance paid by the Plan</th>
<th>PREFERRED PROVIDER</th>
<th>NONPREFERRED PROVIDER</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>80%</td>
<td>60%</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>MEDICAL BENEFITS - PPOA PLAN</th>
<th>PREFERRED PROVIDER</th>
<th>NONPREFERRED PROVIDER</th>
</tr>
</thead>
<tbody>
<tr>
<td>Acupuncture (only covered in lieu of anesthesia or for nausea during pregnancy)</td>
<td>80% after deductible</td>
<td>60% after deductible</td>
</tr>
<tr>
<td>MEDICAL BENEFITS - PPOA PLAN</td>
<td>PREFERRED PROVIDER</td>
<td>NONPREFERRED PROVIDER</td>
</tr>
<tr>
<td>----------------------------------------</td>
<td>-----------------------------------------</td>
<td>------------------------</td>
</tr>
<tr>
<td>Allergy Services</td>
<td>80% after deductible</td>
<td>60% after deductible</td>
</tr>
<tr>
<td>Allergy testing, injections and serum</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Allergy injections without an office visit</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Ambulance</td>
<td>80% after deductible</td>
<td>preferred provider benefit applies</td>
</tr>
<tr>
<td>Applied Behavior Analysis &amp; Therapy (ABA) / Autism Spectrum Disorder</td>
<td>$30 copay deductible waived</td>
<td>60% after deductible</td>
</tr>
<tr>
<td>Birthing Center</td>
<td>$150 copay/day for first 5 days, then 80% after deductible</td>
<td>60% after deductible</td>
</tr>
<tr>
<td>Blood (Blood storage and transfusions)</td>
<td>80% after deductible</td>
<td>60% after deductible</td>
</tr>
<tr>
<td>Breastfeeding Support, Counseling &amp; Supplies</td>
<td>100% deductible waived</td>
<td>60% after deductible</td>
</tr>
<tr>
<td>Lactation counseling (limited to six (6) visits per benefit period)</td>
<td>100% deductible waived</td>
<td>60% after deductible</td>
</tr>
<tr>
<td>Electric breast pumps (limited to two (2) per benefit period)</td>
<td>100% deductible waived</td>
<td>60% after deductible</td>
</tr>
<tr>
<td>Hospital grade breast pumps covered up to purchase price of $150</td>
<td>60% after deductible</td>
<td>60% after deductible</td>
</tr>
<tr>
<td>Cardiac Rehabilitation</td>
<td>80% after deductible</td>
<td>60% after deductible</td>
</tr>
<tr>
<td>Chemotherapy</td>
<td>80% after deductible</td>
<td>60% after deductible</td>
</tr>
<tr>
<td>Chiropractic Care</td>
<td>$70 copay deductible waived</td>
<td>60% after deductible</td>
</tr>
<tr>
<td>Office visits, spinal manipulation, adjustments and x-rays</td>
<td>100% deductible waived</td>
<td>60% after deductible</td>
</tr>
<tr>
<td>Maximum: 35 visits per benefit period for modalities only</td>
<td>60% after deductible</td>
<td>60% after deductible</td>
</tr>
<tr>
<td>Colonoscopy (Preventive)</td>
<td>100% deductible waived</td>
<td>60% after deductible</td>
</tr>
<tr>
<td>Contraceptives</td>
<td>See Women’s Preventive Services</td>
<td></td>
</tr>
<tr>
<td>Diabetic Management (training/nutritional)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Primary care physician</td>
<td>$30 copay deductible waived</td>
<td>60% after deductible</td>
</tr>
<tr>
<td>Specialist</td>
<td>$70 copay deductible waived</td>
<td>60% after deductible</td>
</tr>
<tr>
<td>Diagnostic Mammogram</td>
<td>100% deductible waived</td>
<td>60% after deductible</td>
</tr>
<tr>
<td>Diagnostic Services – Major (such as MRI, CT Scan, PET Scan)</td>
<td>$100 copay/per procedure, then 80% after deductible</td>
<td>60% after deductible</td>
</tr>
<tr>
<td>Diagnostic Services – Minor</td>
<td>100% deductible waived</td>
<td>60% after deductible</td>
</tr>
<tr>
<td>Lab</td>
<td></td>
<td></td>
</tr>
<tr>
<td>X-ray</td>
<td>80% after deductible</td>
<td>60% after deductible</td>
</tr>
<tr>
<td>Dialysis Therapy or Treatment</td>
<td>80% after deductible</td>
<td>60% after deductible</td>
</tr>
<tr>
<td>MEDICAL BENEFITS - PPOA PLAN</td>
<td>PREFERRED PROVIDER</td>
<td>NONPREFERRED PROVIDER</td>
</tr>
<tr>
<td>-----------------------------</td>
<td>--------------------</td>
<td>-----------------------</td>
</tr>
<tr>
<td>Durable Medical Equipment</td>
<td>80% after deductible</td>
<td>60% after deductible</td>
</tr>
</tbody>
</table>

**Emergency Room Services**

*For emergency medical care:*

<table>
<thead>
<tr>
<th>Facility</th>
<th>$250 copay/visit, then 80% after deductible</th>
<th>preferred provider benefit applies</th>
</tr>
</thead>
<tbody>
<tr>
<td>Physician</td>
<td>80% after deductible</td>
<td>preferred provider benefit applies</td>
</tr>
<tr>
<td>Freestanding emergency room</td>
<td>$500 copay/visit, then 80% after deductible</td>
<td>preferred provider benefit applies</td>
</tr>
</tbody>
</table>

*For non-emergency medical care:*

<table>
<thead>
<tr>
<th>Facility</th>
<th>$250 copay/visit, then 80% after deductible</th>
<th>60% after deductible</th>
</tr>
</thead>
<tbody>
<tr>
<td>Physician</td>
<td>80% after deductible</td>
<td>60% after deductible</td>
</tr>
<tr>
<td>Freestanding emergency room</td>
<td>$500 copay/visit, then 80% after deductible</td>
<td>$500 copay/visit, then 60% after deductible</td>
</tr>
</tbody>
</table>

**Extended Care Facility**

<table>
<thead>
<tr>
<th>Facility</th>
<th>80% after deductible</th>
<th>60% after deductible</th>
</tr>
</thead>
<tbody>
<tr>
<td>Maximum: 25 days per benefit period; $500 max per day for all services billed by inpatient nonpreferred providers</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Hearing**

**Routine Exam**

<table>
<thead>
<tr>
<th>Facility</th>
<th>100% deductible waived</th>
<th>60% after deductible</th>
</tr>
</thead>
<tbody>
<tr>
<td>Maximum: Routine hearing exams limited to 1 per benefit period</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Hearing Exam (non-routine)**

| Primary care physician | $30 copay deductible waived | 60% after deductible |
| Specialist             | $70 copay deductible waived | 60% after deductible |

**Hearing Aids**

<table>
<thead>
<tr>
<th>Facility</th>
<th>80% after deductible</th>
<th>60% after deductible</th>
</tr>
</thead>
<tbody>
<tr>
<td>Maximum: $1,000 per 36-month period for members over age 19</td>
<td></td>
<td></td>
</tr>
<tr>
<td>No maximum for dependents under age 19</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Cochlear Implants**

<table>
<thead>
<tr>
<th>Facility</th>
<th>80% after deductible</th>
<th>60% after deductible</th>
</tr>
</thead>
<tbody>
<tr>
<td>Maximum: Only covered for dependents under age 19 every 3 years</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Home Health Care**

**Home health care visits**

<table>
<thead>
<tr>
<th>Facility</th>
<th>80% after deductible</th>
<th>60% after deductible</th>
</tr>
</thead>
</table>

**Home health care supplies & services**

<table>
<thead>
<tr>
<th>Facility</th>
<th>80% after deductible</th>
<th>60% after deductible</th>
</tr>
</thead>
</table>

**IV therapy**

<table>
<thead>
<tr>
<th>Facility</th>
<th>80% after deductible</th>
<th>60% after deductible</th>
</tr>
</thead>
<tbody>
<tr>
<td>Maximum: 60 visits per benefit period</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Hospice Care**

**Inpatient**

<table>
<thead>
<tr>
<th>Facility</th>
<th>80% after deductible</th>
<th>60% after deductible</th>
</tr>
</thead>
</table>

**Outpatient**

<table>
<thead>
<tr>
<th>Facility</th>
<th>80% after deductible</th>
<th>60% after deductible</th>
</tr>
</thead>
</table>
## MEDICAL BENEFITS - PPOA PLAN

<table>
<thead>
<tr>
<th>Service Description</th>
<th>Preferred Provider</th>
<th>NonPreferred Provider</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Hospital – Inpatient Facility</strong></td>
<td>$150 <strong>copay</strong>/day for first 5 days, then 80% after deductible</td>
<td>60% after deductible</td>
</tr>
<tr>
<td><strong>Physician/Surgeon</strong></td>
<td>80% after deductible</td>
<td>60% after deductible</td>
</tr>
<tr>
<td>Note: Per admission <strong>copay</strong> max of $750 applies; $2,250 <strong>copay</strong> max per benefit period for <strong>inpatient preferred provider</strong> only; $500 max per day for <strong>inpatient nonpreferred provider</strong>.</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Hospital – Outpatient &amp; Ambulatory Surgical Facility</strong></td>
<td>$150 <strong>copay</strong>/visit, then 80% after deductible</td>
<td>$150 <strong>copay</strong>/visit, then 60% after deductible</td>
</tr>
<tr>
<td><strong>Physician/Surgeon</strong></td>
<td>80% after deductible</td>
<td>60% after deductible</td>
</tr>
<tr>
<td><strong>Infertility Services</strong></td>
<td>80% after deductible</td>
<td>60% after deductible</td>
</tr>
<tr>
<td>Diagnostic testing to determine infertility</td>
<td>80% after deductible</td>
<td>60% after deductible</td>
</tr>
<tr>
<td>Medications and treatments (to treat underlying condition only)</td>
<td>80% after deductible</td>
<td>60% after deductible</td>
</tr>
<tr>
<td><strong>Infusion Therapy</strong></td>
<td>$500 <strong>copay</strong> deductible waived</td>
<td>$1,000 <strong>copay</strong> deductible waived</td>
</tr>
<tr>
<td><strong>Physician</strong></td>
<td>$30 <strong>copay</strong> deductible waived</td>
<td>$250 <strong>copay</strong> deductible waived</td>
</tr>
<tr>
<td><strong>Massage Therapy (covered when performed by an MD, DC and PT)</strong></td>
<td>$70 <strong>copay</strong> deductible waived</td>
<td>60% after deductible</td>
</tr>
<tr>
<td><strong>Occupational Therapy</strong></td>
<td>80% after deductible</td>
<td>60% after deductible</td>
</tr>
<tr>
<td><strong>Facility</strong></td>
<td>80% after deductible</td>
<td>60% after deductible</td>
</tr>
<tr>
<td><strong>Physician</strong></td>
<td>$30 <strong>copay</strong> deductible waived</td>
<td>60% after deductible</td>
</tr>
<tr>
<td><strong>Office Visit &amp; Other Services</strong> (one <strong>copay</strong> per provider per date of service)</td>
<td>60% after deductible</td>
<td></td>
</tr>
<tr>
<td><strong>Primary care physician</strong> (includes outpatient visits for mental and nervous disorders and substance use disorder)</td>
<td>$30 <strong>copay</strong> deductible waived</td>
<td>60% after deductible</td>
</tr>
<tr>
<td><strong>Specialist</strong></td>
<td>80% after deductible</td>
<td>60% after deductible</td>
</tr>
<tr>
<td><strong>Surgery</strong></td>
<td>80% after deductible</td>
<td>60% after deductible</td>
</tr>
<tr>
<td><strong>Primary care physician</strong></td>
<td>80% after deductible</td>
<td>60% after deductible</td>
</tr>
<tr>
<td><strong>Specialist</strong></td>
<td>80% after deductible</td>
<td>60% after deductible</td>
</tr>
</tbody>
</table>
**MEDICAL BENEFITS - PPOA PLAN**

<table>
<thead>
<tr>
<th>Service</th>
<th>Preferred Provider</th>
<th>Nonpreferred Provider</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Office Visit &amp; Other Services (continued)</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Lab and X-ray</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Primary care physician</strong></td>
<td>100% deductible waived</td>
<td>60% after deductible</td>
</tr>
<tr>
<td>Specialist</td>
<td>100% deductible waived</td>
<td>60% after deductible</td>
</tr>
<tr>
<td><strong>Primary care physician</strong></td>
<td>80% after deductible</td>
<td>60% after deductible</td>
</tr>
<tr>
<td>Specialist</td>
<td>80% after deductible</td>
<td>60% after deductible</td>
</tr>
<tr>
<td><strong>On-Site Clinic (MEHC)</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Office visit (including virtual)</td>
<td>$15 copay deductible waived</td>
<td>Not Covered</td>
</tr>
<tr>
<td>Other services</td>
<td>Based on service provided</td>
<td>Not Covered</td>
</tr>
<tr>
<td><strong>Orthotics</strong></td>
<td>80% after deductible</td>
<td>60% after deductible</td>
</tr>
<tr>
<td>Maximum: Two (2) pairs of therapeutic footwear per benefit period for the prevention of complications associated with Diabetes</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Physical Therapy</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Facility</strong></td>
<td>80% after deductible</td>
<td>60% after deductible</td>
</tr>
<tr>
<td><strong>Physician</strong></td>
<td>$30 copay deductible waived</td>
<td>60% after deductible</td>
</tr>
<tr>
<td><strong>Podiatry Services</strong></td>
<td>Based on service provided</td>
<td>Based on service provided</td>
</tr>
<tr>
<td><strong>Pregnancy</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Initial pre-natal visit and urinalysis</td>
<td>100% deductible waived</td>
<td>60% after deductible</td>
</tr>
<tr>
<td>Subsequent pre-natal visits/care and breastfeeding services and supplies (as required by the <em>Affordable Care Act</em>)</td>
<td>100% deductible waived</td>
<td>60% after deductible</td>
</tr>
<tr>
<td>Post-natal care and other non-routine/non-preventive pregnancy related care.</td>
<td>Based on service provided</td>
<td>Based on service provided</td>
</tr>
<tr>
<td>Delivery</td>
<td>$150 copay/day for first 5 days, then 80% after deductible</td>
<td>60% after deductible</td>
</tr>
<tr>
<td>Note: Per admission copay max of $750 applies; $2,250 copay max per benefit period for inpatient preferred provider only; $500 max per day for inpatient nonpreferred provider.</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Private Duty Nursing</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Inpatient</strong></td>
<td>80% after deductible</td>
<td>60% after deductible</td>
</tr>
<tr>
<td><strong>Outpatient</strong></td>
<td>80% after deductible</td>
<td>60% after deductible</td>
</tr>
<tr>
<td><strong>Prostheses</strong></td>
<td>80% after deductible</td>
<td>60% after deductible</td>
</tr>
<tr>
<td><strong>Radiation Therapy</strong></td>
<td>80% after deductible</td>
<td>60% after deductible</td>
</tr>
<tr>
<td><strong>Respiratory Therapy</strong></td>
<td>80% after deductible</td>
<td>60% after deductible</td>
</tr>
<tr>
<td><strong>Retail Clinic Visits</strong></td>
<td>$30 copay deductible waived</td>
<td>60% after deductible</td>
</tr>
<tr>
<td>MEDICAL BENEFITS - PPOA PLAN</td>
<td>PREFERRED PROVIDER</td>
<td>NONPREFERRED PROVIDER</td>
</tr>
<tr>
<td>-----------------------------</td>
<td>--------------------</td>
<td>-----------------------</td>
</tr>
<tr>
<td><strong>Routine Preventive Care/Wellness Benefits</strong>&lt;br&gt;Includes all evidence-based supplies or services that have in effect a rating of A or B in the current recommendations of the United States Preventive Services Task Force (USPSTF). For additional information visit: <a href="http://www.uspreventiveservicestaskforce.org">http://www.uspreventiveservicestaskforce.org</a></td>
<td>100% deductible waived</td>
<td>60% after deductible</td>
</tr>
<tr>
<td><strong>Routine Prostate Examinations</strong></td>
<td>100% deductible waived</td>
<td>60% after deductible</td>
</tr>
<tr>
<td><strong>Speech Therapy Facility</strong></td>
<td>80% after deductible</td>
<td>60% after deductible</td>
</tr>
<tr>
<td><strong>Speech Therapy Physician</strong></td>
<td>$30 copay deductible waived</td>
<td>60% after deductible</td>
</tr>
<tr>
<td><strong>Telemedicine Services (via Teladoc)</strong>&lt;br&gt;Medical</td>
<td>$12 copay deductible waived</td>
<td></td>
</tr>
<tr>
<td>Behavioral Health</td>
<td>$30 copay deductible waived</td>
<td></td>
</tr>
<tr>
<td><strong>Telemedicine Services (non-Teladoc)</strong>&lt;br&gt;Medical&lt;br&gt;Primary care physician</td>
<td>$30 copay deductible waived</td>
<td>60% after deductible</td>
</tr>
<tr>
<td>Specialist</td>
<td>$70 copay deductible waived</td>
<td>60% after deductible</td>
</tr>
<tr>
<td>Behavioral Health</td>
<td>$30 copay deductible waived</td>
<td>60% after deductible</td>
</tr>
<tr>
<td><strong>Temporomandibular Joint Syndrome (TMJ) Treatment</strong>&lt;br&gt;(excludes appliances, physical therapy, non-diagnostic and non-surgical services)</td>
<td>80% after deductible</td>
<td>60% after deductible</td>
</tr>
<tr>
<td><strong>Transplants (Organ or Tissue)</strong>&lt;br&gt;Blue Distinction Center</td>
<td>$150 copay/day, then no charge after deductible</td>
<td>Not Applicable</td>
</tr>
<tr>
<td>Blue Distinction Plus Center</td>
<td>$150 copay/day, then no charge deductible waived</td>
<td>Not Applicable</td>
</tr>
<tr>
<td>Non-Blue Distinction Center/&lt;br&gt;Non-Blue Distinction Plus Center</td>
<td>$150 copay/day, then 80% after deductible</td>
<td>$150 copay/visit, then 60% after deductible</td>
</tr>
<tr>
<td>Transportation and Lodging</td>
<td>Not Covered</td>
<td>Not Covered</td>
</tr>
<tr>
<td>Note: Per admission copay max of $750 applies; $2,250 copay max per benefit period for inpatient preferred provider only; $500 max per day for inpatient nonpreferred provider.</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Urgent Care Center</strong></td>
<td>$50 copay deductible waived</td>
<td>60% after deductible</td>
</tr>
<tr>
<td>MEDICAL BENEFITS - PPOA PLAN</td>
<td>PREFERRED PROVIDER</td>
<td>NONPREFERRED PROVIDER</td>
</tr>
<tr>
<td>-----------------------------</td>
<td>--------------------</td>
<td>------------------------</td>
</tr>
<tr>
<td><strong>Vision – Routine Services</strong>&lt;br&gt;(Routine vision services required by the Affordable Care Act shall be covered under the Routine Preventive Care benefit)</td>
<td>$70 copay deductible waived</td>
<td>60% after deductible</td>
</tr>
<tr>
<td><strong>Weight Management</strong></td>
<td>Based on service provided</td>
<td>Based on service provided</td>
</tr>
<tr>
<td>Office visit and basic diagnostic testing, including laboratory services and electrocardiograms (EKGs), but does not include advanced imaging services</td>
<td>$5,000 copay then 80% after deductible 100% deductible waived</td>
<td>Not Covered 60% after deductible</td>
</tr>
<tr>
<td>Bariatric surgery (Blue Distinction Plus Center only)</td>
<td>Non-surgical treatment, including therapy and behavior modification</td>
<td></td>
</tr>
<tr>
<td><strong>Wigs</strong> (&lt;i&gt;hair loss due to treatment of injury or disease&lt;/i&gt;)</td>
<td>80% after deductible</td>
<td>60% after deductible</td>
</tr>
<tr>
<td><strong>Women’s Preventive Services</strong>&lt;br&gt;As required by the Affordable Care Act</td>
<td>100% deductible waived</td>
<td>60% after deductible</td>
</tr>
<tr>
<td><strong>All Other Covered Expenses</strong></td>
<td>80% after deductible</td>
<td>60% after deductible</td>
</tr>
</tbody>
</table>
# PRESCRIPTION DRUG PROGRAM

## SCHEDULE OF BENEFITS PPOA PLAN

**Benefit Period:** September 1 – August 31

<table>
<thead>
<tr>
<th>PRESCRIPTION DRUG BENEFITS PPOA PLAN</th>
<th>PREFERRED PROVIDER</th>
<th>NONPREFERRED PROVIDER</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Deductible per benefit period</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Individual</td>
<td>$200</td>
<td>N/A</td>
</tr>
<tr>
<td></td>
<td>does not apply to <em>generic drugs</em></td>
<td></td>
</tr>
<tr>
<td><strong>Out-of-Pocket Expense Limit</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>is the same as and is combined with the Medical Out-of-Pocket Expense Limit</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### Retail Pharmacy (31-day supply)

**Note:** Insulin out-of-pocket costs are $25 *copay* for a 31-day supply; $75 for a 61-90 day supply.

<table>
<thead>
<tr>
<th>Route</th>
<th>Preferred Provider</th>
<th>Non-Preferred Provider</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Generic</strong></td>
<td>Plan 100% deductible waived</td>
<td>100% deductible waived</td>
</tr>
<tr>
<td><strong>Brand Name</strong></td>
<td>Plan 75% after deductible</td>
<td>Member pays additional 20% of the allowable amount plus <em>copay</em></td>
</tr>
<tr>
<td><strong>Non-Preferred Brand Name</strong></td>
<td>Plan 50% after deductible</td>
<td>Member pays additional 20% of the allowable amount plus <em>coinsurance</em></td>
</tr>
</tbody>
</table>

### Mail Order Pharmacy and Extended Supply Network (90-day supply)

<table>
<thead>
<tr>
<th>Route</th>
<th>Preferred Provider</th>
<th>Non-Preferred Provider</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Generic</strong></td>
<td>Plan 100% deductible waived</td>
<td>100% deductible waived</td>
</tr>
<tr>
<td><strong>Brand Name</strong></td>
<td>Plan 75% after deductible</td>
<td>Member pays additional 20% of the allowable amount plus <em>copay</em></td>
</tr>
<tr>
<td><strong>Non-Preferred Brand Name</strong></td>
<td>Plan 50% after deductible</td>
<td>Member pays additional 20% of the allowable amount plus <em>coinsurance</em></td>
</tr>
</tbody>
</table>

### Specialty Drugs (31-day supply)

<table>
<thead>
<tr>
<th>Route</th>
<th>Preferred Provider</th>
<th>Non-Preferred Provider</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Specialty Drugs</strong></td>
<td>Plan 70% after deductible</td>
<td>Not Covered</td>
</tr>
<tr>
<td><strong>Member pays $200 min / $900 max</strong></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Specialty drugs must be obtained from preferred specialty drug provider.

If the *covered person* selects a brand drug when a generic equivalent is available, the *covered person* is responsible for the generic *copay* plus the cost difference between the generic and brand equivalent. If the *physician* indicates no substitutions, the *covered person* is only responsible for the brand *copay*.
MEDICAL SCHEDULE OF BENEFITS  
PPOB PLAN  

Benefit Period: September 1 through August 31  

<table>
<thead>
<tr>
<th>MEDICAL BENEFITS - PPOB PLAN</th>
<th>PREFERRED PROVIDER</th>
<th>NONPREFERRED PROVIDER</th>
</tr>
</thead>
<tbody>
<tr>
<td>Deductible per benefit period</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Individual</td>
<td>$3,000</td>
<td>$5,500</td>
</tr>
<tr>
<td>Family (embedded)</td>
<td>$6,000</td>
<td>$11,000</td>
</tr>
</tbody>
</table>

**Deductible does not share between preferred and nonpreferred**  
Generally, each *covered person* must pay all of the costs from providers up to the deductible amount before the *Plan* begins to pay.  

**Embedded family deductible**: Any number of covered family members may help to satisfy the family deductible, but no family member will incur more than the individual deductible amount.  

<table>
<thead>
<tr>
<th>Out-of-Pocket Expense Limit per benefit period (includes deductible, coinsurance, copays, and prescription drug cost-share)</th>
<th>PREFERRED PROVIDER</th>
<th>NONPREFERRED PROVIDER</th>
</tr>
</thead>
<tbody>
<tr>
<td>Individual</td>
<td>$7,050</td>
<td>$20,250</td>
</tr>
<tr>
<td>Family (embedded)</td>
<td>$14,100</td>
<td>$40,500</td>
</tr>
</tbody>
</table>

**Out-of-pocket expense limit does not share between preferred and nonpreferred**  
The out-of-pocket expense limit is the most the *covered person* could pay in a year for *covered expenses*.  
The *Plan* will pay the designated percentage of *covered expenses* until the out-of-pocket expense limits are reached, at which time the *Plan* will pay 100% of the remainder of *covered expenses* for the rest of the benefit period unless stated otherwise.  

**Embedded family out-of-pocket expense limit**: Any number of covered family members may help to satisfy the family out-of-pocket expense limit, but no family member will incur more than the individual out-of-pocket expense limit.  
The following charges do not apply to the out-of-pocket expense limit and are never paid at 100%:  
- expenses not covered by the *Plan*  
- expenses in excess of amounts covered by the *Plan*  
- expenses in excess of *customary and reasonable amount*  
- expenses incurred as a result of failure to obtain pre-certification  

| Standard coinsurance paid by the *Plan* | 70% | 50% |

<table>
<thead>
<tr>
<th>MEDICAL BENEFITS - PPOB PLAN</th>
<th>PREFERRED PROVIDER</th>
<th>NONPREFERRED PROVIDER</th>
</tr>
</thead>
<tbody>
<tr>
<td>Acupuncture <em>(only covered in lieu of anesthesia or for nausea during pregnancy)</em></td>
<td>70% after deductible</td>
<td>50% after deductible</td>
</tr>
<tr>
<td>MEDICAL BENEFITS - PPOB PLAN</td>
<td>PREFERRED PROVIDER</td>
<td>NONPREFERRED PROVIDER</td>
</tr>
<tr>
<td>-----------------------------</td>
<td>--------------------</td>
<td>------------------------</td>
</tr>
<tr>
<td>Allergy Services</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Allergy testing, injections and serum</td>
<td>70% after deductible</td>
<td>50% after deductible</td>
</tr>
<tr>
<td>Allergy injections without an office visit</td>
<td>70% after deductible</td>
<td>50% after deductible</td>
</tr>
<tr>
<td>Ambulance</td>
<td>70% after deductible</td>
<td>preferred provider benefit applies</td>
</tr>
<tr>
<td>Applied Behavior Analysis &amp; Therapy (ABA) / Autism Spectrum Disorder</td>
<td>70% after deductible</td>
<td>50% after deductible</td>
</tr>
<tr>
<td>Birthing Center</td>
<td>70% after deductible</td>
<td>50% after deductible</td>
</tr>
<tr>
<td>Note: $500 max per day for nonpreferred provider.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Blood (Blood storage and transfusions)</td>
<td>70% after deductible</td>
<td>50% after deductible</td>
</tr>
<tr>
<td>Breastfeeding Support, Counseling &amp; Supplies</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Lactation counseling (limited to six (6) visits per benefit period)</td>
<td>100% deductible waived</td>
<td>50% after deductible</td>
</tr>
<tr>
<td>Electric breast pumps (limited to two (2) per benefit period)</td>
<td>100% deductible waived</td>
<td>50% after deductible</td>
</tr>
<tr>
<td>Hospital grade breast pumps covered up to purchase price of $150</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Cardiac Rehabilitation</td>
<td>70% after deductible</td>
<td>50% after deductible</td>
</tr>
<tr>
<td>Chemotherapy</td>
<td>70% after deductible</td>
<td>50% after deductible</td>
</tr>
<tr>
<td>Chiropractic Care</td>
<td>70% after deductible</td>
<td>50% after deductible</td>
</tr>
<tr>
<td>Office visits, spinal manipulation, adjustments and x-rays</td>
<td>Maximum: 35 visits per benefit period for modalities only</td>
<td></td>
</tr>
<tr>
<td>Colonoscopy (Preventive)</td>
<td>100% deductible waived</td>
<td>50% after deductible</td>
</tr>
<tr>
<td>Contraceptives</td>
<td>See Women’s Preventive Services</td>
<td></td>
</tr>
<tr>
<td>Diabetic Management (training/nutritional)</td>
<td>70% after deductible</td>
<td>50% after deductible</td>
</tr>
<tr>
<td>Diagnostic Mammogram</td>
<td>100% after deductible</td>
<td>50% after deductible</td>
</tr>
<tr>
<td>Diagnostic Services – Major (such as MRI, CT Scan, PET Scan)</td>
<td>70% after deductible</td>
<td>50% after deductible</td>
</tr>
<tr>
<td>Diagnostic Services – Minor</td>
<td>70% after deductible</td>
<td>50% after deductible</td>
</tr>
<tr>
<td>Dialysis Therapy or Treatment</td>
<td>70% after deductible</td>
<td>50% after deductible</td>
</tr>
<tr>
<td>Durable Medical Equipment</td>
<td>70% after deductible</td>
<td>50% after deductible</td>
</tr>
<tr>
<td>MEDICAL BENEFITS - PPOB PLAN</td>
<td>PREFERRED PROVIDER</td>
<td>NONPREFERRED PROVIDER</td>
</tr>
<tr>
<td>-------------------------------</td>
<td>--------------------</td>
<td>-----------------------</td>
</tr>
<tr>
<td><strong>Emergency Room Services</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td><em>Emergency Medical Condition Care</em></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Facility</td>
<td>70% after deductible</td>
<td>preferred provider benefit applies</td>
</tr>
<tr>
<td>Physician</td>
<td>70% after deductible</td>
<td>preferred provider benefit applies</td>
</tr>
<tr>
<td>Freestanding emergency room</td>
<td>$500 copay/visit after deductible, then 70%</td>
<td>preferred provider benefit applies</td>
</tr>
<tr>
<td><strong>Non-Emergency Medical Condition Care</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Facility</td>
<td>70% after deductible</td>
<td>50% after deductible</td>
</tr>
<tr>
<td>Physician</td>
<td>70% after deductible</td>
<td>50% after deductible</td>
</tr>
<tr>
<td>Freestanding emergency room</td>
<td>$500 copay/visit after deductible, then 70%</td>
<td>$500 copay/visit after deductible, then 50%</td>
</tr>
<tr>
<td><strong>Extended Care Facility</strong></td>
<td>70% after deductible</td>
<td>50% after deductible</td>
</tr>
<tr>
<td></td>
<td>Maximum: 25 days per benefit period; $500 max per day for all services billed by inpatient nonpreferred providers</td>
<td></td>
</tr>
<tr>
<td><strong>Hearing</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Routine Exam</td>
<td>100% deductible waived</td>
<td>50% after deductible</td>
</tr>
<tr>
<td></td>
<td>Maximum: Routine hearing exams limited to 1 per benefit period</td>
<td></td>
</tr>
<tr>
<td>Hearing Exam (non-routine)</td>
<td>70% after deductible</td>
<td>50% after deductible</td>
</tr>
<tr>
<td>Hearing Aids</td>
<td>70% after deductible</td>
<td>50% after deductible</td>
</tr>
<tr>
<td></td>
<td>Maximum: $1,000 per 36-month period for members over age 19 No maximum for dependents under age 19</td>
<td></td>
</tr>
<tr>
<td>Cochlear Implants</td>
<td>70% after deductible</td>
<td>50% after deductible</td>
</tr>
<tr>
<td></td>
<td>Maximum: Only covered for dependents under age 19 every 3 years</td>
<td></td>
</tr>
<tr>
<td><strong>Home Health Care</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Home health care visits</td>
<td>70% after deductible</td>
<td>50% after deductible</td>
</tr>
<tr>
<td>Home health care supplies &amp; services</td>
<td>70% after deductible</td>
<td>50% after deductible</td>
</tr>
<tr>
<td>IV therapy</td>
<td>70% after deductible</td>
<td>50% after deductible</td>
</tr>
<tr>
<td></td>
<td>Maximum: 60 visits per benefit period</td>
<td></td>
</tr>
<tr>
<td><strong>Hospice Care</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Inpatient</td>
<td>70% after deductible</td>
<td>50% after deductible</td>
</tr>
<tr>
<td>Outpatient</td>
<td>70% after deductible</td>
<td>50% after deductible</td>
</tr>
<tr>
<td>MEDICAL BENEFITS - PPOB PLAN</td>
<td>PREFERRED PROVIDER</td>
<td>NONPREFERRED PROVIDER</td>
</tr>
<tr>
<td>-----------------------------------------------------</td>
<td>--------------------------------------------</td>
<td>-----------------------</td>
</tr>
<tr>
<td><strong>Hospital – Inpatient</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Facility</td>
<td>70% after deductible</td>
<td>50% after deductible</td>
</tr>
<tr>
<td>Physician/Surgeon</td>
<td>70% after deductible</td>
<td>50% after deductible</td>
</tr>
<tr>
<td>Note: $500 max per day for <strong>inpatient nonpreferred provider</strong>.</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Hospital – Outpatient &amp; Ambulatory Surgical Facility</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Facility</td>
<td>70% after deductible</td>
<td>50% after deductible</td>
</tr>
<tr>
<td>Physician/Surgeon</td>
<td>70% after deductible</td>
<td>50% after deductible</td>
</tr>
<tr>
<td><strong>Infertility Services</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Diagnostic testing to determine infertility</td>
<td>70% after deductible</td>
<td>50% after deductible</td>
</tr>
<tr>
<td>Medications and treatments (<strong>to treat underlying condition only</strong>)</td>
<td>70% after deductible</td>
<td>50% after deductible</td>
</tr>
<tr>
<td><strong>Infusion Therapy</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Facility</td>
<td>$500 <strong>copay</strong> after deductible</td>
<td>$1,000 <strong>copay</strong> after deductible</td>
</tr>
<tr>
<td>Physician</td>
<td>$30 <strong>copay</strong> after deductible</td>
<td>$250 <strong>copay</strong> after deductible</td>
</tr>
<tr>
<td><strong>Occupational Therapy</strong></td>
<td>70% after deductible</td>
<td>50% after deductible</td>
</tr>
<tr>
<td><strong>Office Visit &amp; Other Services</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Office visit</td>
<td>70% after deductible</td>
<td>50% after deductible</td>
</tr>
<tr>
<td><strong>Primary care physician</strong> (includes outpatient visits for mental and nervous disorders and substance use disorder)</td>
<td>70% after deductible</td>
<td>50% after deductible</td>
</tr>
<tr>
<td>Specialist</td>
<td>70% after deductible</td>
<td>50% after deductible</td>
</tr>
<tr>
<td><strong>Surgery</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Primary care physician</strong></td>
<td>70% after deductible</td>
<td>50% after deductible</td>
</tr>
<tr>
<td>Specialist</td>
<td>70% after deductible</td>
<td>50% after deductible</td>
</tr>
<tr>
<td><strong>Lab and X-ray</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Primary care physician</strong></td>
<td>70% after deductible</td>
<td>50% after deductible</td>
</tr>
<tr>
<td>Specialist</td>
<td>70% after deductible</td>
<td>50% after deductible</td>
</tr>
<tr>
<td><strong>Other services</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Primary care physician</strong></td>
<td>70% after deductible</td>
<td>50% after deductible</td>
</tr>
<tr>
<td>Specialist</td>
<td>70% after deductible</td>
<td>50% after deductible</td>
</tr>
<tr>
<td><strong>On-Site Clinic (MEHC)</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Office visit (including virtual)</td>
<td>70% after deductible</td>
<td><strong>Not Covered</strong></td>
</tr>
<tr>
<td>Other services</td>
<td>Based on service provided</td>
<td><strong>Not Covered</strong></td>
</tr>
</tbody>
</table>
## MEDICAL BENEFITS - PPOB PLAN

