Kyrene School District

Kyrene Employee Benefit Trust
Summary Plan Description

Effective
July 1, 2024

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SECTION I—INTRODUCTION

This document is a description of the Kyrene Employee Benefit Trust (*Plan*). No oral interpretations can change this *Plan*. The *Plan* described is designed to protect *plan participants* against certain catastrophic health expenses. Terms which have special meanings when used in this *Plan* will be italicized. For a list of these terms and their meanings, please see the **Defined Terms** section of the Summary Plan Description (SPD). The failure of a term to appear in italics does not waive the special meaning given to that term, unless the context requires otherwise.

The *employer* fully intends to maintain this *Plan* indefinitely. However, it reserves the right to terminate, suspend, discontinue, or amend the *Plan* at any time and for any reason.

Changes in the *Plan* may occur in any or all parts of the *Plan* including benefit coverage, *deductibles*, maximums, *co-payments*, exclusions, limitations, defined terms, eligibility, and the like.

This *Plan* is not a 'grandfathered health plan' under the *Plan Protection and Affordable Care Act (PPACA)*, also known as Health Care Reform. Questions regarding the *Plan's* status can be directed to the *Plan Administrator*. You may also contact the Employee Benefits Security Administration, U.S. Department of Labor at 1-866-444-3272, or visit **www.dol.gov/ebsa/healthreform**.

Failure to follow the eligibility or enrollment requirements of this *Plan* may result in delay of coverage or no coverage at all. Reimbursement from the *Plan* can be reduced or denied because of certain provisions in the *Plan*, such as coordination of benefits, subrogation, exclusions, timeliness of Consolidated Omnibus Budget Reconciliation Act of 1985, as amended (COBRA) elections, utilization review or other cost management requirements, lack of *medical necessity*, lack of timely filing of *claims*, or lack of coverage. These provisions are explained in summary fashion in this document. Additional information is available from the *Plan Administrator* at no extra cost.

Read your benefit materials carefully. Before you receive any services, you need to understand what is covered and excluded under your benefit *Plan*, your cost sharing obligations, and the steps you can take to minimize your out-of-pocket costs. For complete terms of the *Plan* and information about benefits which are not outlined in this summary plan description, refer to your *Plan's* wrap document, which can be obtained from your Human Resources representative. If there is any conflict between this summary plan description and the *Plan's* wrap document, this document will control, unless otherwise specified.

Review your *Explanation of Benefits* (*EOB*) forms, other *claim* related information, and available *claims* history. *Notify* the *Third Party Administrator* of any discrepancies or inconsistencies between amounts shown and amounts you actually paid.

The *Plan* will pay benefits only for the expenses *incurred* while this coverage is in force. No benefits are payable for expenses *incurred* before coverage began or after coverage terminates. An expense for a service or supply is *incurred* on the date the service or supply is furnished.

No action at law or in equity shall be brought to recover under any section of this *Plan* until the *appeal* rights provided have been exercised and the *Plan* benefits requested in such *appeals* have been denied in whole or in part.

If the *Plan* is terminated or amended, or if benefits are eliminated, the rights of *plan participants* are limited to *covered charges incurred* before termination, amendment, or elimination.

A *plan participant* should contact the *Plan Administrator* to obtain additional information, free of charge, about *Plan* coverage of a specific benefit, particular drug, treatment, test, or any other aspect of *Plan* benefits or requirements.

Spanish (Español): Para obtener asistencia en Español, llame al 1-855-961-5408.

A. Quick Reference Information Chart

For Help or Information

When you need information, please check this document first. If you need further help, call the appropriate phone number listed in the following Quick Reference Information Chart:

QUICK REFERENCE INFORMATION	
Information Needed	**Whom to Contact**
Plan Administrator	Kyrene School District 8700 S. Kyrene Rd. Tempe, AZ 85284 1-480-541-1302

Medical Claims Administrator/Third Party Administrator (Medical and Dialysis) • *Claim* Forms (Medical) • Medical *Claims* • First and Second-Level *Appeals* of Post-Service *Claims* • Eligibility for Coverage • Plan Benefit Information	AmeriBen P.O. Box 7186 Boise, ID 83707 1-855-961-5401 **https://kyrene.myameriben.com**
Medical Management Administrator • *Pre-Certification*, Concurrent Review, and Case Management • First and Second-Level *Appeals* of Pre-Service *Claims*	AmeriBen Medical Management P.O. Box 7186 Boise, ID 83707 1-855-961-5401
PPO Provider Network Names of *Physicians* & *Hospitals* • Network Provider Directory – see website	Blue Cross Blue Shield of Arizona 1-855-961-5408 **https://kyrene.myameriben.com**
Pharmacy Benefits Manager • Retail *Network Pharmacies* • Mail Order (Home Delivery) *Pharmacy* • *Prescription Drug* Information & *Formulary* • Preauthorization of Certain Drugs • Reimbursement for *Non-Network* Retail *Pharmacy* Use • Specialty Pharmacy Program	**Retail & Mail Order** MedOne 1590 University Ave. Dubuque, IA 52001 Phone: 1-866-335-9057 Fax: 1-563-588-8725 Email: **memberadvocates@medone-rx.com** **www.medone-rx.com** **Specialty** VIVIO Health 1-800-470-4034 **www.myVIVIO.com**
Employee Assistance Program (EAP) • Lyra Health	Lyra Health 1-877-203-9680 **https://kyrene.lyrahealth.com**
HSA/FSA/DCAP Vendor • HSA/FSA/DCAP/Limited flexible spending account	Optum Bank 1-877-470-1771 **www.optumbank.com**
COBRA Administrator • Continuation Coverage	AmeriBen P.O. Box 7565 Boise, ID 83707 Phone: 1-855-961-5401 Fax: 1-208-424-0595

B. Plan Administrator

The *employer* is the *Plan Administrator*. The name, address, and telephone number of the *Plan Administrator* are:

Kyrene School District
8700 S. Kyrene Rd.
Tempe, AZ 85284
1-480-541-1302

An individual or entity may be appointed by the *Plan Sponsor* to be *Plan Administrator* and serve at the convenience of the *Plan Sponsor*. If the *Plan Administrator* resigns, dies, is otherwise unable to perform, is dissolved, or is removed from the position, the *Plan Sponsor* shall appoint a new *Plan Administrator* as soon as reasonably possible.

The *Plan Administrator* shall administer this *Plan* in accordance with its terms and establish its policies, interpretations, practices, and procedures. It is the express intent of this *Plan* that the *Plan Administrator* shall have maximum legal discretionary authority to construe and interpret the terms and provisions of the *Plan*, to make

determinations regarding issues which relate to eligibility for benefits (including the determination of what services, supplies, care, and treatments are *experimental/investigational*), to decide disputes which may arise relative to a *plan participant's* rights, and to decide questions of *Plan* interpretation and those of fact relating to the *Plan*. The decisions of the *Plan Administrator* as to the facts related to any *claim* for benefits and the meaning and intent of any provision of the *Plan*, or its application to any *claim*, shall receive the maximum deference provided by law and will be final and binding on all interested parties. Benefits under this *Plan* will be paid only if the *Plan Administrator* decides, in its discretion, that the *plan participant* is entitled to them.

Service of legal process may be made upon the *Plan Administrator*.

C. Type of Administration

The *Plan* is a self-funded group health plan, and the *claims* administration is provided through a *Third Party Administrator*. The *Plan* is not insured.

D. Employer Information

The *employer's* legal name, address, telephone number, and federal Employer Identification Number are:

Kyrene Elementary School District
8700 S. Kyrene Rd.
Tempe, AZ 85284
1-480-541-1302
EIN 86-6000494

E. Plan Effective Date

July 1, 2024

F. Trustees

Kyrene Employee Benefit Trust
8700 S. Kyrene Rd.
Tempe, AZ 85284
1-480-541-1302

G. Third Party Administrator

The *Plan Administrator* has contracted with a *Third Party Administrator* (*TPA*) to assist the *Plan Administrator* with *claims* adjudication. The *TPA's* name, address, and telephone number are:

AmeriBen
P.O. Box 7186
Boise, ID 83707
1-855-961-5401

A *Third Party Administrator* is **not** a *fiduciary* under the *Plan*, except to the extent otherwise agreed upon in writing.

SECTION II—ELIGIBILITY, EFFECTIVE DATE, AND TERMINATION PROVISIONS

A. Eligibility

Eligible Classes of Employees

1. All *active employees* of the *employer*.
2. Current and former Governing Board Members who meet eligibility provisions as outlined in the Kyrene Governing Board Policy BIE.

   Surviving spouse and *dependents* of governing board members are covered under the surviving spouse's Social Security number.

Eligibility Requirements for Employee Coverage

A person is eligible for *employee* coverage from the first day that the *employee*:

1. is a full-time, *active employee* of the *employer*

   An *employee* is considered to be full-time if they normally work at least thirty (30) hours per week and are on the regular payroll of the *employer* for that work.

2. is in a class eligible for coverage, as shown above

3. completes the employment *waiting period* of sixty (60) consecutive days as an active *employee*

   A *waiting period* is the time between the first day of *active employment* and the first day of coverage under the *Plan*.

Effective Date of Employee Coverage

An *employee* will be covered under this *Plan* following the date that the *employee* satisfies all of the following:

1. the eligibility requirement
2. the active *employee* requirement
3. the enrollment requirements of the *Plan*, as shown in the Enrollment subsection

Active Employee Requirement

An *employee* must be an active *employee* (as defined by this *Plan*) for this coverage to take effect.

Eligible Classes of Dependents

A *dependent* is any of the following persons:

1. a covered *employee's* spouse

   The term 'spouse' shall mean the person recognized as the covered *employee's* legally married husband or wife and does not include common law marriages. The *Plan Administrator* may require documentation proving a legal marital relationship.

   The term 'spouse' shall also mean the person who is registered with the *employer* as the domestic partner of the *employee*; this includes opposite sex and same sex couples. An individual is a domestic partner of an *employee* if that individual and the *employee* meet each of the following requirements:

   a. The *employee* and individual are eighteen (18) years of age or older and are mentally competent to enter into a legally binding contract.

   b. The *employee* and the individual are not married to anyone.

   c. The *employee* and the individual are not related by blood to a degree of closeness that would prohibit legal marriage between individuals of the opposite sex in the state in which they reside.

   d. The *employee* and the individual share the same principal residence(s), the common necessities of life, the responsibility for each other's welfare, are financially interdependent with each other, and have a long-term committed personal relationship in which each partner is the other's sole domestic partner. Each of the foregoing characteristics of the domestic partner relationship must have been in existence for a period of at least twelve (12) consecutive months and be continuing during the period that the applicable benefit is provided. The *employee* and the individual must have the intention that their relationship will be indefinite.

   e. The *employee* and the individual have common or joint ownership of a residence (home, condominium, or mobile home), motor vehicle, checking account, credit account, mutual fund, joint obligation under a lease for their residence, or similar type of ownership.

   To obtain more detailed information or to apply for this benefit, the *employee* must contact the *Plan Administrator* as outlined in the Quick Reference Information Chart.

   In the event the domestic partnership is terminated, either partner is required to inform Kyrene School District of the termination of the partnership.

2. a covered *employee's* child(ren)

   For the purposes of the *Plan*, an *employee's* child includes their:

a. natural child or stepchild

b. adopted child or a child placed with the *employee* for adoption

c. lawfully placed *foster child* for whom health coverage is not provided by the state

Unless otherwise specified, an *employee's* child will be an eligible *dependent* until reaching the limiting age of twenty-six (26), without regard to student status, marital status, financial dependency, or residency status with the *employee* or any other person. To determine when coverage will end for a child who reaches the applicable limiting age, please refer to the When Dependent Coverage Terminates subsection.

The phrase 'placed for adoption' refers to a child whom a person intends to adopt, whether or not the adoption has become final, and who has not attained the age of eighteen (18) as of the date of such placement for adoption. The term 'placed' means the assumption and retention by such person of a legal obligation for total or partial support of the child in anticipation of adoption of the child. The child must be available for adoption, and the legal process must have commenced.

3. a covered *employee's* qualified *dependents*

The term 'qualified *dependents*' shall include children for whom the *employee* is a *legal guardian*. The term 'qualified *dependents*' shall include the natural, adopted, or *foster children* of the *employee's* domestic partner. To be eligible for *dependent* coverage under the *Plan*, a qualified *dependent* must be under the limiting age as described herein. To determine when coverage will end for a qualified *dependent* who reaches the applicable limiting age, please refer to the When Dependent Coverage Terminates subsection.

Any child of a *plan participant* who is an *alternate recipient* under a *Qualified Medical Child Support Order* (*QMCSO*) or National Medical Support Notice shall be considered as having a right to *dependent* coverage under this *Plan*.

A *participant* of this *Plan* may obtain, without charge, a copy of the procedures governing *QMCSO* determinations from the *Plan Administrator*.

The *Plan Administrator* may require documentation proving eligibility for *dependent* coverage, including birth certificates, tax records, or initiation of legal proceedings severing parental rights.

4. *Dependent* children over the limiting age may enroll in the *Plan* provided the dependent:

a. became *totally disabled* prior to age twenty (26)

b. is claimed as a dependent on the employee's federal income tax return

c. is unmarried

d. is incapable of self-sustaining employment by reason of mental or physical disability

e. is primarily dependent upon the covered *employee* for support and maintenance

f. was covered as a dependent on their prior plan with no break in coverage

The *Plan Administrator* may require, at reasonable intervals, continuing proof of the *total disability* and dependency.

The *Plan Administrator* reserves the right to have such *dependent* examined by a *physician* of the *Plan Administrator's* choice, at the *Plan's* expense, to determine the existence of such incapacity.

Effective Date of Dependent Coverage

A *dependent's* coverage will take effect on the day that the eligibility requirements are met, the *employee* is covered under the *Plan*, and all enrollment requirements are met.

Ineligible Dependent(s)

Unless otherwise provided in this plan document, the following are not considered eligible *dependents*:

1. other individuals living in the covered *employee's* home, but who are not eligible as defined
2. the legally separated or divorced former spouse of the *employee*
3. a person who is covered as an *employee* under the *Plan*
4. any other person not defined above in the subsection entitled Eligible Classes of Dependents

Restrictions on Elections

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

If both spouses or domestic partners are *employees*, their children will be covered as *dependents* of one (1) *employee*, but not of both.

If two (2) *employees* (spouses or domestic partners) are covered under the *Plan,* and the *employee* who is covering the *dependent* children terminates coverage, the *dependent* coverage may be continued by the other covered *employee* with no *waiting period* as long as coverage has been continuous.

Accumulators will transfer if a *dependent* changes from coverage under one (1) parent *employee* to coverage under another parent *employee*.

Eligibility Requirements for Dependent Coverage

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

At any time, the *Plan* may require proof that a spouse, domestic partner, qualified *dependent,* or a child qualifies or continues to qualify as a *dependent* as defined by this *Plan*.

B. Enrollment

Enrollment Requirements

An *employee* must enroll for coverage for themselves and/or their *dependents* by completing the enrollment process along with the appropriate payroll deduction authorization.

Enrollment Requirements for Newborn Children

A newborn child, child placed for adoption, or newly adopted child of a covered *employee* is not automatically enrolled in this *Plan*, even if the covered *employee* has previously elected coverage for other *dependents*. An *employee* must complete an enrollment application as shown in the Qualifying Events Chart subsection. Your *claim* for maternity expenses is not considered as *notification* to your *employer* for coverage.

If the newborn child (and mother/covered parent) is not enrolled in this *Plan* on a timely basis, there will be no payment from the *Plan,* and the covered parent will be responsible for all costs. You will also have to wait until the next *open enrollment period* to add the child as a *dependent*.

C. Timely Enrollment

The enrollment will be timely if the completed form is received by the *Plan Administrator* no later than thirty-one (31) days after the person initially becomes eligible for coverage, or as shown in the Qualifying Events Chart subsection for each type of special enrollment period.

D. Special Enrollment Rights

Federal law provides special enrollment provisions under some circumstances. If an *employee* is declining enrollment for themselves or their *dependents* (including a spouse) because of other health insurance or group health plan coverage, there may be a right to enroll in this *Plan* if there is a loss of eligibility for that other coverage (or if the *employer* stops contributing towards the other coverage). However, a request for enrollment must be made as shown in the Qualifying Events Chart subsection after the coverage ends (or after the *employer* stops contributing towards the other coverage).

In addition, in the case of a birth, marriage, registration of a domestic partnership, adoption, or placement for adoption or foster care, there may be a right to enroll in this *Plan*. However, a request for enrollment must be made as shown in the Qualifying Events Chart subsection.

Coverage changes associated with mid-year change of status opportunity must be prospective and therefore are effective the first day of the month following the date you submit a completed written change/enrollment form to the Human Resource office (except for newborns who are effective on the date of birth and children adopted or placed for adoption who are effective on the date of adoption or placement for adoption). Completed written change/enrollment

form must be received by Human Resources within thirty (30) days of the date of your mid-year status change. Any changes received after thirty-one (31) days will be denied and you will need to wait until open enrollment to make any changes to your benefits.

The special enrollment rules are described in more detail below. To request special enrollment or obtain more detailed information of these portability provisions, contact the *Plan Administrator*, Kyrene School District, 8700 S. Kyrene Rd., Tempe, AZ 85284, 1-480-541-1302.

E. Special Enrollment Periods

The *enrollment date* for anyone who enrolls under a special enrollment period is the first date of coverage. Thus, the time between the date a special enrollee first becomes eligible for enrollment under the *Plan* and the first day of coverage is not treated as a *waiting period*.

Individuals Losing Other Coverage, Creating a Special Enrollment Right

An *employee* or *dependent* who is eligible, but not enrolled in this *Plan*, may enroll if loss of eligibility for coverage meets any of the following conditions:

1. The *employee* or *dependent* was covered under a group health plan or had health insurance coverage at the time coverage under this *Plan* was previously offered to the individual.
2. If required by the *Plan Administrator*, the *employee* stated in writing at the time that coverage was offered that the other health coverage was the reason for declining enrollment.
3. The coverage of the *employee* or *dependent* who had lost the coverage was under COBRA and the COBRA coverage was exhausted or was not under COBRA and either the coverage was terminated as a result of loss of eligibility for the coverage or because *employer* contributions towards the coverage were terminated.
4. The *employee* or *dependent* requests enrollment in this *Plan* no later than as shown in the Qualifying Events Chart subsection after the date of exhaustion of COBRA coverage or the termination of non-COBRA coverage due to loss of eligibility or termination of *employer* contributions, described above.

For purposes of these rules, a loss of eligibility occurs if one (1) of the following occurs:

1. The *employee* or *dependent* has a loss of eligibility due to the *Plan* no longer offering any benefits to a class of similarly situated individuals (e.g., part-time *employees*).
2. The *employee* or *dependent* has a loss of eligibility as a result of legal separation, divorce, cessation of *dependent* status (such as attaining the maximum age to be eligible as a *dependent* child under the *Plan*), death, termination of employment, reduction in the number of hours of employment, or contributions towards the coverage were terminated.

Covered *employees* or *dependents* will not have a special enrollment right if the loss of other coverage results from either:

1. the *employee's* failure to pay premiums or required contributions
2. the *employee* or *dependent* making a fraudulent *claim* or an intentional misrepresentation of a material fact in connection with the *Plan*

Dependent Beneficiaries

If a *dependent* becomes eligible to enroll and the *employee* is not enrolled, the *employee* must enroll in order for the *dependent* to enroll.

If both of the following conditions are met, then the *dependent* (and if not otherwise enrolled, the *employee* and other eligible *dependents*) may be enrolled under this *Plan*:

1. The *employee* is a *plan participant* under this *Plan* (or has met the *waiting period* applicable to becoming a *plan participant* under this *Plan* and is eligible to be enrolled under this *Plan* but for a failure to enroll during a previous enrollment period).
2. A person becomes a *dependent* of the *employee* through marriage, registration of a domestic partnership, birth, adoption, or placement for adoption or foster care.