<table>
<thead>
<tr>
<th>Service</th>
<th>Preferred Provider</th>
<th>Nonpreferred Provider</th>
</tr>
</thead>
<tbody>
<tr>
<td>Orthotics</td>
<td>70% after deductible</td>
<td>50% after deductible</td>
</tr>
<tr>
<td></td>
<td>Maximum: Two (2) pairs of therapeutic footwear per benefit period for the prevention of complications associated with Diabetes</td>
<td></td>
</tr>
<tr>
<td>Physical Therapy</td>
<td>70% after deductible</td>
<td>50% after deductible</td>
</tr>
<tr>
<td>Podiatry Services</td>
<td>Based on service provided</td>
<td>Based on service provided</td>
</tr>
<tr>
<td>Pregnancy</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Initial pre-natal visit and urinalysis</td>
<td>100% deductible waived</td>
<td>50% after deductible</td>
</tr>
<tr>
<td>Subsequent pre-natal visits/care and breastfeeding services and supplies (as required by the Affordable Care Act)</td>
<td>100% deductible waived</td>
<td>50% after deductible</td>
</tr>
<tr>
<td>Post-natal care and other non-routine/non-preventive pregnancy related care.</td>
<td>Based on service provided</td>
<td>Based on service provided</td>
</tr>
<tr>
<td>Delivery</td>
<td>70% after deductible</td>
<td>50% after deductible</td>
</tr>
<tr>
<td>Private Duty Nursing</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Inpatient</td>
<td>70% after deductible</td>
<td>50% after deductible</td>
</tr>
<tr>
<td>Outpatient</td>
<td>70% after deductible</td>
<td>50% after deductible</td>
</tr>
<tr>
<td>Prostheses</td>
<td>70% after deductible</td>
<td>50% after deductible</td>
</tr>
<tr>
<td>Radiation Therapy</td>
<td>70% after deductible</td>
<td>50% after deductible</td>
</tr>
<tr>
<td>Respiratory Therapy</td>
<td>70% after deductible</td>
<td>50% after deductible</td>
</tr>
<tr>
<td>Retail Clinic Visits</td>
<td>70% after deductible</td>
<td>50% after deductible</td>
</tr>
<tr>
<td>Routine Preventive Care/Wellness Benefits</td>
<td>100% deductible waived</td>
<td>50% after deductible</td>
</tr>
<tr>
<td>Routine Prostate Examinations</td>
<td>100% deductible waived</td>
<td>50% after deductible</td>
</tr>
<tr>
<td>Speech Therapy</td>
<td>70% after deductible</td>
<td>50% after deductible</td>
</tr>
<tr>
<td>Telemedicine Services (via Teladoc)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Medical</td>
<td>$42 copay deductible waived</td>
<td></td>
</tr>
<tr>
<td>Behavioral Health</td>
<td>70% after deductible</td>
<td></td>
</tr>
<tr>
<td>Telemedicine Services (non-Teladoc)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Medical</td>
<td>70% after deductible</td>
<td>50% after deductible</td>
</tr>
<tr>
<td>Behavioral Health</td>
<td>70% after deductible</td>
<td>50% after deductible</td>
</tr>
<tr>
<td>MEDICAL BENEFITS - PPOB PLAN</td>
<td>PREFERRED PROVIDER</td>
<td>NONPREFERRED PROVIDER</td>
</tr>
<tr>
<td>-----------------------------------------------------------------</td>
<td>-------------------------------------</td>
<td>----------------------------------------</td>
</tr>
<tr>
<td><strong>Temporomandibular Joint Syndrome (TMJ) Treatment</strong> (excludes appliances, physical therapy, non-diagnostic and non-surgical services)</td>
<td>70% after deductible</td>
<td>50% after deductible</td>
</tr>
<tr>
<td><strong>Transplants (Organ or Tissue)</strong></td>
<td>100% after deductible</td>
<td>Not Applicable</td>
</tr>
<tr>
<td><strong>Blue Distinction Center</strong></td>
<td>100% deductible waived</td>
<td>Not Applicable</td>
</tr>
<tr>
<td><strong>Blue Distinction Plus Center</strong></td>
<td>70% after deductible</td>
<td>50% after deductible</td>
</tr>
<tr>
<td>Non-Blue Distinction Center/Non-Blue Distinction Plus Center</td>
<td>Not Covered</td>
<td>Not Covered</td>
</tr>
<tr>
<td>Transportation and Lodging</td>
<td>Note: $500 max per day for inpatient nonpreferred provider.</td>
<td></td>
</tr>
<tr>
<td><strong>Urgent Care Center</strong></td>
<td>70% after deductible</td>
<td>50% after deductible</td>
</tr>
<tr>
<td><strong>Vision – Routine Services</strong></td>
<td>70% after deductible</td>
<td>50% after deductible</td>
</tr>
<tr>
<td>(Routine vision services required by the Affordable Care Act shall be covered under the Routine Preventive Care benefit)</td>
<td>Maximum: One exam per benefit period</td>
<td></td>
</tr>
<tr>
<td><strong>Weight Management</strong></td>
<td>Based on service provided</td>
<td>Based on service provided</td>
</tr>
<tr>
<td>Office visit and basic diagnostic testing, including laboratory services and electrocardiograms (EKGs), but does not include advanced imaging services</td>
<td>$5,000 copay then 70% after deductible</td>
<td>Not Covered</td>
</tr>
<tr>
<td>Bariatric surgery (Blue Distinction Plus Center only)</td>
<td>Non-surgical treatment, including therapy and behavior modification</td>
<td>100% after deductible 50% after deductible</td>
</tr>
<tr>
<td><strong>Wigs (hair loss due to treatment of injury or disease)</strong></td>
<td>70% after deductible</td>
<td>50% after deductible</td>
</tr>
<tr>
<td><strong>Women’s Preventive Services</strong></td>
<td>100% deductible waived</td>
<td>50% after deductible</td>
</tr>
<tr>
<td>As required by the Affordable Care Act</td>
<td>Maximum: $1,000 while covered by this Plan</td>
<td></td>
</tr>
<tr>
<td><strong>All Other Covered Expenses</strong></td>
<td>70% after deductible</td>
<td>50% after deductible</td>
</tr>
</tbody>
</table>
# PRESCRIPTION DRUG PROGRAM
## SCHEDULE OF BENEFITS PPOB PLAN

**Benefit Period:** September 1 – August 31

<table>
<thead>
<tr>
<th>Prescription Drug Benefits PPOB Plan</th>
<th>Preferred Provider</th>
<th>Nonpreferred Provider</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Deductible</strong> is the same as and is combined with the Medical Deductible</td>
<td>100% deductible waived</td>
<td>100% deductible waived</td>
</tr>
<tr>
<td><strong>Out-of-Pocket Expense Limit</strong> is the same as and is combined with the Medical Out-of-Pocket Expense Limit</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Retail Pharmacy</strong> (31-day supply)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Note: Insulin out-of-pocket costs are 25% after deductible.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Routine preventive drugs required by the Affordable Care Act</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Generic</td>
<td>Plan pays 80% after deductible</td>
<td>Member pays additional 20% of the allowable amount plus coinsurance</td>
</tr>
<tr>
<td>Brand Name</td>
<td>Plan pays 75% after deductible</td>
<td>Member pays additional 20% of the allowable amount plus coinsurance</td>
</tr>
<tr>
<td>Non-Preferred Brand Name</td>
<td>Plan pays 50% after deductible</td>
<td>Member pays additional 20% of the allowable amount plus coinsurance</td>
</tr>
<tr>
<td><strong>Mail Order Pharmacy and Extended Supply Network</strong> (90-day supply)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Routine preventive drugs required by the Affordable Care Act</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Generic</td>
<td>100% deductible waived</td>
<td>Not Applicable</td>
</tr>
<tr>
<td>Brand Name</td>
<td>Plan pays 80% after deductible</td>
<td>Member pays additional 20% of the allowable amount plus coinsurance</td>
</tr>
<tr>
<td>Non-Preferred Brand Name</td>
<td>Plan pays 75% after deductible</td>
<td>Member pays additional 20% of the allowable amount plus coinsurance</td>
</tr>
<tr>
<td>Plan pays 50% after deductible</td>
<td>Member pays additional 20% of the allowable amount plus coinsurance</td>
<td></td>
</tr>
<tr>
<td><strong>Specialty Drugs</strong> (31-day supply)</td>
<td>Plan pays 80% after deductible</td>
<td>Not Covered</td>
</tr>
</tbody>
</table>

Specialty drugs must be obtained from preferred specialty drug provider.

If the covered person selects a brand drug when a generic equivalent is available, the covered person is responsible for the generic copay plus the cost difference between the generic and brand equivalent. If the physician indicates no substitutions, the covered person is only responsible for the brand copay.
## MEDICAL SCHEDULE OF BENEFITS
### EPOA PLAN

**Benefit Period:** September 1 through August 31

<table>
<thead>
<tr>
<th>MEDICAL BENEFITS - EPOA PLAN</th>
<th>PREFERRED PROVIDER</th>
<th>NONPREFERRED PROVIDER</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Deductible</strong> per benefit period</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Individual</td>
<td>$2,500</td>
<td>N/A</td>
</tr>
<tr>
<td>Family (embedded)</td>
<td>$5,000</td>
<td>N/A</td>
</tr>
</tbody>
</table>

Generally, each *covered person* must pay all of the costs from providers up to the deductible amount before the *Plan* begins to pay.

**Embedded family deductible:** Any number of covered family members may help to satisfy the family deductible, but no family member will incur more than the individual deductible amount.

<table>
<thead>
<tr>
<th>Out-of-Pocket Expense Limit per benefit period (includes deductible, <em>coinsurance</em>, <em>copays</em>, and prescription drug cost-share)</th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Individual</td>
<td>$8,150</td>
<td>N/A</td>
</tr>
<tr>
<td>Family (embedded)</td>
<td>$16,300</td>
<td>N/A</td>
</tr>
</tbody>
</table>

The out-of-pocket expense limit is the most the *covered person* could pay in a year for *covered expenses*.

The *Plan* will pay the designated percentage of *covered expenses* until the out-of-pocket expense limits are reached, at which time the *Plan* will pay 100% of the remainder of *covered expenses* for the rest of the benefit period unless stated otherwise.

**Embedded family out-of-pocket expense limit:** Any number of covered family members may help to satisfy the family out-of-pocket expense limit, but no family member will incur more than the individual out-of-pocket expense limit.

The following charges do not apply to the out-of-pocket expense limit and are never paid at 100%:

- expenses not covered by the *Plan*
- expenses in excess of amounts covered by the *Plan*
- expenses in excess of *customary and reasonable amount*
- expenses incurred as a result of failure to obtain pre-certification

| Standard *coinsurance* paid by the *Plan* | 70% | Not Covered |

<table>
<thead>
<tr>
<th>MEDICAL BENEFITS – EPOA PLAN</th>
<th>PREFERRED PROVIDER</th>
<th>NONPREFERRED PROVIDER</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Acupuncture</strong> <em>(only covered in lieu of anesthesia or for nausea during pregnancy)</em></td>
<td>70% after deductible</td>
<td>Not Covered</td>
</tr>
<tr>
<td>MEDICAL BENEFITS – EPOA PLAN</td>
<td>PREFERRED PROVIDER</td>
<td>NONPREFERRED PROVIDER</td>
</tr>
<tr>
<td>-------------------------------</td>
<td>--------------------</td>
<td>-----------------------</td>
</tr>
<tr>
<td><strong>Allergy Services</strong>&lt;br&gt; Allergy testing, injections and serum</td>
<td><em>Primary care physician</em>&lt;br&gt;$30 copay deductible waived&lt;br&gt;$70 copay deductible waived&lt;br&gt;70% after deductible</td>
<td>Not Covered</td>
</tr>
<tr>
<td>Specialist</td>
<td>Not Covered</td>
<td>Not Covered</td>
</tr>
<tr>
<td>Allergy injections without an office visit</td>
<td>Not Covered</td>
<td>Not Covered</td>
</tr>
<tr>
<td><strong>Ambulance</strong></td>
<td>70% after deductible</td>
<td>preferred provider benefit applies</td>
</tr>
<tr>
<td><strong>Applied Behavior Analysis &amp; Therapy (ABA) / Autism Spectrum Disorder</strong></td>
<td>$30 copay deductible waived</td>
<td>Not Covered</td>
</tr>
<tr>
<td><strong>Birthing Center</strong></td>
<td>70% after deductible</td>
<td>Not Covered</td>
</tr>
<tr>
<td><strong>Breastfeeding Support, Counseling &amp; Supplies</strong>&lt;br&gt; Lactation counseling (limited to six (6) visits per benefit period)</td>
<td>100% deductible waived</td>
<td>Not Covered</td>
</tr>
<tr>
<td>Electric breast pumps (limited to two (2) per benefit period)</td>
<td>100% deductible waived</td>
<td>Not Covered</td>
</tr>
<tr>
<td>Hospital grade breast pumps covered up to purchase price of $150</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Cardiac Rehabilitation</strong></td>
<td>70% after deductible</td>
<td>Not Covered</td>
</tr>
<tr>
<td><strong>Chemotherapy</strong></td>
<td>70% after deductible</td>
<td>Not Covered</td>
</tr>
<tr>
<td><strong>Chiropractic Care</strong>&lt;br&gt; Office visits, spinal manipulation, adjustments and x-rays</td>
<td>$70 copay deductible waived</td>
<td>Not Covered</td>
</tr>
<tr>
<td>Maximum: 35 visits per benefit period</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Colonoscopy (Preventive)</strong></td>
<td>100% deductible waived</td>
<td>Not Covered</td>
</tr>
<tr>
<td><strong>Contraceptives</strong></td>
<td>See Women’s Preventive Services</td>
<td></td>
</tr>
<tr>
<td><strong>Diabetic Management</strong>&lt;br&gt; (training/nutritional)</td>
<td></td>
<td></td>
</tr>
<tr>
<td><em>Primary care physician</em>&lt;br&gt;$30 copay deductible waived&lt;br&gt;$70 copay deductible waived&lt;br&gt;70% after deductible</td>
<td>Not Covered</td>
<td>Not Covered</td>
</tr>
<tr>
<td>Specialist</td>
<td>Not Covered</td>
<td>Not Covered</td>
</tr>
<tr>
<td><strong>Diagnostic Mammogram</strong></td>
<td>100% deductible waived</td>
<td>Not Covered</td>
</tr>
<tr>
<td><strong>Diagnostic Services – Major</strong>&lt;br&gt; (such as MRI, CT Scan, PET Scan)</td>
<td>70% after deductible</td>
<td>Not Covered</td>
</tr>
<tr>
<td><strong>Diagnostic Services – Minor</strong>&lt;br&gt; Lab</td>
<td></td>
<td></td>
</tr>
<tr>
<td><em>Hospital outpatient</em>&lt;br&gt;70% after deductible</td>
<td>Not Covered</td>
<td>Not Covered</td>
</tr>
<tr>
<td>Independent lab&lt;br&gt;100% deductible waived</td>
<td>Not Covered</td>
<td>Not Covered</td>
</tr>
<tr>
<td>X-ray&lt;br&gt;70% after deductible</td>
<td>Not Covered</td>
<td>Not Covered</td>
</tr>
<tr>
<td><strong>Dialysis Therapy or Treatment</strong></td>
<td>70% after deductible</td>
<td>Not Covered</td>
</tr>
<tr>
<td>MEDICAL BENEFITS – EPOA PLAN</td>
<td>PREFERRED PROVIDER</td>
<td>NONPREFERRED PROVIDER</td>
</tr>
<tr>
<td>------------------------------</td>
<td>--------------------</td>
<td>-----------------------</td>
</tr>
<tr>
<td>Durable Medical Equipment</td>
<td>70% after deductible</td>
<td>Not Covered</td>
</tr>
</tbody>
</table>

**Emergency Room Services**

*Emergency Medical Condition Care*

- **Facility**
  - Preferred provider benefit applies
  - 70% after deductible

- **Physician**
  - Preferred provider benefit applies
  - 70% after deductible

- Freestanding emergency room
  - $500 **copay**/visit, then 70% after deductible

*Non-Emergency Medical Condition Care*

- **Facility**
  - Preferred provider benefit applies
  - 70% after deductible

- **Physician**
  - Preferred provider benefit applies
  - 70% after deductible

- Freestanding emergency room
  - $500 **copay**/visit, then 70% after deductible

**Extended Care Facility**

- Preferred provider benefit applies
  - 70% after deductible

- Not Covered

- Maximum: 25 days per benefit period

**Hearing**

- **Routine Exam**
  - 100% deductible waived

- Not Covered

- Maximum: Routine hearing exams limited to 1 per benefit period

- **Hearing Exam (non-routine)**
  - Primary care physician
    - $30 **copay** deductible waived

  - Not Covered

  - Specialist
    - $70 **copay** deductible waived

  - Not Covered

  - Hearing Aids
    - 70% after deductible

  - Not Covered

  - Maximum: $1,000 per 36-month period for members over age 19

  - No maximum for **dependents** under age 19

- **Cochlear Implants**
  - 70% after deductible

  - Not Covered

  - Maximum: Only covered for **dependents** under age 19 every 3 years

**Home Health Care**

- **Home health care visits**
  - 70% after deductible

  - Not Covered

- **Home health care supplies & services**
  - 70% after deductible

  - Not Covered

- **IV therapy**
  - 70% after deductible

  - Not Covered

  - Maximum: 60 visits per benefit period

**Hospice Care**

- **Inpatient**
  - 70% after deductible

  - Not Covered

- **Outpatient**
  - 70% after deductible

  - Not Covered
<table>
<thead>
<tr>
<th>MEDICAL BENEFITS – EPOA PLAN</th>
<th>PREFERRED PROVIDER</th>
<th>NONPREFERRED PROVIDER</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hospital – Inpatient</td>
<td></td>
<td></td>
</tr>
<tr>
<td><em>Facility</em></td>
<td>70% after deductible</td>
<td>Not Covered</td>
</tr>
<tr>
<td><em>Physician/Surgeon</em></td>
<td>70% after deductible</td>
<td>Not Covered</td>
</tr>
<tr>
<td>Hospital – Outpatient &amp; Ambulatory Surgical Facility</td>
<td>70% after deductible</td>
<td>Not Covered</td>
</tr>
<tr>
<td>Infertility Services</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Diagnostic testing to determine infertility</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Diagnostic counseling, consultations, planning and treatment services</td>
<td>70% after deductible</td>
<td>Not Covered</td>
</tr>
<tr>
<td><em>Primary care physician</em></td>
<td>$30 copay deductible waived</td>
<td>Not Covered</td>
</tr>
<tr>
<td>Specialist</td>
<td>$70 copay deductible waived</td>
<td>Not Covered</td>
</tr>
<tr>
<td>Medications and treatments <em>(to treat underlying condition only)</em></td>
<td>70% after deductible</td>
<td>Not Covered</td>
</tr>
<tr>
<td>Infusion Therapy</td>
<td></td>
<td></td>
</tr>
<tr>
<td><em>Facility</em></td>
<td>$500 copay deductible waived</td>
<td>Not Covered</td>
</tr>
<tr>
<td><em>Physician</em></td>
<td>$30 copay deductible waived</td>
<td>Not Covered</td>
</tr>
<tr>
<td>Occupational Therapy</td>
<td></td>
<td></td>
</tr>
<tr>
<td><em>Facility</em></td>
<td>70% after deductible</td>
<td>Not Covered</td>
</tr>
<tr>
<td><em>Physician</em></td>
<td>$30 copay deductible waived</td>
<td>Not Covered</td>
</tr>
<tr>
<td>Office Visit &amp; Other Services</td>
<td></td>
<td></td>
</tr>
<tr>
<td><em>(one copay per provider per date of service)</em></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Office visit</td>
<td></td>
<td></td>
</tr>
<tr>
<td><em>Primary care physician</em> (includes outpatient visits for mental and nervous disorders and substance use disorder)</td>
<td>$30 copay deductible waived</td>
<td>Not Covered</td>
</tr>
<tr>
<td>Specialist</td>
<td>$70 copay deductible waived</td>
<td>Not Covered</td>
</tr>
<tr>
<td>Surgery</td>
<td></td>
<td></td>
</tr>
<tr>
<td><em>Primary care physician</em></td>
<td>$30 copay deductible waived</td>
<td>Not Covered</td>
</tr>
<tr>
<td>Specialist</td>
<td>$70 copay deductible waived</td>
<td>Not Covered</td>
</tr>
<tr>
<td>Lab and X-ray</td>
<td></td>
<td></td>
</tr>
<tr>
<td><em>Primary care physician</em></td>
<td>100% deductible waived</td>
<td>Not Covered</td>
</tr>
<tr>
<td>Specialist</td>
<td>100% deductible waived</td>
<td>Not Covered</td>
</tr>
<tr>
<td>MEDICAL BENEFITS – EPOA PLAN</td>
<td>PREFERRED PROVIDER</td>
<td>NONPREFERRED PROVIDER</td>
</tr>
<tr>
<td>------------------------------</td>
<td>------------------------------</td>
<td>------------------------</td>
</tr>
<tr>
<td>Office Visit &amp; Other Services (continued)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Other services</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Primary care physician</td>
<td>70% after deductible</td>
<td>Not Covered</td>
</tr>
<tr>
<td>Specialist</td>
<td>70% after deductible</td>
<td>Not Covered</td>
</tr>
<tr>
<td>On-Site Clinic (MEHC)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Office visit (including virtual)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Other services</td>
<td>$15 copay deductible waived</td>
<td>Not Covered</td>
</tr>
<tr>
<td></td>
<td>Based on service provided</td>
<td>Not Covered</td>
</tr>
<tr>
<td>Orthotics</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>70% after deductible</td>
<td>Not Covered</td>
</tr>
<tr>
<td></td>
<td>Maximum: Two (2) pairs of therapeutic footwear per benefit period for the prevention of complications associated with Diabetes</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Physical Therapy</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Facility</td>
<td>70% after deductible</td>
<td>Not Covered</td>
</tr>
<tr>
<td>Physician</td>
<td>$30 copay deductible waived</td>
<td>Not Covered</td>
</tr>
<tr>
<td>Podiatry Services</td>
<td>Based on service provided</td>
<td>Not Covered</td>
</tr>
<tr>
<td>Pregnancy</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Initial pre-natal visit and urinalysis</td>
<td>100% deductible waived</td>
<td>Not Covered</td>
</tr>
<tr>
<td>Subsequent pre-natal visits/care and breastfeeding services and supplies (as required by the Affordable Care Act)</td>
<td>100% deductible waived</td>
<td>Not Covered</td>
</tr>
<tr>
<td>Post-natal care and other non-routine/non-preventive pregnancy related care.</td>
<td>Based on service provided</td>
<td>Not Covered</td>
</tr>
<tr>
<td>Delivery</td>
<td>70% after deductible</td>
<td>Not Covered</td>
</tr>
<tr>
<td>Private Duty Nursing</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Inpatient</td>
<td>70% after deductible</td>
<td>Not Covered</td>
</tr>
<tr>
<td>Outpatient</td>
<td>70% after deductible</td>
<td>Not Covered</td>
</tr>
<tr>
<td>Prostheses</td>
<td>70% after deductible</td>
<td>Not Covered</td>
</tr>
<tr>
<td>Radiation Therapy</td>
<td>70% after deductible</td>
<td>Not Covered</td>
</tr>
<tr>
<td>Respiratory Therapy</td>
<td>70% after deductible</td>
<td>Not Covered</td>
</tr>
<tr>
<td>Retail Clinic Visits</td>
<td>$30 copay deductible waived</td>
<td>Not Covered</td>
</tr>
<tr>
<td>Routine Preventive Care/Wellness Benefits</td>
<td>Includes all evidence-based supplies or services that have in effect a rating of A or B in the current recommendations of the United States Preventive Services Task Force (USPSTF). For additional information visit: <a href="http://www.uspreventiveservicestaskforce.org">http://www.uspreventiveservicestaskforce.org</a></td>
<td>100% deductible waived</td>
</tr>
<tr>
<td>MEDICAL BENEFITS – EPOA PLAN</td>
<td>PREFERRED PROVIDER</td>
<td>NONPREFERRED PROVIDER</td>
</tr>
<tr>
<td>-----------------------------</td>
<td>--------------------</td>
<td>-----------------------</td>
</tr>
<tr>
<td>Routine Prostate Examinations</td>
<td>100% deductible waived</td>
<td>Not Covered</td>
</tr>
<tr>
<td>Speech Therapy</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Facility</td>
<td>Not Covered</td>
<td></td>
</tr>
<tr>
<td>Physician</td>
<td>Not Covered</td>
<td></td>
</tr>
<tr>
<td>Telemedicine Services (via Teladoc)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Medical</td>
<td>$12 copay deductible waived</td>
<td>Not Covered</td>
</tr>
<tr>
<td>Behavioral Health</td>
<td>$30 copay deductible waived</td>
<td>Not Covered</td>
</tr>
<tr>
<td>Telemedicine Services (non-Teladoc)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Medical</td>
<td>Not Covered</td>
<td></td>
</tr>
<tr>
<td>Primary care physician</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Specialist</td>
<td>Not Covered</td>
<td></td>
</tr>
<tr>
<td>Behavioral Health</td>
<td>Not Covered</td>
<td></td>
</tr>
<tr>
<td>Temporomandibular Joint Syndrome (TMJ) Treatment (excludes appliances, physical therapy, non-diagnostic and non-surgical services)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Medical</td>
<td>70% after deductible</td>
<td>Not Covered</td>
</tr>
<tr>
<td>Behavioral Health</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Transplants (Organ or Tissue)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Blue Distinction Center</td>
<td>100% after deductible</td>
<td>Not Applicable</td>
</tr>
<tr>
<td>Blue Distinction Plus Center</td>
<td>100% deductible waived</td>
<td>Not Applicable</td>
</tr>
<tr>
<td>Non-Blue Distinction Center/Non-Blue Distinction Plus Center</td>
<td>70% after deductible</td>
<td>Not Covered</td>
</tr>
<tr>
<td>Transportation and Lodging</td>
<td>Not Covered</td>
<td>Not Covered</td>
</tr>
<tr>
<td>Urgent Care Center</td>
<td>$50 copay deductible waived</td>
<td>Not Covered</td>
</tr>
<tr>
<td>Vision – Routine Services (Routine vision services required by the Affordable Care Act shall be covered under the Routine Preventive Care benefit)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Medical</td>
<td>$70 copay deductible waived</td>
<td>Not Covered</td>
</tr>
<tr>
<td>Behavioral Health</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Weight Management</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Office visit and basic diagnostic testing, including laboratory services and electrocardiograms (EKGs), but does not include advanced imaging services</td>
<td>Based on service provided</td>
<td>Not Covered</td>
</tr>
<tr>
<td>Bariatric surgery (Blue Distinction Plus Center only)</td>
<td>$5,000 copay then 70% after deductible</td>
<td>Not Covered</td>
</tr>
<tr>
<td>Non-surgical treatment, including therapy and behavior modification</td>
<td>100% deductible waived</td>
<td>Not Covered</td>
</tr>
</tbody>
</table>
# MEDICAL BENEFITS – EPOA PLAN

<table>
<thead>
<tr>
<th></th>
<th>PREFERRED PROVIDER</th>
<th>NONPREFERRED PROVIDER</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Wigs (hair loss due to treatment of injury or disease)</strong></td>
<td>70% after deductible</td>
<td>Not Covered</td>
</tr>
<tr>
<td></td>
<td>Maximum: $1,000 while covered by this Plan</td>
<td></td>
</tr>
<tr>
<td><strong>Women’s Preventive Services</strong></td>
<td>100% deductible waived</td>
<td>Not Covered</td>
</tr>
<tr>
<td>As required by the Affordable Care Act</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>All Other Covered Expenses</strong></td>
<td>70% after deductible</td>
<td>Not Covered</td>
</tr>
</tbody>
</table>

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## PRESCRIPTION DRUG PROGRAM

### SCHEDULE OF BENEFITS EPOA PLAN

**Benefit Period:** September 1 – August 31

### PRESCRIPTION DRUG BENEFITS

<table>
<thead>
<tr>
<th>EPOA PLAN</th>
<th>PREFERRED PROVIDER</th>
<th>NONPREFERRED PROVIDER</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Retail Pharmacy</strong> (31-day supply)</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Note:</strong> Insulin out-of-pocket costs are $25 copay for a 31-day supply; $75 for a 61-90 day supply.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Routine preventive drugs required by the Affordable Care Act</td>
<td>100% Deductible Waived</td>
<td>Not Applicable</td>
</tr>
<tr>
<td>Generic</td>
<td><em>Plan</em> pays 100% after $15 copay after deductible</td>
<td>Not Covered</td>
</tr>
<tr>
<td>Brand Name</td>
<td><em>Plan</em> pays 70% after deductible</td>
<td>Not Covered</td>
</tr>
<tr>
<td>Non-Preferred Brand Name</td>
<td><em>Plan</em> pays 50% after deductible</td>
<td>Not Covered</td>
</tr>
</tbody>
</table>

| **Mail Order Pharmacy and Extended Supply Network** (90-day supply) | | |
| Routine preventive drugs required by the Affordable Care Act | 100% Deductible Waived | Not Applicable |
| Generic | *Plan* pays 100% after $45 copay after deductible | Not Covered |
| Brand Name | *Plan* pays 70% after deductible | Not Covered |
| Non-Preferred Brand Name | *Plan* pays 50% after deductible | Not Covered |

**Specialty Drugs** (31-day supply)  
*Plan* pays 70% after deductible | Not Covered

Specialty drugs must be obtained from preferred specialty drug provider.

If the covered person selects a brand drug when a generic equivalent is available, the covered person is responsible for the generic copay plus the cost difference between the generic and brand equivalent. If the physician indicates no substitutions, the covered person is only responsible for the brand copay.
MEDICAL SCHEDULE OF BENEFITS
EPOB PLAN

Benefit Period: September 1 through August 31

<table>
<thead>
<tr>
<th>MEDICAL BENEFITS - EPOB PLAN</th>
<th>PREFERRED PROVIDER</th>
<th>NONPREFERRED PROVIDER</th>
</tr>
</thead>
<tbody>
<tr>
<td>Deductible per benefit period</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Individual</td>
<td>$1,200</td>
<td>N/A</td>
</tr>
<tr>
<td>Family (embedded)</td>
<td>$3,600</td>
<td>N/A</td>
</tr>
</tbody>
</table>

Generally, each covered person must pay all of the costs from providers up to the deductible amount before the Plan begins to pay.

Embedded family deductible: Any number of covered family members may help to satisfy the family deductible, but no family member will incur more than the individual deductible amount.

<table>
<thead>
<tr>
<th>Out-of-Pocket Expense Limit per benefit period (includes deductible, coinsurance, copays, and prescription drug cost-share)</th>
<th>PREFERRED PROVIDER</th>
<th>NONPREFERRED PROVIDER</th>
</tr>
</thead>
<tbody>
<tr>
<td>Individual</td>
<td>$6,900</td>
<td>N/A</td>
</tr>
<tr>
<td>Family (embedded)</td>
<td>$13,800</td>
<td>N/A</td>
</tr>
</tbody>
</table>

The out-of-pocket expense limit is the most the covered person could pay in a year for covered expenses.

The Plan will pay the designated percentage of covered expenses until the out-of-pocket expense limits are reached, at which time the Plan will pay 100% of the remainder of covered expenses for the rest of the benefit period unless stated otherwise.

Embedded family out-of-pocket expense limit: Any number of covered family members may help to satisfy the family out-of-pocket expense limit, but no family member will incur more than the individual out-of-pocket expense limit.

The following charges do not apply to the out-of-pocket expense limit and are never paid at 100%:

- expenses not covered by the Plan
- expenses in excess of amounts covered by the Plan
- expenses in excess of customary and reasonable amount
- expenses incurred as a result of failure to obtain pre-certification

| Standard coinsurance paid by the Plan | 80% | Not Covered |

<table>
<thead>
<tr>
<th>MEDICAL BENEFITS – EPOB PLAN</th>
<th>PREFERRED PROVIDER</th>
<th>NONPREFERRED PROVIDER</th>
</tr>
</thead>
<tbody>
<tr>
<td>Acupuncture (only covered in lieu of anesthesia or for nausea during pregnancy)</td>
<td>80% after deductible</td>
<td>Not Covered</td>
</tr>
<tr>
<td>MEDICAL BENEFITS – EPOB PLAN</td>
<td>PREFERRED PROVIDER</td>
<td>NONPREFERRED PROVIDER</td>
</tr>
<tr>
<td>----------------------------------------------------------------</td>
<td>--------------------</td>
<td>-----------------------</td>
</tr>
<tr>
<td><strong>Allergy Services</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Allergy testing and evaluation</td>
<td>$30 copay deductible waived</td>
<td>Not Covered</td>
</tr>
<tr>
<td><strong>Primary care physician</strong></td>
<td>$70 copay deductible waived</td>
<td>Not Covered</td>
</tr>
<tr>
<td>Specialist</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Allergy injections and serum</td>
<td>80% after deductible</td>
<td>Not Covered</td>
</tr>
<tr>
<td>Allergy services without an office visit</td>
<td>80% after deductible</td>
<td>Not Covered</td>
</tr>
<tr>
<td><strong>Ambulance</strong></td>
<td>80% after deductible</td>
<td>preferred provider benefit applies</td>
</tr>
<tr>
<td><strong>Applied Behavior Analysis &amp; Therapy (ABA) / Autism Spectrum Disorder</strong></td>
<td>$30 copay deductible waived</td>
<td>Not Covered</td>
</tr>
<tr>
<td><strong>Birthing Center</strong></td>
<td>80% after deductible</td>
<td>Not Covered</td>
</tr>
<tr>
<td><strong>Blood (Blood storage and transfusions)</strong></td>
<td>80% after deductible</td>
<td>Not Covered</td>
</tr>
<tr>
<td><strong>Breastfeeding Support, Counseling &amp; Supplies</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Lactation counseling (limited to six (6) visits per benefit period)</td>
<td>100% deductible waived</td>
<td>Not Covered</td>
</tr>
<tr>
<td>Electric breast pumps (limited to two (2) per benefit period)</td>
<td>100% deductible waived</td>
<td>Not Covered</td>
</tr>
<tr>
<td>Hospital grade breast pumps covered up to purchase price of $150</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Cardiac Rehabilitation</strong></td>
<td>80% after deductible</td>
<td>Not Covered</td>
</tr>
<tr>
<td><strong>Chemotherapy</strong></td>
<td>80% after deductible</td>
<td>Not Covered</td>
</tr>
<tr>
<td><strong>Chiropractic Care</strong></td>
<td>$70 copay deductible waived</td>
<td>Not Covered</td>
</tr>
<tr>
<td>Office visits, spinal manipulation, adjustments and x-rays</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Maximum: 35 visits per benefit period</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Colonoscopy (Preventive)</strong></td>
<td>100% deductible waived</td>
<td>Not Covered</td>
</tr>
<tr>
<td><strong>Contraceptives</strong></td>
<td>See Women’s Preventive Services</td>
<td>Not Covered</td>
</tr>
<tr>
<td><strong>Diabetic Management (training/nutritional)</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Primary care physician</strong></td>
<td>$30 copay deductible waived</td>
<td>Not Covered</td>
</tr>
<tr>
<td>Specialist</td>
<td>$70 copay deductible waived</td>
<td>Not Covered</td>
</tr>
<tr>
<td><strong>Diagnostic Mammogram</strong></td>
<td>100% deductible waived</td>
<td>Not Covered</td>
</tr>
<tr>
<td><strong>Diagnostic Services – Major (such as MRI, CT Scan, PET Scan)</strong></td>
<td>80% after deductible</td>
<td>Not Covered</td>
</tr>
<tr>
<td>MEDICAL BENEFITS – EPOB PLAN</td>
<td>PREFERRED PROVIDER</td>
<td>NONPREFERRED PROVIDER</td>
</tr>
<tr>
<td>------------------------------</td>
<td>--------------------</td>
<td>------------------------</td>
</tr>
<tr>
<td>Diagnostic Services – Minor</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Lab</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Hospital outpatient</td>
<td>80% after deductible</td>
<td>Not Covered</td>
</tr>
<tr>
<td>Independent lab</td>
<td>100% deductible waived</td>
<td>Not Covered</td>
</tr>
<tr>
<td>X-ray</td>
<td>80% after deductible</td>
<td>Not Covered</td>
</tr>
<tr>
<td>Dialysis Therapy or Treatment</td>
<td>80% after deductible</td>
<td>Not Covered</td>
</tr>
<tr>
<td>Durable Medical Equipment</td>
<td>80% after deductible</td>
<td>Not Covered</td>
</tr>
<tr>
<td>Emergency Room Services</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Emergency Medical Condition Care</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Facility</td>
<td>80% after deductible</td>
<td></td>
</tr>
<tr>
<td>Physician</td>
<td>80% after deductible</td>
<td></td>
</tr>
<tr>
<td>Freestanding emergency room</td>
<td>$500 copay/visit, then 80% after deductible</td>
<td></td>
</tr>
<tr>
<td>Non-Emergency Medical Condition Care</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Facility</td>
<td>80% after deductible</td>
<td></td>
</tr>
<tr>
<td>Physician</td>
<td>80% after deductible</td>
<td></td>
</tr>
<tr>
<td>Freestanding emergency room</td>
<td>$500 copay/visit, then 80% after deductible</td>
<td>$500 copay/visit, then 60% after deductible</td>
</tr>
<tr>
<td>Extended Care Facility</td>
<td>80% after deductible</td>
<td>Not Covered</td>
</tr>
<tr>
<td>Hearing</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Routine Exam</td>
<td>100% deductible waived</td>
<td>Not Covered</td>
</tr>
<tr>
<td>Hearing Exam (non-routine)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Primary care physician</td>
<td>$30 copay deductible waived</td>
<td>Not Covered</td>
</tr>
<tr>
<td>Specialist</td>
<td>$70 copay deductible waived</td>
<td>Not Covered</td>
</tr>
<tr>
<td>Hearing Aids</td>
<td>80% after deductible</td>
<td>Not Covered</td>
</tr>
<tr>
<td>Cochlear Implants</td>
<td>80% after deductible</td>
<td>Not Covered</td>
</tr>
</tbody>
</table>
|                             | Maximum: Only covered for dependents under age 19 | Maximum: $1,000 per 36-month period for members over age 19 No maximum for dependents under age 19
<table>
<thead>
<tr>
<th>MEDICAL BENEFITS – EPOB PLAN</th>
<th>PREFERRED PROVIDER</th>
<th>NONPREFERRED PROVIDER</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Home Health Care</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Home health care visits</td>
<td>80% after deductible</td>
<td>Not Covered</td>
</tr>
<tr>
<td>Home health care supplies &amp; services</td>
<td>80% after deductible</td>
<td>Not Covered</td>
</tr>
<tr>
<td>IV therapy</td>
<td>80% after deductible</td>
<td>Not Covered</td>
</tr>
<tr>
<td>Maximum: 60 visits per benefit period</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Hospice Care</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Inpatient</td>
<td>80% after deductible</td>
<td>Not Covered</td>
</tr>
<tr>
<td>Outpatient</td>
<td>80% after deductible</td>
<td>Not Covered</td>
</tr>
<tr>
<td><strong>Hospital – Inpatient</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Facility</td>
<td>80% after deductible</td>
<td>Not Covered</td>
</tr>
<tr>
<td>Physician/Surgeon</td>
<td>80% after deductible</td>
<td>Not Covered</td>
</tr>
<tr>
<td><strong>Hospital – Outpatient &amp; Ambulatory Surgical Facility</strong></td>
<td>80% after deductible</td>
<td>Not Covered</td>
</tr>
<tr>
<td><strong>Infertility Services</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Diagnostic testing to determine infertility</td>
<td>80% after deductible</td>
<td>Not Covered</td>
</tr>
<tr>
<td>Diagnostic counseling, consultations, planning and treatment services</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Primary care physician</td>
<td>$30 copay deductible waived</td>
<td>Not Covered</td>
</tr>
<tr>
<td>Specialist</td>
<td>$70 copay deductible waived</td>
<td>Not Covered</td>
</tr>
<tr>
<td>Medications and treatments (to treat underlying condition only)</td>
<td>80% after deductible</td>
<td>Not Covered</td>
</tr>
<tr>
<td><strong>Infusion Therapy</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Facility</td>
<td>$500 copay deductible waived</td>
<td>Not Covered</td>
</tr>
<tr>
<td>Physician</td>
<td>$30 copay deductible waived</td>
<td>Not Covered</td>
</tr>
<tr>
<td><strong>Occupational Therapy</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Facility</td>
<td>80% after deductible</td>
<td>Not Covered</td>
</tr>
<tr>
<td>Physician</td>
<td>$30 copay deductible waived</td>
<td>Not Covered</td>
</tr>
<tr>
<td>MEDICAL BENEFITS – EPOB PLAN</td>
<td>PREFERRED PROVIDER</td>
<td>NONPREFERRED PROVIDER</td>
</tr>
<tr>
<td>--------------------------------------------</td>
<td>-----------------------------------------------------</td>
<td>------------------------</td>
</tr>
<tr>
<td><strong>Office Visit &amp; Other Services</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>(one copay per provider per date of service)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Office visit</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Primary care physician</strong> (includes outpatient visits for mental and nervous disorders and substance use disorder)</td>
<td>$30 copay deductible waived</td>
<td>Not Covered</td>
</tr>
<tr>
<td>Specialist</td>
<td>$70 copay deductible waived</td>
<td>Not Covered</td>
</tr>
<tr>
<td>Surgery</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Primary care physician</strong></td>
<td>$30 copay deductible waived</td>
<td>Not Covered</td>
</tr>
<tr>
<td>Specialist</td>
<td>$70 copay deductible waived</td>
<td>Not Covered</td>
</tr>
<tr>
<td>Lab and X-ray</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Primary care physician</strong></td>
<td>100% deductible waived</td>
<td>Not Covered</td>
</tr>
<tr>
<td>Specialist</td>
<td>100% deductible waived</td>
<td>Not Covered</td>
</tr>
<tr>
<td>Other services</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Primary care physician</strong></td>
<td>80% after deductible</td>
<td>Not Covered</td>
</tr>
<tr>
<td>Specialist</td>
<td>80% after deductible</td>
<td>Not Covered</td>
</tr>
<tr>
<td><strong>On-Site Clinic (MEHC)</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Office visit (including virtual)</td>
<td>$15 copay deductible waived</td>
<td>Not Covered</td>
</tr>
<tr>
<td>Other services</td>
<td>Based on service provided</td>
<td>Not Covered</td>
</tr>
<tr>
<td><strong>Orthotics</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>80% after deductible</td>
<td>Not Covered</td>
</tr>
<tr>
<td></td>
<td>Maximum: Two (2) pairs of therapeutic footwear per benefit period for the prevention of complications associated with Diabetes</td>
<td></td>
</tr>
<tr>
<td><strong>Physical Therapy</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Facility</strong></td>
<td>80% after deductible</td>
<td>Not Covered</td>
</tr>
<tr>
<td><strong>Physician</strong></td>
<td>$30 copay deductible waived</td>
<td>Not Covered</td>
</tr>
<tr>
<td><strong>Podiatry Services</strong></td>
<td>Based on service provided</td>
<td>Not Covered</td>
</tr>
<tr>
<td><strong>Pregnancy</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Initial pre-natal visit and urinalysis</td>
<td>100% deductible waived</td>
<td>Not Covered</td>
</tr>
<tr>
<td>Subsequent pre-natal visits/care and breastfeeding services and supplies (as required by the Affordable Care Act)</td>
<td>100% deductible waived</td>
<td>Not Covered</td>
</tr>
<tr>
<td>Post-natal care and other non-routine/non-preventive pregnancy related care.</td>
<td>Based on service provided</td>
<td>Not Covered</td>
</tr>
<tr>
<td>Delivery</td>
<td>80% after deductible</td>
<td>Not Covered</td>
</tr>
<tr>
<td>MEDICAL BENEFITS – EPOB PLAN</td>
<td>PREFERRED PROVIDER</td>
<td>NONPREFERRED PROVIDER</td>
</tr>
<tr>
<td>------------------------------</td>
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<td>------------------------</td>
</tr>
<tr>
<td>Private Duty Nursing</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Inpatient</td>
<td>80% after deductible</td>
<td>Not Covered</td>
</tr>
<tr>
<td>Outpatient</td>
<td>80% after deductible</td>
<td>Not Covered</td>
</tr>
<tr>
<td>Prostheses</td>
<td>80% after deductible</td>
<td>Not Covered</td>
</tr>
<tr>
<td>Radiation Therapy</td>
<td>80% after deductible</td>
<td>Not Covered</td>
</tr>
<tr>
<td>Respiratory Therapy</td>
<td>80% after deductible</td>
<td>Not Covered</td>
</tr>
<tr>
<td>Retail Clinic Visits</td>
<td>$30 copay deductible waived</td>
<td>Not Covered</td>
</tr>
<tr>
<td>Routine Preventive Care/Wellness Benefits</td>
<td>100% deductible waived</td>
<td>Not Covered</td>
</tr>
<tr>
<td>Includes all evidence-based supplies or services that have in effect a rating of A or B in the current recommendations of the United States Preventive Services Task Force (USPSTF). For additional information visit: <a href="http://www.uspreventiveservicestaskforce.org">http://www.uspreventiveservicestaskforce.org</a></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Routine Prostate Examinations</td>
<td>100% deductible waived</td>
<td>Not Covered</td>
</tr>
<tr>
<td>Speech Therapy</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Facility</td>
<td>80% after deductible</td>
<td>Not Covered</td>
</tr>
<tr>
<td>Physician</td>
<td>$30 copay deductible waived</td>
<td>Not Covered</td>
</tr>
<tr>
<td>Telemedicine Services (via Teladoc)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Medical</td>
<td>$12 copay deductible waived</td>
<td>Not Covered</td>
</tr>
<tr>
<td>Behavioral Health</td>
<td>$30 copay deductible waived</td>
<td>Not Covered</td>
</tr>
<tr>
<td>Telemedicine Services (non-Teladoc)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Medical</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Primary care physician</td>
<td>$30 copay deductible waived</td>
<td>Not Covered</td>
</tr>
<tr>
<td>Specialist</td>
<td>$70 copay deductible waived</td>
<td>Not Covered</td>
</tr>
<tr>
<td>Transplants (Organ or Tissue)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Blue Distinction Center</td>
<td>100% after deductible</td>
<td>Not Applicable</td>
</tr>
<tr>
<td>Blue Distinction Plus Center</td>
<td>100% deductible waived</td>
<td>Not Applicable</td>
</tr>
<tr>
<td>Non-Blue Distinction Center/Non-Blue Distinction Plus Center</td>
<td>80% after deductible</td>
<td>Not Covered</td>
</tr>
<tr>
<td>Transportation and Lodging</td>
<td>Not Covered</td>
<td>Not Covered</td>
</tr>
<tr>
<td>Urgent Care Center</td>
<td>$50 copay deductible waived</td>
<td>Not Covered</td>
</tr>
<tr>
<td>MEDICAL BENEFITS – EPOB PLAN</td>
<td>PREFERRED PROVIDER</td>
<td>NONPREFERRED PROVIDER</td>
</tr>
<tr>
<td>--------------------------------</td>
<td>--------------------</td>
<td>-----------------------</td>
</tr>
<tr>
<td><strong>Vision – Routine Services</strong> <em>(Routine vision services required by the Affordable Care Act shall be covered under the Routine Preventive Care benefit)</em></td>
<td>$70 <em>copay</em> deductible waived</td>
<td>Not Covered</td>
</tr>
<tr>
<td><strong>Weight Management</strong></td>
<td>Based on service provided</td>
<td>Not Covered</td>
</tr>
<tr>
<td>Office visit and basic diagnostic testing, including laboratory services and electrocardiograms (EKGs), but does not include advanced imaging services</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Bariatric surgery <em>(Blue Distinction Plus Center only)</em></td>
<td>$5,000 <em>copay</em> then 80% after deductible</td>
<td>Not Covered</td>
</tr>
<tr>
<td>Non-surgical treatment, including therapy and behavior modification</td>
<td>100% deductible waived</td>
<td>Not Covered</td>
</tr>
<tr>
<td><strong>Wigs (hair loss due to treatment of injury or disease)</strong></td>
<td>80% after deductible</td>
<td>Not Covered</td>
</tr>
<tr>
<td><em>Maximum: $1,000 while covered by this Plan</em></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Women’s Preventive Services</strong> <em>(As required by the Affordable Care Act)</em></td>
<td>100% deductible waived</td>
<td>Not Covered</td>
</tr>
<tr>
<td><strong>All Other Covered Expenses</strong></td>
<td>80% after deductible</td>
<td>Not Covered</td>
</tr>
</tbody>
</table>
**PRESCRIPTION DRUG PROGRAM**