In the case of the birth or adoption of a child or placement for foster care, the spouse or domestic partner of the covered *employee* may be enrolled as a *dependent* of the covered *employee* if the spouse is otherwise eligible for

coverage. If the *employee* is not enrolled at the time of the event, the *employee* must enroll under this special enrollment period in order for their eligible *dependents* to enroll.

The *dependent* special enrollment period is as shown in the Qualifying Events Chart subsection. To be eligible for this special enrollment, the *dependent* and/or *employee* must request enrollment during the timeframe specified in the Qualifying Events Chart subsection.

F. Qualifying Events Chart

This chart is only a summary of some of the permitted health plan changes and is not all-inclusive.

Qualifying Event	Effective Date	Forms and Notification Must be Received Within:	You May Make the Following Changes(s)
Marriage or registration of a domestic partnership	First of the month following notification	thirty-one (31) days of marriage	Enroll yourself, if applicable Enroll your new spouse and other eligible or newly acquired *dependents*
Divorce or annulment	First of the month following notification	thirty-one (31) of the date of final divorce decree or annulment	Coverage will terminate for your spouse Enroll yourself and *dependent* child(ren) if you, or they, were previously enrolled in your spouse's plan
Birth of your child	Date of event	thirty-one (31) days of birth	Enroll yourself Enroll the newborn child and all other eligible dependents and your spouse.
Adoption, placement for adoption, or legal guardianship of a child	Date of event	thirty-one (31) days of adoption	Enroll yourself Enroll the newly adopted child and all other eligible dependents and your spouse.
Foster child	First of the month following notification	thirty-one (31) days of placement	Enroll yourself Enroll the *foster child* and all other eligible dependents and your spouse.
Your *dependent* child reaches maximum age for coverage	First of the month following notification	thirty-one (31) days of loss of eligibility	Coverage will terminate for the child who lost eligibility from your health coverage
Death of your spouse or *dependent* child	First of the month following notification	thirty-one (31) days of spouse's or *dependent's* death	Coverage will terminate for the *dependent* from your health coverage
A *change in employment status* (including a change from one *employment* classification to another, you or your spouse taking a qualified unpaid *leave of absence*, a strike or lockout, or a change in worksite)	First of the month following notification	thirty-one (31) days of *change in employment status* classification	Enroll yourself, if your employment change results in you being eligible for a new set of benefits Enroll your spouse and other eligible *dependents* Drop health coverage Drop your spouse and other eligible *dependents* from your health coverage
Significant change in or cost of your, or your spouse's, health coverage due to spouse's employment, including open enrollment	First of the month following notification	thirty-one (31) days of effective date of change in coverage	Enroll yourself and other eligible *dependents*
A change in the place of residence of the employee, spouse, or dependent	First of the month following notification	thirty-one (31) days of effective date of change in coverage	Enroll or drop coverage for yourself, your spouse, or covered *dependent* children

Spouse or covered *dependent* obtains coverage in another group health plan	First of the month following notification	thirty (31) days of gain of coverage	Drop coverage for yourself, your spouse, or covered *dependent* children
Loss of other coverage, including COBRA coverage	First of the month following notification	thirty-one (31) days of the date of loss of coverage	Enroll yourself, your spouse and eligible *dependent* children
Spouse's loss of coverage, including COBRA coverage	First of the month following notification	thirty-one (31) days of the date of loss of coverage	Enroll your spouse and eligible *dependent* children Enroll yourself in a health plan if previously not enrolled because you were covered under your spouse's plan
Eligibility for government-sponsored plan, such as *Medicare* (excluding the government-sponsored Marketplace)	First of the month following notification	thirty-one (31) days of eligibility date	Drop coverage for the person who became entitled to *Medicare*, Medicaid, or other eligible coverage
CHIP Special Enrollment – loss of eligibility for coverage under a state Medicaid or CHIP program, or eligibility for state premium assistance under Medicaid or CHIP	First of the month following notification	sixty (60) days of loss of eligibility or eligibility date	Enroll yourself, if applicable Add the person who lost entitlement to CHIP Drop coverage for the person entitled to CHIP coverage
Qualified Medical Support Order affecting a *dependent* child's coverage	First of the month following notification	thirty-one (31) days of order	Enroll yourself, if applicable Enroll the eligible child named on *QMCSO*

G. Termination of Coverage

Rescission of Coverage

The *employer* or *Plan* has the right to rescind any coverage of the *employee* and/or *dependents* for cause, making a fraudulent *claim,* or an intentional material misrepresentation in applying for or obtaining coverage, or obtaining benefits under the *Plan*. The *employer* or *Plan* may either void coverage for the *employee* and/or covered *dependents* for the period of time coverage was in effect, may terminate coverage as of a date to be determined at the *Plan's* discretion, or may immediately terminate coverage. If coverage is to be terminated or voided retroactively for fraud or misrepresentation, the *Plan* will provide at least thirty (30) days' advance written *notice* of such action.

When Employee Coverage Terminates

Employee coverage will terminate on the earliest of these dates (except in certain circumstances, a covered *employee* may be eligible for COBRA continuation coverage):

1. the last day of the calendar month the *Plan* is terminated
2. the last day of the calendar month in which the covered *employee* ceases to be in one (1) of the eligible classes

   This includes termination of *active employment* of the covered *employee*, an *employee* on disability, *leave of absence*, or other *leave of absence*, unless the *Plan* specifically provides for continuation during these periods.
3. the last day of the calendar month of the covered *employee's* death
4. the end of the period for which the required contribution has been paid if the charge for the next period is not paid when due

For a complete explanation of when COBRA continuation coverage is available, what conditions apply, and how to select it, see the section entitled **Continuation Coverage Rights Under COBRA**.

When Dependent Coverage Terminates

A *dependent's* coverage will terminate on the earliest of these dates (except in certain circumstances, a covered *dependent* may be eligible for COBRA continuation coverage):

1. the last day of the calendar month the *Plan* or *dependent* coverage under the *Plan* is terminated

2. the last day of the calendar month that the *employee's* coverage under the *Plan* terminates for any reason including death
3. the last day of the calendar month a covered spouse loses coverage due to loss of dependency
4. the last day of the calendar month a person ceases to be a *dependent* as defined by the *Plan*
5. the last day of the calendar month that a *dependent* child ceases to be a *dependent* as defined by the *Plan* due to age as listed in the Eligible Classes of Dependents provisions
6. the last day of the calendar month of the covered *dependent's* death
7. the end of the period for which the required contribution has been paid if the charge for the next period is not paid when due

For a complete explanation of when COBRA continuation coverage is available, what conditions apply, and how to select it, see the section entitled **Continuation Coverage Rights Under COBRA.**

H. Continuation During Leave of Absence or Family and Medical Leave

For information on continuation during a leave of absence or *Plan* compliance with the Family and Medical Leave Act of 1993 (FMLA), please reference provisions within the Kyrene Employee Benefit Trust wrap document.

I. Rehiring a Terminated Employee

A terminated *employee* who is rehired will be treated as a new hire and required to satisfy all eligibility and enrollment requirements to the extent permitted by the terms of the *Plan* and applicable law. If a terminated *employee* is rehired within twenty-six (26) weeks or when there is no break in service their coverage will be effective the first day of the month following their rehire date. A break in service is a period of at least twenty-six (26) weeks during which an *employee* has no hours of service. This may also include any period for which the *employee* has no hours of service that is at least four (4) consecutive weeks in duration and longer than the prior period of employment.

J. Open Enrollment

Every year during the annual *open enrollment period*, covered *employees* and their covered *dependents* will be able to change some of their benefit decisions based on which benefits and coverages are right for them.

Benefit choices made during the *open enrollment period* will become effective July 1 and remain in effect until the next July 1 unless there is a special enrollment event or change in family status during the year (birth, death, marriage, registration of a domestic partnership, divorce, adoption, placement for foster care) or loss of coverage due to loss of a spouse's employment. To the extent previously satisfied, coverage *waiting periods* will be considered satisfied when changing from one benefit option under the *Plan* to another benefit option under the *Plan*.

A *plan participant* who fails to make an election during an active *open enrollment period* will no longer be covered under this *Plan*. A *plan participant* will automatically retain their present coverages during a passive *open enrollment period*. *Plan participants* will receive detailed information regarding open enrollment from their *employer*.

SECTION III—CONSOLIDATED APPROPRIATIONS ACT OF 2021 AND TRANSPARENCY IN COVERAGE REGULATIONS

The Consolidated Appropriations Act of 2021 (CAA) is a federal law that includes the No Surprises Billing Act. In addition, the Transparency in Coverage (TIC) regulations contain transparency requirements. Portions of the CAA and TIC are described briefly below. Enforcement dates, standards for implementation, coordination with other entities, legal developments, and updates offered by federal and/or state entities directly impact actions and availability of the items described. In addition, some plan types are not subject to the CAA and/or TIC, certain provisions of either.

A. Surprise Billing Claims

Surprise billing claims are claims that are subject to the No Surprises Billing Act requirements. These are:

1. emergency services in an emergency department of a hospital or independent freestanding emergency department provided by *non-network* providers or facility
2. services provided by a *non-network* provider at a *network* facility
3. *non-network* air ambulance services

The section below contains further information about how these *claim* categories apply to your *Plan* and are dependent on covered benefits.

B. No Surprises Billing Act Requirements

Emergency Services

As required by the CAA, emergency services are covered under your *Plan*:

1. without the need for *pre-certification*
2. whether the provider is *network* or *non-network*

If the emergency services you receive in an emergency department of a hospital or independent freestanding emergency department are provided by a *non-network* provider or facility, covered services will be processed at the *network* benefit level in accordance with the CAA.

Note that if you receive emergency services from a *non-network* provider, your out-of-pocket costs will be limited to amounts that would apply if the covered services had been furnished by a *network* provider or facility. However, if the treating non-network provider or facility determines you are stable and satisfies all of the following requirements:

1. determines that you are able to travel to a network facility by non-emergency or non-medical transport to an available *network* provider or facility within a reasonable distance based on your condition
2. complies with the notice and consent requirement
3. determines that you are in a condition to receive the information and provide informed consent

If you are in condition to receive the information and provide informed consent, you will be responsible for all charges.

Non-Network Services Provided at a Network Facility

When you receive covered services from a non-network provider at a network facility, your claims will not be covered if the non-network provider gives you proper notice of its charges, and you give written consent to such charges. This means you will be responsible for all non-network charges for those services. This requirement does not apply to ancillary services. Ancillary services are defined as:

1. items and services related to emergency medicine, anesthesiology, pathology, radiology, and neonatology, whether provided by a *physician* or non-physician practitioner
2. items and services provided by assistant surgeons, hospitalists, and intensivists
3. diagnostic services, including radiology and laboratory services
4. items and services provided by a *non-participating provider* if there is no *participating provider* who can furnish such item or service at such facility

This *notice* and consent exception also does not apply if the covered services furnished by a *non-network* provider result from unforeseen and urgent medical needs arising at the time of service.

Non-network providers satisfy the *notice* and consent requirement by one (1) of the following:

1. by obtaining your consent and offering the required notice no later than seventy-two (72) hours prior to the delivery of services
2. the *notice* is given and consent is obtained on the date of the service, if you make an appointment within seventy-two (72) hours of the services being delivered

To help you determine whether a provider is *non-network*, the *network* is required to confirm the list of *network* providers in its provider directory every ninety (90) days. If you can show that you received inaccurate information from the *network* that a provider was *in-network* on a particular *claim*, then you will only be liable for *network cost sharing amounts* (i.e., *co-payments*, *deductibles*, and/or *co-insurance*) for that *claim*. Your *network* cost-sharing amount will be calculated based upon the *maximum allowed amount*. In addition to your *network* cost-shares, the *non-network* provider can also charge you for the difference between the *maximum allowed amount* and their billed charges.

C. How Cost-Shares Are Calculated

Your cost sharing amounts for emergency services in an emergency department of a hospital or independent freestanding emergency department or for covered services received by a *non-network* provider at a *network* facility, will be calculated as defined by the CAA, such as the lesser of billed charges or the median plan *network* contract rate (called the Qualifying Paying Amount or QPA) that we pay *network* providers for the geographic area where the covered service is provided if other calculation criteria does not apply. Any out-of-pocket cost you pay to a *non-network* provider for either these emergency services or for covered services provided by a *non-network* provider at a *network* facility will be applied to your *network out-of-pocket limit*. Cost-sharing for air ambulance services is based on the lesser of billed charges or the QPA.

D. Appeals

If you receive emergency services in an emergency department of a hospital or independent freestanding emergency department from a *non-network* provider, covered services from a *non-network* provider at a *network* facility, or *non-network* air ambulance services, and believe those services are covered by your *Plan's* benefits and the No Surprise Billing Act, you have the right to appeal that *claim*. If your appeal of a *surprise billing claim* is denied, then you have a right to appeal the adverse decision to an independent review organization as set out in the **Claims and Appeals** section of this summary plan description. A provider can dispute the payment they received from the *Plan* by utilizing a process set up by the CAA, or if applicable, state law. The CAA process includes Open Negotiation, and if unresolved, Independent Dispute Resolution. Importantly, this process does not include the *plan participant*, and you are not required to participate. To learn more about the CAA, you can visit **https://www.cms.gov/nosurprises**.

E. Transparency Requirements

Under your *Plan*, the following are provided as required by the CAA and/or TIC. Depending on how the *Plan* interacts with other entities, these may be provided from the *Third Party Administrator*, the *network*, Pharmacy Benefit Manager, and/or other stakeholders (ex. Customer Care or Member Services)~~,~~:

1. protections with respect to *surprise billing claims* by providers
2. estimates on what *non-network* providers may charge for a particular service
3. information on contacting state and federal agencies in case you believe a provider has violated the No Surprise Billing Act's requirements

When asked, a paper copy of the type of information you request from the above list can be provided.

Through the price comparison/shoppable services tool(s) associated with your *Plan* or through Member Services at the phone number on the back of you ID card, you can receive the following:

1. cost sharing information that you may be responsible for, for a service from a specific *network* provider
2. a list of all *network* providers
3. cost sharing information on *non-network* provider's services based on what you may pay *non-network* provider for the service

1. As applicable, under machine readable requirements from the TIC, the *network*, Pharmacy Benefit Manager, *Third Party Administrator,* and/or entities associated with your *Plan* will provide access through separate publicly accessible websites that contain the following information: *network* negotiated rates
2. historical *non-network* allowed amounts
3. drug pricing information

F. Continuity of Care

If a *network* provider leaves the *network* for any reason other than termination for failure to meet applicable quality standards, fraud, or otherwise defined by the CAA, you may be able to continue seeing that provider for a limited period of time and still receive *network* benefits. CAA permits you to request and decide to continue to have benefits provided under the same terms and conditions as you would have had under the plan document had the provider not moved to *non-network* status. If authorized, continuity of care ends ninety (90) days after you are notified by the *Plan* or its delegate of the right to request continuity of care or the date you are no longer under care of the provider, whichever of these is earlier.

Continuity of care under the CAA is permitted for a *plan participant* who, with respect to a provider, qualifies based on any of the following circumstances:

1. is undergoing a course of treatment for a serious and complex condition from the provider or facility
2. is undergoing a course of institutional or inpatient care from the provider or facility
3. is scheduled to undergo nonelective surgery from the provider, including receipt of postoperative care from such provider or facility with respect to such a surgery
4. is pregnant and undergoing a course of treatment for the pregnancy from the provider or facility
5. is or was determined to be terminally ill (as determined under section 1861(dd)(3)(A) of the Social Security Act) and is receiving treatment for such illness from such provider or facility

Under the CAA, the term 'serious and complex condition' means, with respect to a *participant*, beneficiary, or enrollee under a group health plan or group or individual health insurance coverage, one (1) of the following:

1. 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
2. in the case of a chronic *illness* or condition, a condition that satisfies both of the following criteria:
    a. is life-threatening, degenerative, potentially disabling, or congenital
    b. requires specialized medical care over a prolonged period of time

If you wish to continue seeing the same provider/facility and you believe continuity of care under the CAA applies, you or your provider/facility should contact the entity responsible for Member Services on back of your card for how to apply for continuity of care.

SECTION IV—MEDICAL NETWORK INFORMATION

A. Network and Non-Network Services

Network Provider Information

The *Plan* has entered into an agreement with a medical *network* that maintains contractual agreements with certain *hospitals*, *physicians*, and other health care providers which are called *network* providers. Because these *network* providers have agreed to charge reduced fees to persons covered under the *Plan*, the *Plan* can afford to reimburse a higher percentage of their fees.

Therefore, when a *plan participant* uses a *network* provider, that *plan participant* will receive better benefits from the *Plan* than when a *non-network* provider is used. It is the *plan participant's* choice as to which provider to use.

Non-Network Provider Information

Non-network providers have no agreements with the *Plan* or the *Plan's* medical *network* and are generally free to set their own charges for the services or supplies they provide. The *Plan* will reimburse for the *allowable charges* for any *medically necessary* services or supplies, subject to the *Plan's deductibles*, *co-insurance*, *co-payments*, limitations, and exclusions. *Plan participants* must submit proof of *claim* before any such reimbursement will be made.

Before you obtain services or supplies from a *non-network* provider, you can find out whether the *Plan* will provide *network* or *non-network* benefits for those services or supplies by contacting the *Third Party Administrator* as outlined in the Quick Reference Information Chart.

Refer to the **Consolidated Appropriations Act of 2021 and Transparency in Coverage Regulations** section for additional provisions pertaining to *non-network* services and billing.

Provider Non-Discrimination

To the extent that an item or service is a *covered charge* under the *Plan*, the terms of the *Plan* shall be applied in a manner that does not discriminate against a health care provider who is acting within the scope of the provider's license or other required credentials under applicable state law. This provision does not preclude the *Plan* from setting limits on benefits, including cost sharing provisions, frequency limits, or restrictions on the methods or settings in which treatments are provided, and does not require the *Plan* to accept all types of providers as a *network* provider.

B. Choosing a Physician - Patient Protection Notice

The *Plan* does not require you to select a *primary care physician* (*PCP*) to coordinate your care, and you do not have to obtain a referral to see a specialist.

You do not need prior authorization from the *Plan* or *Third Party Administrator*, or from any other person (including your *PCP*) in order to obtain access to obstetrical or gynecological care from a health care professional in the *network* who specializes in obstetrics or gynecology. The health care provider, however, may be required to comply with certain procedures, including obtaining *pre-certification* for certain services, following a pre-approved treatment plan, or procedures for making referrals.

C. Special Reimbursement Provisions

Under the following circumstances, the higher *network* payment will be made for certain *non-network* services:

1. **Medical Emergency.** In a *medical emergency*, a *plan participant* should try to access a *network* provider for treatment. However, if immediate treatment is required and this is not possible, the services of *non-network* providers will be covered until the *plan participant's* condition has stabilized to the extent that they can be safely transferred to a *network* provider's care. At that point, if the transfer does not take place, *non-network* services will be covered at *non-network* benefit levels. Charges that meet this definition will be paid based on the *maximum allowable charges*. The *plan participant* will be responsible for *notifying* the *Third Party Administrator* for a review of any *claim* that meets this definition.
2. **No Choice of Provider.** If, while receiving treatment at a *network* facility and/or provider (other than from a surgeon in a non-emergency situation), a *plan participant* receives ancillary services or supplies from a *non-network* provider in a situation in which they have no control over provider selection (such as in the selection of an ambulance, emergency room *physician*, anesthesiologist, assistant surgeon, or a provider for *diagnostic services*), such *non-network* services or supplies will be covered at *network* benefit levels. Charges that meet

this definition will be paid based on the *maximum allowable charges*. The *plan participant* will be responsible for *notifying* the *Third Party Administrator* for a review of any *claim* that meets this definition.

3. **Providers Outside of Network Area.** If *non-network primary care physicians* or specialists are used because the necessary specialty is not in the network or is not reasonably accessible to the plan participant due to geographic constraints (over 50 miles from home or work), such non-network specialist care will be covered at network benefit levels. Charges that meet this definition will be paid based on the *maximum allowable charges*. The plan participant will be responsible for notifying the Third Party Administrator for a review of any *claim* that meets this definition.