**SCHEDULE OF BENEFITS EPOB PLAN**

**Benefit Period:** September 1 – August 31

<table>
<thead>
<tr>
<th>PRESCRIPTION DRUG BENEFITS EPOB PLAN</th>
<th>PREFERRED PROVIDER</th>
<th>NONPREFERRED PROVIDER</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Deductible per benefit period</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Individual</td>
<td>$200; does not apply to generics</td>
<td>N/A</td>
</tr>
</tbody>
</table>

Out-of-Pocket Expense Limit is the same as and is combined with the Medical Out-of-Pocket Expense Limit

**Retail Pharmacy** (31-day supply)

**Note:** Insulin out-of-pocket costs are $25 **copay** for a 31-day supply; $75 for a 61-90 day supply.

- Routine preventive drugs required by the Affordable Care Act
  - Generic: Plan pays 100% deductible waived, Not Applicable
  - Brand Name: Plan pays 75% after deductible, Not Covered
  - Non-Preferred Brand Name: Plan pays 50% after deductible, Not Covered

**Mail Order Pharmacy and Extended Supply Network** (90-day supply)

- Routine preventive drugs required by the Affordable Care Act
  - Generic: Plan pays 100% Deductible Waived, Not Applicable
  - Brand Name: Plan pays 75% after deductible, Not Covered
  - Non-Preferred Brand Name: Plan pays 50% after deductible, Not Covered

**Specialty Drugs** (31-day supply)

- Plan pays 70% after deductible, Not Covered

Specialty drugs must be obtained from preferred specialty drug provider.

If the **covered person** selects a brand drug when a generic equivalent is available, the **covered person** is responsible for the generic **copay** plus the cost difference between the generic and brand equivalent. If the **physician** indicates no substitutions, the **covered person** is only responsible for the brand **copay**.
PREFERRED PROVIDER OR NONPREFERRED PROVIDER

Covered persons have the choice of using either a preferred provider or a nonpreferred provider.

PREFERRED PROVIDER

A preferred provider is a physician, hospital or ancillary service provider which has an agreement in effect with the Preferred Provider Organization (PPO) to accept a negotiated rate for services rendered to covered persons. In turn, the PPO has an agreement with the plan administrator or claims processor to allow access to negotiated rates for services rendered to covered persons. The PPO’s name and/or logo is shown on the front of the covered person’s ID card. The preferred provider cannot bill the covered person for any amount in excess of the negotiated rate for covered expenses. Covered persons should contact the employer’s Human Resources Department, contact the claims processor, or review the PPO’s website for a current listing of preferred providers.

NONPREFERRED PROVIDER

A nonpreferred provider does not have an agreement in effect with the Preferred Provider Organization. Except as explained below, the Plan will allow only the customary and reasonable amount as a covered expense. The Plan will pay its percentage of the customary and reasonable amount for the nonpreferred provider covered expenses. The covered person may be responsible for the remaining balance, which may result in greater out-of-pocket expenses to the covered person except as explained below.

1. If a nonpreferred provider has not satisfied the Notice and Consent Criteria described under number 6. below, for certain items and services, covered expenses for such services rendered at a preferred provider facility will be:
   a. Paid in accordance with the preferred provider cost sharing;
   b. Subject to the preferred provider out-of-pocket expense limit; and
   c. Paid based on the lesser of the qualifying payment amount or the nonpreferred provider’s actual charge, or when applicable:
      i. In a State that has in effect an applicable specified State law, the amount determined in accordance with such law; or
      ii. In a State that has an all-payer model agreement that applies to this Plan, the provider, and the item or service, the amount that the State approves under the all-payer model agreement for that item or service.

The covered person’s cost sharing will be calculated based on the recognized amount and nonpreferred providers may not balance bill for amounts in excess of the covered person’s cost sharing. If the out-of-network rate exceeds the recognized amount, the difference will not be subject to the deductible.

The following types of services provided in a preferred provider facility by a nonpreferred provider will be covered as explained in this section, regardless of whether the nonpreferred provider satisfies the Notice and Consent Criteria described in section 6. below:

d. Ancillary services, including:
   i. Items and services related to emergency medicine, anesthesiology, pathology, radiology, neonatology (whether provided by a physician or non-physician practitioner);
   ii. Items and services provided by assistant surgeons, hospitalists, and intensivists;
iii. Diagnostic services including radiology and laboratory services; and

iv. Items and services provided by a nonpreferred provider if there is no preferred provider who can furnish such item or service at such facility; and

e. Items and services furnished as a result of unforeseen, urgent medical needs that arise at the time an item or service is furnished.

2. Covered expenses for emergency services furnished by a nonpreferred provider will be:

a. Paid in accordance with the preferred provider cost sharing;

b. Subject to the preferred provider out-of-pocket expense limit; and

c. Paid based on the lesser of the qualifying payment amount or the nonpreferred provider’s actual charge:

i. In a State that has in effect an applicable specified State law, the amount determined in accordance with such law; or

ii. In a State that has an all-payer model agreement that applies to this Plan, the provider, and the item or service, the amount that the State approves under the all-payer model agreement for that item or service.

The covered person’s cost sharing will be calculated based on the recognized amount and nonpreferred providers may not balance bill for amounts in excess of the covered person’s cost sharing. If the out-of-network rate exceeds the recognized amount, the difference will not be subject to the deductible.

3. Covered expenses for air ambulance services furnished by a nonpreferred provider will be:

a. Paid in accordance with the preferred provider cost sharing;

b. Subject to the preferred provider out-of-pocket expense limit; and

c. Paid based on the lesser of the qualifying payment amount or the nonpreferred provider’s actual charge, or when applicable:

i. In a State that has in effect an applicable specified State law, the amount determined in accordance with such law; or

ii. In a State that has an all-payer model agreement that applies to this Plan, the provider, and the item or service, the amount that the State approves under the all-payer model agreement for that item or service.

The covered person’s cost sharing will be calculated based on the lesser of the qualifying payment amount or the billed amount, and nonpreferred providers may not balance bill for amounts in excess of the covered person’s cost sharing. If the out-of-network rate exceeds the lesser of the qualifying payment amount or the billed amount, the difference will not be subject to the deductible.

4. Open Negotiation Period

a. A nonpreferred provider may initiate an open negotiation period with this Plan regarding covered expenses as described above. This open negotiation period must be initiated during the thirty (30) business day period beginning on the day the nonpreferred provider receives an initial payment or a notice of denial of payment for covered expenses as described above. To initiate the open negotiation period, the nonpreferred provider must send notice, consistent with applicable regulations, to this Plan on a standard form developed by Federal regulators.

b. The day on which the open negotiation notice is sent by the nonpreferred provider is the date the thirty (30) business day open negotiation period begins. Any additional payment amount agreed upon during the open negotiation period must be made by this Plan within thirty (30) days of such agreement and will not be subject to additional cost sharing.
5. Independent Dispute Resolution

   a. In the case of failed negotiations, the nonpreferred provider or this Plan may initiate the Federal independent dispute resolution (IDR) process established under the No Surprises Act. The IDR process must be initiated, consistent with applicable Federal regulations, within four (4) business days beginning on the thirty-first (31) business day after the start of the open negotiation period.

   b. Within thirty (30) days after the date a certified IDR entity is selected, such entity must select a payment amount and notify this Plan and the nonpreferred provider of the determination. In the absence of a fraudulent claim or evidence of intentional misrepresentation of material facts presented to the certified IDR entity, the decision by such entity is binding on all involved parties.

   c. Any additional payment amount due from this Plan resulting from the decision of the certified IDR entity:

      i. Will not be subject to additional cost sharing;

      ii. Must be paid within thirty (30) days of such determination; and

      iii. Will result in this Plan being responsible for payment of all fees properly charged by the certified IDR entity.

   d. If the certified IDR entity determines that no additional payment is due to the nonpreferred provider by this Plan, such provider will be responsible for payment of the certified IDR entity fee. This Plan and the nonpreferred provider will each be responsible for the Federal IDR administrative fee.

   e. The nonpreferred provider and this Plan may agree on a payment amount for an item or service during the independent dispute resolution process but before the date on which the certified IDR entity makes a final payment determination. Such amount will be treated as the out-of-network rate and to the extent this amount exceeds the initial payment amount and any cost sharing amount, the Plan must pay the additional amount to the nonpreferred provider within thirty (30) business days from the date the agreement is reached. This Plan will be responsible for payment of half of all fees charged by the certified IDR entity, unless this Plan and the nonpreferred provider otherwise agree in writing.

6. Notice and Consent Criteria

   a. In order to satisfy the Notice and Consent Criteria, a nonpreferred provider must provide the covered person with a written notice in paper or electronic form, as selected by the covered person, that is physically separate from other documents and contains the following information:

      i. Notification that the health care provider is a nonpreferred provider;

      ii. Notification of the good faith estimate amount that the nonpreferred provider may charge for the items and services, including a notification that the provision of such estimate does not constitute a contract with respect to the estimated charges;

      iii. In the case where a nonpreferred provider would be furnishing items or services at a preferred provider facility, a list of any preferred providers at such facility who are able to furnish the items or services and notification that the covered person may be referred, at their option, to such a preferred provider;

      iv. Information about whether pre-certification or other care management limitations may be required in advance of receiving the items or services.
b. The above information must be provided to a covered person:
   i. No later than seventy-two (72) hours prior to the date on which the covered person is furnished the items or services, when the appointment is scheduled at least seventy-two (72) hours prior; or
   ii. On the date the appointment is scheduled, in the case where the appointment is scheduled within seventy-two (72) hours prior to the appointment. When the covered person is provided with the notice and consent on the same date that the items or services are to be furnished, the notice must be provided no later than three (3) hours prior to furnishing the items or services to which the notice and consent requirements apply.

c. The nonpreferred provider must obtain consent from the covered person to be treated by the nonpreferred provider and must provide a signed copy of such consent to the covered person through mail or email as selected by the covered person and provide a copy to the claims processor.

7. Continuity of Care

   In certain situations, if a preferred provider becomes a nonpreferred provider, and the covered person is a continuing care patient, this Plan will provide the covered person with notice and an opportunity to elect continuing care from such provider. This election will allow the covered person to continue to receive benefits under this Plan in accordance with the preferred provider cost sharing, beginning on the date of the notice and continuing for a period ending of the earlier of:
   a. Ninety (90) days from the date of the notice; or
   b. The date on which the covered person is no longer a continuing care patient with respect to such provider.

**REFERRALS**

Referrals to a nonpreferred provider are covered as nonpreferred provider services, supplies and treatments. It is the responsibility of the covered person to assure services to be rendered are performed by preferred providers in order to receive the preferred provider level of benefits unless described otherwise under the Nonpreferred Provider subsection above.

**EXCEPTIONS**

The following listing of exceptions represents services, supplies or treatments rendered by a nonpreferred provider where covered expenses shall be payable at the preferred provider level of benefits:

1. **Medically necessary** specialty services, supplies or treatments which are not available from a provider within the Preferred Provider Organization.

2. When a covered dependent resides outside the service area of the Preferred Provider Organization.

3. Treatment rendered at a facility of the uniformed services.

4. Transportation by a nonpreferred provider ambulance for a condition that meets the definition of emergency medical condition.

5. Lactation counseling providers.
CLAIM ADMINISTRATOR’S SEPARATE FINANCIAL ARRANGEMENTS WITH PROVIDERS

Claim administrator hereby informs you that it has contracts with certain Providers (“Administrator Providers”) in its service area to provide and pay for health care services to all persons entitled to health care benefits under health policies and contracts to which the claim administrator is a party, including all persons covered under the Plan. Under certain circumstances described in its contracts with Administrator Providers, the claim administrator may:

- Receive substantial payments from Administrator Providers with respect to services rendered to you for which the claim administrator was obligated to pay the Administrator Provider, or
- Pay Administrator Providers substantially less than their claim charges for services, by discount or otherwise, or
- Receive from Administrator Providers other substantial allowances under the claim administrator’s contracts with them.

In the case of hospitals and other facilities, the calculation of any out-of-pocket maximums or any maximum amounts of benefits payable by the claim administrator as described in this Plan and the calculation of all required deductible and coinsurance amounts payable by you as described in this Plan shall be based on the negotiated rate or provider’s claim charge for covered services rendered to you, reduced by the Average Discount Percentage (“ADP”) applicable to your claim or claims. Your employer has been advised that the claim administrator may receive such payments, discounts and/or other allowances during the term of the agreement between your employer and the claim administrator. Neither the employer nor you are entitled to receive any portion of any such payments, discounts and/or other allowances in excess of the ADP.

To help you understand how the claim administrator’s separate financial arrangements with providers work, please consider the following example:

a. Assume you go into the hospital for one night and the normal, full amount the hospital bills for covered services is $1,000. How is the $1,000 bill paid?

b. You personally will have to pay the deductible and coinsurance amounts set out in this Plan.

c. However, for purposes of calculating your deductible and coinsurance amounts, and whether you have reached any out-of-pocket or benefit maximums, the hospital’s negotiated rate would be reduced by the ADP applicable to your claim. In our example, if the applicable ADP were 30%, the $1,000 hospital bill would be reduced by 30% to $700 for purposes of calculating your deductible and coinsurance amounts, and whether you have reached any out-of-pocket or benefit maximums.

d. Assuming you have already satisfied your deductible, you will still have to pay the coinsurance portion of the $1,000 hospital bill after it has been reduced by the ADP. In our example, if your coinsurance obligation is 20%, you personally will have to pay 20% of $700, or $140. You should note that your 20% coinsurance is based on the full $1,000 hospital bill, after it is reduced by the applicable ADP.

e. After taking into account the deductible and coinsurance amounts, the Plan will satisfy its portion of the hospital bill. In most cases, the claim administrator has a contract with hospitals that allows the Plan to pay less, and requires the hospital to accept less, than the amount of money the Plan would be required to pay if the claim administrator did not have a contract with the hospital.

So, in the example we are using, since the full hospital bill is $1,000, your deductible has already been satisfied, and your coinsurance is $140, then the Plan has to satisfy the rest of the hospital bill, or $860. Assuming the claim administrator has a contract with the hospital, the Plan will usually be able to satisfy the $860 bill that remains after your coinsurance and deductible, by paying less than $860 to the hospital, often substantially less than $860. The Plan receives, and keeps for its own account, the difference between the $860 bill and whatever the Plan ultimately pays under the claim administrator’s contracts with Administrator Providers, and neither you nor your employer are entitled to any part of these savings.
CLAIM ADMINISTRATOR’S SEPARATE FINANCIAL ARRANGEMENTS WITH PHARMACY BENEFIT MANAGERS

Claim administrator owns a significant portion of the equity of Prime Therapeutics LLC and informs you that the claim administrator has entered into one or more agreements with Prime Therapeutics LLC or other entities (collectively referred to as “Pharmacy Benefit Managers”) to provide, on the claim administrator’s behalf, claim payments and certain administrative services for your prescription drug benefits. Pharmacy Benefit Managers have agreements with pharmaceutical manufacturers to receive rebates for using their products. The Pharmacy Benefit Manager may share a portion of those rebates with the claim administrator. In addition, the mail-order pharmacy and specialty pharmacy operate through an affiliate partially owned by Prime Therapeutics, LLC. Neither the employer nor you are entitled to receive any portion of such rebates.

Prime negotiates rebate contracts with pharmaceutical manufacturers on behalf of the claim administrator, but does not retain any rebates (although Prime may retain any interest or late fees earned on rebates received from manufacturers to cover the administrative costs of processing late payments). The claim administrator may receive such rebates from Prime. You are not entitled to receive any portion of any such rebates.

INTER-PLAN ARRANGEMENTS

1. Out-of-Area Services

Overview

The claim administrator has a variety of relationships with other Blue Cross and/or Blue Shield Licensees. Generally, these relationships are called “Inter-Plan Arrangements.” These Inter-Plan Arrangements work based on rules and procedures issued by the Blue Cross Blue Shield Association (“Association”). Whenever you access healthcare services outside the geographic area the claim administrator serves, the claim for those services may be processed through one of these Inter-Plan Arrangements. The Inter-Plan Arrangements are described below.

When you receive care outside of the claim administrator’s service area, you will receive it from one of two kinds of providers. Most providers (“participating providers”) contract with the local Blue Cross and/or Blue Shield Licensee in that geographic area (“Host Blue”). Some providers (“nonparticipating providers”) do not contract with the Host Blue. The claim administrator explains below how the claim administrator pays both kinds of providers.

Inter-Plan Arrangements Eligibility – Claim Types

All claim types are eligible to be processed through Inter-Plan Arrangements, as described above, except for all dental care benefits except when paid as medical claims/benefits, and those prescription drug benefits or vision care benefits that may be administered by a third party contracted by the claim administrator to provide the specific service or services.

A. BlueCard® Program

Under the BlueCard® Program, when you receive covered expenses within the geographic area served by a Host Blue, the claim administrator will remain responsible for doing what we agreed to in the contract. However, the Host Blue is responsible for contracting with and generally handling all interactions with its participating providers.

For inpatient facility services received in a hospital, the Host Blue's participating providers is required to obtain Preauthorization. If Preauthorization is not obtained, the participating providers will be sanctioned based on the Host Blue's contractual agreement with the provider, and the member will be held harmless for the provider sanction.

When you receive covered services outside the claim administrator’s service area and the claim is processed through the BlueCard Program, the amount you pay for covered services is calculated based on the lower of:

- The billed charges for covered services, or
- The negotiated price that the Host Blue passes on to the claim administrator.
To help you understand how this calculation would work, please consider the following example:

a. Suppose you receive covered services are received for an illness while you are on vacation outside of Illinois. You show your identification card to the provider to let him or her know that you are covered by the claim administrator.

b. The provider has negotiated with the Host Blue a price of $80, even though the provider’s standard charge for this service is $100. In this example, the provider bills the Host Blue $100.

c. The Host Blue, in turn, forwards the claim to the claim administrator and indicates that the negotiated price for the covered service is $80. The claim administrator would then base the amount you must pay for the service - the amount applied to the deductible, if any, and the coinsurance percentage - on the $80 negotiated price, not the $100 billed charge.

d. So, for example, if your coinsurance is 20%, you would pay $16 (20% of $80), not $20 (20% of $100). You are not responsible for amounts over the negotiated price for a covered service.

PLEASE NOTE: The coinsurance percentage in the above example is for illustration purposes only. The example assumes that you have met your deductible and that there are no copayments associated with the service rendered. Your deductible(s), coinsurance and copayment(s) are specified in this Plan document.

Often, this “negotiated price” will be a simple discount that reflects an actual price that the Host Blue pays to your healthcare provider. Sometimes, it is an estimated price that takes into account special arrangements with the healthcare provider or provider group that may include types of settlements, incentive payments, and/or other credits or charges. Occasionally, it may be an average price, based on a discount that results in expected average savings for similar types of healthcare providers after taking into account the same types of transactions as with an estimated price.

Estimated pricing and average pricing also take into account adjustments to correct for over- or underestimation of modifications of past pricing of claims, as noted above. However, such adjustments will not affect the price the claim administrator has used for your claim because they will not be applied after a claim has already been paid.

B. Negotiated (non–BlueCard Program) Arrangements

With respect to one or more Host Blues, instead of using the BlueCard Program, the claim administrator may process your claims for covered services through Negotiated Arrangements for National Accounts.

The amount you pay for covered services under this arrangement will be calculated based on the lower of either billed charges for covered services or negotiated price (refer to the description of negotiated price under Section A, BlueCard Program) made available to the claim administrator by the Host Blue.

If reference-based benefits, which are service-specific benefit dollar limits for specific procedures, based on a Host Blue’s local market rates, are made available to you, you will be responsible for the amount that the healthcare provider bills above the specific reference benefit limit for the given procedure. For a participating provider, that amount will be the difference between the negotiated price and the reference benefit limit. For a nonparticipating provider, that amount will be the difference between the provider’s billed charge and the reference benefit limit. Where a reference benefit limit is greater than either a negotiated price or a provider’s billed charge, you will incur no liability, other than any related patient cost sharing under this agreement.

C. Special Cases: Value-Based Programs

BlueCard® Program

If you receive covered services under a Value-Based Program inside a Host Blue’s service area, you will not be responsible for paying any of the provider incentives, risk-sharing, and/or Care Coordinator Fees that are a part of such an arrangement, except when a Host Blue passes these fees to the claim administrator through average pricing or fee schedule adjustments.
Value-Based Programs: Negotiated (non–BlueCard Program) Arrangements

If the claim administrator has entered into a Negotiated Arrangement with a Host Blue to provide Value-Based Programs to your employer on your behalf, the claim administrator will follow the same procedures for Value-Based Programs administration and Care Coordinator Fees as noted above for the BlueCard Program.

D. Inter-Plan Programs: Federal/State Taxes/Surcharges/Fees

Federal or state laws or regulations may require a surcharge, tax or other fee that applies to self-funded accounts. If applicable, the claim administrator will include any such surcharge, tax or other fee as part of the Claim Charge passed on to you.

E. Non-Participating Healthcare Providers Outside The Claim Administrator’s Service Area

1. Member Liability Calculation

When covered services are provided outside of the claim administrator’s service area by non-participating providers, the amount(s) you pay for such services will be calculated using the methodology described in this Plan document for non-participating providers located inside the service area. You may be responsible for the difference between the amount that the non-participating providers bills and the payment the claim administrator will make for the covered services as set forth in this paragraph.

2. Exceptions

In certain situations, the claim administrator may use other payment methods, such as billed covered charges, the payment we would make if the healthcare services had been obtained within our service area, or a special negotiated payment to determine the amount the claim administrator will pay for services provided by nonparticipating providers. In these situations, you may be liable for the difference between the amount that the nonparticipating provider bills and the payment the claim administrator will make for the covered services as set forth in this paragraph.

F. Blue Cross Blue Shield Global® Core

If you are outside the United States, the Commonwealth of Puerto Rico, and the U.S. Virgin Islands (hereinafter “BlueCard service area”), you may be able to take advantage of Blue Cross Blue Shield Global Core when accessing covered services. Blue Cross Blue Shield Global Core is unlike the BlueCard Program available in the BlueCard service area in certain ways. For instance, although Blue Cross Blue Shield Global Core assists with accessing a network of inpatient, outpatient and professional providers, the network is not served by a Host Blue. As such, when you receive care from providers outside the BlueCard service area, you will typically have to pay the providers and submit the claims to obtain reimbursement for these services.

If you need medical assistance services (including locating a doctor or hospital) outside the BlueCard service area, you should call the service center at 1.800.810.BLUE (2583) or call collect at 1.804.673.1177, 24 hours a day, seven days a week. An assistance coordinator, working with a medical professional, can arrange a physician appointment or hospitalization, if necessary.

- Inpatient Services

In most cases, if you contact the service center for assistance, hospitals will not require you to pay for covered inpatient services, except for the cost-share amounts/deductibles, coinsurance, etc. In such cases, the hospital will submit the claims to the service center to begin claims processing. However, if you paid in full at the time of service, you must submit a claim to receive reimbursement for covered services. You must contact the claim administrator to obtain pre-certification for non-emergency inpatient services.
• **Outpatient Services**

*Outpatient* services are available for emergency care, *physicians*, urgent care centers and other *outpatient* providers located outside the BlueCard service area and will typically require you to pay in full at the time of service. You must submit a claim to obtain reimbursement for covered services.

• **Submitting a Blue Cross Blue Shield Global Core Claim**

When you pay for covered services outside the BlueCard service area, you must submit a claim to obtain reimbursement. For institutional and professional claims, you should complete a Blue Cross Blue Shield Global Core International claim form and send the claim form with the provider’s itemized bill(s) to the service center (the address is on the form) to initiate claims processing. Following the instructions on the claim form will help ensure timely processing of your claim. The claim form is available from the claim administrator, the service center or online at [www.bcbsglobalcore.com](http://www.bcbsglobalcore.com). If you need assistance with your claim submission, you should call the service center at 1.800.810.BLUE (2583) or call collect at 1.804.673.1177, 24 hours a day, seven days a week.

**YOUR PROVIDER RELATIONSHIPS**

a. The choice of a provider is solely your choice and the claim administrator will not interfere with your relationship with any provider.

b. The claim administrator does not itself undertake to furnish health care services, but solely to make payments to providers for the covered services received by you. The claim administrator is not in any event liable for any act or omission of any provider or the agent or employee of such provider, including, but not limited to, the failure or refusal to render services to you. Professional services which can only be legally performed by a provider are not provided by the claim administrator. Any contractual relationship between a *physician* and an Administrator Provider shall not be construed to mean that the claim administrator is providing professional service.

c. The use of an adjective such as participating, administrator or approved in modifying a provider shall in no way be construed as a recommendation, referral or any other statement as to the ability or quality of such provider. In addition, the omission, non-use or non-designation of participating, administrator, approved or any similar modifier or the use of a term such as non-administrator or non-participating should not be construed as carrying any statement or inference, negative or positive, as to the skill or quality of such provider.

d. Each provider provides covered services only to you and does not deal with or provide any services to the *employer* (other than as an individual *covered person*) or the *employer’s* ERISA health benefit program.

**BLUE DISTINCTION OR BLUE DISTINCTION PLUS CENTERS OF TREATMENT (BDCT)**

Blue Distinction is a designation awarded by Blue Cross Blue Shield companies to health care *facilities* that have demonstrated expertise in delivering quality health care. At the core of the program are Blue Distinction and Blue Distinction Plus Centers for Specialty Care. Blue Distinction and Blue Distinction Plus Centers are recognized for providing distinguished care in the following transplant or benefit specialty areas of:

- Bariatric Surgery
- Cardiac Care
- Hip and Knee Replacement surgery
- Spinal Surgery
- Transplants
The goal of Blue Distinction is to help find specialty care while enabling and encouraging health care providers to improve the overall quality and cost of care nationwide. Although your plan may require you to receive treatment at a Blue Distinction or Blue Distinction Plus Center to get the highest level of benefits, you may still be covered at a non-Blue Distinction Center, but your out-of-pocket costs will usually be higher.
MEDICAL EXPENSE BENEFIT

This section describes the covered expenses of the Plan. All covered expenses are subject to applicable Plan provisions including, but not limited to: deductible, copay, coinsurance and Essential Health Benefits/non-Essential Health Benefits maximum benefit provisions as shown on the Schedule of Benefits, unless otherwise indicated. Any portion of an expense incurred by the covered person for services, supplies or treatment that is greater than the customary and reasonable amount for nonpreferred providers, except as described in the Nonpreferred Provider subsection, under the Preferred Provider or Nonpreferred Provider section, or negotiated rate for preferred providers will not be considered a covered expense by the Plan. Specified preventive care expenses will be considered to be covered expenses.

COPAY

The copay is the amount payable by the covered person for certain services, supplies or treatment as shown on the Schedule of Benefits. The covered person selects a facility or a professional provider and pays the applicable copay. The Plan pays the remaining covered expenses at the negotiated rate for preferred providers or the customary and reasonable amount for nonpreferred providers, except as described in the Nonpreferred Provider subsection, under the Preferred Provider or Nonpreferred Provider section. The copay must be paid each time a treatment or service is rendered.

The copay will not be applied toward the benefit period deductible.

DEDUCTIBLES

The deductible is the dollar amount of covered expenses which each covered person or family must have incurred during each plan year before the Plan pays applicable benefits. The deductible amount is shown on the Schedule of Benefits. If the out-of-network rate exceeds the recognized amount (or the lesser of the billed charges or the qualifying payment amount for purposes of nonpreferred provider air ambulance services), the difference will not be subject to the deductible.

COINSURANCE

The Plan pays a specified percentage of covered expenses at the customary and reasonable amount for nonpreferred providers except as described in the Nonpreferred Provider subsection, under the Preferred Provider or Nonpreferred Provider section, or the percentage of the negotiated rate for preferred providers. That percentage is specified on the Schedule of Benefits. For nonpreferred providers, the covered person may be responsible for the difference between the percentage the Plan paid and one hundred percent (100%) of the billed amount. See the Nonpreferred Provider subsection for more details. The covered person’s portion of the coinsurance is applied to the out-of-pocket expense limit.

OUT-OF-POCKET EXPENSE LIMIT

After the covered person has incurred an amount equal to the out-of-pocket expense limit listed on the Schedule of Benefits for covered expenses, the Plan will begin to pay one hundred percent (100%) of covered expenses for the remainder of the plan year.

Out-of-Pocket Expense Limit Exclusions

The following items do not apply toward satisfaction of the plan year out-of-pocket expense limit and will not be payable at one hundred percent (100%), even if the out-of-pocket expense limit has been satisfied:

1. Expenses for services, supplies and treatments not covered by the Plan, including charges in excess of the customary and reasonable amount or negotiated rate, as applicable.

2. Expenses incurred as a result of failure to obtain pre-certification.
MAXIMUM BENEFIT

The maximum benefit for all non-Essential Health Benefits payable on behalf of a covered person is shown on the Schedule of Benefits. The non-Essential Health Benefits maximum benefit applies to the entire time the covered person is covered under the Plan, either as an employee, dependent, alternate recipient or under COBRA. If the covered person’s coverage under the Plan terminates and at a later date the covered person again becomes covered under the Plan, the non-Essential Health Benefits maximum benefit will include all benefits paid by the Plan for the covered person during any period of coverage.

The Schedule of Benefits may contain separate maximum benefit limitations for specified conditions and/or services. Any separate maximum benefit will include all such benefits paid by the Plan for the covered person during any and all periods of coverage under the Plan. No more than the Essential Health Benefits/non-Essential Health Benefits maximum benefit will be paid for any covered person while covered by the Plan.

Notwithstanding any provision of the Plan to the contrary, all benefits received by an individual under any benefit option, package or coverage under the Plan shall be applied toward the applicable maximum benefit paid by the Plan for any one covered person for such option, package or coverage under the Plan, and also toward the maximum benefit under any other options, packages or coverages under the Plan in which the individual may participate in the future.

HOSPITAL/AMBULATORY SURGICAL FACILITY

Covered expenses shall include:

1. Room and board for treatment in a hospital, including intensive care units, cardiac care units and similar medically necessary accommodations. Covered expenses for room and board shall be limited to the hospital’s semiprivate rate. Covered expenses for intensive care or cardiac care units shall be the customary and reasonable amount for nonpreferred providers except as described in the Nonpreferred Provider subsection, under the Preferred Provider or Nonpreferred Provider section, and the percentage of the negotiated rate for preferred providers. A full private room rate is covered if the private room is necessary for isolation purposes and is not for the convenience of the covered person.