Additional information about this option, as well as a list of *network* providers, will be given to *plan participants*, at no cost, and updated as needed. This list will include providers who specialize in obstetrics or gynecology.

Refer to the **Consolidated Appropriations Act of 2021 and Transparency in Coverage Regulations** section for additional provisions pertaining to *non-network* services and billing.

D. Network Information

You may obtain more information about the providers in the *network* by contacting the *network* by phone or by visiting their website.

Blue Cross Blue Shield of Arizona

1-855-961-5408

https://kyrene.myameriben.com

All locations

NOTE: For those *plan participants* requiring services while traveling or residing outside the primary service area (Blue Cross Blue Shield of Arizona), please contact PHCS at 1-800-678-7427 or visit www.multiplan.com/search.

SECTION V—SCHEDULE OF BENEFITS

A. Verification of Eligibility: 1-855-961-5408

Call this number to verify eligibility for *Plan* benefits **before** charges are *incurred*. Please note that oral or written communications with the *Third Party Administrator* regarding a *plan participant's* or beneficiary's eligibility or coverage under the *Plan* are not *claims* for benefits, and the information provided by the *Third Party Administrator* or other *Plan* representative in such communications does not constitute a certification of benefits or a guarantee that any particular *claim* will be paid. Benefits are determined by the *Plan* at the time a formal *claim* for benefits is submitted according to the procedures outlined within the **Claims and Appeals** section of this plan document.

B. Schedule of Benefits

All benefits described in the **Schedule of Benefits** are subject to the exclusions and limitations described more fully herein, including, but not limited to, the *Plan Administrator's* determination that care and treatment is *medically necessary*; those charges are in accordance with the *maximum allowable charge*; and that services, supplies, and care are not *experimental/investigational*.

This document is intended to describe the benefits provided under the *Plan,* but due to the number and wide variety of different medical procedures and rapid changes in treatment standards, it is impossible to describe all *covered charges* and/or exclusions with specificity. If you have questions about specific supplies, treatments, or procedures, please contact the *Plan Administrator* as outlined in the Quick Reference Information Chart.

The *Plan Administrator* retains the right to audit *claims* to identify treatment(s) that are, or were, not *medically necessary*, *experimental*, *investigational*, or not in accordance with the *maximum allowable charges*.

Pre-Certification

The following services must be *pre-certified*, or reimbursement from the *Plan* may be reduced:

1. *inpatient* pre-admission certification and continued stay reviews (all ages, all diagnoses)
    a. surgical and non-surgical (excluding routine vaginal or cesarean deliveries)
    b. long term acute care facility (LTAC), not *custodial care*
    c. *skilled nursing facility*/rehabilitation facility
    d. *inpatient mental health/substance use disorder* treatment (includes *residential treatment facility* services)

    The attending *physician* does not have to obtain *pre-certification* from the *Plan* for prescribing a maternity length of stay that is forty-eight (48) hours or less for a vaginal delivery or ninety-six (96) hours or less for a cesarean delivery.
2. *inpatient* and *outpatient surgery* including surgical pain management injections

    Pre-certification is **not** required for the following *surgical procedures*:
    a. office *surgeries*
    b. all colonoscopies/sigmoidoscopies (screening and diagnostic)
    c. elective sterilization procedures
    d. intra-articular hyaluronic acid injections.
3. transplant (other than cornea), including, but not limited to, kidney, liver, heart, lung, pancreas, and bone marrow replacement to stem cell transfer after high-dose chemotherapy
4. *adoptive cell therapy*
5. chemotherapy drugs/infusions and radiation treatments for oncology diagnoses
6. clinical trial that is conducted in relation to the prevention, detection, or treatment of cancer or other life-threatening *disease* or condition

    This *Plan* does not cover clinical trials related to other *diseases* or conditions. Refer to the **Medical Benefits** section of this document for a further description and limitations of this benefit.
7. dialysis

8. *durable medical equipment* (DME) in excess of $3,000 (purchase price only)
9. *gene therapy*
10. genetic/genomic testing (excluding amniocentesis)
11. *home health care services*
12. non-emergent air ambulance
13. orthotics/prosthetics in excess of $3,000 purchase price
14. *outpatient* advanced imaging (excluding services rendered in an emergency room setting)
    a. computed tomographic (CT) studies
    b. coronary CT angiography
    c. MR-guided focused ultrasound
    d. MRI/MRA
    e. nuclear cardiology
    f. nuclear medicine (including SPECT scans)
    g. PET scans
15. *outpatient* therapy services (physical therapy, occupational therapy, and speech therapy) in excess of twenty (20) visits per *plan year* per therapy type
16. partial hospitalization and intensive *outpatient* program in excess of twenty (20) visits per *plan year* per service type, for *mental health and substance use disorder* treatment
17. specialty infusion/injectable medications over $3,000 per infusion/injection which are covered under the medical benefits and not obtained through the Prescription Drug Benefits (i.e. provided in an *outpatient* facility, *physician's* office, or home infusion)

    Pre-certification is not required for intra-articular hyaluronic acid injections.

    For specialty drugs obtained through the Prescription Drug Benefits, please contact VIVIO Health for *pre-certification* at 1-800-470-4034 or refer to the **VIVIO Health Program** section for more details.

Services rendered in an emergency room or urgent care setting do not require *pre-certification*.

Please see the Health Care Management Program section in this document for details.

C. Deductible Amount

Deductibles are dollar amounts that the *plan participant* must pay before the *Plan* pays. Before benefits can be paid in a *benefit year,* a *plan participant* must meet the *deductible* shown in the applicable Schedule of Medical Benefits.

This amount will accrue toward the 100% maximum *out-of-pocket limit*.

D. Benefit Payment

Each *plan year*, benefits will be paid for the *covered charges* of a *plan participant* that are in excess of the *deductible*, any *co-payments,* and any amounts paid for the same services. Payment will be made at the rate shown under the reimbursement rate in the applicable Schedule of Medical Benefits. No benefits will be paid in excess of the *maximum benefit* amount or any listed limit of the *Plan*.

Services rendered may have professional, facility, and other components for which *physicians* and facilities may bill separately.

E. Out-of-Pocket Limit

Covered charges are payable at the percentages shown each *plan year* until the *out-of-pocket limit* shown in the applicable Schedule of Medical Benefits is reached. Then, *covered charges incurred* by a *plan participant* will be payable at 100% (except for the charges excluded) for the remainder of the *plan year*.

The *out-of-pocket limit* includes applicable amounts paid for *deductibles*, *co-payments*, and *co-insurance*.

F. Diagnosis Related Grouping (DRG)

Diagnosis related grouping (*DRG*) is a method for reimbursing *hospitals* for *inpatient* services. This is when a provider bills for services that go together in a group, or bundle, instead of the individual services that make up the group separately. The provider has agreed to a set *DRG* rate with the *network*. When a service is rendered, regardless of what the provider bills, the *DRG* amount has already been set for that specific group of services. A *DRG* amount can be higher or lower than the actual billed charge because it is based on an average cost for the services rendered.

In the case where the *DRG* amount on an eligible *claim* is higher than the actual billed charges, the following will determine how each party's cost sharing will be determined:

1. the *Plan* will base their portion of the charge on the billed charges
2. the *plan participant's* portion of the charge will be based on the billed charges
3. the difference in the *network allowed amount* versus the actual billed charges will be the responsibility of the *Plan*

Any amount in excess of the *allowed amount* does not count toward the *Plan's* annual *out-of-pocket limit*. *Plan participants* are responsible for amounts that exceed *allowed amounts* by this *Plan*. This is known as *balance billing*.

Refer to the **Consolidated Appropriations Act of 2021 and Transparency in Coverage Regulations** section for additional provisions pertaining to *non-network* services and billing.

G. Co-Insurance

For *covered charges incurred* with a *network* provider, the *Plan* pays a specified percentage of the negotiated rate. This percentage varies, depending on the type of *covered charge*, and is specified in the applicable Schedule of Medical Benefits. You are responsible for the difference between the percentage the *Plan* pays and 100% of the negotiated rate.

For *covered charges incurred* with a *non-network* provider, the *Plan* pays a specified percentage of *covered charges* at the *maximum allowable charge*. In those circumstances, you are responsible for the difference between the percentage the *Plan* pays and 100% of the billed amount, unless your *claim* is a *surprise billing claim*.

These amounts for which you are responsible are known as *co-insurance*. Unless noted otherwise in the Special Comments column of the applicable Schedule of Medical Benefits, your *co-insurance* applies towards satisfaction of the *out-of-pocket limit*.

H. Co-Payments

In certain cases, instead of paying *co-insurance*, you must pay a specific dollar amount, as specified in the applicable Schedule of Medical Benefits. This amount for which you are responsible is known as a *co-payment* and is typically payable to the health care provider at the time services or supplies are rendered.

Unless otherwise stated in the applicable Schedule of Medical Benefits, *co-payments* are applied per provider per day.

Unless noted otherwise in the Special Comments column of the applicable Schedule of Medical Benefits, your *co-payments* apply toward satisfaction of the *out-of-pocket limit*.

I. Balance Bill

The *balance bill* refers to the amount you may be charged for the difference between a *non-network* provider's billed charges and the *allowable charge*.

Network providers will accept the *allowable charge* for *covered charges*. They will not charge you for the difference between their billed charges and the *allowable charge*.

Non-network providers have no obligation to accept the *allowable charge*. You are responsible to pay a *non-network* provider's billed charges, even though reimbursement is based on the *allowable charge*. Depending on what billing arrangements you make with a *non-network* provider, the provider may charge you for full billed charges at the time of service or seek to *balance bill* you for the difference between billed charges and the amount that is reimbursed on a *claim*.

Any amounts paid for *balance bills* do not count toward the *deductible*, *co-insurance*, or *out-of-pocket limit*.

Refer to the **Consolidated Appropriations Act of 2021 and Transparency in Coverage Regulations** section for additional provisions pertaining to *non-network* services and billing.

Refer to the **Prescription Drug Benefits** section of this plan document for additional information on *prescription drug* coverage.

J. Schedule of Medical Benefits – BCBS Statewide PPO Option

	NETWORK PROVIDERS	NON-NETWORK PROVIDERS
Deductible, per Plan Year *Co-payments, prescription drugs,* and *co-insurance* do not apply to the *deductible*.		
Per *plan participant*	$1,000	Not Covered
Per *family unit*	$2,000	Not Covered
Family Unit - Embedded Deductible If you are enrolled in the family option, your *Plan* contains two (2) components: an individual *deductible* and a *family unit deductible*. Having two (2) components to the *deductible* allows for each member of your *family unit* the opportunity to have your *Plan* cover medical expenses prior to the entire dollar amount of the *family unit deductible* being met. The individual *deductible* is embedded in the family *deductible*. **For example,** if you, your spouse, and child are on a family plan with a $2,000 *family unit* embedded *deductible*, and the individual *deductible* is $1,000, and your child *incurs* $1,000 in medical bills, their *deductible* is met, and your *Plan* will help pay subsequent medical bills for that child during the remainder of the *calendar year*, even though the *family unit deductible* of $2,000 has not been met yet.		
Maximum Out-of-Pocket Limit, per Plan Year The *out-of-pocket limit* includes *co-payments, co-insurance, deductibles,* and covered *prescription drug* charges.		
Per *plan participant*	$7,000	Not Covered
Per *family unit*	$14,000	Not Covered
Family Unit - Embedded Out-of-Pocket Limit If you are enrolled in the *family unit* option, your *Plan* contains two (2) components: an individual *out-of-pocket limit* and a *family unit out-of-pocket limit*. Having two (2) components to the *out-of-pocket limit* allows each member of your *family unit* the opportunity to have their *covered charges* be payable at 100% (except for the charges excluded) prior to the entire dollar amount of the *family unit out-of-pocket limit* being met. The individual *out-of-pocket limit* is embedded in the *family unit out-of-pocket limit*.		
The *Plan* will pay the designated percentage of *covered charges* until *out-of-pocket limits* are reached at which time the *Plan* will pay 100% of the remainder of *covered charges* for the rest of the *plan year* unless stated otherwise. **NOTE: The following charges do not apply toward the out-of-pocket limit amount and are generally not paid by the Plan:** 1. cost containment penalties 2. amounts over *the maximum allowable charges* 3. charges not covered under the *Plan* 4. *balanced billed* charges		

Benefits shown as *co-payments* are listed for what the *plan participant* will pay.

Benefits shown as *co-insurance* are listed for the percentage the *Plan* will pay.

COVERED SERVICES	NETWORK PROVIDERS	NON-NETWORK PROVIDERS	SPECIAL COMMENTS
General Percentage Payment Rule	80% *co-insurance* after *deductible*	Not Covered	Generally, most *covered charges* are subject to the benefit payment percentage contained in this row, unless otherwise noted. This Special Comments column provides additional information and limitations about the applicable *covered charges*, including the expenses that must be *pre-certified* and those expenses to which the *out-of-pocket limit* does not apply.
Advanced Imaging	80% *co-insurance* after *deductible*	Not Covered	Includes Computed Tomographic (CT) studies, Coronary CT angiography, MRI/MRA, MR-guided focused ultrasound, nuclear cardiology, nuclear medicine (including SPECT scans), and PET scans, excluding services rendered in an emergency room setting. ***Pre-certification* is required.**
Ambulance Service	100% *co-insurance*, *deductible* waived		Please refer to the **Medical Benefits** section, Covered Medical Charges, Ambulance, for a further description and limitations of this benefit. ***Pre-certification* is required for non-emergent air ambulance.**
Birthing Center	80% *co-insurance* after *deductible*	Not Covered	***Pre-certification*** is required for inpatient stay in excess of forty-eight (48) hours for a vaginal delivery or ninety-six hours (96) for a cesarean delivery.
Congenital Heart Disease	$250 *co-payment*, then 80% *co-insurance* after *deductible*	Not Covered	Benefits are only for the inpatient facility charges for congenital heart disease. Benefits for diagnostic services, cardiac catheterization, and non-surgical management of the disease will be covered under the applicable benefit.
Dental Injury	80% *co-insurance* after *deductible*	Not Covered	Please refer to the **Medical Benefits** section, Covered Medical Charges, Dental Injuries, for a further description and limitations of this benefit.
Diagnostic Testing	80% *co-insurance* after *deductible*	Not Covered	
Durable Medical Equipment (DME)	80% *co-insurance* after *deductible*	Not Covered	***Pre-certification* is required** for *DME* in excess of $3,000 purchase price.
Emergency Room	$200 *co-payment*, then 80% *co-insurance* after *deductible*		The emergency room *co-payment* applies to the facility charges only. *Co-payment* is waived if *plan participant* is admitted to the hospital.
Foot Orthotics	80% *co-insurance* after *deductible*	Not Covered	**Benefit Limitations:** Limited to once in a period of twelve (12) months for *plan participants* over age nineteen (19) and once in a period of six (6) months for *plan participants* under age nineteen (19) when replacement is required due to growth.

BCBS Statewide PPO Option

COVERED SERVICES	NETWORK PROVIDERS	NON-NETWORK PROVIDERS	SPECIAL COMMENTS
Gender Dysphoria	80% *co-insurance* after *deductible*	Not Covered	
Home Health Care	80% *co-insurance* after *deductible*	Not Covered	**Plan Year Maximum:** One Hundred Twenty (120) days per *plan participant*. Home infusion services do not apply towards the plan year maximum. ***Pre-certification* is required.**
Hospice Care			
Hospice Care	80% *co-insurance* after *deductible*	Not Covered	*Hospice care services and supplies* for *plan participants* with a life expectancy of less than six (6) months.
Bereavement Counseling	80% *co-insurance* after *deductible*	Not Covered	*Bereavement counseling* is covered for family members of *plan participants* within the six (6) months following death.
Inpatient Hospital			
Physician Visits	80% *co-insurance* after *deductible*	Not Covered	
Room and Board	$250 *co-payment*, then 80% *co-insurance* after *deductible*	Not Covered	***Pre-certification* is required.**
Inpatient Rehabilitation Facilities	$250 co-payment, then 80% *co-insurance* after *deductible*	Not Covered	**Plan Year Maximum:** Sixty (60) visits per *plan participant* for inpatient rehabilitation facilities. ***Pre-certification* is required.**
Lab and X-Ray	80% *co-insurance* after *deductible*	Not Covered	
Maternity			
Office Visits (Pre- and post-natal care)	100% *co-insurance*, *deductible* waived	Not Covered	*Dependent* child *pregnancy* is limited to coverage for mandated *preventive care* and complications.
All Other Services	80% *co-insurance* after *deductible*	Not Covered	Office visits for reasons other than *pre-* and *post-natal* care will be covered at the office visit benefit level.
Labor and Delivery	$250 *co-payment*, then 80% *co-insurance* after *deductible*	Not Covered	***Pre-certification* is required for inpatient stay in excess of forty-eight (48) hours for a vaginal delivery or ninety-six hours (96) for a cesarean delivery.** *Co-payment* applies to facility charges.

BCBS Statewide PPO Option

COVERED SERVICES	NETWORK PROVIDERS	NON-NETWORK PROVIDERS	SPECIAL COMMENTS
Mental Disorders & Substance Use Disorder			
Inpatient	$250 *co-payment*, then 80% *co-insurance* after *deductible*	Not Covered	This includes residential treatment facilities. ***Pre-certification* is required.**
Outpatient	80% *co-insurance* after *deductible*	Not Covered	*Outpatient* services are also available through Lyra. For more information, please visit **https://kyrene.lyrahealth.com** or call 1-877-203-9680.
Partial Hospitalization and Outpatient Intensive Day Treatment	80% *co-insurance* after *deductible*	Not Covered	***Pre-certification* is required** in excess of twenty (20) visits per *plan year*, per service type.
Office Visit	80% *co-insurance* after *deductible*	Not Covered	Home visits are covered under the *Plan*.
Orthotic Appliances/ Prosthetics	80% *co-insurance* after *deductible*	Not Covered	***Pre-certification* is required** for orthotics/prosthetics in excess of $3,000 purchase price.
Ostomy Supplies	80% *co-insurance* after *deductible*	Not Covered	
Outpatient Surgery	80% *co-insurance* after *deductible*	Not Covered	***Pre-certification* is required** for *outpatient surgical procedures* (other than office surgeries, colonoscopies, sigmoidoscopies, and intra-articular hyaluronic acid injections).
Routine Newborn Care	80% *co-insurance*, *deductible* waived	Not Covered	Routine newborn care is subject to the mother's *out-of-pocket limit*. If the mother is not covered under the *Plan*, then these expenses apply to the newborn's *out-of-pocket limit*.
Skilled Nursing Facility	80% *co-insurance* after *deductible*	Not Covered	**Plan Year Maximum:** One hundred twenty (120) days per *plan participant*. ***Pre-certification* is required.**
Therapy Services			
Physical Therapy Occupational Therapy Speech Therapy	80% *co-insurance* after *deductible*	Not Covered	***Pre-certification* is required** for outpatient services in excess of twenty (20) visits per *plan year* for each therapy type.
Urgent Care	$25 *co-payment*, then 80% *co-insurance* after *deductible*	Not Covered	*Co-payment* is waived if subsequent immediate hospital admission occurs.
Wigs	80% *co-insurance* after *deductible*		**Limited to hair loss related to chemotherapy.** **Lifetime Maximum:** Limited to one (1) wig per *plan participant* for network providers. Non-network providers and over-the-counter purchases are limited to one (1) wig per *plan participant* up to a $300 maximum.