2. Miscellaneous hospital services, supplies, and treatments including, but not limited to:
   a. Admission fees, and other fees assessed by the hospital for rendering services, supplies and treatments;
   b. Use of operating, treatment or delivery rooms;
   c. Anesthesia, anesthesia supplies and its administration by an employee of the hospital;
   d. Medical and surgical dressings and supplies, casts and splints;
   e. Blood transfusions, including the cost of whole blood, the administration of blood, blood processing and blood derivatives (to the extent blood or blood derivatives are not donated or otherwise replaced);
   f. Drugs and medicines (except drugs not used or consumed in the hospital);
   g. X-ray and diagnostic laboratory procedures and services;
   h. Oxygen and other gas therapy and the administration thereof;
   i. Therapy services.

3. Services, supplies and treatments described above furnished by an ambulatory surgical facility, including follow-up care provided within seventy-two (72) hours of a procedure.
4. Charges for pre-admission testing (x-rays and lab tests) performed within seven (7) days prior to a hospital admission which are related to the condition which is necessitating the confinement. Such tests shall be payable even if they result in additional medical treatment prior to confinement or if they show that hospital confinement is not medically necessary. Such tests shall not be payable if the same tests are performed again after the covered person has been admitted.

**AMBULANCE SERVICES**

*Covered expenses* shall include:

1. Ambulance services for air or ground transportation for the covered person from the place of injury or serious medical incident to the nearest hospital where treatment can be given.

2. Ambulance service is covered in a non-emergency situation only to transport the covered person to or from a hospital or between hospitals for required treatment when such transportation is certified by the attending physician as medically necessary. Such transportation is covered only from the initial hospital to the nearest hospital qualified to render the special treatment.

3. Emergency services actually provided by an advance life support unit, even though the unit does not provide transportation.

If the covered person is admitted to a nonpreferred hospital after treatment for an emergency medical condition, ambulance service is covered to transport the covered person from the nonpreferred hospital to a preferred hospital after the patient’s condition has been stabilized, provided such transport is certified by the attending physician as medically necessary.

**EMERGENCY SERVICES/EMERGENCY ROOM SERVICES**

*Covered expenses* for emergency services in the emergency department of a hospital shall be paid in accordance with the Schedule of Benefits. Emergency services by a nonpreferred provider shall be paid as specified in the section, Preferred Provider or Nonpreferred Provider, under the subsection, Nonpreferred Provider.

Emergency room treatment for conditions that do not meet the definition of emergency medical condition will be considered non-emergency use of the emergency room and will be subject to the terms as shown on the Schedule of Benefits.

The emergency room copay shall be waived if the patient is admitted directly into the hospital.

**URGENT CARE CENTER**

*Covered expenses* shall include charges for treatment in an urgent care center, payable as specified on the Schedule of Benefits.

**PHYSICIAN SERVICES AND PROFESSIONAL PROVIDER SERVICES**

*Covered expenses* shall include the following services when performed by a physician or a professional provider:

1. Medical treatment, services and supplies including, but not limited to: office visits, inpatient visits, retail clinic visits, and home visits.

2. Surgical treatment. Separate payment will not be made for inpatient pre-operative or post-operative care normally provided by a surgeon as part of the surgical procedure.

For related operations or procedures performed through the same incision or in the same operative field, covered expenses shall include the surgical allowance for the highest paying procedure, plus fifty percent (50%) of the surgical allowance for each additional procedure.
When two (2) or more unrelated operations or procedures are performed at the same operative session, covered expenses shall include the surgical allowance for each procedure.

3. Surgical assistance provided by a physician or professional provider if it is determined that the condition of the covered person or the type of surgical procedure requires such assistance. Covered expenses for the services of an assistant surgeon are limited to twenty percent (20%) of the surgical allowance.

4. Furnishing or administering anesthetics, other than local infiltration anesthesia, by other than the surgeon or his assistant. However, benefits will be provided for anesthesia services administered by oral and maxillofacial surgeons when such services are rendered in the surgeon's office.

5. Consultations requested by the attending physician during a hospital confinement. Consultations do not include staff consultations that are required by a hospital's rules and regulations.

6. Radiologist or pathologist services for interpretation of x-rays and laboratory tests necessary for diagnosis and treatment.

7. Radiologist or pathologist services for diagnosis or treatment, including radiation therapy and chemotherapy.

8. Allergy testing consisting of percutaneous, intracutaneous and patch tests and allergy injections.

**DIAGNOSTIC SERVICES AND SUPPLIES**

Covered expenses shall include services and supplies for diagnostic laboratory tests, electronic tests, pathology, ultrasound, nuclear medicine, magnetic imaging and x-rays.

**TRANSPLANT**

Services, supplies and treatments in connection with human-to-human organ and tissue transplant procedures will be considered covered expenses subject to the following conditions:

1. When the recipient is covered under the Plan, the Plan will pay the recipient's covered expenses related to the transplant.

2. When the donor is covered under the Plan, the Plan will pay the donor's covered expenses related to the transplant, provided the recipient is also covered under the Plan. Covered expenses incurred by each person will be considered separately for each person.

3. Expenses incurred by the donor who is not ordinarily covered under the Plan according to eligibility requirements will be covered expenses to the extent that such expenses are not payable by any other form of health coverage, including any government plan or individual policy of health coverage, and provided the recipient is covered under the Plan. The donor’s expenses shall be applied to the recipient's maximum benefit. In no event will benefits be payable in excess of the maximum benefit.

4. Surgical, storage and transportation costs directly related to procurement of an organ or tissue used in a transplant procedure will be covered for each procedure completed. If an organ or tissue is sold rather than donated, the purchase price of such organ or tissue shall not be considered a covered expense under the Plan.

5. Transportation, lodging and meals for the covered recipient and one (1) other person (two (2) other persons if the recipient is an eligible dependent child) to accompany the recipient to and from a facility and for lodging and meals at or near the facility where the recipient is confined, up to any non-Essential Health Benefits maximum benefit specified on the Schedule of Benefits.

If a covered person's transplant procedure is not performed as scheduled due to the intended recipient's medical condition or death, benefits will be paid for organ or tissue procurement as described above.
Centers of Medical Excellence (CME) and Blue Distinction Centers for Transplants (BDCT)

In addition to the above transplant benefits, the covered person may be eligible to participate in a Centers of Medical Excellence (CME) and Blue Distinction Centers for Transplants (BDCT). Covered persons should contact the Health Care Management Organization to discuss this benefit by calling 1-800-480-6658.

A Centers of Medical Excellence (CME) and Blue Distinction Centers for Transplants (BDCT) are facilities within a Centers of Excellence Network that has been chosen for its proficiency in performing one or more transplant procedures. Usually located throughout the United States, the Centers of Medical Excellence (CME) and Blue Distinction Centers for Transplants (BDCT) facilities have greater transplant volumes and surgical team experience than other similar facilities.

Transplant procedures are subject to pre-certification. Failure to obtain pre-certification will result in a reduction of benefits for the hospital confinement as specified in the Claim Filing Procedure section of this document.

PREGNANCY

Covered expenses shall include services, supplies and treatment related to pregnancy or complications of pregnancy for a covered pregnant employee, a covered pregnant spouse of a covered employee, and dependent pregnant children.

The Plan shall cover services, supplies and treatments for medically necessary abortions when the life of the birth parent would be endangered if the fetus were carried to term or where medical complications have arisen from an abortion pursuant to the Pregnancy Discrimination Act if applicable.

BIRTHING CENTER

Covered expenses shall include services, supplies and treatments rendered at a birthing center provided the physician in charge is acting within the scope of the physician’s license and the birthing center meets all legal requirements. Services of a midwife acting within the scope of the midwife’s license or registration are a covered expense provided that the state in which such service is performed has legally recognized midwife delivery.

STERILIZATION

Covered expenses shall include elective surgical sterilization procedures for the covered male employee or covered male spouse. Covered expenses for elective surgical sterilization procedures for women shall be considered under the subsection, Women's Preventive Services. Reversal of surgical sterilization is not a covered expense.

INFERTILITY SERVICES

Covered expenses shall include expenses for infertility testing for employees and their covered spouse.

Covered expenses for infertility testing are limited to the actual testing for a diagnosis of infertility. Any outside intervention procedures (e.g., artificial insemination) will not be considered a covered expense.

CONTRACEPTIVES

Covered expenses shall include charges for medical procedures or supplies related to contraception, including screening, education, counseling, oral contraceptives, contraceptive devices, contraceptive injections and the surgical implantation and removal of contraceptive devices. FDA approved contraceptive methods shall be considered under the subsection, Women’s Preventive Services.

Charges for contraceptives that require a prescription and are dispensed by a pharmacy are covered under the Prescription Drug Program.
WELL NEWBORN CARE

Covered expenses for services, supplies or treatment of the newborn child shall be considered charges of the child and as such, subject to a separate deductible and coinsurance from the birth parent.

Such care shall include, but is not limited to:

1. Physician services
2. Hospital services
3. Circumcision

ROUTINE PREVENTIVE CARE/WELLNESS BENEFITS

Routine Preventive Care/Wellness Benefits shall include:

1. Evidence-based supplies or services that have in effect a rating of A or B in the current recommendations of the United States Preventive Services Task Force (USPSTF).
2. Annual routine mammograms for women age forty (40) and over.
3. Colonoscopies, and follow-up colonoscopies conducted after a positive non-invasive stool-based screening test or direct visualization screening test, including pre-procedure consultation, bowel preparation kits and pathology exam for adults age forty-five (45) and over.
4. Routine immunizations, as recommended by the Advisory Committee on Immunization Practices of the Centers of Disease Control and Prevention for infants and children through age six (6); children and adolescents age seven (7) through eighteen (18) years and adults age nineteen (19) years and older.
5. Evidence-informed Routine Preventive Care and screenings as provided by the Health Resources Services Administration for infants, children, adolescents and adult women, unless included in the USPSTF recommendations.
6. Screening for tobacco use and two (2) tobacco cessation attempts per year and tobacco cessation medications for a ninety (90) day treatment regimen when prescribed by a physician.

The Plan will apply reasonable medical management techniques to determine the appropriate frequency, method, treatment, or setting for a preventive item or service to the extent that such techniques are not specified in the recommendations or guidelines.

WOMEN’S PREVENTIVE SERVICES

Covered expenses shall include preventive services recommended in guidelines issued by the U.S. Department of Health and Human Services’ Health Resources and Services Administration, including, but not limited to:

1. Annual well-woman office visits to obtain preventive care and pregnancy, prenatal, postpartum and interpregnancy office visits;
2. Screening for gestational diabetes in a pregnant woman;
3. Human papillomavirus (HPV) DNA testing no more frequently than every three (3) years for a woman age thirty (30) and above;
4. Annual counseling for sexually transmitted infections for a sexually active woman;
5. Annual counseling and screening for human immune deficiency virus for a sexually active woman;
6. FDA approved contraceptive methods, sterilization procedures and patient education, screening and counseling for a woman with reproductive capacity;

7. Breastfeeding support, supplies and counseling, to include the cost of rental or purchase, whichever is less costly, of breastfeeding equipment;

8. Annual screening and counseling for interpersonal and domestic violence; and

9. Genetic counseling for women identified to be at higher risk of having a potentially harmful gene mutation, and, if indicated, BRCA testing for harmful BRCA mutations.

The Plan will apply reasonable medical management techniques to determine the appropriate frequency, method, treatment, or setting for a preventive item or service to the extent that such techniques are not specified in the recommendations or guidelines.

**ROUTINE PROSTATE EXAMINATIONS**

*Covered expenses* shall include routine prostate examinations and routine prostate specific antigen (PSA) tests, for men age forty (40) and over.

**THERAPY SERVICES**

Therapy services must be ordered by a *physician* to aid restoration of normal function lost due to *illness* or *injury* or for congenital anomaly.

*Covered expenses* shall include:

1. Services of a *professional provider* for physical therapy, occupational therapy, speech therapy or respiratory therapy.

2. Radiation therapy and chemotherapy.

3. Dialysis therapy or treatment.

4. Infusion therapy.

**HABILITATIVE SERVICES**

*Covered expenses* shall include medically necessary habilitative services to help a *covered person* keep, learn or improve skills and functioning for daily living. Examples of habilitative services include therapy for a dependent child who is not walking or talking at the expected age. Services may include physical, occupational and speech therapy.

**EXTENDED CARE FACILITY**

Extended care facility services, supplies and treatments shall be a *covered expense* provided the *covered person* is under a physician’s continuous care and the physician certifies that the *covered person* must have twenty-four (24) hours-per-day nursing care.

*Covered expenses* shall include:

1. *Room and board* (including regular daily services, supplies and treatments furnished by the extended care facility) limited to the facility's average *semiprivate room* rate; and

2. Other services, supplies and treatment ordered by a *physician* and furnished by the extended care facility for *inpatient* medical care.

Extended care facility benefits are subject to the Essential Health Benefits maximum benefit specified on the Schedule of Benefits.
HOME HEALTH CARE

Home health care enables the covered person to receive treatment in the covered person’s home for an illness or injury instead of being confined in a hospital or extended care facility. Covered expenses shall include the following services and supplies provided by a home health care agency:

1. Part-time or intermittent nursing care by a nurse;
2. Physical, respiratory, occupational or speech therapy;
3. Part-time or intermittent home health aide services for a covered person who is receiving covered nursing or therapy services;
4. Medical social service consultations;
5. Nutritional guidance by a registered dietitian and nutritional supplements such as diet substitutes administered intravenously or through hyperalimentation as determined to be medically necessary.

Covered expenses shall be subject to the Essential Health Benefits maximum benefit specified on the Schedule of Benefits.

A visit by a member of a home health care team and four (4) hours of home health aide service will each be considered one (1) home health care visit.

No home health care benefits will be provided for dietitian services (except as may be specifically provided herein), homemaker services, maintenance therapy, dialysis treatment, food or home delivered meals, rental or purchase of durable medical equipment or prescription or non-prescription drugs or biologicals.

HOSPICE CARE

Hospice care is a health care program providing a coordinated set of services rendered at home, in outpatient settings, or in facility settings for a covered person suffering from a condition that has a terminal prognosis.

Hospice care will be covered only if the covered person's attending physician certifies that:

1. The covered person is terminally ill, and
2. The covered person has a life expectancy of six (6) months or less.

Covered expenses shall include:

1. Confinement in a hospice to include ancillary charges and room and board.
2. Services, supplies and treatment provided by a hospice to a covered person in a home setting.
3. Physician services and/or nursing care by a nurse.
4. Physical therapy, occupational therapy, speech therapy or respiratory therapy.
5. Nutrition services to include nutritional advice by a registered dietitian, and nutritional supplements such as diet substitutes administered intravenously or through hyperalimentation as determined to be medically necessary.
6. Counseling services provided through the hospice.

Charges incurred during periods of remission are not eligible under this provision of the Plan. Any covered expense paid under hospice benefits will not be considered a covered expense under any other provision of the Plan.
DURABLE MEDICAL EQUIPMENT

Rental or purchase, whichever is less costly (except as noted below for oxygen concentrators), of medically necessary durable medical equipment which is prescribed by a qualified prescriber and required for therapeutic use by the covered person shall be a covered expense.

A charge for the purchase or rental of durable medical equipment is considered incurred on the date the equipment is received/delivered. Durable medical equipment that is received/delivered after the termination date of a covered person's coverage under the Plan is not covered. Repair or replacement of purchased durable medical equipment which is medically necessary due to normal use or a physiological change in the patient's condition will be considered a covered expense.

Equipment containing features of an aesthetic nature or features of a medical nature which are not required by the covered person's condition, or where there exists a reasonably feasible and medically appropriate alternative piece of equipment which is less costly than the equipment furnished, will be covered based on the usual charge for the equipment which meets the covered person's medical needs.

Ongoing rental charges for oxygen concentrators shall be a covered expense, provided the equipment is determined to be medically necessary for the treatment of chronic conditions or upon diagnosis of severe lung disease or other hypoxia related symptoms or findings.

Covered expenses for the rental of breastfeeding equipment shall be considered under the subsection, Women's Preventive Services.

PROSTHESSES

The initial purchase of a prosthesis (other than dental) provided for functional reasons when replacing all or part of a missing body part (including contiguous tissue) or to replace all or part of the function of a permanently inoperative or malfunctioning body organ shall be a covered expense. A charge for the purchase of a prosthesis is considered incurred on the date the prosthesis is received/delivered. A prosthesis that is received/delivered after the termination date of a covered person's coverage under the Plan is not covered. Repair or replacement of a prosthesis which is medically necessary due to normal use or a physiological change in the patient's condition will be considered a covered expense.

ORTHOTICS

Orthotic devices and appliances (a rigid or semi-rigid supportive device, including custom/molded foot orthotics, which restricts or eliminates motion for a weak or diseased body part), including initial purchase, fitting and repair shall be a covered expense. Orthopedic shoes or corrective shoes and other supportive devices for the feet shall not be covered, unless they are an integral part of a leg brace, or prescribed for a patient with diabetes. Therapeutic footwear for the prevention of complications associated with Diabetes is limited to two (2) pairs per plan year.

DENTAL SERVICES

Covered expenses shall include repair of sound natural teeth or surrounding tissue provided it is the result of an injury. Treatment must be completed within twenty-four (24) months of the injury. Damage to the teeth as a result of chewing or biting shall not be considered an injury under this benefit.

Covered expenses shall include:

- Excision of non-dental related neoplasms, including benign tumors and cysts and all malignant and premalignant lesions and growths;
- Surgical and diagnostic treatment of conditions affecting the temporomandibular joint (including the jaw and the craniofacial joint) as a result of an accident, a trauma, a congenital defect, a developmental defect, or a pathology;
- Incision and drainage of facial abscess; and
Surgical procedures involving salivary glands and ducts and non-dental related procedures of the accessory sinuses.

Facility charges for oral surgery or dental treatment that ordinarily could be performed in the provider’s office will be covered only if the covered person has a chronic disease or condition for which treatment in a facility is determined by the Plan to be medically necessary, or if the age of the covered person prohibits performing the treatment safely in an office setting.

TEMPOROMANDIBULAR JOINT DYSFUNCTION

Surgical treatment of temporomandibular joint dysfunction (TMJ) or myofascial pain syndrome shall be a covered expense (See “Dental Services” above). Non-surgical treatment of TMJ shall not be considered a covered expense.

ORTHOGNATHIC DISORDERS

Surgical and non-surgical treatment of orthognathic disorders shall be a covered expense, but shall not include orthodontia or prosthetic devices even if prescribed by a qualified prescriber.

SPECIAL EQUIPMENT AND SUPPLIES

Covered expenses shall include medically necessary special equipment and supplies including, but not limited to:

- casts;
- splints;
- braces;
- trusses;
- surgical and orthopedic appliances;
- colostomy and ileostomy bags and supplies required for their use;
- catheters;
- allergy serums;
- crutches;
- electronic pacemakers;
- oxygen and the administration thereof;
- the initial pair of eyeglasses or contact lenses due to cataract surgery;
- soft lenses or sclera shells intended for use in the treatment of illness or injury of the eye;
- support or compression stockings, when prescribed by a physician;
- a wig or hairpiece when required due to chemotherapy, radiation therapy, surgery or burns, limited to the non-Essential Health Benefits maximum benefit as stated on the Schedule of Benefits;
- surgical dressings and other medical supplies ordered by a professional provider in connection with medical treatment, but not common first aid supplies.

COSMETIC/RECONSTRUCTIVE SURGERY

Cosmetic surgery or reconstructive surgery shall be a covered expense provided:

1. A covered person receives an injury as a result of an accident and as a result requires surgery. Cosmetic or reconstructive surgery and treatment must be for the purpose of restoring the covered person to his normal function immediately prior to the accident.

2. It is required to correct a congenital anomaly, for example, a birth defect.
**GENDER DYSPHORIA**

*Covered expenses* shall include treatment provided by a *professional provider* for gender dysphoria, a disorder characterized by the specific diagnostic criteria classified in the current edition of the Diagnostic and Statistical Manual of Mental Disorders published by the American Psychiatric Association. Treatment includes *medically necessary* psychotherapy, hormone therapy, prescription drugs and surgery. The following procedures or services to create and maintain gender specific characteristics as part of the overall desired gender reassignment services treatment plan may be considered *medically necessary* for the treatment of gender dysphoria ONLY:

1. Abdominoplasty;
2. Blepharoplasty;
3. Breast enlargement, including augmentation mammoplasty and breast implants;
4. Brow lift;
5. Calf implants;
6. Cheek, chin or nose implants;
7. External penile prosthesis (vacuum erection devices);
8. Face lift (rhytidectomy);
9. Facial bone reconstruction/sculpturing/reduction, includes jaw shortening;
10. Forehead lift or contouring;
11. Hair removal (laser hair removal or electrolysis) which may include donor skin sites; or hair transplantation (hairplasty);
12. Injection of fillers or neurotoxins;
13. Laryngoplasty;
14. Lip augmentation or lip reduction;
15. Liposuction/lipofilling or body contouring or modeling of waist, buttocks, hips, and thighs reduction;
16. Mastopexy;
17. Neck tightening;
18. Pectoral implants for chest masculinization;
19. Reduction thyroid chondroplasty or trachea shaving (reduction of Adam’s apple);
20. Removal of redundant/excessive skin;
21. Rhinoplasty;
22. Skin resurfacing;
23. Testicular expanders;
24. Voice modification surgery;

**MASTECTOMY (WOMEN'S HEALTH AND CANCER RIGHTS ACT OF 1998)**

The *Plan* intends to comply with the provisions of the federal law known as the Women's Health and Cancer Rights Act of 1998.

*Covered expenses* will include eligible charges related to *medically necessary* mastectomy.
For a covered person who elects breast reconstruction in connection with such mastectomy, covered expenses will include:

1. reconstruction of a surgically removed breast, including nipple and areola reconstruction and repigmentation; and
2. surgery and reconstruction of the other breast to produce a symmetrical appearance.

An external breast prosthesis shall be covered once every three (3) calendar years, unless recommended more frequently by a physician. The first permanent internal breast prosthesis necessary because of a mastectomy shall also be a covered expense.

Prostheses (and medically necessary replacements) and physical complications from all stages of mastectomy, including lymphedemas will also be considered covered expenses following all medically necessary mastectomies.

**MENTAL HEALTH DISORDERS**

The Plan will pay for medically necessary covered expenses for inpatient and outpatient treatment, services or supplies for the treatment of mental health disorders.

Covered expenses shall include:

1. Inpatient hospital confinement;
2. Individual psychotherapy;
3. Group psychotherapy;
4. Psychological testing;
5. Electro-Convulsive therapy (electroshock treatment) or convulsive drug therapy, including anesthesia when administered concurrently with the treatment by the same professional provider.

**SUBSTANCE USE DISORDER**

The Plan will pay for medically necessary covered expenses for the inpatient and outpatient treatment of substance use disorder in a hospital or treatment center by a physician or professional provider.

**MEDICAL SPECIALTY DRUG MANAGEMENT**

To promote safety and clinically appropriate care while controlling costs, specialty drug coverage under the Medical Expense Benefit may be restricted in quantity, duration or require step therapy through pre-certification. See the Filing a Pre-certification Claim for Specialty Drugs section of this Plan for more information.

The quantity that will be covered for certain specialty drugs under this Plan every 30-days is limited based on national standards and current medical literature. These limits ensure the quantity of units supplied and duration for each prescription remain consistent with clinical dosing guidelines, including building up a required tolerance for a drug.

**AUTISM SPECTRUM DISORDERS**

Covered expenses shall include services, supplies and treatment for autism spectrum disorders performed by a physician or a professional provider that are focused on behavioral intervention, such as Applied Behavioral Analysis (ABA) evaluation and therapy and behavioral services that are focused on primary building skills and capabilities in communication, social interaction and learning.
ROUTINE PATIENT COSTS FOR APPROVED CLINICAL TRIALS

Covered expenses shall include charges for “routine patient costs” incurred by a “qualified individual” participating in an approved clinical trial. “Routine patient costs” do not include:

1. An investigational item, device or service;
2. An item or service provided solely to satisfy data collection and analysis needs, which are not used in the direct clinical management of the patient; or,
3. A service that is clearly inconsistent with widely accepted and established standards of care for a particular diagnosis.

“Life-threatening disease or condition” means any disease or condition from which the likelihood of death is probable unless the course of the disease or condition is interrupted.

“Qualified Individual” means a covered person who is eligible to participate in an approved clinical trial according to the trial protocol with respect to the treatment of cancer or another “life-threatening disease or condition” and either:

1. The referring health care professional is a participating health care provider and has concluded that the covered person’s participation in such trial would be appropriate; or,
2. The covered person provides medical and scientific information establishing that the covered person’s participation in such trial would be appropriate.

“Routine patient costs” include all items and services consistent with the coverage provide by the Plan that is typically covered for a covered person who is not enrolled in a clinical trial.

PODIATRY SERVICES

Covered expenses shall include surgical podiatry services, including incision and drainage of infected tissues of the foot, removal of lesions of the foot, removal or debridement of infected toenails, surgical removal of nail root, and treatment of fractures or dislocations of bones of the foot.

HEARING BENEFIT

Services of a licensed audiologist to determine and measure hearing loss are a covered expense.

Prescription hearing aids are a covered expense, subject to the non-Essential Health Benefits maximum benefit as specified on the Schedule of Benefits.

ACUPUNCTURE

Acupuncture performed to induce surgical anesthesia shall be a covered expense.

PRIVATE DUTY NURSING

Medically necessary services of a private duty nurse shall be a covered expense.

CHIROPRACTIC CARE

Covered expenses include initial consultation, x-rays and treatment (but not maintenance care), subject to the non-Essential Health Benefits maximum benefit shown on the Schedule of Benefits.
**PATIENT EDUCATION**

*Covered expenses* shall include *medically necessary* patient education programs including, but not limited to diabetic education and ostomy care.

*Covered expenses* for patient education for contraception or lactation training shall be considered under the subsection, *Women's Preventive Services*.

**SURCHARGES**

Any surcharge or assessment (by whatever name called) on *covered expenses*, required by state or federal law to be paid by the *Plan* for services, supplies and/or treatments rendered by a health care provider shall be a *covered expense* subject to the *covered person’s* obligations under the *Plan*.

**OUTPATIENT CARDIAC/PULMONARY REHABILITATION PROGRAMS**

*Covered expenses* shall include charges for qualified *medically necessary outpatient* cardiac/pulmonary rehabilitation programs.

**WEIGHT MANAGEMENT**

*Surgical Treatment for Weight Loss*

*Covered expenses* shall include *medically necessary* surgical treatment for weight loss, including but not limited to gastric by-pass, gastric stapling or gastric balloon.

*Non-Surgical Treatment for Weight Loss*

*Covered expenses* shall include *medically necessary* non-surgical treatment for weight loss that is administered and supervised by a *physician*, including therapy and behavior modification. This program must not be a weight reduction program, but a program designed to treat health problems associated with high-risk obesity. These health conditions may include hypertension, diabetes, cardiovascular disease, sleep apnea and degenerative joint disease. This program does not include any athletic or fitness center membership or training.

**SLEEP DISORDERS**

*Covered expenses* shall include charges for sleep studies and treatment of sleep apnea and other sleep disorders, including charges for sleep apnea monitors.

**ROUTINE VISION**

*Covered expenses* shall include charges for routine vision examinations and eye refractions, subject to the *maximum benefit* shown on the *Schedule of Benefits*.

**TELEMEDICINE SERVICES**

*Covered expenses* shall include *telemedicine services* for *medically necessary* treatment of non-*emergency medical conditions*. Telebehavioral health services through Teladoc are not available to a *covered person* who is under the age of 13 years and telebehavioral health services for *dependent* children between the ages of 13 and 17 will require parental consent and will not include prescriptions for medication.
To promote safety and clinically appropriate care while controlling costs, specialty drug coverage under the Medical Expense Benefit may be restricted in quantity, duration or require step therapy through pre-certification. See the Filing a Pre-certification Claim for Specialty Drugs section of this Plan for more information.

The quantity that will be covered for certain specialty drugs under this Plan every 30-days is limited based on national standards and current medical literature. These limits ensure the quantity of units supplied and duration for each prescription remain consistent with clinical dosing guidelines, including building up a required tolerance for a drug.
MEDICAL EXCLUSIONS

In addition to Plan Exclusions, no benefit will be provided under the Plan for medical expenses for the following:

1. Charges for services, supplies or treatment for the reversal of surgical sterilization procedures.

2. Charges for services, supplies or treatment related to the treatment of infertility and artificial reproductive procedures, including, but not limited to: artificial insemination, in vitro fertilization, surrogate birth parent (unless the surrogate is a covered person, in which case expenses under subsection Women’s Preventive Services and/or Pregnancy, will be covered in accordance with this Plan’s provisions), fertility drugs, embryo implantation, or gamete intrafallopian transfer (GIFT).

3. Charges for treatment or surgery for sexual dysfunction or inadequacies.

4. Charges for hospital admission on Friday, Saturday or Sunday unless the admission is due to an emergency medical condition, or surgery is scheduled within twenty-four (24) hours. If neither situation applies, hospital expenses will be payable commencing on the date of actual surgery.

5. Charges for inpatient room and board in connection with a hospital confinement primarily for diagnostic tests, unless it is determined by the Plan that inpatient care is medically necessary.

6. Charges for services, supplies or treatment for attention deficit disorders, behavior or conduct disorders, hyperactivity, learning disorders, intellectual disability, or senile deterioration. However, the initial examination, office visit and diagnostic testing to determine the illness shall be a covered expense.

7. Charges for biofeedback therapy.

8. Except as specified herein, charges for services, supplies or treatments which are primarily educational in nature, charges for services for educational or vocational testing or training and work hardening programs regardless of diagnosis or symptoms; charges for training or other forms of education.

9. Charges for marriage, career or legal counseling.

10. Except as specifically stated in Medical Expense Benefit, Dental Services, charges for or in connection with: treatment of injury or disease of the teeth; oral surgery; treatment of gums or structures directly supporting or attached to the teeth; removal or replacement of teeth; or dental implants.

11. Charges for vision therapy (orthoptics); eyeglasses or contact lenses, except as specified herein; dispensing optician's services.

12. Charges for any eye surgery solely for the purpose of correcting refractive defects of the eye, such as nearsightedness (myopia) and astigmatism including radial keratotomy by whatever name called; contact lenses and eyeglasses required as a result of such surgery.

13. Except as medically necessary for the treatment of metabolic or peripheral-vascular illness, charges for routine, palliative or cosmetic foot care, including, but not limited to: treatment of weak, unstable, flat, strained or unbalanced feet; subluxations of the foot; treatment of corns or calluses; non-surgical care of toenails.

14. Charges for services, supplies or treatment which constitute personal comfort or beautification items, whether or not recommended by a physician, such as: television, telephone, air conditioners, air conditioners, humidifiers, electric heating units, orthopedic mattresses, blood pressure instruments, scales, elastic bandages, non-hospital adjustable beds, exercise equipment.

15. Charges for nonprescription drugs, such as vitamins, cosmetic dietary aids, and nutritional supplements except as provided in, Routine Preventive Care/Wellness Benefits in accordance with United States Preventive Services Task Force (USPSTF) recommendations.
16. Charges for outpatient prescription drugs, except as specifically indicated in Medical Expense Benefit and except as provided in Medical Expense Benefit, Medical Specialty Drug Management.

17. Charges for prescription drugs that are covered under the Prescription Drug Program or for the Prescription Drug deductible or copay applicable thereto. Outpatient prescription drugs are paid under the Prescription Drug Program and under no other provision of the Plan.

18. Charges for orthopedic shoes (except when they are an integral part of a leg brace and the cost is included in the orthotist's charge or prescribed for a patient with diabetes) or shoe inserts except as specified herein.

19. Expenses for a cosmetic surgery or procedure and all related services, except as specifically stated in Medical Expense Benefit, Cosmetic/Reconstructive Surgery.

20. Charges incurred as a result of, or in connection with, any procedure or treatment excluded by the Plan which has resulted in medical complications, except for complications from a non-covered abortion as specified herein.

21. Charges for services provided to a covered person for an elective abortion (See Medical Expense Benefit, Pregnancy for specifics regarding the coverage of abortions). However, complications from such procedure shall be a covered expense.

22. Charges for services, supplies and treatment for smoking cessation programs, or related to the treatment of nicotine addiction, including smoking deterrent patches, except as required by the United States Preventive Services Task Force (USPSTF) A & B recommendations.

23. Charges for well child care, routine or periodic physical examinations, such as annual physical, screening examination, vaccinations, immunizations, employment physicals, sports physicals, preschool or school examinations, or any related charges, and other care not associated with treatment or diagnosis of an illness or injury, except as specified herein.

24. Except as specifically stated in Medical Expense Benefit, Temporomandibular Joint Dysfunction, charges for treatment of temporomandibular joint dysfunction and myofascial pain syndrome including, but not limited to: charges for treatment to alter vertical dimension or to restore abraded dentition, and orthodontia.

25. Charges for custodial care, domiciliary care or rest cures.

26. Charges for travel or accommodations, whether or not recommended by a physician, except as specifically provided herein.

27. Charges for wigs, artificial hairpieces, artificial hair transplants, or any drug - prescription or otherwise -used to eliminate baldness or stimulate hair growth, except as specified herein.

28. Charges for expenses related to hypnosis.

29. Charges for the expenses of the donor of an organ or tissue for transplant to a recipient who is not a covered person under the Plan.

30. Charges for professional services billed by a professional provider who is an employee of a hospital or any other facility and who is paid by the hospital or other facility for the service provided.

31. Charges for environmental change including hospital or physician charges connected with prescribing an environmental change.

32. Charges for room and board in a facility for days on which the covered person is permitted to leave (a weekend pass, for example).

33. Charges for chelation therapy, except as treatment of heavy metal poisoning.

34. Charges for massage therapy, sex therapy, diversional therapy or recreational therapy.
35. Charges for procurement and storage of one's own blood, unless incurred within three (3) months prior to a scheduled surgery.

36. Charges for holistic medicines or providers of naturopathy.

37. Charges for or related to the following types of treatment:
   a. primal therapy;
   b. rolfing;
   c. psychodrama;
   d. megavitamin therapy;
   e. visual perceptual training.

38. Charges for structural changes to a house or vehicle.


40. Charges for immunizations required for travel.

41. Charges for drugs, devices, supplies, treatments, procedures or services that are considered experimental/investigational by the Plan. The Plan will consider a drug, device, supply, treatment, procedure or service to be “experimental” or “investigational”:
   a. if, in the case of a drug, device or supply, the drug, device or supply cannot be lawfully marketed without approval of the U.S. Food and Drug Administration and approval for marketing has not been given at the time the drug, device or supply is furnished; or
   b. if the drug, device, supply, treatment, procedure or service, or the patient’s informed consent document utilized with respect to the drug, device, supply, treatment, procedure or service was reviewed and approved by the treating facility’s institutional review board or other body serving a similar function, or if federal law requires such review or approval; or
   c. if the plan sponsor (or its designee) determines in its sole discretion that the drug, device, supply, treatment, procedure or service is the subject of on-going Phase I or Phase II clinical trials; is the research, experimental study or investigational arm of on-going Phase III clinical trials, or is otherwise under study to determine maximum tolerated dose, toxicity, safety or efficacy; or
   d. if the plan sponsor (or its designee) determines in its sole discretion based on documentation in one of the standard reference compendia or in substantially accepted peer-reviewed medical literature that the prevailing opinion among experts regarding the drug, device, supply, treatment, procedure or service is that further studies or clinical trials are necessary to determine its maximum tolerated dose, toxicity, safety or efficacy.

42. New specialty drugs to market will be excluded from coverage until the date the medication is reviewed by Archimedes, LLC and a utilization management strategy has been established.

43. Non-oncology specialty drugs that are not provided through the site of care required during the pre-certification process are not covered.

44. Charges for any services, supplies or treatment not specifically provided herein.
PRESCRIPTION DRUG PROGRAM

PRESCRIPTION DRUG DEDUCTIBLES

The prescription drug deductible is the dollar amount of covered expenses that each covered person or family must have incurred for the purchase of prescription drugs during each plan year before the Plan pays applicable benefits. The prescription drug deductible amount is shown on the Schedule of Benefits.

PHARMACY OPTION

Participating pharmacies have contracted with the Plan to charge covered persons reduced fees for covered prescription drugs.

SPECIALTY DRUG PROGRAM

Specialty drugs are high cost drugs used to treat chronic diseases, including, but not limited to: HIV/AIDS, Rheumatoid Arthritis, Cancer, Hepatitis, Hemophilia, Multiple Sclerosis, and Growth Hormone Deficiency. Specialty drugs must be obtained directly through the specialty drug program. For additional information, please contact the Prescription Drug Program Administrator.

PHARMACY OPTION COPAY OR COINSURANCE

The copay or coinsurance is applied to each covered pharmacy drug charge and is shown on the Schedule of Benefits. The copay or coinsurance amount is not a covered expense under the Medical Expense Benefit. Any one prescription is limited to a thirty (30) day supply. Maintenance drugs (drugs which are prescribed for long-term usage) may be dispensed in a ninety (90) day supply.

If the covered person selects a brand drug when a generic drug is available, the covered person is responsible for the generic drug copay plus the cost difference between the generic drug and brand drug equivalent. If the physician indicates no substitutions, the covered person is only responsible for the brand drug copay. The covered person may appeal the adverse benefit determination. Refer to the subsection, Appealing an Adverse Benefit Determination on a Post-Service Prescription Drug Claim, for detailed information on how to initiate the appeal process. This difference between the cost of the brand name drug and the generic drug shall not accumulate toward the out-of-pocket limit.

When the out-of-pocket expense limit is reached, prescription drugs will be paid at 100%.

MAIL ORDER OPTION

The mail order drug benefit option is available for maintenance medications (those that are taken for long periods of time, such as drugs which may be prescribed for heart disease, high blood pressure, asthma, etc.).

MAIL ORDER OPTION COPAY OR COINSURANCE

The copay or coinsurance is applied to each covered mail order prescription charge and is shown on the Schedule of Benefits. The copay or coinsurance is not a covered expense under the Medical Expense Benefit. Any one prescription is limited to a ninety (90) day supply.

If the covered person selects a brand drug when a generic drug is available, the covered person is responsible for the generic drug copay plus the cost difference between the generic drug and brand drug equivalent. If the physician indicates no substitutions, the covered person is only responsible for the brand drug copay.
COVERED PRESCRIPTION DRUGS

1. Drugs prescribed by a qualified prescriber that require a prescription either by federal or state law, including injectables and insulin, except drugs excluded by the Plan.