BCBS Statewide PPO Option

COVERED SERVICES	NETWORK PROVIDERS	NON-NETWORK PROVIDERS	SPECIAL COMMENTS
PREVENTIVE CARE If the service is listed as A or B rated on the U.S. Preventive Service Task Force list, Health Resources and Services Administration (HRSA), the IRS Safe Harbor preventive services list, or *preventive care* for children under Bright Future guidelines, then the service is covered at 100% when performed by a *network* provider at a Routine Wellness Care visit. For more information about preventive services please refer to the following websites: **https://www.healthcare.gov/coverage/preventive-care-benefits/** **https://www.uspreventiveservicestaskforce.org/uspstf/recommendation-topics/uspstf-a-and-b-recommendations** **www.hrsa.gov** **Safe Harbor Services:** **https://www.irs.gov/pub/irs-drop/n-04-23.pdf** **https://www.irs.gov/pub/irs-drop/n-19-45.pdf** The *Plan* does not limit all federally mandated *preventive care* services to age/frequency/gender guidelines as outlined by the USPSTF.			
Routine Wellness Care	100% *co-insurance*, *deductible* waived	Not Covered	Services include routine physical exam, related wellness labs and x-rays, immunizations, gynecological exam, pap smear, PSA test, 2D and 3D mammogram, colorectal cancer screening, blood work, bone density testing, and shingles vaccine. Please refer to the **Medical Benefits** section, Covered Medical Charges, Preventive Care, for a further description and limitations of this benefit.
Breastfeeding Pump and Supplies	100% *co-insurance*, *deductible* waived	Not Covered	Breastfeeding support and supplies, including breast pumps. Please refer to the **Medical Benefits** section, Covered Medical Charges, Preventive Care, for a further description and limitations of this benefit.
Contraceptive Services	100% *co-insurance*, *deductible* waived	Not Covered	Services include FDA-approved contraceptive methods, sterilization procedures, and patient education and counseling, not including drugs that induce abortion.

Refer to the Medical Benefits section, Medical Plan Exclusions subsection for additional information relating to excluded services.

K. Schedule of Telemedicine Benefits – BCBS Statewide PPO Option

Telemedicine benefits are considered under the following benefit structure.

COVERED SERVICES	TELADOC	SPECIAL COMMENTS
TELEMEDICINE		
Telemedicine	100% *co-insurance*, *deductible* waived	Teladoc is a group of state-licensed, board-certified primary care *physicians* providing consultations twenty-four (24) hours a day. Teladoc physicians diagnose routine, non-emergency medical problems via telephone or online, recommend treatment, and prescribe medication when appropriate. To access this service call 1-800-Teladoc (835-2362) or visit **www.teladoc.com**.

L. Schedule of Prescription Drug Benefits – BCBS Statewide PPO Option

The *prescription drug* benefits are separate from the medical benefits. Generic, preferred, non-preferred, and mail order *prescription drugs* are administered by MedOne. Refer to the **Prescription Drug Benefits** section of this plan document for additional information on *prescription drug* coverage.

Prescription drug charges do not apply to the medical *deductible*.

Prescription drug charges do apply to the medical *out-of-pocket* maximum.

Benefits shown as *co-payments* are listed for what the *plan participant* will pay.

	NETWORK	NON-NETWORK
Retail Pharmacy Option (31-Day Supply)		
Generic/Tier 1 Drugs	$5 *co-payment* per prescription	Not Covered
Preferred/Tier 2 Drugs	$40 *co-payment* per prescription	Not Covered
Non-Preferred/Tier 3 Drugs	$80 *co-payment* per prescription	Not Covered
Mail Order Pharmacy Option (90-Day Supply)		
Generic/Tier 1 Drugs	$10 *co-payment* per prescription	Not Applicable
Preferred/Tier 2 Drugs	$80 *co-payment* per prescription	Not Applicable
Non-Preferred/Tier 3 Drugs	$160 *co-payment* per prescription	Not Applicable

Certain *preventive care prescription drugs* [including generic contraceptives (and brand contraceptives when a generic equivalent is not available)] received by a *network pharmacy* are covered at 100% and the *deductible/co-payment/co-insurance* (if applicable) is waived.

Please refer to the following websites for information on the types of payable *preventive care prescription drugs*:
https://www.healthcare.gov/coverage/preventive-care-benefits/ or
https://www.uspreventiveservicestaskforce.org/uspstf/recommendation-topics/uspstf-a-and-b-recommendations

The *Plan* also covers certain Safe Harbor medications at the preventive rate. For a complete list of preventive and Safe Harbor medications, refer to the MedOne list at **www.medone-rx.com** and click on Members->Drug Lookup.

Claims for reimbursement of *prescription drugs* are to be submitted to the Pharmacy Benefits Manager at the address listed in the Quick Reference Information Chart.

NOTE: For a complete list of covered drugs and supplies, and applicable limitations and exclusions, please refer to the MedOne Drug Lookup tool, which is available from MedOne at **www.medone-rx.com**. Click on Members->Drug Lookup. For assistance call the Pharmacy Benefits Manager as listed in the MedOne at 1-866-335-9057the Pharmacy Benefits Manager as listed in the Quick Reference Information Chart.

M. Schedule of Specialty Prescription Drugs – BCBS Statewide PPO Option

Specialty *prescription drugs* are separate from the *prescription drug* benefits with MedOne and are administered by VIVIO Health. Refer to the **VIVIO Health Program** section for more information pertaining to coverage of specialty *prescription drugs*.

Mail Order Pharmacy Option (31-day supply)	**Mail Order Pharmacy Option** (90-day supply)
Specialty Drug Co-Payment $0 *co-payment* per prescription	**Specialty Drug Co-Payment** $0 *co-payment* per prescription

N. High Deductible Health Plan (HDHP)

A qualified *high deductible health plan* (*HDHP*) with a *health savings account* (*HSA*) provides comprehensive coverage for high-cost medical events and a tax-advantaged way to help build savings for future medical expenses. The *Plan* gives you greater control over how health care benefits are used. An *HDHP* satisfies certain statutory requirements with respect to minimum *deductibles* and *out-of-pocket limits* for both individual and family coverage. These minimum *deductibles* and maximum *out-of-pocket limits* are set forth by the U.S. Department of Treasury and will be indexed for inflation in the future.

How This Plan Works

This *Plan* features higher annual *deductibles* and *out-of-pocket limits* than other traditional health plans. With the exception *of preventive care*, you must meet the annual *deductible* before the *Plan* pays benefits. It is called a *high deductible health plan* or *HDHP*.

It is paired with a *health savings account* (*HSA*). You may elect to make pre-tax contributions from your paycheck to your *HSA* each pay period. The *HDHP* provides medical and *prescription drug* coverage, and the *HSA* provides a tax-free way to help you save for health expenses in retirement. The *HDHP* gives you flexibility and discretion to determine how to use your health care benefits.

You can pay your *deductible* with funds from your *HSA*, or you can choose to pay your *deductible* out-of-pocket, allowing your *health savings account* to grow. Preventive care services are not subject to the *deductible*. These benefits are paid at 100%.

Applying Expenses to the Deductible

If you have not met your *deductible*, you will be responsible for 100% of the *allowed amount* for your health care expenses. If you use a *network* provider, the provider will submit the *claim* to the *Third Party Administrator* on your behalf. If you use a *non-network* provider, your *physician* may ask you to pay for the services provided before you leave the office. In that case, you must submit your *claim* to the *Third Party Administrator* to ensure your expenses are applied to the *deductible*. You will subsequently receive an *Explanation of Benefits* from the *Third Party Administrator* stating how much the negotiated payment amount is and the amount for which you are responsible.

O. Requirements for a Health Savings Account (HSA)

To be eligible for enrollment in a *health saving account*, you must:

1. be enrolled in a qualified *HDHP*
2. in general, not have any other non-*HDHP* medical coverage including coverage under a health flexible spending account or health reimbursement account

   You are allowed to have auto, dental, vision, disability, and long-term care insurance at the same time as an *HDHP*.
3. not be enrolled in a general purpose health care flexible spending account (and your spouse may not be enrolled in a general purpose flexible spending account)
4. not be enrolled in *Medicare*
5. not be claimed as a *dependent* on someone else's tax return

Qualified Medical Expenses

A partial list is provided in IRS Publication 502, available at **www.irs.gov**.

P. Schedule of Medical Benefits – BCBS Statewide HSA Option

	NETWORK PROVIDERS	NON-NETWORK PROVIDERS
Deductible, per Plan Year The *deductible* includes *prescription drugs*. *Co-insurance* does not apply to the *deductible*.		
Per *plan participant*	$3,200	Not Covered
Per *family unit*	$6,400	Not Covered
Family Unit - Embedded Deductible If you are enrolled in the family option on the *high deductible health plan*, your *Plan* contains two (2) components: an individual *deductible* and a *family unit deductible*. Having two (2) components to the *deductible* allows for each member of your *family unit* the opportunity to have your *Plan* cover medical expenses prior to the entire dollar amount of the *family unit deductible* being met. The individual *deductible* is embedded in the family *deductible*. **For example,** if you, your spouse, and child are on a family plan with a $6,000 *family unit* embedded *deductible*, and the individual *deductible* is $3,000, and your child *incurs* $3,000 in medical bills, their *deductible* is met, and your *Plan* will help pay subsequent medical bills for that child during the remainder of the *calendar year*, even though the *family unit deductible* of $6,000 has not been met yet.		
Out-of-Pocket Limit, per Plan Year The *out-of-pocket limit* includes *co-insurance*, *deductibles,* and covered *prescription drug* charges.		
Per *plan participant*	$6,900	Not Covered
Per *family unit*	$13,800	Not Covered
Family Unit - Embedded Out-of-Pocket Limit If you are enrolled in the *family unit* option, your *Plan* contains two (2) components: an individual *out-of-pocket limit* and a *family unit out-of-pocket limit*. Having two (2) components to the *out-of-pocket limit* allows each member of your *family unit* the opportunity to have their *covered charges* be payable at 100% (except for the charges excluded) prior to the entire dollar amount of the *family unit out-of-pocket limit* being met. The individual *out-of-pocket limit* is embedded in the *family unit out-of-pocket limit*.		
The *Plan* will pay the designated percentage of *covered charges* until *out-of-pocket limits* are reached at which time the *Plan* will pay 100% of the remainder of *covered charges* for the rest of the *plan year* unless stated otherwise. **NOTE: The following charges do not apply toward the out-of-pocket limit amount and are generally not paid by the Plan:** 1. cost containment penalties 2. amounts over *maximum allowable charges* 3. charges not covered under the *Plan* 4. *balanced billed* charges		

Benefits shown as *co-insurance* are listed for the percentage the *Plan* will pay.

COVERED SERVICES	NETWORK PROVIDERS	NON-NETWORK PROVIDERS	SPECIAL COMMENTS
General Percentage Payment Rule	80% *co-insurance* after *deductible*	Not Covered	Generally, most *covered charges* are subject to the benefit payment percentage contained in this row, unless otherwise noted. This Special Comments column provides additional information and limitations about the applicable *covered charges*, including the expenses that must be *pre-certified* and those expenses to which the *out-of-pocket limit* does not apply.
Advanced Imaging	80% *co-insurance* after *deductible*	Not Covered	Includes Computed Tomographic (CT) studies, Coronary CT angiography, MRI/MRA, MR-guided focused ultrasound, nuclear cardiology, nuclear medicine (including SPECT scans), and PET scans, excluding services rendered in an emergency room setting. ***Pre-certification* is required.**
Ambulance Service	80% *co-insurance* after *deductible*		Please refer to the **Medical Benefits** section, Covered Medical Charges, Ambulance, for a further description and limitations of this benefit. ***Pre-certification* is required for non-emergent air ambulance.**
Birthing Center	80% *co-insurance* after *deductible*	Not Covered	***Pre-certification* is required for inpatient stay in excess of forty-eight (48) hours for a vaginal delivery or ninety-six hours (96) for a cesarean delivery.**
Congenital Heart Disease	80% *co-insurance* after *deductible*	Not Covered	Benefits are only for the inpatient facility charges for congenital heart disease. Benefits for diagnostic services, cardiac catheterization, and non-surgical management of the disease will be covered under the applicable benefit.
Dental Injury	80% *co-insurance* after *deductible*	Not Covered	
Diagnostic Testing	80% *co-insurance* after *deductible*	Not Covered	
Durable Medical Equipment (DME)	80% *co-insurance* after *deductible*	Not Covered	***Pre-certification* is required** for *DME* in excess of $3,000 purchase price.
Emergency Room	80% *co-insurance* after *deductible*		
Foot Orthotics	80% *co-insurance* after *deductible*	Not Covered	**Benefit Limitations:** Limited to once in a period of twelve (12) months for *plan participants* over age nineteen (19) and once in a period of six (6) months for *plan participants* under age nineteen (19) when replacement is required due to growth.

COVERED SERVICES	NETWORK PROVIDERS	NON-NETWORK PROVIDERS	SPECIAL COMMENTS
Gender Dysphoria	80% *co-insurance* after *deductible*	Not Covered	
Home Health Care	80% *co-insurance* after *deductible*	Not Covered	**Plan Year Maximum:** One Hundred Twenty (120) days per *plan participant*. Home infusion services do not apply towards the plan year maximum. ***Pre-certification* is required.**
Hospice Care			
Hospice Care	80% *co-insurance* after *deductible*	Not Covered	*Hospice care services and supplies* for *plan participants* with a life expectancy of less than six (6) months.
Bereavement Counseling	80% *co-insurance* after *deductible*	Not Covered	*Bereavement counseling* is covered for family members of *plan participants* within the six (6) months following death.
Inpatient Hospital	80% *co-insurance* after *deductible*	Not Covered	***Pre-certification* is required.**
Inpatient Rehabilitation Facilities	80% *co-insurance* after *deductible*	Not Covered	**Plan Year Maximum:** Sixty (60) visits per *plan participant* for inpatient rehabilitation facilities. ***Pre-certification* is required.**
Lab and X-Ray	80% *co-insurance* after *deductible*	Not Covered	
Maternity			
Office Visit (Pre- and post-natal care)	100% *co-insurance*, *deductible* waived	Not Covered	*Dependent* child *pregnancy* is limited to coverage for mandated services and complications.
All Other Services	80% *co-insurance* after *deductible*	Not Covered	Office visits for reasons other than *pre-* and *post-natal* care will be covered at the office visit benefit level.
Labor and Delivery	80% *co-insurance* after *deductible*	Not Covered	***Pre-certification* is required for inpatient stay in excess of forty-eight (48) hours for a vaginal delivery or ninety-six hours (96) for a cesarean delivery.**
Mental Disorders & Substance Use Disorder			
Inpatient	80% *co-insurance* after *deductible*	Not Covered	This includes residential treatment facilities. ***Pre-certification* is required.**
Outpatient	80% *co-insurance* after *deductible*	Not Covered	*Outpatient* services are also available through Lyra. For more information please visit **https://kyrene.lyrahealth.com** or call 1-877-203-9680.
Partial Hospitalization and Outpatient Intensive Day Treatment	80% *co-insurance* after *deductible*	Not Covered	***Pre-certification* is required** in excess of twenty (20) visits per *plan year*, per service type.

COVERED SERVICES	NETWORK PROVIDERS	NON-NETWORK PROVIDERS	SPECIAL COMMENTS
Office Visit	80% *co-insurance* after *deductible*	Not Covered	Home visits are covered under the *Plan*.
Orthotic Appliances/Prosthetics	80% *co-insurance* after *deductible*	Not Covered	***Pre-certification* is required** for orthotics/prosthetics in excess of $3,000 purchase price.
Ostomy Supplies	80% *co-insurance* after *deductible*	Not Covered	
Outpatient Surgery	80% *co-insurance* after *deductible*	Not Covered	***Pre-certification* is required** for *outpatient surgical procedures* (other than office surgeries, colonoscopies, sigmoidoscopies, and intra-articular hyaluronic acid injections).
Routine Newborn Care	80% *co-insurance* after *deductible*	Not Covered	Routine newborn care is subject to the mother's *deductible* and *out-of-pocket limit*. If the mother is not covered under the *Plan*, then these expenses apply to the newborn's *deductible* and *out-of-pocket limit*.
Skilled Nursing Facility	80% *co-insurance* after *deductible*	Not Covered	**Plan Year Maximum:** One hundred twenty (120) days per *plan participant*. ***Pre-certification* is required.**
Therapy Services			
Physical Therapy Occupational Therapy Speech Therapy	80% *co-insurance* after *deductible*	Not Covered	***Pre-certification* is required** for outpatient services in excess of twenty (20) visits per *plan year* for each therapy type.
Urgent Care	80% *co-insurance* after *deductible*	Not Covered	
Wigs	80% *co-insurance* after *deductible*		Limited to hair loss related to chemotherapy. **Lifetime Maximum:** Limited to one (1) wig per *plan participant* for network providers. Non-network providers and over-the-counter purchases are limited to one (1) wig per *plan participant* up to a $300 maximum.

COVERED SERVICES	NETWORK PROVIDERS	NON-NETWORK PROVIDERS	SPECIAL COMMENTS
PREVENTIVE CARE If the service is listed as A or B rated on the U.S. Preventive Service Task Force list, Health Resources and Services Administration (HRSA), the IRS Safe Harbor preventive services list, or *preventive care* for children under Bright Future guidelines, then the service is covered at 100% when performed by a *network* provider at a Routine Wellness Care visit. For more information about preventive services please refer to the following websites: **https://www.healthcare.gov/coverage/preventive-care-benefits/** **https://www.uspreventiveservicestaskforce.org/uspstf/recommendation-topics/uspstf-a-and-b-recommendations** **www.hrsa.gov** **Safe Harbor Services:** **https://www.irs.gov/pub/irs-drop/n-04-23.pdf** **https://www.irs.gov/pub/irs-drop/n-19-45.pdf** Non-Preventive Care services which are ordered or performed at a Routine Wellness Care visit are not considered under the Preventive Care benefit. Those services will apply to their applicable benefit level or exclusion as appropriate. The *Plan* does not limit all federally mandated *preventive care* services to age/frequency/gender guidelines as outlined by the USPSTF.			
Routine Wellness Care	100% *co-insurance*, *deductible* waived	Not Covered	Services include routine physical exam, labs and x-rays, immunizations, gynecological exam, pap smear, PSA test, 2D and 3D mammogram, colorectal cancer screening, blood work, bone density testing, and shingles vaccine. Please refer to the **Medical Benefits** section, Covered Medical Charges, Preventive Care, for a further description and limitations of this benefit.
Breastfeeding Pump and Supplies	100% *co-insurance*, *deductible* waived	Not Covered	Breastfeeding support and supplies, including breast pumps. Please refer to the **Medical Benefits** section, Covered Medical Charges, Preventive Care, for a further description and limitations of this benefit.
Contraceptive Services	100% *co-insurance*, *deductible* waived	Not Covered	Services include FDA-approved contraceptive methods, sterilization procedures, and patient education and counseling, not including drugs that induce abortion. **Benefit Limitations:** Sterilization services are available to all female *plan participants* at no cost sharing. Male sterilization services are subject to the *deductible*.

Refer to the Medical Benefits section, Medical Plan Exclusions subsection for additional information relating to excluded services.

Q. Schedule of Telemedicine Benefits – BCBS Statewide HSA Option

Telemedicine benefits are considered under the following benefit structure.

COVERED SERVICES	TELADOC	SPECIAL COMMENTS
TELEMEDICINE		
Telemedicine	80% *co-insurance* after *deductible*	Teladoc is a group of state-licensed, board-certified primary care *physicians* providing consultations twenty-four (24) hours a day. Teladoc physicians diagnose routine, non-emergency medical problems via telephone or online, recommend treatment, and prescribe medication when appropriate. To access this service call 1-800-Teladoc (835-2362) or visit **www.teladoc.com**.

R. Schedule of Prescription Drug Benefits – BCBS Statewide HSA Option

The *prescription drug* benefits are separate from the medical benefits. Generic, preferred, non-preferred, and mail order *prescription drugs* are administered by MedOne. Refer to the **Prescription Drug Benefits** section of this plan document for additional information on *prescription drug* coverage.

Prescription drug charges apply to the medical *deductible*.

Prescription drug charges apply to the medical out-of-pocket maximum.

Benefits shown as *co-insurance* are listed for the percentage the *Plan* will pay.