2. Compounded prescriptions containing at least one prescription ingredient with a therapeutic quantity.

3. Insulin, insulin needles and syringes and diabetic supplies when prescribed by a qualified prescriber.

4. Oral contraceptives, regardless of the reason prescribed.

5. Contraceptive devices.


7. Dietary formulas for treatment of phenylketonuria or other heritable diseases.

8. Tretinoins, all dosage forms.


10. Routine preventive drugs as required by the Affordable Care Act.

11. Any other drug which, under the applicable state law, may be dispensed only upon the written prescription of a qualified prescriber.

LIMITS TO THIS BENEFIT

This benefit applies only when a covered person incurs a covered prescription drug charge. The covered drug charge for any one prescription will be limited to:

1. Refills only up to the number of times specified by a physician.

2. Refills up to one year from the date of order by a physician.

EXPENSES NOT COVERED

1. A drug or medicine that can legally be purchased without a written prescription. This does not apply to injectable insulin or routine preventive drugs as required by the Affordable Care Act.

2. Devices of any type, even though such devices may require a prescription. These include, but are not limited to: therapeutic devices, artificial appliances, braces, support garments, or any similar device.

3. Immunization agents or biological sera, blood or blood plasma.

4. A drug or medicine labeled: “Caution - limited by federal law to investigational use.”

5. Experimental drugs and medicines, even though a charge is made to the covered person.

6. Any charge for the administration of a covered prescription drug.

7. Any drug or medicine that is consumed or administered at the place where it is dispensed.

8. A drug or medicine that is to be taken by the covered person, in whole or in part, while hospital confined. This includes being confined in any institution that has a facility for dispensing drugs.

9. A charge for prescription drugs which may be properly received without charge under local, state or federal programs.
10. A charge for prescription drugs for smoking cessation purposes, including smoking deterrent patches, except as required by the United States Preventive Services Task Force (USPSTF) A & B recommendations.

11. A charge for infertility medication.

12. A charge for legend vitamins, except pre-natal legend vitamins.


15. A charge for medications that are cosmetic in nature (i.e., treating hair loss, wrinkles, etc.).

16. A charge for weight loss drugs.

17. A charge for Levonorgestrel (Norplant implants).

18. A charge for Hematinics.

19. A charge for drugs used in the treatment of erectile dysfunction (i.e., Viagra).

20. A charge for non-legend drugs, other than as specifically listed herein or as required by the United States Preventive Services Task Force (USPSTF) A & B recommendations.

**NOTICE OF AUTHORIZED REPRESENTATIVE**

The **covered person** may provide the **plan administrator** (or its designee) with a written authorization for an authorized representative to represent and act on behalf of a **covered person** and consent to the release of information related to the **covered person** to the authorized representative with respect to a claim for benefits or an appeal. Authorization forms may be obtained from the Human Resources Department.

**APPEALING AN ADVERSE BENEFIT DETERMINATION ON A POST-SERVICE PRESCRIPTION DRUG CLAIM**

A **covered person**, or the **covered person**’s authorized representative, may request a review of an **adverse benefit determination** on a Post-Service prescription drug claim by making written request to the **claims processor** within one hundred eighty (180) calendar days from receipt of notification of the **adverse benefit determination** and stating the reasons the **covered person** feels the claim should not have been denied.

The following describes the review process and rights of the **covered person** for a full and fair review:

1. The **covered person** has the right to submit documents, information and comments and to present evidence and testimony.

2. The **covered person** has the right to access, free of charge, **relevant information** to the claim for benefits.

3. Before a final **adverse benefit determination** on appeal is rendered, the **covered person** will be provided, free of charge, with any new or additional rationale or evidence considered, relied upon, or generated by the **Plan** in connection with the claim. Such information will be provided as soon as possible and sufficiently in advance of the notice of final internal **adverse benefit determination** to give the **covered person** an opportunity to respond. The period for providing notice of final determination on appeal will be tolled until the earliest of the following dates:
   a. The date the **covered person** responds to the new or additional rationale or evidence; or
   b. Three (3) weeks from the date the new or additional rationale or evidence was mailed to the **covered person**.

4. The review takes into account all information submitted by the **covered person**, even if it was not considered in the initial benefit determination.
5. The review by the claims processor will not afford deference to the original adverse benefit determination.

6. The claims processor will not be:
   a. The individual who originally denied the claim, nor
   b. Subordinate to the individual who originally denied the claim.

7. If original adverse benefit determination was, in whole or in part, based on medical judgment:
   a. The claims processor will consult with a professional provider who has appropriate training and experience in the field involving the medical judgment; and
   b. The professional provider utilized by the claims processor will be neither:
      (i.) An individual who was consulted in connection with the original adverse benefit determination, nor
      (ii.) A subordinate of any other professional provider who was consulted in connection with the original adverse benefit determination.

8. If requested, the claims processor will identify the medical or vocational expert(s) who gave advice in connection with the original adverse benefit determination, whether or not the advice was relied upon.

NOTICE OF BENEFIT DETERMINATION ON A PRESCRIPTION DRUG CLAIM APPEAL

The plan administrator (or its designee) shall provide the covered person (or authorized representative) with a written notice of the appeal decision within sixty (60) calendar days of receipt of a written request for the appeal.

If the appeal is denied, the Notice of Appeal Decision will contain an explanation of the Decision, including:

1. The specific reasons for the adverse benefit determination.
2. Reference to specific Plan provisions on which the adverse benefit determination is based.
3. A statement that the covered person has the right to access, free of charge, relevant information to the claim for benefits.
4. A statement of the covered person’s right to request an external review and a description of the process for requesting such a review.
5. If an internal rule, guideline, protocol or other similar criterion was relied upon, the Notice of Appeal Decision will contain either:
   a. A copy of that criterion, or
   b. A statement that such criterion was relied upon and will be supplied free of charge, upon request.
6. If the adverse benefit determination was based on medical necessity, experimental/investigational treatment or similar exclusion or limit, the plan administrator (or its designee) will supply either:
   a. An explanation of the scientific or clinical judgment, applying the terms of the Plan to the claimant’s medical circumstances, or
   b. A statement that such explanation will be supplied free of charge, upon request.

EXTERNAL APPEAL

A covered person, or the covered person’s authorized representative, may request a review of an adverse benefit determination appeal if the claim determination involves medical judgment or a rescission by making written request to the claims processor within four (4) months of receipt of notification of the final internal adverse benefit determination. Medical judgment includes, but is not limited to:

1. Medical necessity;
2. Appropriateness;
3. Experimental or investigational treatment;
4. Health care setting;
5. Level of care; and
6. Effectiveness of a covered expense.
If there is no corresponding date four (4) months after the date of receipt of such a notice, then the request must be made by the first day of the fifth month following the receipt of the notice of final internal adverse benefit determination. {Note: If the date of receipt of the notice is October 30, because there is no February 30, the request must be filed by March 1, or the next day if March 1st falls on a Saturday, Sunday or Federal holiday.}

**RIGHT TO EXTERNAL APPEAL**

Within five (5) business days of receipt of the request, the claims processor will perform a preliminary review of the request to determine if the request is eligible for external review, based on confirmation that the final internal adverse benefit determination was the result of:

1. Medical judgment; or
2. Rescission of coverage under this Plan.

**NOTICE OF RIGHT TO EXTERNAL APPEAL**

The plan administrator (or its designee) shall provide the covered person (or authorized representative) with a written notice of the decision as to whether the claim is eligible for external review within one (1) business day after completion of the preliminary review.

The Notice of Right to External Appeal shall include the following:

1. The reason for ineligibility and the availability of the Employee Benefits Security Administration at 1-866-444-3272, if the request is complete but not eligible for external review.
2. If the request is incomplete, the information or materials necessary to make the request complete and the opportunity for the covered person to perfect the external review request by the later of the following:
   a. The four (4) month filing period; or
   b. Within the forty-eight (48) hour time period following the covered person’s receipt of notification.

**INDEPENDENT REVIEW ORGANIZATION**

For external reviews by an Independent Review Organization (IRO), such IRO shall be accredited by URAC or a similar nationally recognized accrediting organization and shall be assigned to conduct the external review. The assigned IRO will timely notify the covered person in writing of the request’s eligibility and acceptance for external review.

**NOTICE OF EXTERNAL REVIEW DETERMINATION**

The assigned IRO shall provide the plan administrator (or its designee) and the covered person (or authorized representative) with a written notice of the final external review decision within forty-five (45) days after receipt of the external review request.

The Notice of Final External Review Decision from the IRO is binding on the covered person, the Plan and claims processor, except to the extent that other remedies may be available under State or Federal law.

**EXPEDITED EXTERNAL REVIEW**

The plan administrator (or its designee) shall provide the covered person (or authorized representative) the right to request an expedited external review upon the covered person’s receipt of either of the following:

1. An adverse benefit determination involving a medical condition for which the timeframe noted above for completion of an internal appeal would seriously jeopardize the health or life of the covered person or the
covered person’s ability to regain maximum function and the covered person has filed an internal appeal request.

2. A final internal adverse benefit determination involving a medical condition for which the timeframe for completion of a standard external review would seriously jeopardize the health or life of the covered person or the covered person’s ability to regain maximum function or if the final internal adverse benefit determination involves any of the following:
   a. An admission,
   b. Availability of care,
   c. Continued stay, or
   d. A health care item or service for which the covered person received emergency services, but has not yet been discharged from a facility.

Immediately upon receipt of the request for Expedited External Review, the Plan will do all of the following:

1. Perform a preliminary review to determine whether the request meets the requirements in the subsection, Right to External Appeal.

2. Send notice of the Plan’s decision, as described in the subsection, Notice of Right to External Appeal.

Upon determination that a request is eligible for external review, the Plan will do all of the following:

1. Assign an IRO as described in the subsection, Independent Review Organization.

2. Provide all necessary documents or information used to make the adverse benefit determination or final adverse benefit determination to the IRO either by telephone, facsimile, electronically or other expeditious method.

The assigned IRO will provide notice of final external review decision as expeditiously as the covered person’s medical condition or circumstances require, but in no event more than seventy-two (72) hours after receipt of the expedited external review request. The notice shall follow the requirements in the subsection, Notice of External Review Determination. If the notice of the expedited external review determination was not in writing, the assigned IRO shall provide the plan administrator (or its designee) and the covered person (or authorized representative) written confirmation of its decision within forty-eight (48) hours after the date of providing that notice.
PLAN EXCLUSIONS

The Plan will not provide benefits for any of the items listed in this section, regardless of medical necessity or recommendation of a physician or professional provider.

1. Charges for services, supplies or treatment from any hospital owned or operated by the United States government or any agency thereof or any government outside the United States, or charges for services, treatment or supplies furnished by the United States government or any agency thereof or any government outside the United States, unless payment is legally required.

2. Charges for an injury sustained or illness contracted while on active duty in military service, unless payment is legally required.

3. Charges for services, treatment or supplies for treatment of illness or injury which is caused by or attributed to by war or any act of war, participation in a riot, civil disobedience or insurrection. "War" means declared or undeclared war, whether civil or international, or any substantial armed conflict between organized forces of a military nature.

4. Any condition for which benefits of any nature are payable or are found to be eligible, either by adjudication or settlement, under any Workers' Compensation law, Employer's liability law, or occupational disease law, even though the covered person fails to claim rights to such benefits or fails to enroll or purchase such coverage. This does not include a covered person that is a sole proprietor, partner or executive officer that is not required by law to have workers' compensation or similar coverage and does not have such coverage.

5. Charges made for services, supplies and treatment which are not medically necessary for the treatment of illness or injury or which are not recommended and approved by the attending physician, except as specifically stated herein, or to the extent that the charges exceed the customary and reasonable amount, qualifying payment amount (subject to the out-of-network rate) or the negotiated rate, as applicable.

6. Charges in connection with any illness or injury of the covered person resulting from or occurring during the covered person's commission or attempted commission of a criminal battery or felony. Claims shall be denied if the plan administrator has reason to believe, based on objective evidence such as police reports or medical records, that a criminal battery or felony was committed by the covered person. This exclusion will not apply to an illness and/or injury sustained due to a medical condition (physical or mental) or domestic violence.

7. To the extent that payment under the Plan is prohibited by any law of any jurisdiction in which the covered person resides at the time the expense is incurred.

8. Charges for services rendered and/or supplies received prior to the effective date or after the termination date of a person's coverage.

9. Any services, supplies or treatment for which the covered person is not legally required to pay; or for which no charge would usually be made; or for which such charge, if made, would not usually be collected if no coverage existed; or to the extent the charge for the care exceeds the charge that would have been made and collected if no coverage existed.

10. Charges for services, supplies and treatment that are considered experimental/investigational.

11. Charges incurred outside the United States if the covered person traveled to such a location for the sole purpose of obtaining services, supplies or treatment.

12. Charges for services, supplies or treatment rendered by any individual who is a close relative of the covered person or who resides in the same household as the covered person or if the covered person provides treatment for themselves.
13. Charges for services, supplies or treatment rendered by physicians or professional providers beyond the scope of their license; for any treatment, confinement or service which is not recommended by or performed by an appropriate professional provider.

14. Charges for illnesses or injuries suffered by a covered person due to the action or inaction of any party if the covered person fails to provide information as specified in the section, Subrogation/Reimbursement.

15. Claims not submitted within the Plan's filing limit deadlines as specified in the section, Claim Filing Procedure.

16. Charges for completion of claim forms and charges associated with missed appointments.

17. This Plan will not pay for any charge which has been refused by another plan covering the covered person as a penalty assessed due to non-compliance with that plan's rules and regulations, if shown on the primary carrier's explanation of benefits.

18. Benefits which are payable under any separate plan sponsored by the employer, whether self-insured or fully-insured, shall not be payable as a benefit under this Plan and shall not be eligible under the Coordination of Benefits section.

19. Charges for services, supplies, care or treatment to a covered person for an injury which occurred as a result of that covered person's illegal use of alcohol. Claims shall be denied if the plan administrator has reason to believe, based on objective evidence such as police reports or medical records of the covered person's illegal use of alcohol. Expenses will be covered for injured covered persons other than the person illegally using alcohol and expenses will be covered for substance use disorder treatment as specified on the Schedule of Benefits. This exclusion does not apply if the injury resulted from an act of domestic violence or an underlying medical condition.
ELIGIBILITY, ENROLLMENT AND EFFECTIVE DATE

This section identifies the Plan’s requirements for a person to participate in the Plan.

EMPLOYEE ELIGIBILITY

All employees regularly scheduled to work at least ten (10) hours per work week shall be eligible to enroll for coverage under the Plan. This does not include independent contractors or volunteers or employees working less than an average of ten (10) hours per work week over the employer’s measurement period.

If applicable under the Affordable Care Act, an employee of the employer who is not currently working the minimum number of hours, but was working on average the minimum number of hours during the employer’s measurement period and is eligible during the employer’s stability period, as documented by the employer and consistent with the Affordable Care Act, applicable regulations and regulatory guidance, is eligible to enroll under the Plan, provided the employee is a member of a class eligible for coverage and has satisfied any waiting period that may be required by the employer.

Under Section 22.004, Texas Education Code, an employee who is participating in TRS-ActiveCare is entitled to continue participating in TRS-ActiveCare if the employee resigns after the end of the instructional year. TRS Rule, Section 41.38, Texas Administrative Code, will be applied by TRS-ActiveCare in determining the appropriate termination date of TRS-ActiveCare coverage. Mesquite ISD extends this policy to all insurance benefits (if the employee elects to continue their health insurance through August, the employee must continue all other insurance through August, too).

EMPLOYEE ENROLLMENT

An employee must file a written application (or electronic, if applicable) with the employer for coverage hereunder within thirty (30) days of becoming eligible for coverage. The employee shall have the responsibility of timely forwarding to the employer all applications for enrollment hereunder. If the employee failed to make timely enrollment, the employee is considered a late enrollee and not eligible for coverage under the Plan until the next open enrollment period unless the employee otherwise qualifies for special enrollment during the plan year.

EMPLOYEE(S) EFFECTIVE DATE

Eligible employees, as described in Employee Eligibility, are covered under the Plan on the first day of the month coincident with or following completion of thirty (30) days of continuous employment provided the employee has enrolled for coverage as described in Employee Enrollment.

DEPENDENT(S) ELIGIBILITY

The following describes dependent eligibility requirements. The employer will require proof of dependent status.

1. The term "spouse" means the spouse of the employee under a legally valid existing marriage, as defined by the state in which the employee was legally married, unless court ordered separation exists.

2. The employee’s natural child, stepchild, legally adopted child, child placed for adoption, foster child, and a child for whom the employee has been appointed legal guardian, through the end of the month in which the child reaches twenty-six (26) years of age.
3. A grandchild under age 26 whose primary residence is the household of the employee and who is a dependent of the employee for federal income tax purposes for the reporting year in which coverage of the grandchild is in effect.

4. An eligible child shall also include any other child of an employee or their spouse who is recognized in a National Medical Support Notice (NMSN) which has been issued by any court judgment, decree, or order as being entitled to enrollment for coverage under the Plan. Such child shall be referred to as an alternate recipient. Alternate recipients are eligible for coverage only if the employee is also covered under the Plan. An application for enrollment must be submitted to the employer for coverage under the Plan. The employer/plan administrator shall establish written procedures for determining whether a medical child support order is a NMSN and for administering the provision of benefits under the Plan pursuant to a valid NMSN. Within a reasonable period after receipt of a medical child support order, the employer/plan administrator shall determine whether such order is a NMSN, as defined in 42 U.S.C.A §666 of the Child Support Performance and Incentive Act of 1998.

The employer/plan administrator reserves the right, waivable at its discretion, to seek clarification with respect to the order from the court or administrative agency which issued the order, up to and including the right to seek a hearing before the court or agency.

5. A dependent child who was covered under the Plan prior to the end of the month in which the child reached twenty-six (26) years of age and who lives with the employee, is unmarried, incapable of self-sustaining employment and dependent upon the employee for support due to a mental and/or physical disability, will remain eligible for coverage under the Plan beyond the date coverage would otherwise terminate.

Proof of incapacitation for such dependent child who reaches age twenty-six (26) after the effective date shown on the first page of this Plan document must be provided within thirty-one (31) days of the date the coverage would otherwise terminate.

Proof of incapacitation for any dependent child after age twenty-six (26) may be requested by the employer or claims processor, but not more than once every two (2) years. Eligibility may not be continued beyond the earliest of the following:

a. Cessation of the mental and/or physical disability;

b. Failure to furnish any required proof of mental and/or physical disability or to submit to any required examination.

Every eligible employee may enroll eligible dependents. However, if both the employee and their spouse are employees, they may choose to have one covered as the employee, and the spouse covered as the dependent of the employee, or they may choose to have both covered as employees. Eligible children may be enrolled as dependents of one spouse, but not both.

**DEPENDENT ENROLLMENT**

An employee must file a written application (or electronic, if applicable) with the employer for coverage hereunder for the employee’s eligible dependents within thirty (30) days of becoming eligible for coverage; and within thirty (30) days of marriage or the acquiring of children or birth of a child. The employee shall have the responsibility of timely forwarding to the employer all applications for enrollment hereunder. If the employee failed to make timely enrollment for the employee’s eligible dependents, the dependents are considered late enrollees and not eligible for coverage under the Plan until the next open enrollment period, unless the dependent otherwise qualifies for a special enrollment during the plan year.
DEPENDENT(S) EFFECTIVE DATE

Eligible dependent(s), as described in Dependent(s) Eligibility, will become covered under the Plan on the later of the dates listed below, provided the employee has enrolled them in the Plan within thirty (30) days of meeting the Plan's eligibility requirements and any required contributions are made.

1. The date the employee's coverage becomes effective.
2. The date the dependent is acquired, provided the employee has applied for dependent coverage within thirty (30) days of the date acquired.
3. Newborn children will be considered a dependent under the Plan for thirty (30) days immediately following birth. For coverage under the Plan for the newborn beyond that date, the employee must submit an application for enrollment within thirty (30) days of birth.
4. Coverage for a newly adopted or to be adopted child shall be effective on the date the child is placed for adoption, provided the employee has applied for dependent coverage within thirty (30) days of the date the child is placed for adoption.

SPECIAL ENROLLMENT PERIOD (OTHER COVERAGE)

An employee or dependent who did not enroll for coverage under this Plan because the employee or dependent was covered under other group coverage or had health insurance coverage at the time the employee or dependent was initially eligible for coverage under this Plan, may request a special enrollment period if the employee or dependent is no longer eligible for the other coverage. Special enrollment periods will be granted if the individual's loss of eligibility is due to:

1. Termination of the other coverage (including exhaustion of COBRA benefits).
2. Cessation of employer contributions toward the other coverage.
3. Legal separation or divorce.
4. Termination of other employment or reduction in number of hours of other employment.
5. Death of dependent or spouse.
6. Cessation of other coverage because employee or dependent no longer resides or works in the service area and no other benefit package is available to the individual.
7. Cessation of dependent status under other coverage and dependent is otherwise eligible under employee’s Plan.

Notwithstanding any provision of the Plan to the contrary, all benefits received by an individual under any benefit option, package or coverage under the Plan shall be applied toward any applicable maximum benefit paid by the Plan for any one covered person for such option, package or coverage under the Plan, and also toward any applicable maximum benefit under any other options, packages or coverages under the Plan in which the individual may participate in the future.

The end of any extended benefits period, which has been provided due to any of the above, will also be considered a loss of eligibility.

However, loss of eligibility does not include a loss due to failure of the individual to pay premiums or contributions on a timely basis or termination of coverage for cause (such as making a fraudulent claim or an intentional misrepresentation of a material fact in connection with the other coverage).

The employee or dependent must request the special enrollment and enroll no later than thirty (30) days from the date of loss of other coverage.

The effective date of coverage as the result of a special enrollment shall be the first day of the first calendar month following the plan administrator's receipt of the completed enrollment form.
SPECIAL ENROLLMENT PERIOD (DEPENDENT ACQUISITION)

An employee who is currently covered or not covered under the Plan, but who acquires a new dependent may request a special enrollment period for that employee, if applicable, the employee’s newly acquired dependent and spouse, if not already covered under the Plan and otherwise eligible for coverage.

For the purposes of this provision, the acquisition of a new dependent includes:

- marriage
- birth of a dependent child
- adoption or placement for adoption of a dependent child
- legal guardianship of a dependent child
- a foster child being placed with the employee

The employee must request the special enrollment within thirty (30) days of the acquisition of the dependent.

The effective date of coverage as the result of a special enrollment shall be:

1. in the case of marriage, the first day of the first calendar month following the plan administrator's receipt of the completed enrollment form;
2. in the case of a dependent's birth, the date of such birth;
3. in the case of adoption or placement for adoption, the date of such adoption or placement for adoption;
4. in the case of legal guardianship, the date on which such child is placed in the covered employee’s home pursuant to a court order appointing the covered employee as legal guardian for the child;
5. in the case of a foster child being placed with the employee, on the date on which such child is placed with the employee by an authorized placement agency or by judgment, decree or other order of a court of competent jurisdiction.

SPECIAL ENROLLMENT PERIOD (CHILDREN'S HEALTH INSURANCE PROGRAM (CHIP) REAUTHORIZATION ACT OF 2009)

The Plan intends to comply with the Children's Health Insurance Program Reauthorization Act of 2009.

An employee who is currently covered or not covered under the Plan may request a special enrollment period for that employee, if applicable, and such employee’s dependent. Special enrollment periods will be granted if:

1. the individual's loss of eligibility is due to termination of coverage under a state children's health insurance program or Medicaid; or,
2. the individual is eligible for any applicable premium assistance under a state children's health insurance program or Medicaid.

The employee or dependent must request the special enrollment and enroll no later than sixty (60) days from the date of loss of other coverage or from the date the individual becomes eligible for any applicable premium assistance.
OPEN ENROLLMENT

Open enrollment is the period designated by the employer during which the employee may change benefit plans or enroll in the Plan if the employee did not do so when first eligible or does not qualify for a special enrollment period. An open enrollment will be permitted once in each plan year as designated by the employer.

During this open enrollment period, an employee and the employee’s dependents who are covered under the Plan or covered under any employer sponsored health plan may elect coverage or change coverage under the Plan. An employee must make written application (or electronic, if applicable) as provided by the employer during the open enrollment period to change benefit plans.

Except for a status change listed below, the open enrollment period is the only time an employee may change benefit options or modify enrollment. Status changes include:

1. Change in family status. A change in family status shall include only:
   a. Change in employee's legal marital status;
   b. Change in number of dependents;
   c. Termination or commencement of employment by the employee, spouse or dependent;
   d. Change in work schedule;
   e. Dependent satisfies (or ceases to satisfy) dependent eligibility requirements;
   f. Change in residence or worksite of employee, spouse or dependent.

2. Significant change in the cost of coverage under the employer's group medical plan.

3. Cessation of required contributions.

4. Taking or returning from a leave of absence under the Family and Medical Leave Act of 1993.

5. Significant change in the health coverage of the employee or spouse attributable to the spouse's employment.

6. A Special Enrollment Period as mandated by the Health Insurance Portability and Accountability Act of 1996.

7. A court order, judgment or decree.

8. Entitlement to Medicare or Medicaid, or enrollment in a state child health insurance program (CHIP).

9. A COBRA qualifying event.
TERMINATION OF COVERAGE

Except as provided in the Plan's Continuation of Coverage (COBRA) provision, coverage will terminate on the earliest of the following dates:

**TERMINATION OF EMPLOYEE COVERAGE**

1. The date the employee terminates the Plan and offers no other group health plan.
2. The last day of the month in which the employee ceases to meet the eligibility requirements of the Plan.
3. The last day of the month in which employment terminates, as defined by the employer's personnel policies.
4. The date the employee becomes a full-time, active duty member of the armed forces of any country.
5. The date the employee ceases to make any required contributions.

If an employee elects to become covered under another employer-sponsored health plan, coverage under this Plan will terminate on the day before the effective date of the other coverage. Any provisions which would extend or continue benefits beyond that date will not apply.

**TERMINATION OF DEPENDENT(S) COVERAGE**

1. The date the employer terminates the Plan and offers no other group health plan.
2. The date the employee's coverage terminates.
3. The date such person ceases to meet the eligibility requirements of the Plan, except that for a dependent child, termination shall be the last day of the month in which the dependent child reaches age twenty-six (26).
4. The date the employee ceases to make any required contributions on the dependent's behalf.
5. The date the employee's dependent spouse becomes a full-time, active duty member of the armed forces of any country.
6. The date the Plan discontinues dependent coverage for any and all dependents.
7. The date the employee's dependent spouse becomes eligible as an employee.

**LEAVE OF ABSENCE**

Coverage may be continued for a limited time, contingent upon payment of any required contributions for employees and/or dependents, when the employee is on an authorized leave of absence from the employer. In no event will coverage continue for more than sixty (60) days after the employee's active service ends for family medical leave or one hundred eighty (180) days for temporary disability leave.

**FAMILY AND MEDICAL LEAVE ACT (FMLA)**

**Eligible Leave**

An employee who is eligible for unpaid leave and benefits under the terms of the Family and Medical Leave Act of 1993 (FMLA), as amended, has the right to continue coverage under the Plan for up to twelve (12) weeks, or (twenty-six (26) weeks in certain circumstances). Employees should contact the employer to determine whether they are eligible under FMLA.
Contributions

During this leave, the employer will continue to pay the same portion of the employee's contribution for the Plan. The employee shall be responsible to continue payment for eligible dependent's coverage and any remaining employee contributions. If the covered employee fails to make the required contribution during a FMLA leave within thirty (30) days after the date the contribution was due, the coverage will terminate effective on the date the contribution was due.

Reinstatement

If coverage under the Plan was terminated during an approved FMLA leave, and the employee returns to active work immediately upon completion of that leave, Plan coverage will be reinstated on the date the employee returns to active work as if coverage had not terminated, provided the employee makes any necessary contributions and enrolls for coverage within thirty (30) days of his return to active work.

Repayment Requirement

The employer may require employees who fail to return from a leave under FMLA to repay any contributions paid by the employer on the employee's behalf during an unpaid leave. This repayment will be required only if the employee's failure to return from such leave is not related to a "serious health condition," as defined in FMLA, or events beyond the employee's control.

EMPLOYEE REINSTATEMENT

Employees and eligible dependents who lost coverage due to an approved leave of absence, layoff, or termination of employment with the employer are eligible for reinstatement of coverage as follows:

1. Reinstatement of coverage is available to employees and dependents who were previously covered under the Plan.

2. Rehire or return to active service must occur within twenty-six (26) weeks of the last day worked.

3. The employee must submit the completed application for enrollment to the employer within thirty (30) days of rehire or return to work.

4. Coverage shall be effective from the date of rehire or return to work. Prior benefits and limitations, such as deductible, Essential Health Benefits/non-Essential Health Benefits maximum benefit shall be applied with no break in coverage.

If the provisions of (1) through (3) above are not met, the Plan's provisions for eligibility and application for enrollment shall apply.

An employee who returns to work more than twenty-six (26) weeks following an approved leave of absence, layoff, or termination of employment will be considered a new employee for purposes of eligibility and will be subject to all eligibility requirements, including all requirements relating to the effective date of coverage.

EXTENSION OF BENEFITS DURING TOTAL DISABILITY

If on the date coverage terminates an employee or dependent is totally disabled, benefits will be extended only for the condition causing such total disability and only during the uninterrupted continuance of that disability. This extended benefit will terminate on the earlier of the following:

1. The date the person is no longer totally disabled;

2. The date the person becomes eligible for Medicare;

3. Upon eligibility for coverage in any other group health plan that does not limit coverage for the disabling condition;
4. The date the Essential Health Benefits/non-Essential Health Benefits maximum benefit under the Plan have been paid on the person's behalf;

5. Six (6) months following the date coverage terminated;

6. The date the Plan terminates.

If COBRA continuation coverage is elected by the covered person, this provision for coverage shall apply after the COBRA continuation coverage period ends.
CONTINUATION OF COVERAGE

In order to comply with federal regulations, the Plan includes a continuation of coverage option for certain individuals whose coverage would otherwise terminate. The following is intended to comply with the Public Health Services Act. This continuation of coverage may be commonly referred to as "COBRA coverage" or "continuation coverage."

The coverage which may be continued under this provision consists of health coverage. It does not include life insurance benefits, accidental death and dismemberment benefits, or income replacement benefits. Health coverage includes: medical and prescription drug benefits as provided under the Plan.

QUALIFYING EVENTS

Qualifying events are any one of the following events that would cause a covered person to lose coverage under the Plan or cause an increase in required contributions, even if such loss of coverage or increase in required contributions does not take effect immediately, and allow such person to continue coverage beyond the date described in Termination of Coverage:

1. Death of the employee.

2. The employee's termination of employment (other than termination for gross misconduct), or reduction in work hours to less than the minimum required for coverage under the Plan. This event is referred to below as an "18-Month Qualifying Event."

3. Divorce or legal separation from the employee.

4. The employee's entitlement to Medicare benefits under Title XVIII of the Social Security Act, if it results in the loss of coverage under this Plan.

5. A dependent child no longer meets the eligibility requirements of the Plan.

NOTIFICATION REQUIREMENTS

1. When eligibility for continuation of coverage results from a spouse being divorced or legally separated from a covered employee, or a child's loss of dependent status, the employee or dependent must submit a completed Qualifying Event Notification form to the plan administrator (or its designee) within sixty (60) days of the latest of:
   a. The date of the event;
   b. The date on which coverage under the Plan is or would be lost as a result of that event; or
   c. The date on which the employee or dependent is furnished with a copy of this Plan Document.

   A copy of the Qualifying Event Notification form is available from the plan administrator (or its designee). In addition, the employee or dependent may be required to promptly provide any supporting documentation as may be reasonably requested for purposes of verification. Failure to provide such notice and any requested supporting documentation will result in the person forfeiting their rights to continuation of coverage under this provision.

   Within fourteen (14) days of the receipt of a properly completed Qualifying Event Notification, the plan administrator (or its designee) will notify the employee or dependent of that employee or dependent's rights to continuation of coverage, and what process is required to elect continuation of coverage. This notice is referred to below as "Election Notice."

2. When eligibility for continuation of coverage results from any qualifying event under the Plan other than the ones described in Paragraph 1 above, the plan administrator (or its designee) will furnish an Election Notice
to the employee or dependent not later than forty-four (44) days after the date on which the employee or dependent loses coverage under the Plan due to the qualifying event.

3. In the event it is determined that an individual seeking continuation of coverage (or extension of continuation coverage) is not entitled to such coverage, the plan administrator (or its designee) will provide to such individual an explanation as to why the individual is not entitled to continuation coverage. This notice is referred to here as the "Non-Eligibility Notice." The Non-Eligibility Notice will be furnished in accordance with the same time frame as applicable to the furnishing of the Election Notice.

4. In the event an Election Notice is furnished, the eligible employee or dependent has sixty (60) days to decide whether to elect continued coverage. Each person who is described in the Election Notice and was covered under the Plan on the day before the qualifying event has the right to elect continuation of coverage on an individual basis, regardless of family enrollment. If the employee or dependent chooses to have continuation coverage, the employee or dependent must advise the plan administrator (or its designee) of this choice by returning to the plan administrator (or its designee) a properly completed Election Notice not later than the last day of the sixty (60) day period. If the Election Notice is mailed to the plan administrator (or its designee), it must be postmarked on or before the last day of the sixty (60) day period. This sixty (60) day period begins on the later of the following:

   a. The date coverage under the Plan would otherwise end; or
   b. The date the person receives the Election Notice from the plan administrator (or its designee).

5. Within forty-five (45) days after the date the person notifies the plan administrator (or its designee) that the person or designee has chosen to continue coverage, the person must make the initial payment. The initial payment will be the amount needed to provide coverage from the date continued benefits begin, through the last day of the month in which the initial payment is made. Thereafter, payments for the continuation coverage are to be made monthly, and are due in advance, on the first day each month.

COST OF COVERAGE

1. The Plan requires that covered persons pay the entire costs of their continuation coverage, plus a two percent (2%) administrative fee. Except for the initial payment (see above), payments must be remitted to the plan administrator (or its designee) by or before the first day of each month during the continuation period. The payment must be remitted on a timely basis in order to maintain the coverage in force.

2. For a person originally covered as an employee or as a spouse, the cost of coverage is the amount applicable to an employee if coverage is continued for that employee alone. For a person originally covered as a child and continuing coverage independent of the family unit, the cost of coverage is the amount applicable to an employee.

WHEN CONTINUATION COVERAGE BEGINS

When continuation coverage is elected and the initial payment is made within the time period required, coverage is reinstated back to the date of the loss of coverage, so that no break in coverage occurs. Coverage for dependents acquired and properly enrolled during the continuation period begins in accordance with the enrollment provisions of the Plan.

FAMILY MEMBERS ACQUIRED DURING CONTINUATION

A spouse or dependent child newly acquired during continuation coverage is eligible to be enrolled as a dependent. The standard enrollment provision of the Plan applies to enrollees during continuation coverage. A dependent acquired and enrolled after the original qualifying event, other than a child born to or placed for adoption with a covered employee during a period of COBRA continuation coverage, is not eligible for a separate continuation if a subsequent event results in the person's loss of coverage.
EXTENSION OF CONTINUATION COVERAGE

1. In the event any of the following events occur during the period of continuation coverage resulting from an 18-Month Qualifying Event, it is possible for a dependent's continuation coverage to be extended:
   a. Death of the employee.
   b. Divorce or legal separation from the employee.
   c. The child's loss of dependent status.

Written notice of such event must be provided by submitting a completed Additional Extension Event Notification form to the plan administrator (or its designee) within sixty (60) days of the latest of:
   (i.) The date of that event;
   (ii.) The date on which coverage under the Plan would be lost as a result of that event if the first qualifying event had not occurred; or
   (iii.) The date on which the employee or dependent is furnished with a copy of the Plan Document.

A copy of the Additional Extension Event Notification form is available from the plan administrator (or its designee). In addition, the dependent may be required to promptly provide any supporting documentation as may be reasonably required for purposes of verification. Failure to properly provide the Additional Extension Event Notification and any requested supporting documentation will result in the person forfeiting their rights to extend continuation coverage under this provision. In no event will any extension of continuation coverage extend beyond thirty-six (36) months from the later of the date of the first qualifying event or the date as of which continuation coverage began.

Only a person covered prior to the original qualifying event or a child born to or placed for adoption with a covered employee during a period of COBRA coverage may be eligible to continue coverage through an extension of continuation coverage as described above. Any other dependent acquired during continuation coverage is not eligible to extend continuation coverage as described above.

2. A person who loses coverage on account of an 18-Month Qualifying Event may extend the maximum period of continuation coverage from eighteen (18) months to up to twenty-nine (29) months in the event both of the following occur:
   a. That person (or another person who is entitled to continuation coverage on account of the same 18-Month Qualifying Event) is determined by the Social Security Administration, under Title II or Title XVI of the Social Security Act, to have been disabled before the sixtieth (60th) day of continuation coverage; and
   b. The disability status, as determined by the Social Security Administration, lasts at least until the end of the initial eighteen (18) month period of continuation coverage.

The disabled person (or the disabled person’s representative) must submit written proof of the Social Security Administration’s disability determination to the plan administrator (or its designee) within the initial eighteen (18) month period of continuation coverage and no later than sixty (60) days after the latest of:
   (i.) The date of the disability determination by the Social Security Administration;
   (ii.) The date of the 18-Month Qualifying Event;
   (iii.) The date on which the person loses (or would lose) coverage under the Plan as a result of the 18-Month Qualifying Event; or
   (iv.) The date on which the person is furnished with a copy of the Plan Document.
Should the disabled person fail to notify the plan administrator (or its designee) in writing within the time frame described above, the disabled person (and others entitled to disability extension on account of that person) will then be entitled to whatever period of continuation the disabled person or (others entitled to disability extension on account of that person) would otherwise be entitled to, if any. The Plan may require that the individual pay one hundred and fifty percent (150%) of the cost of continuation coverage during the additional eleven (11) months of continuation coverage. In the event the Social Security Administration makes a final determination that the individual is no longer disabled, the individual must provide notice of that final determination no later than thirty (30) days after the later of:

(A.) The date of the final determination by the Social Security Administration; or

(B.) The date on which the individual is furnished with a copy of the Plan Document.