<table>
<tr><th></th><th>NETWORK</th><th>NON-NETWORK</th></tr>
<tr><td colspan="3">Retail Pharmacy Option (30-Day Supply)</td></tr>
<tr><td>Generic/Tier 1 Drugs</td><td rowspan="3">You pay 20% co-insurance after Medical Plan deductible is met</td><td rowspan="3">Not Covered</td></tr>
<tr><td>Preferred/Tier 2 Drugs</td></tr>
<tr><td>Non-Preferred/Tier 3 Drugs</td></tr>
<tr><td colspan="3">Mail Order Pharmacy Option (90-Day Supply)</td></tr>
<tr><td>Generic/Tier 1 Drugs</td><td rowspan="3">You pay 20% co-insurance after Medical Plan deductible is met</td><td>Not Applicable</td></tr>
<tr><td>Preferred/Tier 2 Drugs</td><td>Not Applicable</td></tr>
<tr><td>Non-Preferred/Tier 3 Drugs</td><td>Not Applicable</td></tr>
<tr><td colspan="3">Certain preventive care prescription drugs [including generic contraceptives (and brand contraceptives when a generic equivalent is not available)] received by a network pharmacy are covered at 100% and the deductible/co-payment/co-insurance (if applicable) is waived.

Please refer to the following website for information on the types of payable preventive care prescription drugs: https://www.healthcare.gov/coverage/preventive-care-benefits/ or https://www.uspreventiveservicestaskforce.org/uspstf/recommendation-topics/uspstf-a-and-b-recommendations.

The Plan also covers certain Safe Harbor medications at the preventive rate. For a complete list of preventive and Safe Harbor medications, refer to the MedOne list at www.medone-rx.com and click on Members->Drug Lookup.</td></tr>
</table>

Claims for reimbursement of *prescription drugs* are to be submitted to the Pharmacy Benefits Manager at the address listed in the Quick Reference Information Chart.

NOTE: For a complete list of covered drugs and supplies, and applicable limitations and exclusions, please refer to the MedOne Drug Lookup tool, which is available from MedOne at **www.medone-rx.com**. Click on Members->Drug Lookup. For assistance call the Pharmacy Benefits Manager as listed in the Quick Reference Information Chart.

S. Schedule of Specialty Prescription Drugs – BCBS Statewide HSA Option

Specialty prescription drugs are separate from the prescription drug benefits with MedOne and are administered by VIVIO Health. Refer to the **VIVIO Health Program** section for more information pertaining to coverage of specialty *prescription drugs*.

Mail Order Pharmacy Option (31-day supply)	**Mail Order Pharmacy Option** (90-day supply)
Specialty Drug Co-Insurance You pay 0% *co-insurance* after Medical Plan *deductible* is met	**Specialty Drug Co-Insurance** You pay 0% *co-insurance* after Medical Plan *deductible* is met

T. Schedule of Outpatient Dialysis Services – Both Plan Options

The *outpatient* dialysis benefits are separate from the medical benefits and are administered by AmeriBen. Refer to the **Outpatient Dialysis Services** section of this plan document for additional information on *outpatient* dialysis services coverage.

COVERED SERVICES	ALL PROVIDERS	SPECIAL COMMENTS
DIALYSIS, OUTPATIENT		
Dialysis, outpatient	80% *co-insurance* after *deductible*	The following *outpatient* dialysis services will be considered at 140% of *Medicare*, and then *Plan* benefits will apply: • facility and professional charges from *outpatient hospital*s and dialysis facilities • home dialysis charges Refer to the **Outpatient Dialysis Services** section for a further description and limitations of this benefit. ***Pre-certification* is required.**

U. Schedule of Transplant Services – Both Plan Options

The transplant benefits are considered under the following benefit structure. Refer to the **Transplant Program** section of this plan document for additional information on transplant services coverage.

COVERED SERVICES	NETWORK PROVIDERS	NON-NETWORK PROVIDERS	SPECIAL COMMENTS
TRANSPLANTS			
Organ Transplants	80% *co-insurance* after *deductible*	Not Covered	Refer to the **Transplant Program** section for a further description and limitations of this benefit. All other related services will pay at the applicable benefit level. ***Pre-certification* is required.**

SECTION VI—MEDICAL BENEFITS

Medical benefits apply when *covered charges* are *incurred* for care of an *injury* or *illness* while a *plan participant* is covered for these benefits under the *Plan*.

A. Covered Medical Charges

Covered charges are the *maximum allowable charges* that are *incurred* for the following items of service and supply. These charges are subject to the benefit limits, exclusions, and other provisions of this *Plan*. A charge is *incurred* on the date that the service or supply is performed or furnished.

1. **3D Mammogram.**
2. **Abortion.** Services, supplies, care, or treatment in connection with an abortion only in instances where the life of the mother is endangered by the continued *pregnancy* or the *pregnancy* is the result of rape or incest. Refer the Medical Plan Exclusions for services not covered under the *Plan*.
3. **Adoptive Cell Therapy.** For FDA approved adoptive cell therapy such as chimeric antigen receptor T-cell (CAR T) therapy along with associated services and supplies.

   ***Pre-certification* is required**. Refer to the Travel Expenses provision in the Covered Medical Charges for applicable travel benefits.
4. **Advanced Imaging.** Charges for advanced imaging, including Computed Tomographic (CT) studies, Coronary CT angiography, MRI/MRA, MR-guided focused ultrasound, nuclear cardiology, nuclear medicine (including SPECT scans), and PET scans. Charges include the readings of these medical tests/scans.

   ***Pre-certification* is required.** *Covered charges* will be payable as shown in the applicable Schedule of Medical Benefits.
5. **Allergy Services.** Charges for allergy testing and the cost of the resultant serum preparation (antigen) and its administration, when rendered by a *physician* or in the *physician's* office.
6. **Ambulance.** Benefits will be provided for licensed ground, air, and water ambulance services used to transport you from the place where you are *injured* or stricken by *illness*, or for inter-facility transport, as deemed *medically necessary,* to the nearest accredited general *network hospital* with adequate facilities for treatment. Inter-facility transport is also available to a *network hospital* after you have been stabilized at a *non-network hospital*. Charges for services requested for a licensed ground, air, or water ambulance service, when the patient is not transported, will be covered by the *Plan*. Services for chartered flights will not be covered by the *Plan*. *Covered charges* will be payable as shown in the applicable Schedule of Medical Benefits.

   ***Pre-certification* is required for non-emergent air ambulance.**
7. **Anesthetics.** Includes anesthetic, oxygen, intravenous injections/solutions, and the administration of these items.
8. **Birthing Center.** The medical services and supplies furnished by a *birthing center*. *Covered charges* will be payable as shown in the applicable Schedule of Medical Benefits.
9. **Blood.** Non-replaced blood, blood plasma, short term [less than thirty (30) days] cord blood harvesting and storage, blood derivatives, and their administration and processing.
10. **Cardiac Rehabilitation.** Cardiac rehabilitation as deemed *medically necessary,* provided services are:
    a. Initiated within twelve (12) weeks after other treatment for the medical condition ends
    b. rendered in a *medical care facility* as defined by this *Plan*
11. **Cataract Surgery.** Services and supplies associated with cataract *surgery*.
12. **Chemotherapy/Radiation.** Radiation or chemotherapy and treatment with radioactive substances, including materials and services of technicians. ***Pre-certification* is required.**
13. **Circumcision.** Circumcision for newborns from birth to six (6) months. After six (6) months, only *medically necessary* circumcisions will be covered.

14. **Clinical Trials.** This *Plan* will cover routine patient costs for a *qualified individual* participating in an *approved clinical trial* that is conducted in connection with the prevention, detection, or treatment of cancer or other *life-threatening disease or condition* and is federally funded through a variety of entities or departments of the federal government, is conducted in connection with an *investigational* new drug application reviewed by the Food and Drug Administration, or is exempt from *investigational* new drug application requirements. Refer to the Medical Plan Exclusions subsection for a further description and limitations of this benefit. ***Pre-certification* is required.**

15. **Congenital Heart Disease.** *Covered charges* will be payable as shown in the applicable Schedule of Medical Benefits. Refer to the Travel Expenses provision in the Covered Medical Charges for applicable travel benefits.

16. **Contraceptives.** Injections, implants, devices, and associated *physician* charges are covered under the *Preventive Care* provision of this *Plan*. Self-administered contraceptives (not over-the-counter), are covered under the **Prescription Drug Benefits** section of this *Plan*.

17. **COVID-19 Services.** The *Plan* provides coverage for diagnostic testing (excluding over-the-counter or administrative/return-to-work testing) and treatment. *Experimental/investigational* treatment is not covered.

18. **Dental Injuries.** *Injury* to or care of the mouth, teeth, gums, and alveolar processes will be *covered charges* under this *Plan* only if that care is initiated within three (3) months following the injury and is for the following oral *surgical procedures*:

    a. *emergency* repair due to *injury*

    b. *surgery* needed to correct *accidental injuries* to the jaws, cheeks, lips, tongue, floor, and roof of the mouth

    NOTE: No charge will be covered under this *Plan* for dental and oral *surgical procedures* involving orthodontic care of teeth, periodontal *disease*, and preparing the mouth for fitting of or continued use of dentures.

    Covered charges will be payable as shown in the applicable Schedule of Medical Benefits.

19. **Diabetic Education.** Services and supplies used in *outpatient* diabetes self-management programs are covered under this *Plan* when they are provided by a *physician*. This is different from nutritional counseling/nutritional therapy.

20. **Diagnostic Testing.** *Covered charges* will be payable as shown in the applicable Schedule of Medical Benefits.

21. **Durable Medical Equipment (DME).** Rental of *durable medical equipment* (*DME*) if deemed *medically necessary*. The total rental fee for *durable medical equipment* will not exceed the purchase price of the equipment. If the purchase price is not available, rental is allowed for the lifetime of the equipment. Repair, delivery, set-up, and education charges pertaining to DME are covered.

    ***Pre-certification* is required when the purchase and/or rental price is expected to exceed $3,000.**

    Replacement of purchased equipment if either:

    a. the replacement is needed because of a change in your physical condition

    b. it is likely to cost less to replace the item than to repair the existing item or rent a similar item

    Maintenance and repairs needed due to misuse or abuse are not covered.

    The following items will be considered under the DME benefit:

    a. **Diabetic Equipment.** Includes insulin pumps and continuous glucose monitors. For additional diabetic supplies, refer to the Medical Supplies benefit or the **Prescription Drug Benefits** section of this *Plan*.

       Refer to the *Preventive Care* provision or visit **https://www.irs.gov/pub/irs-drop/n-19-45.pdf** for a current listing of diabetic equipment and supplies related *preventive care* benefits.

    b. **Oxygen.** Oxygen and its administration, including oxygen concentrators. Oxygen concentrators are not subject to purchase price requirements.

    c. **Sleep Apnea Oral Devices.**

    Covered charges will be payable as shown in the applicable Schedule of Medical Benefits.

22. **Educational Services.** Medical education services that are provided in a physician's office by appropriately licensed or registered healthcare professionals.

23. **Family History.** Charges related to services provided with a diagnosis of family history, including as covered under applicable federal law.

24. **Foot Care.** Treatment for metabolic or peripheral-vascular *disease,* plantar fasciitis, neuromas, nail bed removal, or cutting/surgical procedures when *medically necessary* and not otherwise excluded. Includes prescribed diabetic shoes and custom/non-custom molded foot orthotics when provided by a physician for a covered treatment and limited as shown in the applicable Schedule of Medical Benefits.

25. **Gender.** Services will be considered under the applicable benefit level and limited as any other service outlined in the plan document. Services will not be limited based on an individual's documented gender.

26. **Gene Therapy.** ***Pre-certification*** **is required**.

    Genetic/Genomic Testing and Counseling. Genetic and genomic testing to identify the potential for, or existence of, a medical condition and/or to examine abnormalities in groups of genes to aid in designing specific treatment options for an individual's condition—as mandated under applicable federal law or as *medically necessary*. ***Pre-certification*** **is required.**

27. **Home Health Care.** Charges for *home health care services and supplies* are covered only for care and treatment of an *illness* or *injury* when *hospital* or *skilled nursing facility* confinement would otherwise be required. The diagnosis, care, and treatment must be certified by the attending *physician* and be contained in a *home health care plan*.

    a. Benefit payment for nursing, home health aide, and therapy services are subject to the home health care limit shown in the applicable Schedule of Medical Benefits.

    b. A home health care visit will be considered a periodic visit by a *physician* acting within the scope of their license and/or as defined under *home health care services*.

    Pre-certification **is required.** *Covered charges* will be payable as shown in the applicable Schedule of Medical Benefits.

28. **Home Infusion Therapy.** Home infusion therapy does not apply to the home health care maximum.

29. **Home Visits.** When a provider visits the home for covered services, commonly known as a 'house call.' This is separate from home health care and therapy done in the home.

30. **Hospice Care.** *Hospice care services and supplies* for *plan participants* with a life expectancy of less than six (6) months. Services must be rendered by a state-licensed *hospice care agency* and included in a written *hospice care plan* established and periodically reviewed by the attending *physician*. The *physician* must certify the *plan participant* is terminally *ill* and that *hospital* confinement would be required in the absence of the hospice care. The *hospice care plan* shall also describe the services and supplies for palliative care and *medically necessary* treatment to be provided to the *plan participant* by the *hospice care agency*. Benefits are provided for:

    a. medical supplies

    b. visits by a *physician*

    c. bereavement counseling services for the hospice patient's immediate family (covered spouse and/or other covered *dependents*) only when the hospice patient is a *plan participant*

       Bereavement services must be furnished within six (6) months after the patient's death. A licensed pastoral counselor will be considered a covered provider for purposes of bereavement counseling, subject to all other *Plan* provisions.

    Covered charges will be payable as shown in the applicable Schedule of Medical Benefits.

31. **Hospital Care.** The medical services and supplies furnished by a *hospital* or *ambulatory surgical facility*. *Covered charges* for *room and board* will be payable as shown in the applicable Schedule of Medical Benefits.

    Pre-certification **is required for inpatient admissions.**

32. **Implantable Hearing Devices.** Charges for services, supplies, and hearing exams in connection with cochlear implants and exams for their fitting. Benefits include aural therapy in connection with covered implantable hearing devices and apply to the Speech Therapy benefit level.

33. **Impotence.** Care, treatment, services, supplies, or medication in connection with treatment for organic impotence, based on *medical necessity*.

34. **Infertility.** Services include office visits and initial *diagnostic testing*. Refer to the Medical Plan Exclusions for services not covered under the *Plan*.

35. **Injections and Infusion Therapy.** Benefits are available for injections and infusion therapies received in a *physician's* office or other covered facility. For specialty drugs covered through VIVIO Health a one (1) time grace fill will be allowed.

36. **Laboratory Studies.** *Covered charges* for diagnostic lab testing and services. *Covered charges* will be payable as shown in the applicable Schedule of Medical Benefits.

37. **Lenses.** The initial purchase of eyeglasses, contact lenses, or intraocular lenses for the following conditions:

    a. following cataract surgery

    b. damaged lens due to eye trauma

    c. congenital cataract

    d. congenital aphakia

    e. lens subluxation/displacement

    f. anisometropia of two (2) diopters or greater, and uncorrectable vision with the use of glasses or contacts

    g. replacement of a previously implanted, *medically necessary* intraocular lens due to anatomical change, inflammatory response, or mechanical failure

    A clear lens extraction intraocular lens implant for the correction of refractive error is not considered *medically necessary*. Intraocular lenses used to correct presbyopia and astigmatism are not considered *medically necessary*.

38. **Manipulations.** Expenses for chiropractic and/or osteopathic manipulations. Limited to twenty (20) visits per *plan year* for *plan participants* eighteen (18) years or older.

39. **Mastectomy Bras and Camisoles.** Mastectomy bra and camisole purchases will be limited to four (4) items per type, per *plan participant,* per *plan year*.

40. **Maternity.** *Pregnancy* and complications of *pregnancy* shall be covered as any other *illness* for the *employee* or spouse. Benefits include pre-and post-natal care, obstetrical delivery, caesarean section, miscarriage, and complications resulting from the *pregnancy*. Charges for a planned home birth will be considered a covered benefit. Maternity coverage for *dependent* child *pregnancy* is limited to mandated services and complications.

    NOTE: Breastfeeding maintenance, breast milk storage supplies, pump parts, and other supplies are also available as outlined in the applicable Schedule of Medical Benefits. Lactation counseling will be paid as other preventive services.

    Pregnancy tests are not considered *preventive care* even when performed in conjunction with covered birth control services. Refer to the *Preventive Care* provision or visit **https://www.healthcare.gov/coverage/preventive-care-benefits/** or **http://www.uspreventiveservicestaskforce.org/Page/Name/uspstf-a-and-b-recommendations/** for a current listing of required *pregnancy* related *preventive care* benefits.

    Delivery and hospitalization stay may be subject to *pre-certification* if over the standards set forth in the Newborns' and Mothers' Health Protection Act. Refer to the **Federal Notices** section for the statement of rights under the Newborns' and Mothers' Health Protection Act for certain protections mothers and newborns have regarding *hospital* stays.

    Covered charges will be payable as shown in the applicable Schedule of Medical Benefits.

41. **Medical Foods.** Enteral and parenteral medical foods are considered a *covered charge* if intravenous therapy (IV) or tube feedings are *medically necessary*. Medical foods taken orally are not covered under the *Plan*, except for PKU formula when *medically necessary*.

42. **Medical Supplies.** Charges for surgical dressings, splints, casts, and other devices used in the reduction of fractures and dislocations. Also included are supplies and dressings when *medically necessary* for surgical wounds, cancer, burns, diabetic ulcers, colostomy bags and catheters, supplies for insulin pumps and continuous blood glucose monitor, and surgical and orthopedic braces. Jobst/compression stockings are limited to four (4) units, or two (2) pairs, per *plan participant* per *plan year*.

    Visit **https://www.irs.gov/pub/irs-drop/n-19-45.pdf** and **https://www.irs.gov/pub/irs-drop/n-04-23.pdf** for a current listing of medical supplies related *preventive care* benefits.

43. **Mental Disorders and Substance Use Disorder.** Coverage for mental health treatments are considered the same as benefits provided for other medical conditions. *Inpatient* and *outpatient* treatment for *mental disorders* will be eligible when rendered by a licensed psychiatrist or licensed psychologist or when rendered by

a *physician* as defined. Includes *applied behavioral analysis* (*ABA*) therapy, psychiatric day treatment, residential treatment, partial hospitalization, and intensive *outpatient* programs. Benefits for counseling, including marital counseling; counseling for family problems; and group or family counseling are also covered. *Covered charges* will be payable as shown in the applicable Schedule of Medical Benefits.

***Pre-certification* is required for inpatient admissions, partial hospitalizations, and outpatient intensive day treatment.**

Refer to the **Federal Notices** section for the statement of rights under the *Mental Health Parity and Addiction Equity Act of 2008*.

44. **Midwife Services.** Benefits for midwife services performed by a certified nurse midwife (CNM) who is licensed as such and acting within the scope of their license. This *Plan* will not provide benefits for lay midwives or other individuals who become midwives by virtue of their experience in performing deliveries.

45. **National/Public Health Emergency.** In the event of a declared National Health Emergency (or Public Health Emergency), the *Plan* will offer coverage as mandated for the condition(s) as required by federal regulation. The *Plan* will also cover medications authorized for emergency use by the appropriate federal agencies in the event of a public health emergency. This provision shall override any potentially conflicting, specific exclusions, defined terms, or other *Plan* provisions as necessary to provide, and limited to, any mandated services as outlined in the national and/or public health emergency, and corresponding regulation(s). Such coverage shall remain in effect until the national and/or public health emergency, as declared by the governing federal agency, has ended.

46. **Neuropsychological Testing.** Tests used to evaluate patients who have experienced a traumatic brain injury, brain damage, or organic neurological problems (e.g., dementia). May also be used to evaluate the progress of a patient who has undergone treatment or rehabilitation for a neurological *injury* or *illness*.