END OF CONTINUATION

Continuation of coverage under this provision will end on the earliest of the following dates:

1. Eighteen (18) months (or twenty-nine (29) months if continuation coverage is extended due to certain disability status as described above) from the date continuation began because of an 18-Month Qualifying Event or the last day of leave under the Family and Medical Leave Act of 1993.

2. Twenty-four (24) months from the date continuation began because of the call-up to military duty.

3. Thirty-six (36) months from the date continuation began for dependents whose coverage ended because of the death of the employee, divorce or legal separation from the employee, or the child's loss of dependent status.

4. The end of the period for which contributions are paid if the covered person fails to make a payment by the date specified by the plan administrator (or its designee). In the event continuation coverage is terminated for this reason, the individual will receive a notice describing the reason for the termination of coverage, the effective date of termination, and any rights the individual may have under the Plan or under applicable law to elect an alternative group or individual coverage, such as a conversion right. This notice is referred to below as an "Early Termination Notice."

5. The date coverage under the Plan ends and the employer offers no other group health benefit plan. In the event continuation coverage is terminated for this reason, the individual will receive an Early Termination Notice.

6. The date the covered person first becomes entitled, after the date of the covered person's original election of continuation coverage, to Medicare benefits under Title XVIII of the Social Security Act. In the event continuation coverage is terminated for this reason, the individual will receive an Early Termination Notice.

7. The date the covered person first becomes covered under any other employer’s group health plan after the original date of the covered person’s election of continuation coverage.

8. For the spouse or dependent child of a covered employee who becomes entitled to Medicare prior to the spouse’s or dependent’s election for continuation coverage, thirty-six (36) months from the date the covered employee becomes entitled to Medicare.

SPECIAL RULES REGARDING NOTICES

1. Any notice required in connection with continuation coverage under the Plan must, at minimum, contain sufficient information so that the plan administrator (or its designee) is able to determine from such notice the employee and dependent(s) (if any), the qualifying event or disability, and the date on which the qualifying event occurred.

2. In connection with continuation coverage under the Plan, any notice required to be provided by any individual who is either the employee or a dependent with respect to the qualifying event may be provided by a
representative acting on behalf of the employee or the dependent, and the provision of the notice by one individual shall satisfy any responsibility to provide notice on behalf of all related eligible individuals with respect to the qualifying event.

3. As to an Election Notice, Non-Eligibility Notice or Early Termination Notice:
   a. A single notice addressed to both the employee and the spouse will be sufficient as to both individuals if, on the basis of the most recent information available to the Plan, the spouse resides at the same location as the employee; and
   b. A single notice addressed to the employee or the spouse will be sufficient as to each dependent child of the employee if, on the basis of the most recent information available to the Plan, the dependent child resides at the same location as the individual to whom such notice is provided.

MILITARY MOBILIZATION

If an employee is called for active duty by the United States Armed Services (including the Coast Guard, the National Guard or the Public Health Service), the employee and the employee's dependent may continue their health coverages, pursuant to the Uniformed Services Employment and Reemployment Rights Act (USERRA).

When the leave is less than thirty-one (31) days, the employee and the employee's dependent may not be required to pay more than the employee's share, if any, applicable to that coverage. If the leave is thirty-one (31) days or longer, then the plan administrator (or its designee) may require the employee and the employee's dependent to pay no more than one hundred and two percent (102%) of the full contribution.

The maximum length of the continuation coverage required under the Uniformed Services Employment and Reemployment Rights Act (USERRA) is the lesser of:

1. Twenty-four (24) months beginning on the day that the leave commences, or
2. A period beginning on the day that the leave began and ending on the day after the employee fails to return to employment within the time allowed.

The period of continuation coverage under USERRA will be counted toward any continuation coverage period concurrently available under COBRA. Upon return from active duty, the employee and the employee's dependent will be reinstated without a waiting period, regardless of their election of COBRA continuation coverage.

PLAN CONTACT INFORMATION

Questions concerning the Plan, including any available continuation coverage, can be directed to the plan administrator (or its designee).

ADDRESS CHANGES

In order to help ensure the appropriate protection of rights and benefits under the Plan, covered persons should keep the plan administrator (or its designee) informed of any changes to their current addresses.
CLAIM FILING PROCEDURE

A “pre-service claim” is a claim for a Plan benefit that is subject to the pre-certification rules, as described in the section, Pre-Service Claim Procedure. All other claims for Plan benefits are “post-service claims” and are subject to the rules described in the section, Post-Service Claim Procedure.

POST-SERVICE CLAIM PROCEDURE

FILING A CLAIM

1. A claim form is to be completed for each covered family member at the beginning of the plan year and for each claim involving an injury. Appropriate claim forms are available from the Human Resources Department.

2. Claims should be submitted to the address shown on the ID card.

   The date of receipt will be the date the claim is received by the claims processor.

3. All claims submitted for benefits must contain all of the following:
   a. Name of patient.
   b. Patient’s date of birth.
   c. Name of employee.
   d. Address of employee.
   e. Name of employer and group number.
   f. Name, address and tax identification number of provider.
   g. Employee Member Identification Number.
   h. Date of service.
   i. Diagnosis and diagnosis code.
   j. Description of service and procedure number.
   k. Charge for service.
   l. The nature of the accident, injury or illness being treated.

   Cash register receipts, credit card copies, labels from containers and cancelled checks are not acceptable.

4. All claims not submitted within twelve (12) months from the date the services were rendered will not be a covered expense and will be denied.

The covered person may ask the health care provider to submit the claim directly to the claims processor or to the Preferred Provider Organization as outlined above, or the covered person may submit the bill with a claim form. However, it is ultimately the covered person's responsibility to make sure the claim for benefits has been filed.

NOTICE OF AUTHORIZED REPRESENTATIVE

The covered person may provide the plan administrator (or its designee) with a written authorization for an authorized representative to represent and act on behalf of a covered person and consent to the release of information related to the covered person to the authorized representative with respect to a claim for benefits or an appeal. Authorization forms may be obtained from the Human Resources Department.

NOTICE OF CLAIM

A claim for benefits should be submitted to the claims processor within ninety (90) calendar days after the occurrence or commencement of any services by the Plan, or as soon thereafter as reasonably possible.
Failure to file a claim within the time provided shall not invalidate or reduce a claim for benefits if: (1) it was not reasonably possible to file a claim within that time; and (2) that such claim was furnished as soon as possible, but no later than twelve (12) months after the loss occurs or commences unless the claimant is legally incapacitated.

Notice given by or on behalf of a covered person or the covered person’s beneficiary, if any, to the plan administrator or to any authorized agent of the Plan, with information sufficient to identify the covered person, shall be deemed notice of claim.

TIME FRAME FOR BENEFIT DETERMINATION

After a completed claim has been submitted to the claims processor, and no additional information is required, the claims processor will generally complete its determination of the claim within thirty (30) calendar days of receipt of the completed claim unless an extension is necessary due to circumstances beyond the Plan’s control.

After a completed claim has been submitted to the claims processor, and if additional information is needed for determination of the claim, the claims processor will provide the covered person (or authorized representative) with a notice detailing information needed. The notice will be provided within thirty (30) calendar days of receipt of the completed claim and will state the date as of which the Plan expects to make a decision. The covered person will have forty-five (45) calendar days to provide the information requested, and the Plan will complete its determination of the claim within fifteen (15) calendar days of receipt by the claims processor of the requested information. Failure to respond in a timely and complete manner will result in an adverse benefit determination.

NOTICE OF ADVERSE BENEFIT DETERMINATION

If the claim for benefits is denied, the plan administrator (or its designee) shall provide the covered person (or authorized representative) with a written Notice of Adverse Benefit Determination within the time frames described immediately above.

The Notice of Adverse Benefit Determination shall include an explanation of the denial, including:

1. Information sufficient to identify the claim involved.
2. The specific reasons for the adverse benefit determination, to include:
   a. The denial code and its specific meaning, and
   b. A description of the Plan’s standards, if any, used when denying the claim.
3. Reference to the Plan provisions on which the adverse benefit determination is based.
4. A description of any additional material or information needed and an explanation of why such material or information is necessary.
5. A description of the Plan’s claim appeal procedure and applicable time limits.
6. If an internal rule, guideline, protocol or other similar criterion was relied upon, the Notice of Adverse Benefit Determination will contain either:
   a. A copy of that criterion, or
   b. A statement that such criterion was relied upon and will be supplied free of charge, upon request.
7. If the adverse benefit determination was based on medical necessity, experimental/investigational treatment or similar exclusion or limit, the plan administrator (or its designee) will supply either:
   a. An explanation of the scientific or clinical judgment, applying the terms of the Plan to the covered person’s medical circumstances, or
   b. A statement that such explanation will be supplied free of charge, upon request.

APPEALING AN ADVERSE BENEFIT DETERMINATION ON A POST-SERVICE CLAIM

A covered person, or the covered person’s authorized representative, may request a review of an adverse benefit determination on a Post-Service claim by making written request to the claims processor within one hundred eighty (180) calendar days from receipt of notification of the adverse benefit determination and stating the reasons the covered person feels the claim should not have been denied.
The following describes the review process and rights of the *covered person* for a full and fair review:

1. The *covered person* has the right to submit documents, information and comments and to present evidence and testimony.
2. The *covered person* has the right to access, free of charge, *relevant information* to the claim for benefits.
3. Before a final *adverse benefit determination* on appeal is rendered, the *covered person* will be provided, free of charge, with any new or additional rationale or evidence considered, relied upon, or generated by the *Plan* in connection with the claim. Such information will be provided as soon as possible and sufficiently in advance of the notice of final *internal adverse benefit determination*. However, there could be circumstances where the new or additional evidence or rationale could be received so late that it would be impossible to provide to the *covered person* in time to have a reasonable opportunity to respond. In these circumstances, the period for providing notice of final determination on appeal will be tolled until the earliest of the following dates:
   a. The date the *covered person* responds to the new or additional rationale or evidence; or
   b. Three (3) weeks from the date the new or additional rationale or evidence was mailed to the *covered person*.
4. The review takes into account all information submitted by the *covered person*, even if it was not considered in the initial benefit determination.
5. The review by the *claims processor* will not afford deference to the original *adverse benefit determination*.
6. The *claims processor* will not be:
   a. The individual who originally denied the claim, nor
   b. Subordinate to the individual who originally denied the claim.
7. If the original *adverse benefit determination* was, in whole or in part, based on medical judgment:
   a. The *claims processor* will consult with a *professional provider* who has appropriate training and experience in the field involving the medical judgment; and
   b. The *professional provider* utilized by the *claims processor* will be neither:
      (i.) An individual who was consulted in connection with the original *adverse benefit determination*, nor
      (ii.) A subordinate of any other *professional provider* who was consulted in connection with the original *adverse benefit determination*.
8. If requested, the *claims processor* will identify the medical or vocational expert(s) who gave advice in connection with the original *adverse benefit determination*, whether or not the advice was relied upon.

**NOTICE OF BENEFIT DETERMINATION ON APPEAL**

The *plan administrator* (or its designee) shall provide the *covered person* (or authorized representative) with a written notice of the appeal decision within sixty (60) calendar days of receipt of a written request for the appeal.

If the appeal is denied, the Notice of Appeal Decision will contain an explanation of the Decision, including:

1. The specific reasons for the *adverse benefit determination*.
2. Reference to specific *Plan* provisions on which the *adverse benefit determination* is based.
3. A statement that the *covered person* has the right to access, free of charge, *relevant information* to the claim for benefits.
4. A statement of the *covered person’s* right to request an external review and a description of the process for requesting such a review.
5. If an internal rule, guideline, protocol or other similar criterion was relied upon, the Notice of Appeal Decision will contain either:
   a. A copy of that criterion, or
   b. A statement that such criterion was relied upon and will be supplied free of charge, upon request.
6. If the *adverse benefit determination* was based on medical necessity, experimental/investigational treatment or similar exclusion or limit, the *plan administrator* (or its designee) will supply either:
   a. An explanation of the scientific or clinical judgment, applying the terms of the *Plan* to the claimant’s medical circumstances, or
   b. A statement that such explanation will be supplied free of charge, upon request.
FOREIGN CLAIMS

In the event a covered person incurs a covered expense in a foreign country, the covered person shall be responsible for submitting the claim form, provider invoice and any documentation required to process the claim in the English language to the claims processor before payment of any benefits due are payable.

PRE-SERVICE CLAIM PROCEDURE

HEALTH CARE MANAGEMENT

Health care management is the process of evaluating whether proposed services, supplies or treatments are medically necessary and appropriate to help ensure quality, cost-effective care.

Certification of medical necessity and appropriateness by the Health Care Management Organization does not establish eligibility under the Plan nor guarantee benefits.

FILING A PRE-CERTIFICATION CLAIM

This pre-certification provision will be waived by the Health Care Management Organization if the covered expense is rendered/provided outside of the United States of America or any U.S. Commonwealth, Territory or Possession.

All non-emergency medical condition inpatient admissions, partial confinement, home health care (excluding supplies and durable medical equipment), hospice care, skilled nursing visits, private duty nursing, organ or tissue transplants, and those services shown below are to be certified by the Health Care Management Organization. For non-emergency medical conditions, the covered person (or their authorized representative) must call the Health Care Management Organization prior to initiation of services. If the Health Care Management Organization is not called prior to initiation of services for non-emergency medical conditions, benefits may be reduced.

Covered persons shall contact the Health Care Management Organization by calling the number found on the covered person’s ID card

Inpatient Services
  • Non-emergency medical condition inpatient hospital (excludes observation setting)
  • Extended care facilities/skilled nursing facilities
  • Rehabilitation facilities
  • Long-term acute care facilities
  • Mental health disorders or substance use disorder treatment facilities
  • Organ and tissue transplants (in all settings)

Outpatient Services
  • Home health care
  • Partial confinement

Outpatient Procedures
  • Bariatric surgery (must be performed at Blue Distinction Plus Center only)
  • Spinal
    o Lumbar Laminectomy
    o Cervical Laminectomy
    o Lumbar Discectomy, Foraminotomy, or Laminotomy
    o Cervical Discectomy or Microdiscectomy, Foraminotomy, Laminotomy
    o Cervical Fusion, Anterior
    o Disk Arthroplasty, Cervical
    o Vertebroplasty and Kyphoplasty
    o Disk Arthroplasty, Lumbar
    o Automated Percutaneous Lumbar Discectomy (APLD), Low Back Pain
• Joint Replacements
  o Knee
  o Hip
• Cosmetic Procedures
  o Reduction mammoplasty
  o Breast Reconstruction- Mastectomy, Complete, with Insertion of Breast Prosthesis or Tissue Expander
• Cochlear Implants

Additional Services and Procedures
• **Durable medical equipment** over $2,500
• Radiation therapy
  o Brachytherapy
  o IMRT
  o Radiofrequency ablation of tumor
  o Radionuclide (Strontium, Samarium, Radium) therapy of bone metastases
  o Stereotactic body radiotherapy
  o Proton beam
• Genetic Testing
  o Breast cancer: BRCA, breast cancer (Hereditary) - gene panel; breast cancer - HER2 testing; breast cancer gene expression assays; breast or ovarian cancer, hereditary - BRCA1 and BRCA2 genes
  o Prostate cancer: prostate cancer - BRCA1 and BRCA2 genes; prostate cancer - genetic profiles; prostate cancer - HOXB13, MMR, PTEN, and TMPRSS2-ETS fusion genes; prostate cancer - PCA3 genes; prostate cancer gene expression testing – Decipher; prostate cancer gene expression testing - Oncotype DX; prostate cancer gene expression Ttsting – Prolaris
  o Melanoma: Malignant mlanoma (Cutaneous) - BAP1, CDK4, and CDKN2A genes; malignant melanoma (Uveal) - BAP1, CDK4, and CDKN2A genes; malignant melanoma - BRAF V600 testing; melanoma (cutaneous) - gene expression profiling; Melanoma (Uveal) - gene expression profiling
  o Hereditary colon cancer: colorectal cancer (hereditary) - gene panel
• MRI/MRA/PET Scans (Not done in the emergency room)
  o MRI
  o MRA
  o PET
• **Intensive outpatient treatment**
• Home hospice:
  o Codes: G0151, G0152, G0153, G0155, G0156, G0157, G0158, G0162, G0299, G9473, G9474, G9476, G9477, G9479, Q5001, Q5002, Q5009, Q5010, S0255, S9123, S9124, S9126, T2042, T2043
• Stress Test – HCM has these 3 requirements listed together as stress testing myocardial perfusion imaging single photon SPECT/PET – codes are under single photon SPECT/PET
• Myocardial perfusion imaging
• Single photon SPECT/PET
  o Codes: G0151, G0152, G0153, G0155, G0156, G0157, G0158, G0162, G0299, G9473, G9474, G9476, G9477, G9479, Q5001, Q5002, Q5009, Q5010, S0255, S9123, S9124, S9126, T2042, T2043
• Implantable Cardiac Devices Pacemakers and Defibrillators are grouped together
  o Pacemakers
  o Defibrillators
• Bone conduction hearing aids
  o Codes: 69710, 69711, 69714, 69715, 69716, 69717, 69718, 69719, 69726, 69727, 69728, 69729, 69730, L8625, L8690, L8691, L8692, L8693, L8694
• Nasal and sinus surgery
  o Codes: 30400, 30410, 30420, 30430, 30435, 30450, 30460, 30462, 30520
• Gastric electrical stimulation (GES)
  o Codes: 43647, 43648, 43881, 43882, 64590, 64595
• Deep brain stimulation
  o Codes: 61863, 61864, 61867, 61868, 61880, 61885, 61886, 61888, 95961, 95962, 95970, 95983, 95984
• Sacral nerve neuromodulation/stimulation
  o Codes: 43647, 43648, 43881, 43882, 64561, 64569, 64570, 64582, 64583, 64584, 95970
• Vagus nerve stimulation (VNS)
  o Codes: 43647, 43648, 43881, 43882, 64561, 64569, 64570, 64582, 64583, 64584, 95970
• Surgical deactivation of HA trigger sites
• Joint/Spinal Injections
  o Codes: 64490, 64491, 64492, 64493, 64494, 64495, 0213T, 0214T, 0215T, 0216T, 0217T, 0218T
• Radiofrequency spinal facet joint ablation/denervation
  o Codes: 64625
• Spinal cord stimulators
  o Code: 63650, 63655, 63685, 63688, C1767, C1823, E0764, L8685, L8686, L8687, L8688
• Advanced imaging
  o CTA
  o Codes: 70496, 70498, 71275, 72191, 73206, 73706, 74174, 74175, 75574, 75635, 75774
• Nuclear Medicine
  o Codes: PET - 78429, 78608, 78609, 78811, 78812, 78813, 78814, 78815, 78816
  Radionuclide - 78428, 78445, 78453, 78454, 78456, 78457, 78458, 78459, 78466, 78468, 78469, 78472, 78473, 78481, 78483, 78496, 78499,
  Nuclear - 78414, 78610, 78630, 78635, 78645, 78650, 78999
  SPECT - 78469, 78494, 78803, 78830, 78831, 78832, 78835
• Sleep studies/Home sleep studies:
  o Codes: G0398, G0399, G0400, 95782, 95783, 95800, 95801, 95806, 95807, 95808, 95810, 95811
• CPAP/PAP /BiPap (DME benefit applies)
  o Codes: E0601, E0470, E0471, E0472
• Hyperbaric oxygen therapy
  o Codes: G0277
• Outpatient electroconvulsive therapy
  o Codes: 90870
• Repetitive transcranial stimulation
  o Codes: 90867, 90868, 90869

When a covered person (or authorized representative) calls the Health Care Management Organization, the covered person (or authorized representative) should be prepared to provide all of the following information:

1. Employee's name, address, phone number and Member Identification Number.
2. Employer's name.
3. If not the employee, the patient’s name, address, phone number.
4. Admitting physician’s name and phone number.
5. Name of facility or home health care agency.
6. Date of admission or proposed date of admission.
7. Condition for which patient is being admitted.

Group health plans generally may not, under federal law, restrict benefits for any hospital length of stay in connection with childbirth for the birth parent 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 generally does not prohibit the birth parent’s or newborn’s attending provider, after consulting with the birth parent, from discharging the birth parent or newborn earlier than forty-eight (48) hours (or ninety-six (96) hours as applicable). In any case, plans may not, under federal law, require that a provider obtain authorization from the Plan for prescribing a length of stay not in excess of the above periods.

However, hospital maternity stays in excess of forty-eight (48) or ninety-six (96) hours as specified above must be pre-certified.

If the covered person (or authorized representative) fails to contact the Health Care Management Organization prior to the hospitalization or outpatient surgery and within the timelines detailed above, the amount of benefits payable for covered expenses incurred by a nonpreferred provider shall be reduced by $250 for the purpose of determining benefits payable. This reduction shall not apply when the agreement between a preferred provider and preferred provider organization prohibits a reduction in benefits for failure to pre-certify.

If the Health Care Management Organization declines to grant the full pre-certification requested, benefits for days not certified as medically necessary by the Health Care Management Organization shall be denied. (Refer to Post-Service Claim Procedure discussion above.)

**FILING A PRE-CERTIFICATION CLAIM FOR SPECIALTY DRUGS**

All specialty drugs dispensed by a facility or professional provider listed under the URL, shown below, under Specialty Drugs are to be certified by Archimedes, LLC.

*Covered persons* shall contact Archimedes, LLC by calling the phone number for precertification found on the back of the covered person’s ID card

Specialty Drugs

https://www.luminarehealth.com/What-We-Do/Networks-and-Administrative-Solutions/Archimedes-Drug-List-ON

Any non-oncology specialty drugs that are not provided through the site of care required during the pre-certification process by Archimedes, LLC are not covered. See *Medical Exclusions* section.

**NOTIFICATION REQUIREMENT**

Notification is required within forty-eight (48) hours or the next business day of an emergency medical condition admission by the calling the number on the covered person’s ID card.

**NOTICE OF AUTHORIZED REPRESENTATIVE**

The covered person may provide the plan administrator (or its designee) with a written authorization for an authorized representative to represent and act on behalf of a covered person and consent to release of information related to the covered person to the authorized representative with respect to a claim for benefits or an appeal. Authorization forms may be obtained from the Human Resources Department. Notwithstanding the foregoing, requests for pre-certification and other pre-service claims or requests by a person or entity other than the covered person may be processed without a
written authorization if the request or claim appears to the plan administrator (or its designee) to come from a reasonably appropriate and reliable source (e.g., physician’s office, individuals identifying themselves as immediate relatives, etc.).

**TIME FRAME FOR PRE-SERVICE CLAIM DETERMINATION**

1. In the event the Plan receives from the covered person (or authorized representative) a communication that fails to follow the pre-certification procedure as described above but communicates at least the name of the covered person, a specific medical condition or symptom, and a specific treatment, service or product for which prior approval is requested, the covered person (or the authorized representative) will be orally notified (and in writing if requested), within five (5) calendar days of the failure of the proper procedure to be followed.

2. After a completed pre-certification request for non-urgent care has been submitted to the Plan, and if no additional information is required, the Plan will generally complete its determination of the claim within a reasonable period of time, but no later than fifteen (15) calendar days from receipt of the request.

3. After a pre-certification request for non-urgent care has been submitted to the Plan, and if an extension of time to make a decision is necessary due to circumstances beyond the control of the Plan, the Plan will, within fifteen (15) calendar days from receipt of the request, provide the covered person (or authorized representative) with a notice detailing the circumstances and the date by which the Plan expects to render a decision. If the circumstances include a failure to submit necessary information, the notice will specifically describe the needed information. The covered person will have forty-five (45) calendar days to provide the information requested, and the Plan will complete its determination of the claim no later than fifteen (15) calendar days after receipt by the Plan of the requested information. Failure to respond in a timely and complete manner will result in an adverse benefit determination.

**CONCURRENT CARE CLAIMS**

If an extension beyond the original certification is required, the covered person (or authorized representative) shall call the Health Care Management Organization for continuation of certification.

If a covered person (or authorized representative) requests to extend a previously approved hospitalization or an ongoing course of treatment, and;

a. The request involves non-urgent care, then the extension request must be processed within fifteen (15) calendar days after the request was received.

b. The inpatient admission or ongoing course of treatment involves urgent care, and

   (i.) The request is received at least twenty-four (24) hours before the scheduled end of a hospitalization or course of treatment, then the request must be ruled upon and the covered person (or authorized representative) notified as soon as possible taking into consideration medical exigencies but no later than twenty-four (24) hours after the request was received; or

   (ii.) The request is received less than twenty-four (24) hours before the scheduled end of the hospitalization or course of treatment, then the request must be ruled upon and the covered person (or authorized representative) notified as soon as possible but no later than seventy-two (72) hours after the request was received; or

   (iii.) The request is received less than twenty-four (24) hours before the scheduled end of the hospitalization or course of treatment and additional information is required, the covered person (or authorized representative) will be notified within twenty-four (24) hours of the additional information required. The covered person (or authorized representative) has forty-eight (48) hours to provide such information (may be oral unless written is requested). Upon timely response, the covered person (or authorized representative) will be notified as soon as possible but no later than forty-eight (48) hours after receipt of additional information. Failure to submit requested information timely will result in an adverse benefit determination of such request.
If the Health Care Management Organization determines that the hospital stay or course of treatment should be decreased or terminated before the end of the fixed number of days and/or treatments, or the fixed time period that was previously approved, then the Health Care Management Organization shall:

1. Notify the covered person of the proposed change, and
2. Allow the covered person to file an appeal and obtain a decision, before the end of the fixed number of days and/or treatments, or the fixed time period that was previously approved.

If, at the end of a previously approved hospitalization or course of treatment, the Health Care Management Organization determines that continued confinement is no longer medically necessary, additional days will not be certified. (Refer to Appealing an Adverse Benefit Determination of a Pre-Service Claim discussion below.)

NOTICE OF ADVERSE BENEFIT DETERMINATION ON A PRE-SERVICE CLAIM

If a pre-certification request is denied in whole or in part, the plan administrator (or its designee) shall provide the covered person (or authorized representative) with a written Notice of an Adverse Benefit Determination on a Pre-Service Claim within the time frames above.

The Notice of Adverse Benefit Determination on a Pre-Service Claim shall include an explanation of the denial, including:

1. Information sufficient to identify the claim involved.
2. The specific reasons for the denial, to include:
   a. The denial code and its specific meaning, and
   b. A description of the Plan’s standards, if any, used when denying the claim.
3. Reference to the Plan provisions on which the adverse benefit determination is based.
4. A description of any additional material or information needed and an explanation of why such material or information is necessary.
5. A description of the Plan’s claim appeal procedure and applicable time limits.
6. If an internal rule, guideline, protocol or other similar criterion was relied upon, the Notice of Adverse Benefit Determination on a Pre-Service Claim will contain either:
   a. A copy of that criterion, or
   b. A statement that such criterion was relied upon and will be supplied free of charge, upon request.
7. If the adverse benefit determination was based on medical necessity, experimental/investigational treatment or similar exclusion or limit, the plan administrator (or its designee) will supply either:
   a. An explanation of the scientific or clinical judgment, applying the terms of the Plan to the covered person’s medical circumstances, or
   b. A statement that such explanation will be supplied free of charge, upon request.

NOTICE OF ADVERSE BENEFIT DETERMINATION ON A PRE-SERVICE CLAIM FOR SPECIALTY DRUGS

If a pre-certification request is denied in whole or in part, the plan administrator (or its designee) shall provide the covered person (or authorized representative) with a written Notice of an Adverse Benefit Determination on a Pre-Service Claim within the time frames above.

The Notice of Adverse Benefit Determination on a Pre-Service Claim shall include an explanation of the denial, including:

1. Information sufficient to identify the claim involved.
2. The specific reasons for the denial, to include:
   a. The denial code and its specific meaning, and
   b. A description of the Plan’s standards, if any, used when denying the claim.
3. Reference to the Plan provisions on which the adverse benefit determination is based.
4. A description of any additional material or information needed and an explanation of why such material or information is necessary.
5. A description of the Plan’s claim appeal procedure and applicable time limits.
6. If an internal rule, guideline, protocol or other similar criterion was relied upon, the Notice of Adverse Benefit Determination on a Pre-Service Claim will contain either:
   a. A copy of that criterion, or
   b. A statement that such criterion was relied upon and will be supplied free of charge, upon request.
7. If the adverse benefit determination was based on medical necessity, experimental/investigational treatment or similar exclusion or limit, the plan administrator (or its designee) will supply either:
   a. An explanation of the scientific or clinical judgment, applying the terms of the Plan to the covered person’s medical circumstances, or
   b. A statement that such explanation will be supplied free of charge, upon request.

APPEALING AN ADVERSE BENEFIT DETERMINATION OF A DENIED PRE-SERVICE CLAIM

A covered person (or authorized representative) may request a review of an adverse benefit determination of a pre-service claim by making a verbal or written request to the claims processor within one hundred eighty (180) calendar days from receipt of notification of the adverse benefit determination and stating the reasons the covered person feels the claim should not have been denied. If the covered person (or authorized representative) wishes to appeal the adverse benefit determination when the services in question have already been rendered, such an appeal will be considered as a separate post-service claim. (Refer to Post-Service Claim Procedure discussion above.)

The following describes the review process and rights of the covered person for a full and fair review:

1. The covered person has the right to submit documents, information and comments and to present testimony.
2. The covered person has the right to access, free of charge, relevant information to the claim for benefits.
3. Before a final determination on appeal is rendered, the covered person will be provided, free of charge, with any new or additional rationale or evidence considered, relied upon, or generated by the Plan in connection with the claim. Such information will be provided as soon as possible and sufficiently in advance of the notice of final internal determination to give the covered person an opportunity to respond. The period for providing notice of final determination on appeal will be tolled until the earliest of the following dates:
   a. The date the covered person responds to the new or additional rationale or evidence; or
   b. Three (3) weeks from the date the new or additional rationale or evidence was mailed to the covered person.
4. The review takes into account all information submitted by the covered person, even if it was not considered in the initial benefit determination.
5. The review by the claims processor will not afford deference to the original adverse benefit determination.
6. The claims processor will not be:
   a. The individual who originally denied the claim, nor
   b. Subordinate to the individual who originally denied the claim.
7. If the original adverse benefit determination was, in whole or in part, based on medical judgment:
   a. The claims processor will consult with a professional provider who has appropriate training and experience in the field involving the medical judgment.
   b. The professional provider utilized by the claims processor will be neither:
      (i.) An individual who was consulted in connection with the original adverse benefit determination, nor
      (ii.) A subordinate of any other professional provider who was consulted in connection with the original adverse benefit determination.
8. If requested, the claims processor will identify the medical or vocational expert(s) who gave advice in connection with the original adverse benefit determination, whether or not the advice was relied upon.
APPEALING AN ADVERSE BENEFIT DETERMINATION OF A DENIED PRE-SERVICE CLAIM FOR SPECIALTY DRUGS

A covered person (or authorized representative) may request a review of an Adverse Benefit Determination of a Pre-Service claim by making a verbal or written request to the named fiduciary within one hundred eighty (180) calendar days from receipt of notification of the adverse benefit determination and stating the reasons the covered person feels the claim should not have been denied. If the covered person (or authorized representative) wishes to appeal the adverse benefit determination when the services in question have already been rendered, such an appeal will be considered as a separate post-service claim. (Refer to Post-Service Claim Procedure discussion above.)

The following describes the review process and rights of the covered person for a full and fair review:

1. The covered person has the right to submit documents, information and comments and to present testimony.
2. The covered person has the right to access, free of charge, relevant information to the claim for benefits.
3. Before a final determination on appeal is rendered, the covered person will be provided, free of charge, with any new or additional rationale or evidence considered, relied upon, or generated by the Plan in connection with the claim. Such information will be provided as soon as possible and sufficiently in advance of the notice of final internal determination to give the covered person an opportunity to respond. The period for providing notice of final determination on appeal will be tolled until the earliest of the following dates:
   a. The date the covered person responds to the new or additional rationale or evidence; or
   b. Three (3) weeks from the date the new or additional rationale or evidence was mailed to the covered person.
4. The review takes into account all information submitted by the covered person, even if it was not considered in the initial benefit determination.
5. The review by the claims processor will not afford deference to the original adverse benefit determination.
6. The claims processor will not be:
   a. The individual who originally denied the claim, nor
   b. Subordinate to the individual who originally denied the claim.
7. If the original adverse benefit determination was, in whole or in part, based on medical judgment:
   a. The claims processor will consult with a professional provider who has appropriate training and experience in the field involving the medical judgment.
   b. The professional provider utilized by the claims processor will be neither:
      (i.) An individual who was consulted in connection with the original adverse benefit determination, nor
      (ii.) A subordinate of any other professional provider who was consulted in connection with the original adverse benefit determination.
8. If requested, the claims processor will identify the medical or vocational expert(s) who gave advice in connection with the original adverse benefit determination, whether or not the advice was relied upon.

NOTICE OF PRE-SERVICE DETERMINATION ON APPEAL

The plan administrator (or its designee) shall provide the covered person (or authorized representative) with a written Notice of Appeal Decision as soon as possible, but not later than thirty (30) calendar days from receipt of the appeal (not applicable to urgent care claims).

If the appeal is denied, the Notice of Appeal Decision will contain an explanation of the decision, including:

1. The specific reasons for the adverse benefit determination.
2. Reference to specific Plan provisions on which the adverse benefit determination is based.
3. A statement that the covered person has the right to access, free of charge, relevant information to the claim for benefits.
4. A statement of the covered person’s right to request an external review and a description of the process for requesting such a review.
5. If an internal rule, guideline, protocol or other similar criterion was relied upon, the Notice of Appeal Decision will contain either:
CASE MANAGEMENT

In cases where the covered person’s condition is expected to be or is of a serious nature, the Health Care Management Organization may arrange for review and/or case management services from a professional qualified to perform such services. The plan administrator shall have the right to alter or waive the normal provisions of the Plan when it is reasonable to expect a cost-effective result without a sacrifice to the quality of care.

In addition, the Health Care Management Organization may recommend (or change) alternative:
- methods of medical care or treatment;
- equipment; or
- supplies;

that differ from the medical care or treatment, equipment or supplies that are considered covered expenses under the Plan.

The recommended alternatives will be considered as covered expenses under the Plan provided the expenses can be shown to be viable, medically necessary, and are included in a written case management report or treatment plan proposed by the Health Care Management Organization.

Case management will be determined on the merits of each individual case, and any care or treatment provided will not be considered as setting any precedent or creating any future liability with respect to that covered person or any other covered person.

POST-SERVICE AND PRE-SERVICE CLAIM EXTERNAL APPEALS PROTOCOL

EXTERNAL APPEAL

A covered person, or the covered person’s authorized representative, may request a review of an adverse benefit determination appeal if the claim determination involves medical judgment; whether items or services are subject to the requirements specified in numbers 1. through 6. in the subsection Nonpreferred Provider, under the section, Preferred Provider or Nonpreferred Preferred Provider; or a rescission by making written request to the claims processor within four (4) months of receipt of notification of the final internal adverse benefit determination. Medical judgment includes, but is not limited to:

1. Medical necessity;
2. Appropriateness;
3. Experimental or investigational treatment;
4. Health care setting;
5. Level of care; and
6. Effectiveness of a covered expense.

If there is no corresponding date four (4) months after the date of receipt of such a notice, then the request must be made by the first day of the fifth month following the receipt of the notice of final internal adverse benefit determination. (Note: If the date of receipt of the notice is October 30, because there is no February 30, the request must be filed by March 1, or the next day if March 1st falls on a Saturday, Sunday or Federal holiday.)
RIGHT TO EXTERNAL APPEAL

Within five (5) business days of receipt of the request, the claims processor will perform a preliminary review of the request to determine if the request is eligible for external review, based on confirmation that the final internal adverse benefit determination was the result of:

1. Medical judgment;
2. Whether items or services are subject to the requirements specified in numbers 1. through 6. in the Nonpreferred Provider subsection, under the Preferred Provider or Nonpreferred Provider section; or
3. Rescission of coverage under this Plan.

NOTICE OF RIGHT TO EXTERNAL APPEAL

The plan administrator (or its designee) shall provide the covered person (or authorized representative) with a written notice of the decision as to whether the claim is eligible for external review within one (1) business day after completion of the preliminary review.

The Notice of Right to External Appeal shall include the following:

1. The reason for ineligibility and the availability of the Employee Benefits Security Administration at 1-866-444-3272, if the request is complete but not eligible for external review.
2. If the request is incomplete, the information or materials necessary to make the request complete and the opportunity for the covered person to perfect the external review request by the later of the following:
   a. The four (4) month filing period; or
   b. Within the forty-eight (48) hour time period following the covered person’s receipt of notification.

INDEPENDENT REVIEW ORGANIZATION

For external reviews by an Independent Review Organization (IRO), such IRO shall be accredited by URAC or a similar nationally recognized accrediting organization and shall be assigned to conduct the external review. The assigned IRO will timely notify the covered person in writing of the request’s eligibility and acceptance for external review.

NOTICE OF EXTERNAL REVIEW DETERMINATION

The assigned IRO shall provide the plan administrator (or its designee) and the covered person (or authorized representative) with a written notice of the final external review decision within forty-five (45) days after receipt of the external review request.

The Notice of Final External Review Decision from the IRO is binding on the covered person, the Plan and claims processor, except to the extent that other remedies may be available under State or Federal law.

EXPEDITED EXTERNAL REVIEW

The plan administrator (or its designee) shall provide the covered person (or authorized representative) the right to request an expedited external review upon the covered person’s receipt of either of the following:

1. An adverse benefit determination involving a medical condition for which the timeframe noted above for completion of an internal appeal would seriously jeopardize the health or life of the covered person or the covered person’s ability to regain maximum function and the covered person has filed an internal appeal request.
2. A final internal adverse benefit determination involving a medical condition for which the timeframe for completion of a standard external review would seriously jeopardize the health or life of the covered person or the covered person’s ability to regain maximum function or if the final internal adverse benefit determination involves any of the following:

   a. An admission,

   b. Availability of care,

   c. Continued stay, or

   d. A health care item or service for which the covered person received emergency services, but has not yet been discharged from a facility.

Immediately upon receipt of the request for Expedited External Review, the Plan will do all of the following:

1. Perform a preliminary review to determine whether the request meets the requirements in the subsection, Right to External Appeal.

2. Send notice of the Plan’s decision, as described in the subsection, Notice of Right to External Appeal.

Upon determination that a request is eligible for external review, the Plan will do all of the following:

1. Assign an IRO as described in the subsection, Independent Review Organization.

2. Provide all necessary documents or information used to make the adverse benefit determination or final adverse benefit determination to the IRO either by telephone, facsimile, electronically or other expeditious method.

The assigned IRO will provide notice of final external review decision as expeditiously as the covered person’s medical condition or circumstances require, but in no event more than seventy-two (72) hours after receipt of the expedited external review request. The notice shall follow the requirements in the subsection, Notice of External Review Determination. If the notice of the expedited external review determination was not in writing, the assigned IRO shall provide the plan administrator (or its designee) and the covered person (or authorized representative) written confirmation of its decision within forty-eight (48) hours after the date of providing that notice.
COORDINATION OF BENEFITS

The Coordination of Benefits provision is intended to prevent duplication of benefits. It applies when the covered person is also covered by any Other Plan(s). When more than one coverage exists, one plan normally pays its benefits in full, referred to as the primary plan. The Other Plan(s), referred to as secondary plan, pays a reduced benefit. When coordination of benefits occurs, the total benefit payable by all plans will not exceed one hundred percent (100%) of "allowable expenses." Only the amount paid by this Plan will be charged against the Essential Health Benefits/non-Essential Health Benefits maximum benefit.

The Coordination of Benefits provision applies whether or not a claim is filed under the Other Plan(s). If another plan provides benefits in the form of services rather than cash, the reasonable value of the service rendered shall be deemed the benefit paid.

DEFINITIONS APPLICABLE TO THIS PROVISION

"Allowable Expenses" means any reasonable, necessary, and customary expenses incurred while covered under this Plan, part or all of which would be covered under this Plan. Allowable Expenses do not include expenses contained in the "Exclusions" sections of this Plan.

When this Plan is secondary, "Allowable Expense" will include any deductible or coinsurance amounts not paid by the Other Plan(s).

This Plan is not eligible to be elected as primary coverage in lieu of automobile benefits. Payments from automobile insurance will always be primary and this Plan shall be secondary only.

When this Plan is secondary, "Allowable Expense" shall not include any amount that is not payable under the primary plan as a result of a contract between the primary plan and a provider of service in which such provider agrees to accept a reduced payment and not to bill the covered person for the difference between the provider's contracted amount and the provider's regular billed charge.

"Other Plan" means any plan, policy or coverage providing benefits or services for, or by reason of medical, dental or vision care. Such Other Plan(s) do not include flexible spending accounts (FSA), health reimbursement accounts (HRA), health savings accounts (HSA), or individual medical, dental or vision insurance policies. "Other Plan" also does not include Tricare, Medicare, Medicaid or a state child health insurance program (CHIP). Such Other Plan(s) may include, without limitation:

1. Group insurance or any other arrangement for coverage for covered persons in a group, whether on an insured or uninsured basis, including, but not limited to, hospital indemnity benefits and hospital reimbursement-type plans;

2. Hospital or medical service organization on a group basis, group practice, and other group prepayment plans or on an individual basis having a provision similar in effect to this provision;

3. A licensed Health Maintenance Organization (HMO);

4. Any coverage for students which is sponsored by, or provided through, a school or other educational institution;

5. Any coverage under a government program and any coverage required or provided by any statute;

6. Group automobile insurance;

7. Individual automobile insurance coverage;

8. Individual automobile insurance coverage based upon the principles of "No-fault" coverage;
9. Any plan or policies funded in whole or in part by an employer, or deductions made by an employer from a person's compensation or retirement benefits;

10. Labor/management trustees, union welfare, employer organization, or employee benefit organization plans.

"This Plan" shall mean that portion of the employer's Plan which provides benefits that are subject to this provision.

"Claim Determination Period" means a plan year or that portion of a plan year during which the covered person for whom a claim is made has been covered under this Plan.

EFFECT ON BENEFITS

This provision shall apply in determining the benefits for a covered person for each claim determination period for the Allowable Expenses. If this Plan is secondary, the benefits paid under this Plan may be reduced so that the sum of benefits paid by all plans does not exceed 100% of total Allowable Expenses.

If the rules set forth below would require this Plan to determine its benefits before such Other Plan, then the benefits of such Other Plan will be ignored for the purposes of determining the benefits under this Plan.

ORDER OF BENEFIT DETERMINATION

Except as provided below in Coordination with Medicare, each plan will make its claim payment according to the first applicable provision in the following list of provisions which determine the order of benefit payment:

1. **No Coordination of Benefits Provision**
   If the Other Plan contains no provisions for coordination of benefits, then its benefits shall be paid before all Other Plan(s).

2. **Member/Dependent**
   The plan which covers the claimant directly pays before a plan that covers the claimant as a dependent.

3. **Dependent Children of Parents not Separated or Divorced**
   The plan covering the parent whose birthday (month and day) occurs earlier in the year pays first. The plan covering the parent whose birthday falls later in the year pays second. If both parents have the same birthday, the plan that covered a parent longer pays first. A parent's year of birth is not relevant in applying this rule.

4. **Dependent Children of Separated or Divorced Parents**
   When parents are separated or divorced, the birthday rule does not apply, instead:
   a. If a court decree has given one parent financial responsibility for the child's health care, the plan of that parent pays first. The plan of the stepparent married to that parent, if any, pays second. The plan of the other natural parent pays third. The plan of the spouse of the other natural parent, if any, pays fourth.
   b. In the absence of such a court decree, the plan of the parent with custody pays first. The plan of the stepparent married to the parent with custody, if any, pays second. The plan of the parent without custody pays third. The plan of the spouse of the parent without custody, if any, pays fourth.

5. **Active/Inactive**
   The plan covering a person as an active (not laid off or retired) employee or as that person's dependent pays first. The plan covering that person as a laid off or retired employee, or as that person's dependent pays second.
6. **Longer/Shorter Length of Coverage**

If none of the above rules determine the order of benefits, the plan covering a person longer pays first. The plan covering that person for a shorter time pays second.

**COORDINATION WITH MEDICARE**

Individuals may be eligible for Medicare Part A at no cost if they: (i) are age 65 or older, (ii) have been determined by the Social Security Administration to be disabled, or (iii) have end stage renal disease. Participation in Medicare Part B and D is available to all individuals who make application and pay the full cost of the coverage.

1. When an *employee* becomes entitled to Medicare coverage (due to age or disability) and is still actively at work, the *employee* may continue health coverage under this *Plan* at the same level of benefits and contribution rate that applied before reaching Medicare entitlement.

2. When a *dependent* becomes entitled to Medicare coverage (due to age or disability) and the *employee* is still actively at work, the *dependent* may continue health coverage under this *Plan* at the same level of benefits and contribution rate that applied before reaching Medicare entitlement.

3. If the *employee* and/or *dependent* are also enrolled in Medicare (due to age or disability), this *Plan* shall pay as the primary plan. If, however, the Medicare enrollment is due to end stage renal disease, the Plan’s primary payment obligation will end at the end of the thirty (30) month “coordination period” as provided in Medicare law and regulations. If the *employee* and/or *dependent* does not elect Medicare, but is otherwise eligible due to end stage renal disease, benefits will be paid as if Medicare has been elected and this *Plan* will pay secondary benefits upon completion of the thirty (30) month “coordination period.”

4. Notwithstanding Paragraphs 1 to 3 above, if the *employee* (including certain affiliated entities that are considered the same employer for this purpose) has fewer than one hundred (100) *employees*, when a covered *dependent* becomes entitled to Medicare coverage due to total disability, as determined by the Social Security Administration, and the *employee* is actively-at-work, Medicare will pay as the primary payer for claims of the *dependent* and this *Plan* will pay secondary.

5. If the *employee* and/or *dependent* elect to discontinue health coverage under this *Plan* and enroll under the Medicare program, no benefits will be paid under this *Plan*. Medicare will be the only payor.

This section is subject to the terms of the Medicare laws and regulations. Any changes in these related laws and regulations will apply to the provisions of this section.

**LIMITATIONS ON PAYMENTS**

In no event shall the *covered person* recover under this *Plan* and all Other Plan(s) combined more than the total Allowable Expenses offered by this *Plan* and the Other Plan(s). Nothing contained in this section shall entitle the *covered person* to benefits in excess of the total Essential Health Benefits/non-Essential Health Benefits maximum benefit of this *Plan* during the claim determination period. The *covered person* shall refund to the *employer* any excess it may have paid.

**RIGHT TO RECEIVE AND RELEASE NECESSARY INFORMATION**

For the purposes of determining the applicability of and implementing the terms of this Coordination of Benefits provision, the *Plan* may, without the consent of or notice to any person, release to or obtain from any insurance company or any other organization any information, regarding other insurance, with respect to any *covered person*. Any person claiming benefits under this *Plan* shall furnish to the *employer* such information as may be necessary to implement the Coordination of Benefits provision.
FACILITY OF BENEFIT PAYMENT

Whenever payments which should have been made under this Plan in accordance with this provision have been made under any Other Plan, the employer shall have the right, exercisable alone and in its sole discretion, to pay over to any organization making such other payments any amounts it shall determine to be warranted in order to satisfy the intent of this provision. Amounts so paid shall be deemed to be benefits paid under this Plan and, to the extent of such payments, the employer shall be fully discharged from liability.

AUTOMOBILE ACCIDENT BENEFITS

The Plan’s liability for expenses arising out of an automobile accident shall always be secondary to any automobile insurance, irrespective of the type of automobile insurance law that is in effect in the covered person’s state of residence. Currently, there are three (3) types of state automobile insurance laws.

1. No-fault automobile insurance laws
2. Financial responsibility laws
3. Other automobile liability insurance laws

No Fault Automobile Insurance Laws. In no event will the Plan pay any claim presented by or on behalf of a covered person for medical benefits that would have been payable under an automobile insurance policy but for an election made by the principal named insured under the automobile policy that reduced covered levels and/or subsequent premium. This is intended to exclude, as a covered expense, a covered person’s medical expenses arising from an automobile accident that are payable under an automobile insurance policy or that would have been payable under an automobile insurance policy but for such an election.

1. In the event a covered person incurs medical expenses as a result of injuries sustained in an automobile accident while “covered by an automobile insurance policy,” as an operator of the vehicle, as a passenger, or as a pedestrian, benefits will be further limited to medical expenses, that would in no event be payable under the automobile insurance.

2. For the purposes of this section the following people are deemed “covered by an automobile insurance policy.”
   a. An owner or principal named insured individual under such policy.
   b. A family member of an insured person for whom coverage is provided under the terms and conditions of the automobile insurance policy.
   c. Any other person who, except for the existence of the Plan, would be eligible for medical expense benefits under an automobile insurance policy.

Financial Responsibility Laws. The Plan will be secondary to any potentially applicable automobile insurance even if the state’s “financial responsibility law” does not allow the Plan to be secondary.

Other Automobile Liability Insurance. If the state does not have a no-fault automobile insurance law or a “financial responsibility” law, the Plan is secondary to automobile insurance coverage or to any other person or entity who caused the accident or who may be liable for the covered person’s medical expenses pursuant to the general rule for Subrogation/Reimbursement.
SUBROGATION/REIMBURSEMENT

The Plan is designed to only pay covered expenses for which payment is not available from anyone else, including any insurance company or another health plan. In order to help a covered person in a time of need, however, the Plan may pay covered expenses that may be or become the responsibility of another person, provided that the Plan later receives reimbursement for those payments (hereinafter called “Reimbursable Payments”).

Therefore, by enrolling in the Plan, as well as by applying for payment of covered expenses, a covered person is subject to, and agrees to, the following terms and conditions with respect to the amount of covered expenses paid by the Plan:

1. Assignment of Rights (Subrogation). The covered person automatically assigns to the Plan any rights the covered person may have to recover any or all of the same covered expenses from any party, including an insurer or another group health program (except flexible spending accounts, health reimbursement accounts and health savings accounts), but limited to the amount of Reimbursable Payments made by the Plan. This assignment includes, without limitation, the assignment of a right to any funds paid by a third party to a covered person or paid to another for the benefit of the covered person. This assignment applies on a first-dollar basis (i.e., has priority over other rights), applies whether the funds paid to (or for the benefit of) the covered person constitute a full or a partial recovery, and even applies to funds actually or allegedly paid for non-medical or dental charges, attorney fees, or other costs and expenses. This assignment also allows the Plan to pursue any claim that the covered person may have, whether or not the covered person chooses to pursue that claim. By this assignment, the Plan’s right to recover from insurers includes, without limitation, such recovery rights against no-fault auto insurance carriers in a situation where no third party may be liable, and from any uninsured or underinsured motorist coverage.

2. Equitable Lien and other Equitable Remedies. The Plan shall have an equitable lien against any rights the covered person may have to recover any or all of the same covered expenses from any party, including an insurer or another group health program, but limited to the amount of Reimbursable Payments made by the Plan. The equitable lien also attaches to any right to payment from workers’ compensation, whether or not the covered person has paid covered expenses prior to a determination that the covered expenses arose out of and in the course of employment. Payment by workers’ compensation insurers or the employer will be deemed to mean that such a determination has been made.

This equitable lien shall also attach to any money or property that is obtained by anybody (including, but not limited to, the covered person, the covered person’s attorney, and/or a trust) as a result of an exercise of the covered person’s rights of recovery (sometimes referred to as “proceeds”). The Plan shall also be entitled to seek any other equitable remedy against any party possessing or controlling such proceeds. At the discretion of the plan administrator, the Plan may reduce any future covered expenses otherwise available to the covered person under the Plan by an amount up to the total amount of Reimbursable Payments made by the Plan that is subject to the equitable lien.

This and any other provisions of the Plan concerning equitable liens and other equitable remedies are intended to meet the standards for enforcement under ERISA that were enunciated in the United States Supreme Court’s decision entitled, Great-West Life & Annuity Insurance Co. v. Knudson, 534 US 204 (2002). The provisions of the Plan concerning subrogation, equitable liens and other equitable remedies are also intended to supercede the applicability of the federal common law doctrines commonly referred to as the “make whole” rule and the “common fund” rule.

3. Assisting in Plan’s Reimbursement Activities. The covered person has an obligation to assist the Plan to obtain reimbursement of the Reimbursable Payments that it has made on behalf of the covered person, and to provide the Plan with any information concerning the covered person’s other insurance coverage (whether through automobile insurance, other group health program, or otherwise) and any other person or entity (including their insurer(s)) that may be obligated to provide payments or benefits to or for the benefit of the covered person. The covered person is required to (a) cooperate fully in the Plan’s (or any Plan fiduciary’s) enforcement of the terms of the Plan, including the exercise of the Plan’s right to subrogation and reimbursement, whether against the covered person or any third party, (b) not do anything to prejudice those
enforcement efforts or rights (such as settling a claim against another party without including the *Plan* as a co-payee for the amount of the Reimbursable Payments and notifying the *Plan*), (c) sign any document deemed by the *plan administrator* to be relevant to protecting the *Plan’s* subrogation, reimbursement or other rights, and (d) provide relevant information when requested. The term “information” includes any documents, insurance policies, police reports, or any reasonable request by the *plan administrator* or *claims processor* to enforce the *Plan’s* rights.

The *plan administrator* has delegated to the *claims processor* for medical claims the right to perform ministerial functions required to assert the *Plan’s* rights with regard to such claims and benefits; however, the *plan administrator* shall retain discretionary authority with regard to asserting the *Plan’s* recovery rights.
GENERAL PROVISIONS

ADMINISTRATION OF THE PLAN

The Plan is administered through the Human Resources Department of the employer. The employer is the plan administrator. The plan administrator shall have full charge of the operation and management of the Plan. The employer has retained the services of an independent claims processor experienced in claims review.

The employer is the sponsor of the Plan. The employer maintains authority to review all denied claims under appeal for benefits under the Plan. The employer maintains authority to interpret the terms of the Plan, including but not limited to, determination of eligibility for and entitlement to Plan benefits in accordance with the terms of the Plan; any interpretation or determination made pursuant to such authority shall be given full force and effect, unless it can be shown that the interpretation or determination was arbitrary and capricious.

APPLICABLE LAW

Except to the extent preempted by federal law, all provisions of the Plan shall be construed and administered in a manner consistent with the requirements under the laws of the State of Texas.

ASSIGNMENT

Coverage and the covered person’s rights under this Plan may not be assigned. A direction to pay a provider is not an assignment of any right under this Plan or of any legal or equitable right to institute any court proceeding.

Payment of Benefits

Benefits will be processed as soon as the necessary proof to support the claim is received. Written proof must be provided for all benefits. All covered health benefits are payable to the covered person. However, the Plan has the right to pay any health benefits to the service provider. This will be done unless the covered person has told the claims processor otherwise by the time the covered person files the claim and a reasonable amount of time for the claims processor to process the covered person’s request.

Preferred providers normally bill the Plan directly. If services, supplies or treatments have been received from such a provider, benefits are automatically paid to that provider. The covered person’s portion of the negotiated rate, after the Plan’s payment, will then be billed to the covered person by the preferred provider.

The Plan will pay benefits to the responsible party of an alternate recipient as designated in a Qualified Medical Child Support Order (QMCSO) or National Medical Support Notice (NMSN).

Additional Provisions

The Plan’s, Plan Sponsor’s, or claim processor’s failure to implement or insist upon compliance with any provision of this Plan at any given time or times, shall not constitute a waiver of the right to implement or insist upon compliance with that provision at any other time or times.

BENEFITS NOT TRANSFERABLE

Except as otherwise stated herein, no person other than an eligible covered person is entitled to receive benefits under the Plan. Such right to benefits is not transferable.
CLAIM EDITS

Claim edits derived from nationally recognized standards, including but not limited to: CPT, HCPCS, ICD-10 and modifiers, may be applied to covered expenses to ensure appropriate valid code relationships and to identify bundling and unbundling scenarios. As a result, covered expenses may be reduced.

CLERICAL ERROR

No clerical error on the part of the employer or claims processor shall operate to defeat any of the rights, privileges, services, or benefits of any employee or any dependent(s) hereunder, nor create or continue coverage which would not otherwise validly become effective or continue in force hereunder. An equitable adjustment of contributions and/or benefits will be made when the error or delay is discovered. However, if more than six (6) months has elapsed prior to discovery of any error, any adjustment of contributions shall be waived. No party shall be liable for the failure of any other party to perform.

CONFORMITY WITH STATUTE(S)

Any provision of the Plan which is in conflict with statutes which are applicable to the Plan is hereby amended to conform to the minimum requirements of said statute(s).

EFFECTIVE DATE OF THE PLAN

The effective date of this Plan is September 1, 2023.

FRAUD OR INTENTIONAL MISREPRESENTATION

If the covered person or anyone acting on behalf of a covered person makes a false statement on the application for enrollment, or withholds information with intent to deceive or affect the acceptance of the enrollment application or the risks assumed by the Plan, or otherwise misleads the Plan, the Plan shall be entitled to recover its damages, including legal fees, from the covered person, or from any other person responsible for misleading the Plan, and from the person for whom the benefits were provided. Any fraud or intentional misrepresentation of a material fact on the part of the covered person or an individual seeking coverage on behalf of the individual making application for coverage, or any application for reclassification thereof, or for service thereunder is prohibited and shall render the coverage under the Plan null and void.

FREE CHOICE OF HOSPITAL AND PHYSICIAN

Nothing contained in the Plan shall in any way or manner restrict or interfere with the right of any person entitled to benefits hereunder to select a hospital or to make a free choice of the attending physician or professional provider. However, benefits will be paid in accordance with the provisions of the Plan, and the covered person may have higher out-of-pocket expenses if the covered person uses the services of a nonpreferred provider.

INCAPACITY

If, in the opinion of the employer, a covered person for whom a claim has been made is incapable of furnishing a valid receipt of payment due the covered person and in the absence of written evidence to the Plan of the qualification of a guardian or personal representative for the covered person’s estate, the employer may on behalf of the Plan, at his discretion, make any and all such payments to the provider of services or other person providing for the care and support of such person. Any payment so made will constitute a complete discharge of the Plan’s obligation to the extent of such payment.
INCONTESTABILITY

All statements made by the employer or by the employee covered under the Plan shall be deemed representations and not warranties. Such statements shall not void or reduce the benefits under the Plan or be used in defense to a claim unless they are contained in writing and signed by the employer or by the covered person, as the case may be. A statement made shall not be used in any legal contest unless a copy of the instrument containing the statement is or has been furnished to the other party to such a contest.

INFORMATION AND RECORDS

You agree that it is your responsibility to insure that any provider, other Blue Cross and Blue Shield Plan, insurance company, employee benefit association, government body or program, any other person or entity, having knowledge of or records relating to (a) any illness or injury for which a claim or claims for benefits are made under the Plan, (b) any medical history which might be pertinent to such illness, injury, claim or claims, or (c) any benefits or indemnity on account of such illness or injury or on account of any previous illness or injury which might be pertinent to such claim or claims, furnish to the claim administrator or its agent, and agree that any such provider, person or other entity may furnish to the claim administrator or its agent, at any time upon its request, any and all information and records (including copies of records) relating to such illness, injury, claim or claims. In addition, the claim administrator may furnish similar information and records (or copies of records) to providers, Blue Cross and Blue Shield Plans, insurance companies, governmental bodies or programs or other entities providing insurance-type benefits requesting the same. It is also your responsibility to furnish the claim administrator and/or your employer or group administrator information regarding your or your dependents becoming eligible for Medicare, termination of Medicare eligibility or any changes in Medicare eligibility status in order that the claim administrator be able to make claim payments in accordance with MSP laws.

LIMITATIONS OF ACTIONS

No legal action may be brought to recover under the Plan as described herein, prior to the expiration of sixty (60) days after a claim has been furnished to the claim administrator in accordance with the requirements described in this Plan. In addition, no such action shall be brought after the expiration of three (3) years after the time a claim is required to be furnished to the claim administrator in accordance with the requirements described in this Plan.

LIMITS ON LIABILITY

Liability hereunder is limited to the services and benefits specified, and the employer shall not be liable for any obligation of the covered person incurred in excess thereof. The employer shall not be liable for the negligence, wrongful act, or omission of any physician, professional provider, hospital, or other institution, or their employees, or any other person. The liability of the Plan shall be limited to the reasonable cost of covered expenses and shall not include any liability for suffering or general damages.

LOST DISTRIBUTEES

Any benefit payable hereunder shall be deemed forfeited if the plan administrator is unable to locate the covered person to whom payment is due, provided, however, that such benefits shall be reinstated if a claim is made by the covered person for the forfeited benefits within the time prescribed in the applicable Claim Filing Procedure section of this document.

MEDICAID ELIGIBILITY AND ASSIGNMENT OF RIGHTS

The Plan will not take into account whether an individual is eligible for, or is currently receiving, medical assistance under a state plan for medical assistance as provided under Title XIX of the Social Security Act ("State Medicaid Plan") either in enrolling that individual as a covered person or in determining or making any payment of benefits to that individual. The Plan will pay benefits with respect to such individual in accordance with any assignment of rights made by or on behalf of such individual as required under a state Medicaid plan pursuant to § 1912(a)(1)(A) of the.
Social Security Act. To the extent payment has been made to such individual under a state Medicaid Plan and this Plan has a legal liability to make payments for the same services, supplies or treatment, payment under the Plan will be made in accordance with any state law which provides that the state has acquired the rights with respect to such individual to payment for such services, supplies or treatment under the Plan.

NOTICES

Any information or notice which you furnish to the claim administrator under the Plan as described herein must be in writing and sent to Blue Cross and Blue Shield of Illinois at its offices at 300 East Randolph, Chicago, Illinois 60601 (unless another address has been stated in this Plan for a specific situation). Any information or notice which the claim administrator furnishes to you must be in writing and sent to you at your address as it appears on the claim administrator’s records or in care of your employer and if applicable, in the case of a Qualified Medical Child Support Order, to the designated representative as it appears on the claim administrator’s records. The claim administrator may also provide such notices electronically to the extent permitted by applicable law.

PHYSICAL EXAMINATIONS REQUIRED BY THE PLAN

The Plan, at its own expense, shall have the right to require an examination of a person covered under the Plan when and as often as it may reasonably require during the pendency of a claim.

PLAN IS NOT A CONTRACT

The Plan shall not be deemed to constitute a contract between the employer and any employee or to be a consideration for, or an inducement or condition of, the employment of any employee. Nothing in the Plan shall be deemed to give any employee the right to be retained in the service of the employer or to interfere with the right of the employer to terminate the employment of any employee at any time.

PLAN MODIFICATION AND AMENDMENT

The employer may modify or amend the Plan from time to time at its sole discretion, and such amendments or modifications which affect covered persons will be communicated to the covered persons. Any such amendments shall be in writing, setting forth the modified provisions of the Plan, the effective date of the modifications, and shall be signed by the employer’s designee.

Such modification or amendment shall be duly incorporated in writing into the master copy of the Plan on file with the employer, or a written copy thereof shall be deposited with such master copy of the Plan. Appropriate filing and reporting of any such modification or amendment with governmental authorities, if applicable, and to covered persons shall be timely made by the employer.

PLAN TERMINATION

The employer reserves the right to terminate the Plan at any time. Upon termination, the rights of the covered persons to benefits are limited to claims incurred up to the date of termination. Any termination of the Plan will be communicated to the covered persons.

PRIOR PLAN COVERAGE

Employees and dependents who are covered under the employer's prior plan as of the day immediately prior to the effective date of this Plan shall be covered hereunder, provided they have elected coverage under this Plan. Employees who have not satisfied the prior plan's waiting period shall become effective under this Plan upon completing the waiting period of the prior plan.
PRONOUNS

All personal pronouns used in the Plan shall include either gender unless the context clearly indicates to the contrary.

RECOVERY FOR OVERPAYMENT

If this Plan pays benefits for covered expenses incurred by you or your dependents and it is found that the payment was more than it should have been, or it was made in error (“Overpayment”), this Plan or the claim administrator has the right to obtain a refund of the Overpayment amount from: (i) the person to, or for whom, such benefits were paid, or (ii) any insurance company or plan, or (iii) any other persons, entities, or organizations, including, but not limited to preferred providers or nonpreferred providers.

If no refund is received, this Plan and/or claim administrator (either in its capacity as insurer or administrator) has the right to deduct any refund for any Overpayment due up to an amount equal to the Overpayment, from:

a. Any future benefit payment made to any person or entity under this Plan, whether for the same or a different member; or
b. Any future benefit payment made to any person or entity under another Blue Cross and Blue Shield administered ASO benefit program; or
c. Any future benefit payment made to any person or entity under another Blue Cross and Blue Shield insured group benefit plan or individual policy; or
d. Any future benefit payment, or other payment, made to any person or entity; or
e. Any future benefit payment owed to one or more preferred providers or nonpreferred providers.

Further, the claim administrator has the right to reduce your benefit plan’s payment to a Provider by the amount necessary to recover another plan’s Overpayment to the same Provider and to remit the recovered amount to the other plan.

SEVERABILITY

Should any part of this Plan subsequently be invalidated by a court of competent jurisdiction, the remainder of the Plan shall be given effect to the maximum extent possible.

STATUS CHANGE

If an employee or dependent has a status change while covered under this Plan (i.e., dependent to employee, COBRA to active) and no interruption in coverage has occurred, the Plan will provide continuous coverage with respect to any deductible(s), coinsurance and Essential Health Benefits/non-Essential Health Benefits maximum benefit.

TIME EFFECTIVE

The effective time with respect to any dates used in the Plan shall be 12:01 a.m. as may be legally in effect at the address of the plan administrator.

WORKERS’ COMPENSATION NOT AFFECTED

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

The following provisions are intended to comply with applicable Plan amendment requirements under Federal regulation implementing Section 264 of the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

DISCLOSURE BY PLAN TO PLAN SPONSOR

The Plan may take the following actions only upon receipt of a Plan amendment certification:

1. Disclose protected health information to the plan sponsor.
2. Provide for or permit the disclosure of protected health information to the plan sponsor by a health insurance issuer or HMO with respect to the Plan.

USE AND DISCLOSURE BY PLAN SPONSOR

The plan sponsor may use or disclose protected health information received from the Plan to the extent not inconsistent with the provisions of this HIPAA Privacy section or the privacy rule.

OBLIGATIONS OF PLAN SPONSOR

The plan sponsor shall have the following obligations:

1. Ensure that:
   a. Any agents (including a subcontractor) to whom it provides protected health information received from the Plan agree to the same restrictions and conditions that apply to the plan sponsor with respect to such information; and
   b. Adequate separation between the Plan and the plan sponsor is established in compliance with the requirement in 45 C.F.R. 164.504(f)(2)(iii).
2. Not use or further disclose protected health information received from the Plan, other than as permitted or required by the Plan documents or as required by law.
3. Not use or disclose protected health information received from the Plan:
   a. For employment-related actions and decisions; or
   b. In connection with any other benefit or employee benefit plan of the plan sponsor.
4. Report to the Plan any use or disclosure of the protected health information received from the Plan that is inconsistent with the use or disclosure provided for of which it becomes aware.
5. Make available protected health information received from the Plan, as and to the extent required by the privacy rule:
   a. For access to the individual;
   b. For amendment and incorporate any amendments to protected health information received from the Plan; and
   c. To provide an accounting of disclosures.
6. Make its internal practices, books, and records relating to the use and disclosure of protected health information received from the Plan available to the Secretary of the U.S. Department of Health and Human Services for purposes of determining compliance by the Plan with the privacy rule.
7. Return or destroy all protected health information received from the Plan that the plan sponsor still maintains in any form and retain no copies when no longer needed for the purpose for which the disclosure by the Plan was made, but if such return or destruction is not feasible, limit further uses and disclosures to those purposes that make the return or destruction of the information infeasible.

8. Provide protected health information only to those individuals, under the control of the plan sponsor who perform administrative functions for the Plan, (i.e., eligibility, enrollment, payroll deduction, benefit determination, claim reconciliation assistance), and to make clear to such individuals that they are not to use protected health information for any reason other than for Plan administrative functions nor to release protected health information to an unauthorized individual.

9. Provide protected health information only to those entities required to receive the information in order to maintain the Plan (i.e., claim administrator, case management vendor, pharmacy benefit manager, claim subrogation vendor, claim auditor, network manager, stop-loss insurance carrier, insurance broker/consultant, and any other entity subcontracted to assist in administering the Plan).

10. Provide an effective mechanism for resolving issues of noncompliance with regard to the items mentioned in this provision.

11. Reasonably and appropriately safeguard electronic protected health information created, received, maintained, or transmitted to or by the plan sponsor on behalf of the Plan. Specifically, such safeguarding entails an obligation to:
   a. Implement administrative, physical, and technical safeguards that reasonably and appropriately protect the confidentiality, integrity, and availability of the electronic protected health information that the plan sponsor creates, receives, maintains, or transmits on behalf of the Plan;
   b. Ensure that the adequate separation as required by 45 C.F.R. 164.504(f)(2)(iii) is supported by reasonable and appropriate security measures;
   c. Ensure that any agent, including a subcontractor, to whom it provides this information agrees to implement reasonable and appropriate security measures to protect the information; and
   d. Report to the Plan any security incident of which it becomes aware.

**EXCEPTIONS**

Notwithstanding any other provision of this HIPAA Privacy section, the Plan (or a health insurance issuer or HMO with respect to the Plan) may:

1. Disclose summary health information to the plan sponsor if the plan sponsor requests it for the purpose of:
   a. Obtaining premium bids from health plans for providing health insurance coverage under the Plan; or
   b. Modifying, amending, or terminating the Plan;

2. Disclose to the plan sponsor information on whether the individual is participating in the Plan, or is enrolled in or has disenrolled from a health insurance issuer or HMO offered by the Plan;

3. Use or disclose protected health information:
   a. With (and consistent with) a valid authorization obtained in accordance with the privacy rule;
   b. To carry out treatment, payment, or health care operations in accordance with the privacy rule; or
   c. As otherwise permitted or required by the privacy rule.
NOTICE OF PRIVACY PRACTICES

Effective Date of this Notice: Same as the effective date on the cover page of this Plan

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please review it carefully.

Your Rights

You have the right to:

- Get a copy of your health and claims records
- Correct your health and claims records
- Request confidential communication
- Ask us to limit the information we share
- Get a list of those with whom we’ve shared your information
- Get a copy of this privacy notice
- Choose someone to act for you
- File a complaint if you believe your privacy rights have been violated

Your Choices

You have some choices in the way that we use and share information as we:

- Answer coverage questions from your family and friends
- Provide disaster relief
- Market our services and sell your information

Our Uses and Disclosures

We may use and share your information as we:

- Help manage the health care treatment you receive
- Run our organization
- Pay for your health services
- Administer your health plan
- Help with public health and safety issues
- Do research
- Comply with the law
- Respond to organ and tissue donation requests and work with a medical examiner or funeral director
- Address workers’ compensation, law enforcement, and other government requests
- Respond to lawsuits and legal actions

Your Rights

When it comes to your health information, you have certain rights. This section explains your rights and some of our responsibilities to help you.

Get a copy of health and claims records

- You can ask to see or get a copy of your health and claims records and other health information we have about you. Ask us how to do this.
We will provide a copy or a summary of your health and claims records, usually within 30 days of your request. We may charge a reasonable, cost-based fee.

**Ask us to correct health and claims records**

- You can ask us to correct your health and claims records if you think they are incorrect or incomplete. Ask us how to do this.
- We may say “no” to your request, but we’ll tell you why in writing within 60 days.

**Request confidential communications**

- You can ask us to contact you in a specific way (for example, home or office phone) or to send mail to a different address.
- We will consider all reasonable requests, and must say “yes” if you tell us you would be in danger if we do not.

**Ask us to limit what we use or share**

- You can ask us not to use or share certain health information for treatment, payment, or our operations.
- We are not required to agree to your request, and we may say “no” if it would affect your care.

**Get a list of those with whom we’ve shared information**

- You can ask for a list (accounting) of the times we’ve shared your health information for six years prior to the date you ask, who we shared it with, and why.
- We will include all the disclosures except for those about treatment, payment, and health care operations, and certain other disclosures (such as any you asked us to make). We’ll provide one accounting a year for free but will charge a reasonable, cost-based fee if you ask for another one within 12 months.

**Get a copy of this privacy notice**

You can ask for a paper copy of this notice at any time, even if you have agreed to receive the notice electronically. We will provide you with a paper copy promptly.

**Choose someone to act for you**

- If you have given someone medical power of attorney or if someone is your legal guardian, that person can exercise your rights and make choices about your health information.
- We will make sure the person has this authority and can act for you before we take any action.

**File a complaint if you feel your rights are violated**

- You can complain if you feel we have violated your rights by contacting us using the information on page 1.
- You can file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights by sending a letter to 200 Independence Avenue, S.W., Washington, D.C. 20201, calling 1-877-696-6775, or visiting [www.hhs.gov/ocr/privacy/hipaa/complaints/](http://www.hhs.gov/ocr/privacy/hipaa/complaints/).
- We will not retaliate against you for filing a complaint.

**Your Choices**

For certain health information, you can tell us your choices about what we share. If you have a clear preference for how we share your information in the situations described below, talk to us. Tell us what you want us to do, and we will follow your instructions.
In these cases, you have both the right and choice to tell us to:

- Share information with your family, close friends, or others involved in payment for your care
- Share information in a disaster relief situation

*If you are not able to tell us your preference, for example if you are unconscious, we may go ahead and share your information if we believe it is in your best interest. We may also share your information when needed to lessen a serious and imminent threat to health or safety.*

In these cases we *never* share your information unless you give us written permission:

- Marketing purposes
- Sale of your information

**Our Uses and Disclosures**

**How do we typically use or share your health information?**

We typically use or share your health information in the following ways.

**Help manage the health care treatment you receive**

We can use your health information and share it with professionals who are treating you.

*Example: A doctor sends us information about your diagnosis and treatment plan so we can arrange additional services.*

**Run our organization**

- We can use and disclose your information to run our organization and contact you when necessary.
- We are not allowed to use genetic information to decide whether we will give you coverage and the price of that coverage. This does not apply to long term care plans.

*Example: We use health information about you to develop better services for you.*

**Pay for your health services**

We can use and disclose your health information as we pay for your health services.

*Example: We share information about you with your dental plan to coordinate payment for your dental work.*

**Administer your plan**

We may disclose your health information to your health plan sponsor for plan administration.

*Example: Your company contracts with us to provide a health plan, and we provide your company with certain statistics to explain the premiums we charge.*

**How else can we use or share your health information?**

We are allowed or required to share your information in other ways – usually in ways that contribute to the public good, such as public health and research. We have to meet many conditions in the law before we can share your information for these purposes. For more information see: [www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/index.html](http://www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/index.html).

**Help with public health and safety issues**

We can share health information about you for certain situations such as:

- Preventing disease
Helping with product recalls
Reporting adverse reactions to medications
Reporting suspected abuse, neglect, or domestic violence
Preventing or reducing a serious threat to anyone’s health or safety

Do research

We can use or share your information for health research.

Comply with the law

We will share information about you if state or federal laws require it, including with the Department of Health and Human Services if it wants to see that we’re complying with federal privacy law.

Respond to organ and tissue donation requests and work with a medical examiner or funeral director

• We can share health information about you with organ procurement organizations.
• We can share health information with a coroner, medical examiner, or funeral director when an individual dies.

Address workers’ compensation, law enforcement, and other government requests

We can use or share health information about you:
• For workers’ compensation claims
• For law enforcement purposes or with a law enforcement official
• With health oversight agencies for activities authorized by law
• For special government functions such as military, national security, and presidential protective services

Respond to lawsuits and legal actions

We can share health information about you in response to a court or administrative order, or in response to a subpoena.

Our Responsibilities

• We are required by law to maintain the privacy and security of your protected health information.
• We will let you know promptly if a breach occurs that may have compromised the privacy or security of your information.
• We must follow the duties and privacy practices described in this notice and give you a copy of it.
• We will not use or share your information other than as described here unless you tell us we can in writing. If you tell us we can, you may change your mind at any time. Let us know in writing if you change your mind.

For more information see: www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/noticepp.html.

Changes to the Terms of this Notice

We can change the terms of this notice, and the changes will apply to all information we have about you. The new notice will be available upon request, on our web site, and we will mail a copy to you.
DEFINITIONS

Certain words and terms used herein shall be defined as follows and are shown in **bold and italics** throughout the document:

**Accident**

An unforeseen event resulting in *injury*.