47. **Nutritional Therapy/Counseling.** Nutritional counseling services, other than as part of Diabetic Education, when provided as part of treatment for a disease by licensed or registered health care professionals when both of the following are true:

    a. nutritional education required for a disease in which patient self-management is an important component of treatment

    b. there exists a knowledge deficit regarding the disease which requires the intervention of a trained health professional

48. **Oral Surgery.** Care of the mouth, teeth, gums, and alveolar processes will be a *covered charge* under this *Plan* only if that care is for the following oral *surgical procedures*:

    a. excision of tumors and cysts of the jaw, cheeks, lips, tongue, roof, and floor of the mouth

    b. excision of benign bony growths of the jaw and hard palate

    c. external incision and drainage of cellulitis

    d. incision of sensory sinuses, salivary glands, or ducts

    e. removal of all teeth at an *inpatient* or *outpatient hospital* or *dentist*'s office if removal of the teeth is part of standard medical treatment that is required before the *plan participant* can undergo radiation therapy for a covered medical condition

    f. organ transplant preparation

    g. removal of bony impacted teeth

    h. reduction of dislocations and excision of *temporomandibular joints (TMJ)*

    NOTE: No charge will be covered under this *Plan* for dental and oral *surgical procedures* involving orthodontic care of teeth, periodontal *disease,* and preparing the mouth for fitting of or continued use of dentures.

49. **Orthotic Appliances.** The initial purchase, fitting, and repair of orthotic appliances such as braces, splints, cranial helmets, or other appliances which are required for support for an *injured* or deformed part of the body as a result of a disabling congenital condition or an *injury* or *illness*. Benefits for repair or replacement of an orthotic appliance due to normal use, adolescent growth, or pathological changes will be provided.

    ***Pre-certification* is required when the purchase price is expected to exceed $3,000.** *Covered charges* will be payable as shown in the applicable Schedule of Medical Benefits.

50. **Physician Care.** The professional services of a *physician* for medical services. If an assistant surgeon is required, the assistant surgeon's covered charge will not exceed 20% of the surgeon's *maximum allowable charge*.

    Charges for **multiple *surgical procedures*** will be a *covered charge* subject to the following provisions:

    a. If bilateral or multiple *surgical procedures* are performed by one (1) surgeon, benefits will be determined based on the *maximum allowable charge* that is allowed for the primary procedures; 50% of the *maximum allowable charge* will be allowed for each additional procedure performed through the same incision. Any procedure that would not be an integral part of the primary procedure or is unrelated to the diagnosis will be considered incidental, and no benefits will be provided for such procedures.

    b. If multiple unrelated *surgical procedures* are performed by two (2) or more surgeons on separate operative fields, benefits will be based on the *maximum allowable charge* for each surgeon's primary procedure. If two (2) or more surgeons perform a procedure that is normally performed by one (1) surgeon, benefits for all surgeons will not exceed the *maximum allowable charge* allowed for that procedure.

    c. If a co-surgeon is required, meaning skills of both surgeons are necessary to perform distinct parts of a specific operative procedure, payment is based for each physician on the *maximum allowable charge* dividing the payment equally between the two (2) surgeons. *Surgeries* performed by co-surgeons that have the same specialty are not covered under the *Plan,* unless *medically necessary*.

51. **Pre-Admission Testing.** Includes diagnostic labs, x-rays, and EKGs that you obtain on an *outpatient* basis prior to your scheduled admission to the *hospital*. You should make sure your *hospital* will accept the results of these tests.

52. **Preventive Care.** Benefits will be provided for *preventive care,* including, but not limited to:

    a. **Adult Physical Examination, Well-Baby, and Well-Child Examinations.**

    b. **Breastfeeding Pump and Supplies.** Includes the cost of renting one (1) breast pump per pregnancy in conjunction with childbirth. Benefits for breast pumps also include the cost of purchasing one (1) breast pump per pregnancy in conjunction with childbirth.

       If more than one breast pump can meet your needs, benefits are available only for the most cost-effective pump, determined based on the following:

       i. which pump is the most cost-effective

       ii. whether the pump should be purchased or rented

       iii. duration of a rental

       iv. timing of an acquisition

    c. **Colorectal Cancer Screening.**

    d. **Contraceptives.** Injections, implants, devices, and associated *physician* charges are covered under the medical benefits of this *Plan*. Self-administered contraceptives are covered under the Prescription Drug Benefits.

    e. **Gynecological Exam.**

    f. **Lactation Counseling**

    g. **Mammogram.**

    h. **Pap Smear.** Limited to one (1) per *plan year* for *plan participants* of all ages.

    i. **Prostate Specific Antigen Test.**

    j. **Immunizations.** Pediatric and adult preventive vaccinations, inoculations, and immunizations, as recommended by the Centers for Disease Control and Prevention (CDC), including, but not limited to:

       i. **HPV Vaccine.**

       ii. **Influenza Vaccine.**

       iii. **Shingles Vaccine.**

       The *Plan* contributes to at least one (1) state-funded vaccination program, which covers the provider's costs associated with immunization serum for eligible, minor children up to the age of nineteen (19).

Should a provider bill a vaccine charge for a child who is covered by that state's immunization program, regardless of their eligibility under the *Plan*, the *Plan* will consider its financial obligation of that *claim* satisfied through its contribution to the state funded immunization program and will not remit payment for that *claim*, except as may be required by applicable federal law. The administration of immunizations is covered.

k. **Preventive Lab and X-Ray.** Screening and wellness laboratory and x-ray services related to routine examinations.

l. **Sterilization.** Services for vasectomy, tubal ligation, or other voluntary sterilization procedures for *plan participants* are covered. Vasectomy is subject to the *deductible* under the *HDHP*.

m. **Tobacco Cessation.** Education, counseling, and behavioral intervention services provided by a *physician* for smoking cessation up to two (2) attempts per *calendar year*, consisting of four (4) visits lasting ten (10) minutes each.

NOTE: Additional *preventive care* shall be covered as required by applicable law if provided by a *network* provider. A current listing of required *preventive care* can be accessed at the following websites:

a. **https://www.healthcare.gov/coverage/preventive-care-benefits/**

b. **https://www.uspreventiveservicestaskforce.org/uspstf/recommendation-topics/uspstf-a-and-b-recommendations**

c. **https://www.irs.gov/pub/irs-drop/n-04-23.pdf**

d. **https://www.irs.gov/pub/irs-drop/n-19-45.pdf**

53. **Prosthetic Devices.** The initial purchase of artificial limbs, eyes, and breast prostheses, including service and repair of an artificial limb, eye, or breast prosthesis, but not replacement of such items unless the attending *physician* indicates *medical necessity* due to a change in the body condition, and the artificial limb or eye cannot be repaired or made serviceable.

***Pre-certification* is required when the purchase price is expected to exceed $3,000.** *Covered charges* will be payable as shown in the applicable Schedule of Medical Benefits.

TMJ Oral devices will be considered under the prosthetic benefit.

54. **Reconstructive Surgery.** Reconstructive *surgery* expenses are covered in the following circumstances:

a. when needed to correct damage caused by a birth defect resulting in the malformation or absence of a body part

Surgical services must be initiated for *plan participants* before the age of nineteen (19).

b. to correct damage caused by an *accidental injury*

c. for breast reconstruction following a total or partial *mastectomy*, as follows:

i. reconstruction of the breast on which the *mastectomy* has been performed

ii. *surgery* and reconstruction of the other breast to produce a symmetrical appearance

iii. prosthesis and treatment of physical complications of all stages of *mastectomy*, including lymphedemas

All other reconstructive *surgeries* will be covered under the *Plan* when *medically necessary*, except as otherwise excluded herein.

Refer to the **Federal Notices** section for the statement of rights to *surgery* and prostheses following a covered *mastectomy* under the Women's Health and Cancer Rights Act of 1998 (WHCRA).

55. **Retail Clinics.**

56. **Routine Newborn Care.** Routine well-baby care is care while the newborn is *hospital*-confined after birth and includes *room and board* and other normal care for which a *hospital* makes a charge.

a. This coverage is only provided if the newborn child is an eligible *dependent* and a parent either:

i. is a *plan participant* who was covered under the *Plan* at the time of the birth

ii. enrolls (as well as the newborn child if required) in accordance with the Special Enrollment Periods provisions with coverage effective as of the date of birth

b. The benefit is limited to *allowable charges* for well-baby care after birth while the newborn child is *hospital* confined as a result of the child's birth.

Covered charges will be payable as shown in the applicable Schedule of Medical Benefits.

57. **Second Surgical Opinion.** If your doctor recommends *surgery* or other medical treatment, it is often in your best interest to obtain a second opinion with a specialist regarding the necessity of the procedure. In many cases an alternative method of treatment is available that would save yourself the discomfort of *surgery* or other medical treatment as well as the time and extra expenses.

58. **Skilled Nursing Facility.** The *room and board* and nursing care furnished by a *skilled nursing facility* will be payable if and when:

    a. The patient is confined as a bed patient in the facility.

    b. The attending *physician* certifies that the confinement is needed for further care of the condition that caused the *hospital* confinement.

    c. The attending *physician* completes a treatment plan which includes a diagnosis, the proposed course of treatment, and the projected date of discharge from the *skilled nursing facility*.

    ***Pre-certification* is required for inpatient admissions.** *Covered charges* will be payable as shown in the applicable Schedule of Medical Benefits.

59. **Sleep Disorders/Sleep Studies.** Care and treatment for sleep disorders, including sleep studies performed in the home.

60. **Smoking Cessation.** Care and treatment for tobacco cessation programs shall be covered to the extent required under the *Preventive Care* provision and then covered at the applicable benefit level after.

61. **Sterilization.** Services for vasectomy, other voluntary sterilization procedures, female sterilization and family planning counseling are covered under the Preventive Care provision of this *Plan*. The *Plan* does not cover the reversal of voluntary sterilization procedures, including related follow-up care.

62. **Surgery.** Benefits for the treatment of *illnesses* and *injuries,* including fractures and dislocations, are covered for the surgeon, assistant surgeon, anesthesiologist, and surgical supplies. ***Pre-certification* is required for certain surgical procedures. Refer to Schedule of Benefits, Pre-Certification for details.**

63. **Temporomandibular Joint Syndrome (TMJ).** Benefits for medical or dental services for treatment of *temporomandibular joint* disorders.

64. **Therapy Services.** Services include the following therapy types rendered on an *inpatient* or *outpatient* basis:

    a. **Physical Therapy.** Benefits include aquatic therapy.

    b. **Occupational Therapy.**

    c. **Speech Therapy.** Benefits include aural therapy following a covered implantable hearing device.

    Therapy in the home applies to the *outpatient* Therapy Services maximum unless rendered as part of a *home health care plan*. Refer to the applicable Schedule of Medical Benefits for any limitations that may apply.

    Rehabilitation Services. The *Plan* covers rehabilitation services to help a *plan participant* achieve a previous level of function, independence, and quality of life.

    Habilitation Services. The *Plan* covers *habilitation services* that help a *plan participant* keep, learn, or improve skills and functions for daily living that they may not be developing as expected for their age range.

65. **Transplants.** Refer to the **Transplant Program** section for details.

66. **Travel Expenses.** Covered travel and lodging expenses are only covered for services related to transplants, *adoptive cell therapy*, cancer treatment, and congenital heart treatment. The *plan participant* must be receiving services at a designated *network* facility. Transplant services must be received at a *network* facility, refer to the **Transplant Program** section for details.

    a. Eligible expenses for travel, lodging and meals up to a combined maximum of $10,000 for the *plan participant* (while not a *hospital inpatient*) and companion(s) who are traveling on the same day(s) to and/or from the site of treatment for the purpose of an evaluation, the procedure, and/or necessary post-discharge follow-up. Benefits are paid at a per diem (per day) rate of up to $50 per day for the *plan participant* or up to $100 per day for the *plan participant* plus one (1) companion. If the *plan participant* is an enrolled *dependent* and minor child, the transportation expenses of two (2)

companions will be covered and lodging expenses will be reimbursed at a per diem rate up to $100 per day.

Travel and lodging expenses are only available if the *plan participant* and/or the donor lives more than fifty (50) miles from the designated *network* facility. These benefits will be reimbursed upon the submission to the *Plan* of dated receipts showing the service provided, the cost of the service, and the name, address, and phone number of the service provider. Refer to the **Claims and Appeals** section for instructions on how to submit a *claim* for reimbursement. The listed expenses must be *incurred* within five (5) days prior to the procedure and one hundred twenty (120) days after the procedure. Applicable travel expenses will also be covered during the transplant evaluation period. The *Plan Administrator* reserves the right not to reimburse any such expenses that it, in its sole discretion, deems inappropriate, excessive, or not in keeping with the intent of this provision. Examples of eligible travel expenses may include airfare (at coach rate), taxi or ground transportation, or mileage reimbursement at the IRS rate for the most direct route between the *plan participant's* home and the designated *network* facility. Refer to the Medical Plan Exclusions subsection for a further description and limitations of eligible travel expenses for reimbursement.

67. **Virtual Visits.** Services rendered electronically or telephonically but are not associated with a telemedicine vendor, when performed for otherwise covered services.
68. **Vision Benefits.** Benefits are available for vision examinations, including refraction, when performed in conjunction with a medical diagnosis.
69. **Wigs**. *Covered charges* will be payable as shown in the applicable Schedule of Medical Benefits.
70. **X-Rays.** Diagnostic x-rays. *Covered charges* will be payable as shown in the applicable Schedule of Medical Benefits.

B. Medical Plan Exclusions

The following list is intended to give you a general description of expenses for services and supplies that are not covered by the *Plan*. Items that are not listed as excluded may be considered based on *medical necessity*, standard of care, and medical appropriateness. This list is not exhaustive.

NOTE: All exclusions related to prescription drugs are shown in the Prescription Drug Benefits section.

1. **Abortion.** Services, supplies, care, treatment, or drugs in connection with an abortion unless the life of the mother is endangered by the continued *pregnancy* or the *pregnancy* is the result of rape or incest.
2. **Alcohol.** Expenses incurred by any *plan participant* for injuries caused in a motor vehicle accident if the *plan participant* was operating the vehicle and the *Plan Administrator* determines its sole discretion that the *plan participant*:
    a. had a blood alcohol level that exceeded the legal limit of the jurisdiction in which the accident occurred; or
    b. no breathalyzer exam was performed or the person refused to submit to a requested breathalyzer or blood test; or
    c. was under the influence of drugs that are illegal in the jurisdiction in which the accident occurred

    Unless the injuries arise as a result of a physical or mental health condition, or as a result of domestic violence, the *Plan Administrator's* discretionary determination that this exclusion applies will not be affected by any subsequent official action or determination with respect to prosecution of the *plan participant* (including, without limitation, acquittal, or failure to prosecute) in connection with the motor vehicle accident.
3. **Alternative Medicine.** Charges for the following, including related drugs, are excluded under this *Plan*: holistic or homeopathic treatment, naturopathic services, thermography, acupuncture, acupressure, aromatherapy, hypnotism, massage therapy, rolfing (holistic tissue massage), art therapy, music therapy, dance therapy, horseback therapy, and other forms of alternative treatment as defined by the National Center for Complementary and Alternative Medicine (NCCAM) of the National Institutes of Health.
4. **Armed Forces.** Services or supplies furnished, paid for, or for which benefits are provided or required by reason of past or present service of any *plan participant* in the armed forces of a government.
5. **Athletic Training.**
6. **Biofeedback.**
7. **Chelation Therapy.** Except for lead poisoning.
8. **Clinical Trials.** The following items are excluded from *approved clinical trial* coverage under this *Plan*:
    a. the *investigational* item, device, or service, itself
    b. items and services that are provided solely to satisfy data collection and analysis needs and are not used in the direct clinical management of the patient
    c. a service that is clearly inconsistent with widely accepted and established standards of care for a particular diagnosis

    If one (1) or more *participating providers* do participate in the *approved clinical trial*, the qualified *plan participant* must participate in the *approved clinical trial* through a *participating network* provider, if the provider will accept the *plan participant* into the trial.

    The *Plan* does not cover routine patient care services that are provided outside of this *Plan's* health care provider *network* unless *non-network* benefits are otherwise provided under this *Plan*.
9. **Complications from a Non-Covered Service.** Services for complications related to a non-covered service. This exclusion does not apply to services the *Plan* would otherwise determine to be covered if they are to treat complications that arise from the non-covered service. Complications for an otherwise non-covered *dependent* pregnancy will be covered.
10. **Cord Blood.** Long-term [more than thirty (30) days] storage of umbilical cord blood.

11. **Cosmetic.** Cosmetic or reconstructive procedures and attendant hospitalization, except for newborn children or due to trauma or *disease*, done for aesthetic purposes and not to restore an impaired function of the body including but not limited to:

    a. Liposuction or removal of fat deposits considered undesirable, including fat accumulation under the male breast and nipple

    b. Pharmacological regimens, nutritional procedures or treatments

    c. Scar or tattoo removal or revision procedures such as salabrasion, chemosurgery and other such skin abrasion procedures

    d. Sclerotherapy treatment of veins

    e. Hair removal or replacement by any means

    f. Treatments for skin wrinkles or any treatment to improve the appearance of the skin

    g. Treatment for spider veins

    h. Skin abrasion procedures performed as a treatment for acne

    i. Treatments for hair loss

    j. Varicose vein treatment of the lower extremities, when it is considered cosmetic

    Cosmetic procedures will not be covered regardless of the fact that the lack of correction causes emotional or psychological effects. Complications or subsequent *surgery* related in any way to any previous cosmetic procedure shall not be covered, regardless of *medical necessity*.

12. **Counseling.** Benefits for counseling in the absence of *illness* or *injury*, including, but not limited to, education, social, behavioral, or recreational therapy; sex or interpersonal relationship counseling; or counseling provided by *plan participant's* friends, *employer*, school counselor, or school teacher.

13. **Court-Ordered Treatment.** Any treatment of a *plan participant* in a public or private *institution* as the result of a court order due to a criminal offense. This exclusion does not apply to *mental health or substance use disorder holds*, as they are not court-ordered treatments.

14. **COVID-19 Services.** At-home (over-the-counter) COVID-19 tests, administrative/return-to-work testing, and *experimental/investigational* treatment are excluded under the medical plan.

15. **Custodial Care.** Services or supplies provided mainly as a rest cure, maintenance, or *custodial care*.

16. **Dental Care.** Dental care (which includes dental x-rays, supplies and appliances, and all associated expenses, including hospitalization and anesthesia) except as otherwise specifically provided herein. This includes dental care that is required to treat the effects of a medical condition but that is not necessary to directly treat the medical condition. Specifically excluded are charges for endodontics, periodontal surgery, restorative surgery treatment, dental implants, dental braces, bone grafts, and other implant related procedures. Treatment of congenitally missing, malpositioned or supernumerary (extra) teeth are excluded, even if part of a congenital anomaly.

17. **Dialysis, Outpatient.** Refer to **Outpatient Dialysis Services** section for coverage.

18. **Educational or Vocational Testing.** Services for educational or vocational testing or training. Educational services, such as Lamaze, except as specifically covered herein.

19. **Error.** Any charge for care, supplies, treatment, and/or services that are required to treat *injuries* that are sustained, or an *illness* that is contracted, including infections and complications, while the *plan participant* was under, and due to, the care of a provider wherein such *illness*, *injury*, infection, or complication is not reasonably expected to occur. This exclusion will apply to expenses directly or indirectly resulting from the circumstances of the course of treatment that, in the opinion of the *Plan Administrator*, in its sole discretion, unreasonably gave rise to the expense.

20. **Examinations.** Any health examination required by any law of a government to secure insurance or school admissions (including sports physicals) or professional or other licenses, except as required under applicable federal law.

21. **Excess Charges.** Any charge for care, supplies, treatment, and/or services that are not payable under the *Plan* due to application of any *Plan* maximum or limit, charges which are in excess of the *maximum allowable charge*, or services not deemed to be *reasonable* or *medically necessary*, based upon the *Plan Administrator's* determination as set forth by and within the terms of this document.

22. **Exercise Programs.** Exercise programs for treatment of any condition, except for *physician* supervised cardiac rehabilitation, occupational, or physical therapy, if covered by this *Plan*.

23. **Experimental/Investigational.** Care and treatment that is *experimental/investigational*. This exclusion shall not apply if the charge is for routine patient care for costs *incurred* by a *qualified individual* who is a *participant* in an *approved clinical trial*. Charges will be covered only to the extent specifically set forth in this plan document.