**Adverse Benefit Determination**

*Adverse benefit determination* shall mean any of the following:

1. A denial in benefits.
3. A rescission of coverage, even if the rescission does not impact a current claim for benefits.
5. A failure to provide or make payment (in whole or in part) for a benefit, including any such denial, reduction, termination, or failure to provide or make payment that is based on a determination of a *covered person's* eligibility to participate in the *Plan*.
6. A denial, reduction, or termination of, or a failure to provide or make payment (in whole or in part) for, a benefit resulting from the application of any utilization review.
7. A failure to cover an item or service for which benefits are otherwise provided because it is determined to be *experimental/investigational* or not *medically necessary* or appropriate.

**Affordable Care Act**

The Patient Protection and Affordable Care Act, as amended by the Health Care and Education Reconciliation Act of 2010 and all applicable regulations and regulatory guidance.

**Air Mileage Rate**

A *contracted rate* expressed in dollars per loaded mile (statute miles not nautical miles) flown.

**Alternate Recipient**

Any child of an *employee* or their spouse who is recognized in a Qualified Medical Child Support Order (QMCSO) or National Medical Support Notice (NMSN) which has been issued by any court judgment, decree, or order as being entitled to enrollment for coverage under the *Plan*.

**Ambulatory Surgical Facility**

A *facility* provider with an organized staff of *physicians* which has been approved by the Joint Commission on the Accreditation of Healthcare Organizations, or by the Accreditation Association for Ambulatory Health, Inc., or by *Medicare*; or that has a contract with the *Preferred Provider Organization* as a *preferred provider*. An *ambulatory surgical facility* is a *facility* that:

1. Has permanent facilities and equipment for the purpose of performing surgical procedures on an *outpatient* basis;
2. Provides treatment by or under the supervision of physicians and nursing services whenever the covered person is in the ambulatory surgical facility;

3. Does not provide inpatient accommodations; and

4. Is not, other than incidentally, a facility used as an office or clinic for the private practice of a physician.

Anesthesia Conversion Factor

A median contracted rate expressed in dollars per unit.

Applied Behavioral Analysis (ABA)

A type of intensive behavioral therapy in which individuals trained in objective observation, evidence based assessment, data collection, and functional analyses utilize these data to produce meaningful changes in human behavior.

Approved Clinical Trial

A Phase I, Phase II, Phase III, or Phase IV clinical trial that is conducted in relation to the prevention, detection, or treatment of cancer or other “life-threatening disease or condition” and is further described in accordance with federal law and applicable federal regulations.

Autism Spectrum Disorder

A condition related to brain development that affects how a person perceives and socializes with others, causing problems in social interaction and communication. This disorder also includes limited and repetitive behavior.

Base Unit

For an anesthesia service code, base units are specified in the most recent edition (as of the date of service) of the American Society of Anesthesiologists Relative Value Guide.

Birthing Center

A facility that meets professionally recognized standards and complies with all licensing and other legal requirements that apply.

Certified IDR Entity

An entity responsible for conducting payment determinations, through the Federal independent dispute resolution process, that has been certified by the Secretaries of Labor, Health and Human Services and the Treasury.

Chiropractic Care

Services as provided by a licensed Chiropractor, M.D., or D.O. for manipulation or manual modalities in the treatment of the spinal column, neck, extremities or other joints, other than for a fracture or surgery.

Claims Processor

Refer to the Facts About the Plan section of this document.

Close Relative

The employee's spouse, children, brothers, sisters, or parents; or the children, brothers, sisters or parents of the employee's spouse.
**Coinsurance**

The benefit percentage of covered expenses payable by the Plan for benefits that are provided under the Plan. The coinsurance is applied to covered expenses after the deductible(s) have been met, if applicable.

**Complications of Pregnancy**

A disease, disorder or condition which is diagnosed as distinct from pregnancy, but is adversely affected by or caused by pregnancy. Some examples are:

1. Intra-abdominal surgery (but not elective Cesarean Section).
2. Ectopic pregnancy.
3. Toxemia with convulsions (Eclampsia).
4. Pernicious vomiting (hyperemesis gravidarum).
5. Nephrosis.
6. Cardiac Decompensation.
7. Missed Abortion.
8. Miscarriage.

These conditions are not included: false labor; occasional spotting; rest during pregnancy even if prescribed by a physician; morning sickness; or like conditions that are not medically termed as complications of pregnancy.

**Continuing Care Patient**

A covered person who, with respect to a preferred provider is:

1. Undergoing a course of treatment for a serious and complex condition from the preferred provider;
2. Undergoing a course of institutional or inpatient care from the preferred provider;
3. Scheduled to undergo nonelective surgery from the preferred provider, including postoperative care;
4. Pregnant and undergoing a course of treatment for the pregnancy from the preferred provider; or
5. Determined to be terminally ill with a life expectancy of 6 months or less, and is receiving treatment for such illness from the preferred provider.

**Contracted Rate**

The total amount (including cost sharing) that plan sponsors of self-funded plans administered by claims processor are contractually agreed to pay a preferred provider for covered expenses.

**Copay**

A cost sharing arrangement whereby a covered person pays a set amount to a provider for a specific service at the time the service is provided.

**Cosmetic Surgery**

Surgery for the restoration, repair, or reconstruction of body structures directed toward altering appearance.
Cost Sharing

The amount a covered person is responsible for paying for covered expenses. Cost sharing includes applicable copays, coinsurance and deductible. Cost sharing does not include balance billing by nonpreferred providers, or the cost of items or services that are not covered expenses.

Covered Expenses

Medically necessary services, supplies or treatments that are recommended or provided by a physician, professional provider or covered facility for the treatment of an illness or injury and that are not specifically excluded from coverage herein. Covered expenses shall include specified preventive care services.

Covered Person

A person who is eligible for coverage under the Plan, or becomes eligible at a later date, and for whom the coverage provided by the Plan is in effect.

Custodial Care

Care provided primarily for maintenance of the covered person or which is designed essentially to assist the covered person in meeting his activities of daily living and which is not primarily provided for its therapeutic value in the treatment of an illness or injury. Custodial care includes, but is not limited to: help in walking, bathing, dressing, feeding, preparation of special diets and supervision over self-administration of medications. Such services shall be considered custodial care without regard to the provider by whom or by which they are prescribed, recommended or performed.

Room and board and skilled nursing services are not, however, considered custodial care (1) if provided during confinement in an institution for which coverage is available under the Plan, and (2) if combined with other medically necessary therapeutic services, under accepted medical standards, which can reasonably be expected to substantially improve the covered person’s medical condition.

Customary and Reasonable Amount

The customary and reasonable amount will be (a) in the case of a health care provider, other than a professional provider, which does not have a written agreement with the claim administrator or another Blue Cross and/or Blue Shield Plan to provide care to participants in the benefit program, or is not designated as a preferred provider by any Blue Cross and/or Blue Shield Plan at the time covered services are rendered, the following amount:

(i) the lesser of (unless otherwise required by applicable law or arrangement with the nonpreferred provider) (a) the provider’s billed charges, and (b) an amount determined by the claim administrator to be approximately 100% of the base Medicare reimbursement rate, excluding any Medicare adjustment(s) which is/are based on information on the claim; or

(ii) if there is no base Medicare reimbursement rate available for a particular covered service, or if the base Medicare reimbursement amount cannot otherwise be determined under subsection (i) above based upon the information submitted on the claim, the lesser of (unless otherwise required by applicable law or arrangement with the nonpreferred provider) (a) the provider’s billed charges and (b) an amount determined by the claim administrator to be 150% of the negotiated rate that would apply if the services were rendered by a preferred professional provider on the date of service; or

(iii) if the base Medicare reimbursement amount and the customary and reasonable amount cannot be determined under subsections (i) or (ii) above, based upon the information submitted on the claim, then the amount will be 50% of the provider’s billed charges (unless otherwise required by applicable law or arrangement with the nonpreferred provider), provided, however, that the claim administrator may limit such amount to the lowest contracted rate that the claim administrator has with a preferred provider for the same or similar services based upon the type of provider and the information submitted on the claim, as of January 1 of the same year that the covered services are rendered to you.
The claim administrator will utilize the same claim processing rules, edits or methodologies that it utilizes in processing preferred provider claims for processing claims submitted by nonpreferred providers which may also alter the customary and reasonable amount for a particular service. In the event the claim administrator does not have any claim edits, rules or methodologies, the claim administrator may utilize the Medicare claim rules or edits that are used by Medicare in processing the claims. The customary and reasonable amount will not include any additional payments that may be permitted under the Medicare laws or regulations which are not directly attributable to a specific claim, including, but not limited to, disproportionate share payments and graduate medical education payments. In the event the customary and reasonable amount does not equate to the nonpreferred provider’s claim charge, you will be responsible for the difference between such amount and the claim charge, along with any applicable copay, coinsurance and deductible amount(s).

Any change to the Medicare reimbursement amount will be implemented by the claim administrator within one hundred and ninety (190) days after the effective date that such change is implemented by the Centers for Medicaid and Medicare Services, or its successor.

The customary and reasonable amount will be (b) in the case of nonpreferred professional providers, the lesser of (unless otherwise required by applicable law or arrangement with nonpreferred providers):

(i) the provider’s claim charge, or;

(ii) the claim administrator’s customary and reasonable amount. Except as otherwise provided in this section, the customary and reasonable amount is developed from base Medicare reimbursements and represents approximately 100% of the base Medicare reimbursement rate and will exclude any Medicare adjustment(s) which is/are based on information on the claim. Notwithstanding the preceding sentence, (1) the customary and reasonable amount for home health care covered services will be 50% of the nonpreferred professional provider’s standard claim charge for such covered services, (2) the customary and reasonable amount for ambulance services provided by providers (other than providers that bill through a preferred provider, which use a negotiated rate) will be such provider’s billed charge, and (3) the customary and reasonable amount for other unsolicited providers will be the same as the negotiated rate.

When a Medicare reimbursement rate is not available for a covered service or is unable to be determined based on the information submitted on the claim, the customary and reasonable amount for nonpreferred professional providers will be 100% of the claim administrator’s rate for such covered services according to its current schedule of maximum allowances. If there is no rate according to the schedule of maximum allowances, then the customary and reasonable amount will be 25% of claim charges.

The claim administrator will utilize the same claim processing rules, edits or methodologies that it utilizes in processing preferred professional provider claims for processing claims submitted by nonpreferred professional providers which may also alter the customary and reasonable amount for a particular covered service. In the event the claim administrator does not have any claim edits, rules or methodologies, the claim administrator may utilize the Medicare claim rules or edits that are used by Medicare in processing such claims. The customary and reasonable amount will not include any additional payments that may be permitted under the Medicare laws or regulations which are not directly attributable to a specific claim, including, but not limited to, disproportionate share payments and graduate medical education payments. In the event the customary and reasonable amount does not equate to the nonpreferred professional provider’s claim charge, you will be responsible for the difference between such amount and the claim charge, along with any applicable copay, coinsurance and deductible amount(s).

Any change to the Medicare reimbursement amount will be implemented by the claim administrator within one hundred and ninety (190) days after the effective date that such change is implemented by the Centers for Medicaid and Medicare Services, or its successor.

Covered expenses provided by a nonpreferred provider subject to the requirements specified in numbers 1., 2., or 3. in the Nonpreferred Provider subsection, under the Preferred Provider or Nonpreferred Provider section, are not subject to the customary and reasonable amount, but instead are subject to the lesser of the qualifying payment amount or the nonpreferred provider’s actual charge.
Dentist

A Doctor of Dental Medicine (D.M.D.), a Doctor of Dental Surgery (D.D.S.), a Doctor of Medicine (M.D.), or a Doctor of Osteopathy (D.O.), other than a close relative of the covered person, who is practicing within the scope of that Doctor’s license.

Dependent

Refer to the Eligibility, Enrollment and Effective Date, Dependent(s) Eligibility section for what constitutes a dependent.

Durable Medical Equipment

Medical equipment which:

1. Can withstand repeated use;
2. Is primarily and customarily used to serve a medical purpose;
3. Is generally not used in the absence of an illness or injury;
4. Is appropriate for use in the home.

All provisions of this definition must be met before an item can be considered durable medical equipment. Durable medical equipment includes, but is not limited to: crutches, wheel chairs, hospital beds, etc.

Effective Date

The date of the Plan or the date on which the covered person’s coverage commences, whichever occurs later.

Emergency Medical Condition

A medical condition, including a mental health disorder or substance use disorder, manifesting itself by acute symptoms of sufficient severity (including severe pain) so that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in:

1. Placing the covered person’s life (or with respect to a pregnant covered person, the health of the covered person or the pregnant covered person’s unborn child) in serious jeopardy, or
2. Causing serious impairment to bodily functions, or
3. Causing serious dysfunction of any bodily organ or part.

Emergency Services

1. With respect to an emergency medical condition, a medical screening examination that is within the capability of the emergency department of a hospital, or of an independent freestanding emergency department, including ancillary services routinely available to the emergency department to evaluate such emergency medical condition, and such further medical examination and treatment, to the extent they are within the capabilities of the staff and facilities available at a hospital or an independent freestanding emergency department, as are required to stabilize the patient; and
2. Additional items and services,
   a. For which benefits are provided or covered under this Plan; and
   b. That are furnished by a nonpreferred provider (regardless of the department of the hospital or independent freestanding emergency department in which such items or services are furnished) after the covered person is stabilized and as part of outpatient observation or an inpatient or outpatient
stay with respect to the visit in which the services provided by the emergency department are furnished; however, such items and services shall not be included as emergency services if:

i. The attending physician or treating provider determines that the covered person is able to travel using nonmedical transportation or nonemergency medical transportation to an available preferred provider or facility located within a reasonable travel distance, taking into account the individual’s medical condition;

ii. Notice and Consent Criteria is satisfied, as specified in section, Preferred Provider or Nonpreferred Provider, under number 6. of subsection Nonpreferred Provider; and

iii. The covered person (or an authorized representative) is in a condition to receive the notice and consent described in the Notice and Consent Criteria as determined by the attending emergency physician or treating provider using appropriate medical judgement, and to provide informed consent in accordance with applicable law.

Employee

A person directly involved in the regular business of and compensated for services, as reported on the individual's annual W-2 form, by the employer, who is regularly scheduled to work not less than the hours per week as listed in the section titled Eligibility, Enrollment and Effective Date, Employee Eligibility on a full-time status basis.

Employer

The employer is Mesquite ISD.

Essential Health Benefits

Those benefits identified by the U.S. Secretary of Health and Human Services, including benefits for covered expenses incurred for the following services:

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. Habilitative services, rehabilitative services and habilitative and rehabilitative devices;
8. Laboratory services;
9. Preventive and wellness services and chronic disease management;
10. Pediatric services, including oral and vision care.

Experimental/Investigational

Services, supplies, drugs and treatment which do not constitute accepted medical practice properly within the range of appropriate medical practice under the standards of the case and by the standards of a reasonably substantial, qualified, responsible, relevant segment of the medical community or government oversight agencies at the time services were rendered.

The claims processor, employer/plan administrator, or their designee must make an independent evaluation of the experimental/non-experimental standings of specific technologies. The claims processor, employer/plan administrator or their designee shall be guided by a reasonable interpretation of Plan provisions and information provided by qualified independent vendors who have also reviewed the information provided. The decisions shall be made in good faith and rendered following a factual background investigation of the claim and the proposed treatment. The claims processor, employer/plan administrator or their designee will be guided by the following examples of experimental services and supplies:
1. If the drug or device cannot be lawfully marketed without approval of the U.S. Food and Drug Administration and approval for marketing has not been given at the time the drug or device is furnished; or

2. If the drug, device, medical treatment or procedure, was not reviewed and approved by the treating facility’s institutional review board or other body serving a similar function, or if federal law requires such review or approval; or

3. If “reliable evidence” shows that the drug, device, medical treatment or procedure is the subject of on-going Phase I or Phase II clinical trials, is in the research, experimental, study or investigational arm of on-going Phase III clinical trials, or is otherwise under study to determine its maximum tolerated dose, its toxicity, its safety, or its efficacy as compared with a standard means of treatment or diagnosis; or

4. If “reliable evidence” shows that prevailing opinion among experts regarding the drug, device, medical treatment or procedure is that further studies or clinical trials are necessary to determine its maximum tolerated dose, its toxicity, its safety, or its efficacy as compared with standard means of treatment or diagnosis.

“Reliable evidence” shall mean only published reports and articles in the authoritative medical and scientific literature; the written protocol or protocols used by the treating facility or the protocol(s) of another facility studying substantially the same drug, device, medical treatment or procedure; or the written informed consent used by the treating facility or by another facility studying substantially the same drug, device, medical treatment or procedure.

Extended Care Facility

An institution, or distinct part thereof, operated pursuant to law and one which meets all of the following conditions:

1. It is licensed to provide, and is engaged in providing, on an inpatient basis, for persons convalescing from illness or injury, professional nursing services, and physical restoration services to assist covered persons to reach a degree of body functioning to permit self-care in essential daily living activities. Such services must be rendered by a Registered Nurse or by a Licensed Practical Nurse under the direction of a Registered Nurse.

2. Its services are provided for compensation from its covered persons and under the full-time supervision of a physician or Registered Nurse.

3. It provides twenty-four (24) hour-a-day nursing services.

4. It maintains a complete medical record on each covered person.

5. It is not, other than incidentally, a place for rest, a place for the aged or a place for custodial or educational care.

6. It is approved and licensed by Medicare.

This term shall also apply to expenses incurred in an institution referring to itself as a skilled nursing facility, convalescent nursing facility, or any such other similar designation.

Facility

A healthcare institution which meets all applicable state or local licensure requirements.

Final Internal Adverse Benefit Determination

An adverse benefit determination that has been upheld by this Plan at the conclusion of the internal claim and appeal process, or an adverse benefit determination with respect to which the internal claim and appeal process has been deemed exhausted.
Foster Child

A child who is placed with the employee by an authorized placement agency or by judgment, decree, or other order of any court of competent jurisdiction.

Full-time

Employees who are regularly scheduled to work not less than the hours per work week as listed in the section titled Eligibility, Enrollment and Effective Date, Employee Eligibility.

Generic Drug

A prescription drug that is generally equivalent to a higher-priced brand name drug with the same use and metabolic disintegration. The drug must meet all Federal Drug Administration (FDA) bioavailability standards and be dispensed according to the professional standards of a licensed pharmacist or physician and must be clearly designated by the pharmacist or physician as generic.

Habilitative and Rehabilitative Devices

Medically necessary devices that are designed to assist a covered person in acquiring, improving, or maintaining, partially or fully, skills and functioning for daily living. Such devices include, but are not limited to, durable medical equipment, orthotics, prosthetics, and low vision aids.

Habilitative Services

Medically necessary health care services that help a covered person keep, learn or improve skills and functioning for daily living. Examples of habilitative services include therapy for a dependent child who is not walking or talking at the expected age. These services may include physical and occupational therapy, speech-language pathology and other medically necessary services for people with disabilities in a variety of inpatient and/or outpatient settings. Habilitative services that are not medically necessary, for example when therapy has reached an end point and goals have been reached, will not be a covered expense.

Health Care Management Organization

The individual or organization designated by the employer for the process of evaluating whether the service, supply, or treatment is medically necessary. The Health Care Management Organization may be contacted by calling the telephone number for pre-certification found on the covered person’s ID card.

Home Health Aide Services

Services which may be provided by a person, other than a Registered Nurse, which are medically necessary for the proper care and treatment of a person.

Home Health Care Agency

An agency or organization which meets fully every one of the following requirements:

1. It is primarily engaged in and duly licensed, if licensing is required, by the appropriate licensing authority, to provide skilled nursing and other therapeutic services.
2. It has a policy established by a professional group associated with the agency or organization to govern the services provided. This professional group must include at least one physician and at least one Registered Nurse. It must provide for full-time supervision of such services by a physician or Registered Nurse.
3. It maintains a complete medical record on each covered person.
4. It has a full-time administrator.
5. It qualifies as a reimbursable service under Medicare.
**Hospice**

An agency that provides counseling and medical services and may provide *room and board* to a terminally ill *covered person* and which meets all of the following tests:

1. It has obtained any required state or governmental Certificate of Need approval.
2. It provides service twenty-four (24) hours-per-day, seven (7) days a week.
3. It is under the direct supervision of a *physician*.
4. It has a Nurse coordinator who is a Registered Nurse.
5. It has a social service coordinator who is licensed.
6. It is an agency that has as its primary purpose the provision of *hospice* services.
7. It has a full-time administrator.
8. It maintains written records of services provided to the *covered person*.
9. It is licensed, if licensing is required.

**Hospital**

An institution which meets the following conditions:

1. It is licensed and operated in accordance with the laws of the jurisdiction in which it is located which pertain to *hospitals*.
2. It is engaged primarily in providing medical care and treatment to *ill* and *injured* persons on an *inpatient* basis at the *covered person’s* expense.
3. It maintains on its premises all the facilities necessary to provide for the diagnosis and medical and surgical treatment of an *illness* or *injury*; and such treatment is provided by or under the supervision of a *physician* with continuous twenty-four (24) hour nursing services by or under the supervision of Registered Nurses.
4. It qualifies as a *hospital* and is accredited by the Joint Commission on the Accreditation of Healthcare Organizations. This condition may be waived in the case of treatment for an *emergency medical condition* in a *hospital* outside of the United States.
5. It must be approved by *Medicare*. This condition may be waived in the case of treatment for an *emergency medical condition* in a *hospital* outside of the United States.

Under no circumstances will a *hospital* be, other than incidentally, a place for rest, a place for the aged, or a nursing home.

*Hospital* shall include a facility designed exclusively for physical *rehabilitative services* where the *covered person* received treatment as a result of an *illness* or *injury*.

The term *hospital*, when used in conjunction with *inpatient confinement* for *mental health disorders* or *substance use disorders*, will be deemed to include an institution which is licensed as a mental *hospital* or *substance use disorder* rehabilitation and/or detoxification *facility* by the regulatory authority having responsibility for such licensing under the laws of the jurisdiction in which it is located.

**Illness**

A bodily disorder, disease, physical sickness, or *pregnancy* of a *covered person*. 
Incurred or Incurred Date

With respect to a covered expense, the date the services, supplies or treatment are provided.

Independent Freestanding Emergency Department

A health care facility that is geographically separate and distinct and licensed separately from a hospital under applicable State law and provides emergency services.

Injury

A physical harm or disability which is the result of a specific incident caused by external means. The physical harm or disability must have occurred at an identifiable time and place. Injury does not include illness or infection of a cut or wound.

Inpatient

A confinement of a covered person in a hospital, hospice, or extended care facility as a registered bed patient, for twenty-three (23) or more consecutive hours and for whom charges are made for room and board.

Intensive Care

A service which is reserved for critically and seriously ill covered persons requiring constant audio-visual surveillance which is prescribed by the attending physician.

Intensive Care Unit

A separate, clearly designated service area which is maintained within a hospital solely for the provision of intensive care. It must meet the following conditions:

1. Facilities for special nursing care not available in regular rooms and wards of the hospital;
2. Special life saving equipment which is immediately available at all times;
3. At least two beds for the accommodation of the critically ill; and
4. At least one Registered Nurse in continuous and constant attendance twenty-four (24) hours-per-day.

This term does not include care in a surgical recovery room, but does include cardiac care unit or any such other similar designation.

Intensive Outpatient Treatment

An outpatient substance use disorder program that operates a minimum of (3) three hours per day at least (3) three days per week, which includes an individualized treatment plan consisting of assessment, counseling, crisis intervention, and activity therapies or education.

Late Enrollee

A covered person who did not enroll in the Plan when first eligible or as the result of a special enrollment period.

Layoff

A period of time during which the employee, at the employer's request, does not work for the employer, but which is of a stated or limited duration and after which time the employee is expected to return to full-time, active work. Layoffs will otherwise be in accordance with the employer's standard personnel practices and policies.
Leave of Absence

A period of time during which the employee does not work, but which is of a stated duration after which time the employee is expected to return to active work.

Maximum Benefit [for Essential Health Benefits/non-Essential Health Benefits]

Any one of the following, or any combination of the following Essential Health Benefits/non-Essential Health Benefits:

1. The maximum amount paid by the Plan for any one covered person during the entire time the covered person is covered by the Plan.

2. The maximum amount paid by the Plan for any one covered person for a particular covered expense. The maximum amount can be for:
   a. The entire time the covered person is covered under the Plan, or
   b. A specified period of time, such as a plan year.

3. The maximum number as outlined in the Plan as a covered expense. The maximum number relates to the number of:
   a. Treatments during a specified period of time, or
   b. Days of confinement, or
   c. Visits by a home health care agency.

The maximum benefit for Essential Health Benefits and non-Essential Health Benefits is tracked separately.

Measurement Period

The period of time, as determined by the employer and consistent with Federal law, regulation and guidance, utilized by the employer to determine whether a variable hour employee worked on average thirty (30) hours per week for the employer.

Median Contracted Rate

The rate calculated by arranging in order from least to greatest all of the contracted rates in a geographic area for the same or similar item or service that is provided by a provider or facility in the same or similar specialty or facility type, and selecting the middle number. If there are an even number of contracted rates, the median contracted rate is the average of the middle two contracted rates. Median contracted rates are:

a. calculated separately for CPT code modifiers 26 (professional component) and TC (technical component);

b. based on an anesthesia conversion factor for each anesthesia service code;

c. based on air mileage service codes (A0435 and A0436) for air ambulance services; and

d. calculated separately for each service code-modifier, when contracted rates vary based on application of a modifier.

Medically Necessary (or Medical Necessity)

Service, supply or treatment which is determined by the claims processor, employer/plan administrator (or its designee) to be:
1. Appropriate and consistent with the symptoms and provided for the diagnosis or treatment of the covered person's illness or injury and which could not have been omitted without adversely affecting the covered person's condition or the quality of the care rendered; and

2. Supplied or performed in accordance with current standards of medical practice within the United States; and

3. Not primarily for the convenience of the covered person or the covered person's family or professional provider; and

4. Is an appropriate supply or level of service that safely can be provided; and

5. Is recommended or approved by the attending professional provider.

The fact that a professional provider may prescribe, order, recommend, perform or approve a service, supply or treatment does not, in and of itself, make the service, supply or treatment medically necessary and the claims processor, employer/plan administrator (or its designee), may request and rely upon the opinion of a physician or physicians. The determination of the claims processor, employer/plan administrator (or its designee) shall be final and binding.

Medicare

The programs established by Title XVIII known as the Health Insurance for the Aged Act, which includes: Part A, Hospital Benefits For The Aged; Part B, Supplementary Medical Insurance Benefits For The Aged; Part C, Miscellaneous provisions regarding both programs; and Part D, Medicare Prescription Drug Benefit, including any subsequent changes or additions to those programs.

Mental Health Disorder

An emotional or mental condition characterized by abnormal functioning of the mind or emotions. Diagnosis and classifications of these conditions will be determined based on standard DSM (diagnostic and statistical manual of mental disorders) or the current edition of International Classification of Diseases, published by the U.S. Department of Health and Human Services.

Negotiated Rate

The rate the preferred providers have contracted to accept as payment in full for covered expenses of the Plan.

Nonparticipating Pharmacy

Any pharmacy, including a hospital pharmacy, physician or other organization, licensed to dispense prescription drugs which does not fall within the definition of a participating pharmacy.

Nonpreferred Provider

A physician, hospital, or other health care provider who does not have an agreement in effect with the Preferred Provider Organization at the time services are rendered.

Nurse

A licensed person holding the degree Registered Nurse (R.N.), Licensed Practical Nurse (L.P.N.), Licensed Vocational Nurse (L.V.N.) or Doctorate of Nursing Practice (D.N.P.) who is practicing within the scope of their license.

Out-of-Network Rate

The final payment amount under this Plan for covered expenses from a nonpreferred provider is:

1. Subject to number 3. below, in a State that has in effect an applicable specified State law, the amount determined in accordance with such law.
2. Subject to number 3. below, if no applicable specified State law:
   a. Subject to number 2.b. below, the agreed amount if the nonpreferred provider and this Plan agree on an amount of payment (including if the amount agreed upon is the initial amount paid by this Plan or is agreed through negotiations); or
   b. The amount determined by the certified IDR entity.

3. In a State that has an all-payer model agreement that applies to this Plan, the provider, and the item or service, the amount that the State approves under the all-payer model agreement for that item or service.

**Outpatient**

A covered person shall be considered to be an outpatient if the covered person is treated at:

1. A hospital as other than an inpatient;
2. A physician's office, laboratory or x-ray facility; or
3. An ambulatory surgical facility; and

The stay is less than twenty-three (23) consecutive hours.

**Partial Confinement**

A period of at least six (6) hours but less than twenty-four (24) hours per day of active treatment up to five (5) days per week in a facility licensed or certified by the state in which treatment is received to provide one or more of the following:

1. Psychiatric services.
2. Treatment of mental health disorders.

It may include day, early evening, evening, night care, or a combination of these four.

**Participating Pharmacy**

Any pharmacy licensed to dispense prescription drugs which is contracted with the pharmacy benefit manager.

**Pharmacy Benefit Manager**

The pharmacy benefit manager is Prime Therapeutics.

**Physical Status Modifier**

The standard modifier describing the physical status of the patient used to distinguish between various levels of complexity of an anesthesia service provided expressed as a unit with a value between zero (0) and three (3).

**Physician**

A Doctor of Medicine (M.D.) or a Doctor of Osteopathy (D.O.), other than a close relative of the covered person who is practicing within the scope of his license.

**Placed For Adoption**

The date the employee assumes legal obligation for the total or partial financial support of a child during the adoption process.
Plan

"Plan" refers to the benefits and provisions for payment of same as described herein. The Plan is the Mesquite ISD Employee Health Care Benefit Plan.

Plan Administrator

The plan administrator is responsible for the day-to-day functions and management of the Plan. The plan administrator is the employer.

Plan Sponsor

The plan sponsor is Mesquite ISD.

Preferred Provider

A physician, facility or other health care provider who has an agreement in effect with the Preferred Provider Organization at the time services are rendered. Preferred providers agree to accept the negotiated rate as payment in full.

Preferred Provider Organization

The organization, designated by the plan administrator, who selects and contracts with certain hospitals, physicians, and other health care providers to provide services, supplies and treatment to covered persons at a negotiated rate. The Preferred Provider Organization’s name and/or logo is shown on the front of the covered person’s ID card.

Pregnancy

The physical state which results in childbirth or miscarriage.

Primary Care Physician (PCP)

A licensed Doctor of Medicine (M.D.) or Doctor of Osteopathy (D.O.) who is a general or family practitioner, pediatrician, gynecologist/obstetrician or general internist.

Prior Plan

Any plan of group accident and health benefits provided by the employer (or its predecessor) for an employee group which has been replaced by coverage under this Plan.

Privacy Rule


Professional Provider

A licensed physician; surgeon; or any other licensed practitioner required to be recognized by state law, if applicable, and performing services within the scope of such license, who is not a family member.

Qualified Prescriber

A physician, dentist or other health care practitioner other than a close relative of the covered person who may, in the legal scope of their license, prescribe drugs or medicines.
**Qualifying Payment Amount**

a. For items or services furnished during 2022, the *median contracted rate* on January 31, 2019;

b. For items or services furnished after 2022, the *median contracted rate* in the immediately preceding year;

c. For items or services for which there is insufficient information to calculate the *median contracted rate*, the *qualifying payment amount* will be calculated by identifying the rate that is equal to the median of the *negotiated rates* for the same or similar item or service provided in the geographic region in the year immediately preceding the year in which the item or service is furnished determined through the use of any eligible database;

The amount in a., b., or c. above is increased for inflation in accordance with the CPI-U published by the Bureau of Labor Statistics of the Department of Labor.

d. For items or services furnished during 2022 and billed under a new service code where there is insufficient information to calculate the *median contracted rates*, a reasonably related service code that existed in the immediately preceding year will be identified.

i. If the Centers for Medicare & Medicaid Services has established a Medicare payment rate for the item or service billed under the new service code, the *qualifying payment amount* will be calculated by first calculating the ratio of the rate that Medicare pays for the new service code compared to the rate that Medicare pays for the related service code. This ratio is then multiplied by the *qualifying payment amount* for the related service code for the year in which the item or service is furnished.

ii. If the Centers for Medicare & Medicaid Services has not established a Medicare payment rate for the item or service billed under the new service code, the *qualifying payment amount* will be calculated by first calculating the ratio of the rate that this Plan reimburses for the new service code compared to the rate this Plan reimburses for the related service code. This ratio is then multiplied by the *qualifying payment amount* for the related service code.

e. For items or services furnished after 2022 and billed under a new service code, the *qualifying payment amount* described in letter d. above will be increased for inflation in accordance with the percentage increase in the CPI-U published by federal regulators.

f. For anesthesia services furnished during 2022, the *median contracted rate* for the anesthesia conversion factor on January 31, 2019 increased for inflation in accordance with the increase in the CPI-U published by federal regulators (referred to as the indexed *median contracted rate* for the anesthesia conversion factor), multiplied by the sum of the base unit, time unit (measured in 15-minute increments or a fraction thereof), and physical status modifier unit. For anesthesia services furnished during 2023 or later, the indexed *median contracted rate* for the anesthesia conversion factor will be based on the same or similar item or service in the immediately preceding year.

g. For air ambulance services billed using air mileage service codes (A0435 and A0436), the *median contracted rate* increased for inflation in accordance with the increase in the CPI-U published by federal regulators (referred to as the indexed median air mileage rate), multiplied by the number of loaded miles (the number of miles a patient is transported in the air ambulance vehicle). The *qualifying payment amount* for other service codes associated with air ambulance services is calculated consistent with a. through e above.

h. For any other items or services where payment is determined by multiplying a contracted rate by another unit value, the *qualifying payment amount* for such items or services will be based on a calculation methodology similar to f. and g. above.
Recognized Amount

With respect to covered expenses furnished by a nonpreferred provider:

(a) Subject to letter c. of this definition, in a State that has in effect an applicable specified State law, the amount determined in accordance with such law;

(b) Subject to letter c. of this definition, in a State that does not have in effect an applicable specified State law, the lesser of:
   (i) The provider’s actual charge; or
   (ii) The qualifying payment amount;

(c) In a State that has an all-payer model agreement that applies to this Plan, the provider, and the item or service, the amount that the State approves under the all-payer model agreement for that item or service.

Reconstructive Surgery

Surgical repair of abnormal structures of the body, caused by congenital defects, developmental abnormalities, trauma, infection, tumors or disease.

Rehabilitative Services

Medically necessary health care services that help a covered person get back, keep, or improve skills for daily living that have been lost or impaired after sickness, injury, or disability. These services assist individuals in improving or maintaining, partially or fully, skills and functioning for daily living. Rehabilitative services include, but are not limited to, physical therapy, occupational therapy, speech-language pathology and audiology, and psychiatric rehabilitation.

Relevant Information

Relevant information, when used in connection with a claim for benefits or a claim appeal, means any document, record or other information:

1. Relied on in making the benefit determination; or

2. That was submitted, considered or generated in the course of making a benefit determination, whether or not relied upon; or

3. That demonstrates compliance with the duties to make benefit decisions in accordance with Plan documents and to make consistent decisions; or

4. That constitutes a statement of policy or guidance for the Plan concerning the denied treatment or benefit for the covered person’s diagnosis, even if not relied upon.

Required By Law

The same meaning as the term “required by law” as defined in 45 CFR 164.501, to the extent not preempted by ERISA or other Federal law.

Retail Clinic

A clinic whose primary function is to provide limited routine medical services in a retail-based store location staffed with licensed professional providers.

Room and Board

Room and linen service, dietary service, including meals, special diets and nourishments, and general nursing service. Room and board does not include personal items.
**Semiprivate**

The daily *room and board* charge which a *facility* applies to the greatest number of beds in its *semiprivate* rooms containing two (2) or more beds.

**Serious and Complex Condition**

In the case of an acute *illness*, a condition that is serious enough to require specialized medical treatment to avoid the reasonable possibility of death or permanent harm. In the case of a chronic *illness* or condition, a condition that:

1. Is life-threatening, degenerative, potentially disabling, or congenital; and
2. Requires specialized medical care over a prolonged period of time.

**Stability Period**

The period of time as determined by the *employer* and consistent with Federal law, regulation and guidance, after the *measurement period* has been completed.

**Stabilize**

To provide medical treatment of an *emergency medical condition* as necessary, to assure within reasonable medical probability, that no material deterioration of the condition is likely to result from or occur during the transfer of the *covered person* from a *facility*, including delivery with respect to a pregnant woman who is having contractions.

**Substance Use Disorder**

Any disease or condition that is classified as a *substance use disorder* in the current edition of the International Classification of Diseases, in effect at the time services are rendered. The fact that a disorder is listed in the International Classification of Diseases or any other publication does not mean that treatment of the disorder is covered by this *Plan*.

**Telemedicine Services**

Telephone or web-based video consultations and health information provided by a state licensed *physician*. Such services include telebehavioral health or *mental health disorder* health services provided by a *physician* or other licensed provider.

**Telemedicine Services Vendor**

The *telemedicine services vendor* is Teladoc.

**Total Disability or Totally Disabled**

The *employee* is prevented from engaging in the *employee’s* regular, customary occupation due to *illness* or *accident*, and is performing no work of any kind for compensation or profit; or a *dependent* is prevented from engaging in all of the normal activities of a person of like age and sex who is in good health due to *illness* or *accident*.

**Treatment Center**

1. An institution which does not qualify as a *hospital*, but which does provide a program of effective medical and therapeutic treatment for *substance use disorder*, and
2. Where coverage of such treatment is mandated by law, has been licensed and approved by the regulatory authority having responsibility for such licensing and approval under the law, or
3. Where coverage of such treatment is not mandated by law, meets all of the following requirements:
   a. It is established and operated in accordance with the applicable laws of the jurisdiction in which it is located.
b. It provides a program of treatment approved by the physician.

c. It has or maintains a written, specific, and detailed regimen requiring full-time residence and full-time participation by the covered person.

d. It provides at least the following basic services:

   (i.) *Room and board*

   (ii.) Evaluation and diagnosis

   (iii.) Counseling

   (iv.) Referral and orientation to specialized community resources.

**Urgent Care**

An emergency medical condition or an onset of severe pain that cannot be managed without immediate treatment.

**Urgent Care Center**

A facility which is engaged primarily in providing minor emergency and episodic medical care and which has:

1. a board-certified physician, a Registered Nurse (RN) and a registered x-ray technician in attendance at all times;

2. has x-ray and laboratory equipment and life support systems.

An urgent care center may include a clinic located at, operated in conjunction with, or which is part of a regular hospital.

**Variable Hour Employee**

An employee as defined by Federal law, regulation and guidance.