24. **Foot Care.** Services for routine, palliative, or cosmetic foot care. Examples include flat foot conditions, supportive devices for the foot (orthotics), treatment of subluxation of the foot, care of corns, bunions (except capsular or bone *surgery*), callouses, toe nails, fallen arches, weak feet, chronic foot strain, or symptomatic complaints of the feet, unless *medically necessary*.

25. **Foreign Travel.** Expenses for planned and/or routine services received or supplies purchased outside the United States, including those rendered on a cruise ship, are excluded under this *Plan*. Services in the case of a *medical emergency* are a *covered charge*.

26. **Government Coverage.** Care, treatment, or supplies furnished by a program or agency funded by any government, except as stated herein. This exclusion does not apply to Medicaid, a Veteran's Administration facility, or when otherwise prohibited by applicable law. If a *plan participant* receives services in a U.S. Department of Veterans Affairs Hospital or Military Medical Facility on account of a military service-related *illness* or *injury*, benefits are not covered by this *Plan*. If a *plan participant* receives services in a U.S. Department of Veterans Affairs Hospital or Military Medical Facility on account of any other condition that is not a military service-related *illness* or *injury*, benefits are covered by the *Plan* to the extent those services are *medically necessary* and the charges are within this *Plan's maximum allowable charge*.

27. **Growth Hormones.**

28. **Hair Loss.** Care and treatment for hair loss including wigs, hair transplants, or any drug that promises hair growth, whether or not prescribed by a *physician*, except for wigs as shown in the applicable Schedule of Medical Benefits. This exclusion does not apply to hair loss services attributed to a covered medical condition.

29. **Hearing Aids and Implantable Hearing Devices.** Charges for services or supplies in connection with hearing aids and implantable hearing devices, except for cochlear implants and exams for their fitting.

30. **Hearing Exam.** Charges for a hearing exam, except as may be covered under applicable federal law, or as specifically provided herein.

31. **Hospice Care.** Services for spiritual counseling; services performed by a family member or volunteer workers, homemaker, or housekeeping services; food services (such as Meals on Wheels); legal and financial counseling services; respite care; and services or supplies not included in the *hospice care plan* or not specifically set forth as a hospice benefit.

32. **Hospital Employees.** Professional services billed by a *physician* or nurse who is an *employee* of a *hospital* or *skilled nursing facility* and paid by the *hospital* or facility for the service.

33. **Hospital Services.** *Hospital* services when hospitalization is primarily for *diagnostic testing*/studies or physical therapy when such procedures could have been done adequately and safely on an *outpatient* basis.

34. **Illegal Acts.** Any charge for care, supplies, treatment, and/or services for any *injury* or *illness* which is *incurred* while taking part, or attempting to take part in, an illegal activity, including, but not limited to, misdemeanors and felonies. It is not necessary that an arrest occur, criminal charges be filed, or, if filed, that a conviction result. Proof beyond a reasonable doubt is not required to be deemed an illegal act.

35. **Illegal Drugs or Medications.** Services, supplies, care, or treatment to a *plan participant* for *injury* or *illness* resulting from that *plan participant's* voluntary taking of, or being under the influence of, any controlled substance, drug, hallucinogen, or narcotic not administered on the advice of a *physician*. Expenses will be covered for *injured plan participants* other than the person using controlled substances.

36. **Immediate Family Member.** Any charge for care, supplies, treatment, and/or services that are rendered by a provider who is related to the *plan participant* by blood or marriage or who ordinarily dwells in the *plan participant's* household.

37. **Immunizations.** Immunizations and vaccinations for the purpose of travel outside of the United States.

38. **Infertility.** Care, supplies, services, and treatment for *infertility*, including, but not limited to, artificial insemination, in vitro fertilization, or any assisted reproductive technology (ART) procedure, except for *diagnostic services* rendered for *infertility* evaluation.

39. **Long Term Care.**

40. **Manipulations**. Expenses for manipulations for *plan participants* under eighteen (18) years of age.

41. **Maternity.** Care and treatment of *pregnancy* for a *dependent* daughter only, except for mandated *preventive care* and complications. Charges for services related to surrogate *pregnancy* when the surrogate is not a *plan participant*.

42. **Medicare.** Any charge for benefits that are provided, or which would have been provided had the *plan participant* enrolled, applied for, or maintained eligibility for such care and service benefits, under Title XVIII of the Federal Social Security Act of 1965 (*Medicare*), including any amendments thereto, or under any federal law or regulation, except as provided in the sections entitled **Coordination of Benefits** and **Medicare**.

43. **Milieu Therapy.** A treatment program based on manipulation of the *plan participant's* environment for their benefit.

44. **Negligence.** Care and treatment of an *injury* or *illness* that results from activity where the *plan participant* is found by a court of competent jurisdiction and/or a jury of their peers to have been negligent in their actions, as negligence is defined by the jurisdiction where the activity occurred.

45. **No Charge.** Care and treatment for which there would not have been a charge if no coverage had been in force.

46. **No Legal Obligation.** Any charge for care, supplies, treatment, and/or services that are provided to a *plan participant* for which the provider of a service customarily makes no direct charge, for which the *plan participant* is not legally obligated to pay, or for which no charges would be made in the absence of this coverage, including, but not limited to, fees, care, supplies, or services for which a person, company, or any other entity except the *plan participant* or this benefit *Plan*, may be liable for necessitating the fees, care, supplies, or services.

47. **No Physician Recommendation.** Care, treatment, services, or supplies not recommended and approved by a *physician*. Treatment, services, or supplies when the *plan participant* is not under the regular care of a *physician*. Regular care means ongoing medical supervision or treatment which is appropriate care for the *injury* or *illness*.

48. **Non-Emergency Hospital Admissions.** Care and treatment billed by a *hospital* for *medical non-emergency care* admissions on a Friday or a Saturday. This does not apply if *surgery* is performed within twenty-four (24) hours of admission.

49. **Non-Medical Expenses.** Expenses including, but not limited to, those for preparing medical reports or itemized bills, completion of claim forms or medical records unless otherwise required by law, calling a patient to provide their test results, sales tax, shipping and handling, services for telephone consultations (except Teladoc), expenses for failure to keep a scheduled visit or appointment, *physician* or *hospital* stand-by services, holiday or overtime rates, membership or access fees, educational brochures, or reports prepared in connection with litigation.

50. **Non-Prescription Medication.** Drugs and supplies not requiring a prescription order (unless required under applicable federal law), including, but not limited to, aspirin, antacid, benzyl peroxide preparations, cosmetics, medicated soaps, food supplements, syringes, bandages, or Rogaine hair preparations, special foods or diets, vitamins, minerals, dietary and nutritional supplements, *experimental* drugs, including those labeled "Caution: Federal law prohibits dispensing without prescription," and prescription medications related to health care services which are not covered under this *Plan*.

51. **Not Actually Rendered.** Any charge for care, supplies, treatment, and/or services that are not actually rendered.

52. **Not Medically Necessary.** Any charge for care, supplies, treatment, and/or services that are not *medically necessary*, unless specifically stated as covered herein.

53. **Obesity/Morbid Obesity.** Screening and counseling for obesity will be covered to the extent required under applicable federal law. Other care or treatment of obesity, weight loss, or dietary control whether or not it is, in any case, a part of the treatment plan for another *illness*, is not covered under the *Plan*. Specifically excluded are charges for bariatric *surgery*, including, but not limited to, gastric bypass, stapling and intestinal bypass, and lap band *surgery*, including reversals.

54. **Occupational or Workers' Compensation.** Charges for care, supplies, treatment, and/or services for any condition, *illness*, *injury*, or complication thereof arising out of or in the course of employment (including self-employment), or an activity for wage or profit. If you are covered as a *dependent* under this *Plan* and you are self-employed or employed by an *employer* that does not provide health benefits, make sure that you have other medical benefits to provide for your medical care in the event that you are hurt on the job. In most cases workers' compensation insurance will cover your costs, but if you do not have such coverage, fail to file, or receive a denial for failure to file timely, you may end up with no coverage at all.

55. **Orthognathic Surgery/LeFort Procedures.** *Surgery* to correct malposition in the bones of the jaw.

56. **Other than Attending Physician.** Any charge for care, supplies, treatment, and/or services by a *provider* who did not render an actual service to the *participant*. *Covered charges* are limited to those certified by a *physician* who is attending the *plan participant* as required for the treatment of *injury* or *disease*, and performed by an appropriate provider. This exclusion does not apply to interdisciplinary team conferences to coordinate patient care.

57. **Personal Comfort Items.** Personal comfort items or other equipment, such as, but not limited to, air conditioners, air-purification units, humidifiers, electric heating units, orthopedic mattresses, blood pressure instruments, scales, elastic bandages, non-medical grade stockings/items (except as specified herein), non-*prescription drugs* and medicines, first-aid supplies, seat risers, and non-hospital adjustable beds.

58. **Personal Injury Insurance.** Expenses in connection with an automobile *accident* for which benefits payable hereunder are, or would be otherwise covered by, mandatory *no-fault automobile insurance* or any other similar type of personal injury insurance required by state or federal law, without regard to whether or not the *plan participant* actually had such mandatory coverage. This exclusion does not apply if the *injured* person is a passenger in a non-family-owned vehicle or a pedestrian.

59. **Prescription Drugs.** Prescription drugs charges covered under the Prescription Drug Benefits, other than those covered in a *physician's* office or *inpatient* admission.

60. **Prior to Effective Date or After Termination Date.** Services, supplies, or accommodations provided prior to the *plan participant's* effective date or after the termination of coverage. In the event coverage is terminated during a *hospital* admission, the *Plan* will only consider *covered charges* as those *incurred* before coverage was terminated, unless extension of benefits applies.

61. **Private Duty Nursing.** Charges in connection with care, treatment, or services of a private duty nurse, except as included as a part of another covered service(s), as stated herein.

62. **Prohibited by Law.** Any charge for care, supplies, treatment, and/or services to the extent that payment under this *Plan* is prohibited by law.

63. **Repair of Purchased Equipment.** Maintenance and repairs needed due to misuse or abuse are not covered.

64. **Replacement Devices.** Replacement of orthotics or prosthetics such as braces of the leg, arm, back, neck, or artificial arms or legs, unless there is sufficient change in the *plan participant's* physical condition to make the original device no longer functional.

65. **Residential Accommodations.** Residential accommodations to treat medical or behavioral health conditions, except when provided in a *hospital*, *hospice unit*, *skilled nursing facility*, *inpatient rehabilitation hospital*, or *residential treatment facility* licensed and regulated by a state or federal agency and is acting within the scope of their license.

66. **School.** Services performed in a school setting. This exclusion also applies to services that are solely educational in nature or otherwise paid under state or federal law for purely educational purposes. Tuition for or services that are school-based for children and adolescents required to be provided by, or paid for by, the school.

67. **Self-Inflicted.** Any loss due to an intentionally self-inflicted *injury*. This exclusion does not apply in either of the following circumstances:

    a. to an *injury* resulting from being the victim of an act of domestic violence

    b. to an *injury* resulting from a medical (including both physical and *mental health*) condition

68. **Sterilization Reversal.** Care and treatment for reversal of surgical sterilization.

69. **Subrogation, Reimbursement, and/or Third-Party Responsibility.** Any charges for care, supplies, treatment, and/or services of an *injury* or *illness* not payable by virtue of the *Plan's* subrogation, reimbursement, and/or third-party responsibility provisions. Refer to the **Reimbursement, Subrogation, and Recovery Provisions** section.

70. **Transplants.** Services and supplies that are incurred for care and treatment due to a bone marrow, organ, or tissue transplant are subject to the exclusions stated in the **Transplant Program** section.

71. **Travel or Accommodations.** Charges for travel accommodations, whether or not recommended by a *physician*, except for ambulance charges defined as a *covered charge* or travel required for an approved organ or tissue transplant, *adoptive cell therapy*, cancer treatment, or congenital heart treatment. Any of the following or similar items associated with travel required for an approved condition:

    a. entertainment items such as alcohol, cigarettes, toys, books, movies, theater tickets, theme park tickets, flowers, greeting cards, stationary, stamps, postage, gifts, internet service, tips, coupons, vouchers, or travel tickets, frequent flyer miles

    b. convenience items such as toiletries, paper products, maid service, laundry/dry cleaning, kennel fees, babysitter/childcare, valet parking, faxing, cell phones, phone calls, newspapers

    c. mortgage, rent, security deposit, furniture, utility bills, appliances, utensils, vacation/apartment rentals

    d. vehicle maintenance, automobile mileage, taxi fares, parking, moving trucks/vehicles, mileage within the medical transplant facility city

    e. cash advances/lost wages

    f. rental cars, buses, taxis, or shuttle service, except as specifically approved by the *Claims Administrator*

    g. prepayments or deposits

    h. taxes

    i. travel costs for donor companion/caregiver

    j. return visits for the donor for a treatment of an *illness* found during the evaluation

    Refer to the **Transplant Program** section for further details.

72. **Vision Care Exclusions.** Expenses for the following:

    a. surgical correction of refractive errors and refractive keratoplasty procedures, including, but not limited to, Radial Keratotomy (RK), Automated Lamellar Keratoplasty (ALK), or Laser In-Situ Keratomileusis (LASIK)

    b. diagnosis and treatment of refractive errors, including routine eye examinations, purchase, fitting, and repair of eyeglasses or lenses and associated supplies

        This exclusion does not apply when services are performed in conjunction with a medical diagnosis and as listed herein.

    c. orthoptics (eye muscle exercises), orthoptic therapy, vision training, or subnormal vision aids

    d. orthokeratology lenses for reshaping the cornea of the eye to improve vision

73. **War.** Any loss that is due to a declared or undeclared act of war.

SECTION VII—OUTPATIENT DIALYSIS SERVICES

The following *outpatient* dialysis services are not included under the *network* arrangement of this *Plan:*

1. facility and professional charges from:
    a. *outpatient hospitals*
    b. dialysis facilities
2. home dialysis charges

A. Coordination with Medicare

If you are diagnosed with a condition requiring dialysis, you may be able to enroll in *Medicare*. Upon beginning dialysis treatments, *Medicare*, if applicable, will coordinate benefits with the *Plan* as the secondary payer for months four (4) through thirty-three (33) of the coordination period while you are receiving dialysis treatments. Your *outpatient* dialysis medical *claims* as described in this section will be considered at 140% of *Medicare's* reimbursement level.

The *Plan* will not enroll you in *Medicare*; it is your decision and your responsibility to enroll in *Medicare*, if applicable.

If you are eligible but do not enroll for both Part A and Part B of *Medicare*, the *Plan* will pay benefits as if you have enrolled. Your *claims* will be reduced as secondary under this *Plan* regardless of enrollment status under *Medicare*.

Refer to the **Coordination of Benefits** and **Medicare** sections of this document for more information.

B. Medical Management

All dialysis services require *pre-certification*. To begin the *pre-certification* process, call AmeriBen at 1-855-961-5401.

C. ID Cards

Plan participants requiring dialysis services will be issued a separate Dialysis Identification Card. This card will be sent to you by AmeriBen upon your initial *pre-certification* call.

D. Submitting Outpatient Dialysis Claims

All *outpatient* dialysis medical *claims* will be submitted to:

AmeriBen
P.O. Box 7186
Boise, ID 83707

Please refer to the **Claims and Appeals** section for information regarding filing *claims*.

SECTION VIII—TRANSPLANT PROGRAM

A. Transplant Program

The Transplant Program provides access to a *network* of transplant centers that perform many transplants each year and have historically high success rates. They are often affiliated with renowned teaching and research facilities with access to experienced surgeons and advanced medical techniques. Using a *hospital* with transplant experience can result in shorter *hospital* stays, fewer complications, and fewer repeat transplants.

Under the Transplant Program, the *Plan* reimburses you for covered services and supplies arising out of human organ and tissue transplants for a *plan participant* recipient.

Donor expenses are not payable by this *Plan* unless the recipient is a *plan participant*.

Donor expenses (not subject to *deductibles*, *co-insurance*, or *co-payments*) are covered to the extent that the donor is not covered by their own insurance/health plan.

Medical and surgical treatment or devices related to transplantation that are *experimental*, *investigational*, or unproven are those not approved by the U.S. Food and Drug Administration (FDA) to be lawfully marketed for the proposed use, subject to review and approval by any Institutional Review Board for the proposed use; or non-demonstrative through prevailing peer-reviewed medical literature to be efficacious for the treatment of the *disease* state at the time of the request. The *Plan* reserves the right to make final judgment regarding coverage of *experimental*, *investigational*, and unproven procedures and treatments. *Medically necessary* means those transplant-related services which are determined by the *Plan* to be medically appropriate for the diagnosis and clinical status of the *plan participants* and their *dependents*, rendered in an appropriate setting, and of demonstrated medical value. The fact that a *physician* has performed or prescribed a transplant-related service, or the fact that it may be the only treatment for a *disease,* does not mean that is *medically necessary*.

Transplant-related services are services and supplies up to one (1) year following the transplant, which are related to transplantation when recommended by a *physician,* provided at or arranged by a transplant *hospital*, and determined to be *medically necessary*. Such services and supplies include, but are not limited to, *hospital* charges, *physician* charges, organ acquisition charges, tissue typing donor search charges, and ancillary services.

B. Program Benefits

1. access to a transplant *network* providers
2. reimbursement for travel, lodging, and meal expenses *incurred* during the transplant for *plan participant* and companion(s) who are traveling on the same day(s) to and/or from the site of treatment, for the purposes of an evaluation, the procedure, and/or necessary post-discharge follow-up up to a total maximum of $10,000

   Benefits are paid at a per diem (per day) rate of up to $50 per day for the *plan participant* or up to $100 per day for the *plan participant* plus one (1) companion. If the *plan participant* is an enrolled *dependent* and minor child, the transportation expenses of two (2) companions will be covered and lodging expenses will be reimbursed at a per diem rate up to $100 per day.
3. services of a transplant case manager, who will coordinate services and savings

Travel and lodging benefits will be reimbursed upon the submission to the *Plan* of dated receipts showing the service provided, the cost of the service, and the name, address, and phone number of the service provider. Refer to the **Claims and Appeals** section for instructions on how to submit a claim for reimbursement. The listed expenses must be *incurred* within five (5) days prior to the transplant and one hundred twenty (120) days after the transplant. Applicable travel expenses will also be covered during the transplant evaluation period. The *Plan Administrator* reserves the right not to reimburse any such expenses that it, in its sole discretion, deems inappropriate, excessive, or not in keeping with the intent of this provision.

C. Requirements

Transplant benefits under the *Plan* are only available when a *plan participant* fully utilizes a *network* facility and meets all of the following requirements:

1. *Pre-certification* **must** be obtained as outlined in the **Health Care Management Program** section.
2. All transplant services must be rendered at a *network* transplant center facility.

If these requirements are not met, transplant benefits are not available under the Plan.

D. Transplant Exclusions

The following transplant-related expenses are not covered by the *Plan*:

1. when the recipient is not an eligible *plan participant*
2. when the organ or tissue is sold rather than donated to the recipient
3. charges related to transportation costs, including without limitation ambulance or air services for the donor or to move a donated organ or tissue
4. charges that are covered or funded by governmental, foundation, or charitable grants or programs
5. charges for any artificial or mechanical organ

   This exclusion does not apply to cardiac assist devices such as LVADs.
6. charges for any animal organs, unless approved by the Food and Drug Administration (FDA)
7. services for a condition that is not directly related, or a direct result, of the transplant

   All other covered services will fall to the applicable benefit as billed and will be subject to all other *Plan* provisions.
8. any of the following or similar items associated with travel:
   a. entertainment items such as alcohol, cigarettes, toys, books, movies, theater tickets, theme park tickets, flowers, greeting cards, stationary, stamps, postage, gifts, internet service, tips, coupons, vouchers, or travel tickets, frequent flyer miles
   b. convenience items such as toiletries, paper products, maid service, laundry/dry cleaning, kennel fees, baby-sitter/childcare, valet parking, faxing, cell phones, phone calls, newspapers
   c. mortgage, rent, security deposit, furniture, utility bills, appliances, utensils, vacation/apartment rentals
   d. vehicle maintenance, automobile mileage, taxi fares, parking, moving trucks/vehicles, mileage within the medical transplant facility city
   e. cash advances/lost wages
   f. rental cars, buses, taxis, or shuttle service, except as specifically approved by the *Claims Administrator*
   g. prepayments or deposits
   h. taxes
   i. travel costs for donor companion/caregiver
   j. return visits for the donor for a treatment of an *illness* found during the evaluation

SECTION IX—HEALTH CARE MANAGEMENT PROGRAM

A. Introduction

The health care management program consists of several components to assist *plan participants* in staying well: providing optimal management of chronic conditions, provisions of support, and service coordination during times of acute or new onset of a medical condition.

The scope of the health care management program consists of the following components (each of which will be further discussed in this section):

1. utilization review
2. concurrent review and discharge planning
3. case management
4. wellness program

B. Utilization Review

The utilization review program is designed to help ensure all *plan participants* receive *medically necessary* and appropriate health care while avoiding unnecessary expenses.

The purpose of the program is to determine what services are *medically necessary* and eligible for payment by the *Plan*. This program is not designed to be the practice of medicine or to be a substitute for the medical judgment of the attending *physician* or other health care provider.

If a particular course of treatment or medical service is not *pre-certified*, it means that either the *Plan* will not pay for the charges, or the *Plan* will not consider that course of treatment as *medically necessary* and appropriate for the maximum reimbursement under the *Plan*. The patient is urged to review why there is a discrepancy between what was requested and what was certified before *incurring* charges.

Your *employer* has contracted with the *Medical Management Administrator* in order to assist you in determining whether or not proposed services are appropriate for reimbursement under the *Plan*. The program is not intended to diagnose or treat medical conditions, guarantee benefits, or validate eligibility.

Elements of the Utilization Review Program

The program consists of:

1. **Pre-Certification.** Review of the *medical necessity* for non-emergency services before medical and/or surgical services are provided.
2. **Retrospective Review.** Review of the *medical necessity* of the health care services provided on an *emergency* basis, after they have been provided.
3. **Concurrent Review.** Ongoing assessment of the health care as it is being provided, especially, but not limited to, *inpatient* confinement in a *hospital* or covered *medical care facility* (based on the admitting diagnosis and the listed services requested by the attending *physician*).
4. **Discharge Planning.** Certification of services and planning for discharge from a *medical care facility* or cessation of medical treatment.

What Services Must Be Pre-Certified (Approved Before they are Provided)

The provider, patient, or family member must call the *Medical Management Administrator* to receive certification of certain health care management services. This call must be made at least forty-eight (48) hours in advance of services being rendered or within forty-eight (48) hours after an *emergency*.

The following services must be *pre-certified*, or reimbursement from the *Plan* may be reduced:

1. *inpatient* pre-admission certification and continued stay reviews (all ages, all diagnoses)
    a. surgical and non-surgical (excluding routine vaginal or cesarean deliveries)
    b. long term acute care facility (LTAC), not *custodial care*
    c. *skilled nursing facility*/rehabilitation facility

d. *inpatient mental health/substance use disorder* treatment (includes *residential treatment facility* services)

The attending *physician* does not have to obtain *pre-certification* from the *Plan* for prescribing a maternity length of stay that is forty-eight (48) hours or less for a vaginal delivery or ninety-six (96) hours or less for a cesarean delivery.

2. *inpatient* and *outpatient surgery*, including surgical pain management injections

   Pre-certification is not required for the following *surgical procedures*:

   a. office *surgeries*
   b. all colonoscopies/sigmoidoscopies (screening and diagnostic)
   c. elective sterilization procedures
   d. intra-articular hyaluronic acid injections.

3. transplant (other than cornea), including, but not limited to, kidney, liver, heart, lung, pancreas, and bone marrow replacement to stem cell transfer after high-dose chemotherapy
4. *adoptive cell therapy*
5. chemotherapy drugs/infusions and radiation treatments for oncology diagnoses
6. clinical trial that is conducted in relation to the prevention, detection, or treatment of cancer or other life-threatening *disease* or condition

   This *Plan* does not cover clinical trials related to other *diseases* or conditions. Refer to the **Medical Benefits** section of this document for a further description and limitations of this benefit.

7. dialysis
8. *durable medical equipment* in excess of $3,000 (purchase price only)
9. *gene therapy*
10. genetic/genomic testing (excluding amniocentesis)
11. *home health care services*
12. non-emergent air ambulance
13. orthotics/prosthetics in excess of $3,000 purchase price
14. *outpatient* advanced imaging (excluding services rendered in an emergency room setting)
    a. computed tomographic (CT) studies
    b. coronary CT angiography
    c. MR-guided focused ultrasound
    d. MRI/MRA
    e. nuclear cardiology
    f. nuclear medicine (including SPECT scans)
    g. PET scans
15. *outpatient* therapy *services* (physical therapy, occupational therapy, and speech therapy) in excess of twenty (20) visits per *plan year* per therapy type
16. partial hospitalization and intensive *outpatient* program in excess of 20 (twenty) visits per *plan year* per service type, for *mental health and substance use disorder* treatment
17. specialty infusion/injectable medications over $1,000 per infusion/injection which are covered under the medical benefits and not obtained through the Prescription Drug Benefits (i.e. provided in an *outpatient* facility, *physician's* office, or home infusion)

    For specialty drugs obtained through the Prescription Drug Benefits, please contact VIVIO Health for *pre-certification* at 1-800-470-4034 or refer to the **VIVIO Health Program** section for more details.

Services rendered in an emergency room or urgent care setting do not require *pre-certification*.

In order to maximize Plan reimbursements, please read the following provisions carefully.

How to Request Pre-Certification

Before a *plan participant* enters a *medical care facility* on a non-emergency basis or receives other listed medical services, the *Medical Management Administrator* will, in conjunction with the attending *physician*, certify the care as *medically necessary* for *Plan* reimbursement. A non-emergency stay in a *medical care facility* is one that can be scheduled in advance.

The medical management program is set in motion by a telephone call from, or on behalf of, the *plan participant*. Contact the *Medical Management Administrator* **at least forty-eight (48) hours before** services are scheduled to be rendered with the following information:

1. the name of the *plan participant* and relationship to the covered *employee*
2. the name, *employee* identification number, and address of the covered *employee*
3. the name of the *employer*
4. the name and telephone number of the attending *physician*
5. the name of the *medical care facility*
6. the proposed medical services
7. the proposed date(s) of services
8. the proposed length of stay

If there is an *emergency* admission to the *medical care facility*, the patient, patient's family member, *medical care facility*, or attending *physician* must contact the *Medical Management Administrator* within **forty-eight (48) hours** of the first business day after the admission. Refer to the Quick Reference Information Chart for contact information.

The *Medical Management Administrator* will determine the number of days of *medical care facility* confinement or use of other listed medical services authorized for payment. **Failure to follow this procedure may reduce reimbursement received from the *Plan*.**

Warning: Obtaining *pre-certification* of particular services does not guarantee that they will be reimbursed by the *Plan*. Benefits are determined by the *Plan* at the time a formal *claim* for benefits is submitted according to the procedures outlined within the **Claims and Appeals** section of this plan document.

NOTE: If your admission or service is determined to **not** be *medically necessary*, you may pursue an *appeal* by following the provisions described in the **Claims and Appeals** section (First Level Appeal of a Pre-Service Claim subsection) of this document. The *plan participant* and provider will be informed of any denial or non-certification in writing.

Penalty for Failure to Pre-Certify

When the required *pre-certification* procedures are followed, your benefits will be unaffected. However, if you do not follow the *pre-certification* requirements outlined above, **you may be subject to a $100 penalty for any resulting *claims*.** Penalty will be applied to the facility charge, if applicable. Amounts assessed under this penalty will not go towards satisfaction of your *out-of-pocket limit*.

Appeals of a Denial of Pre-Certification from the Medical Management Administrator

Pre-certification decisions are considered *claims* decisions that are subject to *appeal*. Refer to the **Claims and Appeals** section (Other Pre-Service Claims subsection) for details on how to *appeal* and the timeframes for appealing a *pre-service claim* decision.

C. Concurrent Review and Discharge Planning

How Concurrent Review Works

Concurrent review of a course of treatment and discharge planning from a *medical care facility* are part of the medical management program. The *Medical Management Administrator* will monitor the *plan participant's medical care facility* stay or use of other medical services and coordinate with the attending *physician*, *medical care facilities*, and *plan participant* either the scheduled release or an extension of the *medical care facility* stay or extension or cessation of the use of other medical services.

If the attending *physician* feels that it is *medically necessary* for a *plan participant* to receive additional services or to stay in the *medical care facility* for a greater length of time than has been *pre-certified*, the attending *physician* must request the additional services or days.

How to File a Concurrent Claim for Benefits under this Plan

Refer to the **Claims and Appeals** section (Concurrent Care Claims subsection) for details on how to *appeal* a denial of a concurrent review. No benefits will be paid for any charges related to days of confinement to a *hospital* or other *health care facility* that have not been determined to be *medically necessary* by the *Medical Management Administrator*.

D. Case Management

Case management is designed to help manage the care of patients who have special or extended care *illnesses* or *injuries*. Case management is a collaborative process that assesses, plans, implements, coordinates, monitors, and evaluates the options and services required to meet a *plan participant's* health needs, using communication and available resources to promote quality, cost-effective outcomes. The primary objective of case management is to identify and coordinate cost-effective medical care, which meets accepted standards of medical practice. Case management also monitors the care of the patient, offers emotional support to the family, and coordinates communications among health care providers, patients, and others.

Cases are identified for possible case management involvement based on a request for review or the presence of a number of parameters, such as, but not limited to:

1. admissions that exceed the recommended or approved length of stay
2. utilization of health care services that generates ongoing and/or excessively high costs
3. conditions that are known to require extensive and/or long-term follow-up care and/or treatment

The *Plan* may elect, at its sole discretion, when acting on a basis that precludes individual selection, to provide alternative benefits that are otherwise excluded under the *Plan*. The alternative benefits shall be determined on a case-by-case basis, and the *Plan's* determination to provide the benefits in one (1) instance shall not obligate the *Plan* to provide the same or similar alternative benefits for the same or any other *plan participant*, nor shall it be deemed to waive the right of the *Plan* to strictly enforce the provisions of the *Plan*.

The case manager will coordinate and implement the case management program by providing guidance and information on available resources and suggesting the most appropriate treatment plan. The *Plan Administrator*, attending *physician*, patient, and patient's family must all agree to the alternate treatment plan.

Once agreement has been reached, the *Plan Administrator* will direct the *Plan* to reimburse for *medically necessary* expenses as stated in the treatment plan, even if these expenses normally would not be paid by the *Plan*. Unless specifically provided to the contrary in the *Plan Administrator's* instructions, reimbursement for expenses *incurred* in connection with the treatment plan shall be subject to all *Plan* limits and cost sharing provisions.

Benefits under case management may be provided if the *Medical Management Administrator* determines that the services are *medically necessary*, appropriate, cost-effective, and feasible. All decisions made by case management are based on the individual circumstances of that *plan participant's* case. Each case is reviewed on its own merits, and any benefits provided are under individual consideration.

All case management is a voluntary service. There are no reductions of benefits or penalties assessed if the patient and family choose not to participate.

Each treatment plan is individually tailored to a specific patient and should not be seen as appropriate or recommended for any other patient, even one with the same diagnosis.

E. Courtesy Reviews

The *Medical Management Administrator* perform *courtesy reviews*. *Courtesy reviews* are a pre-service assessment of *medical necessity* only and are not a guarantee of benefits. *Courtesy reviews* will be made as soon as possible after the request has been submitted, but no later than thirty (30) days. Completion of a *courtesy review* is not a requirement of the *Plan* and should not be a cause for delay in treatment of *medically necessary* care. Contact the *Medical Management Administrator* for any questions by phone at 1-800-786-7930 or by fax at 1-208-955-1541. Refer to the **Claims and Appeals** section for timeframes and other information regarding filing *claims*.

F. Wellness Program

Your *employer* has contracted with Healthy Steps, AmeriBen's wellness program, as part of your healthcare coverage through the Kyrene Employee Benefit Trust.

How the Wellness Program Works

This program is designed to educate and assist *plan participants* with meeting their wellness goals. Participation in the program is voluntary and confidential.

Program Highlights:

Includes the following:

1. **Wellness Portal.** Our customizable wellness portal is truly a one-stop shop for everything related to workforce and your health. Through the wellness portal, you can identify your individual health risks, look up benefits information, and much more. The portal is convenient and easy to use.
2. **Online HRA (Health Risk Assessment).** You can complete a customizable NCQA-certified health risk assessment questionnaire about your lifestyle, demographics, and personal medical history. This information is used to calculate the *plan participant's* Health Management Indicator results and Risk-for-Disease profile. This also includes a lifetime risk for up to sixteen (16) diseases and conditions. This data then provides you with individualized feedback, suggestions for ways to lower your risk, and a personalized plan for wellness.
3. **Healthwise Health Content.** The member portal features health and wellness information provided by Healthwise, a leading provider of peer-reviewed and evidence-based online health education resources. Much more than an online encyclopedia, it offers thousands of easy-to-understand explanations of medical conditions, symptoms, tests, and treatments; the knowledge base also provided hundreds of interactive decision aids and tools.

How to Enroll in the Wellness Program

Your health Plan is committed to helping you achieve your best health. You may enroll in the program by calling Healthy Steps directly at 1-855-961-5401 or by visiting **https://kyrene.myameriben.com**. Rewards for participating in a wellness program are available to all employees. If you think you might be unable to meet a standard for a reward under this wellness program, you might qualify for an opportunity to earn the same reward by different means. Contact Healthy Steps directly, and we will work with you (and if you wish, with your physician) to find a wellness program that is right for you.

SECTION X—PRESCRIPTION DRUG BENEFITS

A. About Your Prescription Benefits

The prescription drug benefits are separate from the medical benefits and are administered by MedOne (PBM Vendor). This program allows you to use your MedOne ID card at a nationwide *network* of participating *pharmacies* to purchase your prescriptions. When purchasing *prescription drugs* at retail *pharmacies* or through mail order, using your ID card at participating *pharmacies* provides you with the best economic benefit.

If you purchase your *prescription drugs* from a *non-network pharmacy*, you will have to pay the full price of the prescription.

Claims for reimbursement of *prescription drugs* are to be submitted to the Pharmacy Benefits Manager at the address listed in the Quick Reference Information Chart.

B. Co-Payments - BCBS Statewide PPO Option Ony

The *co-payment* is applied to each covered *pharmacy* drug or mail order drug charge and is shown in the applicable Schedule of Prescription Drug Benefits. The *co-payment* amount is not a *covered charge* under the Medical Plan.

C. Co-Insurance - BCBS Statewide HSA Option

Once you have met the Medical Plan's *calendar year deductible*, your *co-insurance* is applied to each covered *pharmacy* drug or mail order drug charge and is shown in the applicable Schedule of Prescription Drug Benefits.

D. Manufacturer Coupons

Any amounts in the form of manufacturer coupons or drug savings discount cards used for brand name drugs when there is a generic equivalent available, unless the brand name is *medically necessary*, do not apply to the *deductible* or *out-of-pocket limit*.

E. Mail Order Drug Benefit Option

The mail order drug benefit option is available for maintenance medications (those that are taken for long periods of time, such as drugs sometimes prescribed for heart *disease*, high blood pressure, asthma, etc.). Because of volume buying, , the mail order *pharmacy*, may be able to offer *plan participants* significant savings on their prescriptions.

F. Prior Authorization

Prescriptions for certain medications or circumstances require clinical approval before they can be filled, even with a valid prescription. Prescriptions may be limited to quantity, frequency, dosage, or may have age restrictions. The authorization process may be initiated by the *plan participant*, the local *pharmacy*, or the *physician* by calling MedOne at 1-866-335-9057.

G. Step Therapy Program

Step therapy is a program where you first try a proven, cost-effective medication (called a 'prerequisite drug' in this document) before moving to a more costly drug treatment option. With this program, trying one (1) or more prerequisite drugs is required before a certain prescription medication will be covered under your *pharmacy* benefits plan. Prerequisite drugs are FDA-approved and treat the same condition as the corresponding step therapy drugs. Step therapy promotes the appropriate use of equally effective but lower-cost drugs first. You, your *physician*, or the person you appoint to manage your care can ask for an exception if it is *medically necessary* for you to use a more expensive drug on the step therapy list. If the request is approved, MedOne will *notify* you or your *physician*. The medication will then be covered at the applicable *co-insurance/co-payment* under your *Plan*. You will also be *notified* of approvals where states require it. If the request is denied, MedOne will *notify* you and your *physician*. For information on which drugs are part of the step therapy program under your *Plan* call the MedOne customer service number on your ID card.

H. Medicare Part D Prescription Drug Plans for Medicare Eligible Participants

Plan participants enrolled in either Part A or Part B of *Medicare* are also eligible for *Medicare* Part D Prescription Drug benefits. It has been determined that the *prescription drug* coverage provided in this *Plan* is generally better than the standard *Medicare* Part D *prescription drug* benefits. Because this *Plan's prescription drug* coverage is considered creditable coverage, you do not need to enroll in *Medicare* Part D to avoid a late penalty under *Medicare*. If you enroll in *Medicare* Part D while covered under this *Plan*, payment under this *Plan* may coordinate benefit payment with *Medicare*. Refer to the **Coordination of Benefits** section of the *Plan* for information on how this *Plan* will coordinate benefit payment.

I. Covered Prescription Drug Charges

1. **Compounded Prescription Drugs.** All compounded *prescription drugs* containing at least one (1) prescription ingredient in a therapeutic quantity.
2. **Diabetic.** Insulin, glucometer, and other diabetic supplies when prescribed by a *physician*.

   Visit **https://www.irs.gov/pub/irs-drop/n-19-45.pdf** for a current listing of diabetic supplies related *preventive care* benefits.
3. **Prescribed by Physician.** All drugs prescribed by a *physician* that require a prescription either by federal or state law.

   This excludes any drugs stated as not covered under this *Plan*.
4. **Prescription Drugs mandated under PPACA.** Certain preventive medications (including contraceptives) received by a *network pharmacy* are covered and subject to the following limitations:

   a. generic preventive *prescription drugs* are covered at 100%, and the *deductible/co-payment* (if applicable) is waived

   b. if no *generic drug* is available, then the *preferred brand* will be covered at 100%, and the *deductible/co-payment/co-insurance* (if applicable) is waived

   This provision includes, but is not limited to, the following categories of drugs (In order for these medications to be covered at 100%, a prescription is required from your *physician*, including over-the-counter drugs.):

   a. **Breast Cancer Risk-Reducing Medications.** Medications such as tamoxifen or raloxifene for women who are at increased risk for breast cancer and at low risk for adverse medication effects.

   b. **Contraceptives**. Women's contraceptives including, but not limited to, oral contraceptives, transdermal contraceptives (i.e., Ortho-Evra), vaginal rings (i.e., Nuvaring), implantable contraceptive devices, injectable contraceptives, and *emergency* contraception.

   c. **Immunizations.** Certain vaccinations are available without cost sharing including vaccines for influenza, pneumonia, tetanus, hepatitis, shingles, measles, mumps, HPV (human papillomavirus), pertussis, varicella, and meningitis.

   d. **Tobacco Cessation Products**. Such as nicotine gum, smoking deterrent patches, or generic tobacco cessation medications.

   e. **Preparation 'Prep' Products for a Colon Cancer Screening Test.** The *Plan* covers the over-the-counter or prescription strength products prescribed as preparation for a payable preventive colon cancer screening test, such as a colonoscopy.

   Please refer to the following website for information on the types of payable preventive medications: **https://www.healthcare.gov/coverage/preventive-care-benefits/** or **http://www.uspreventiveservicestaskforce.org/Page/Name/uspstf-a-and-b-recommendations/**.

J. Limits to This Benefit

This benefit applies only when a *plan participant incurs* a covered *prescription drug* charge. The covered drug charge for any one (1) prescription will be limited to:

1. refills only up to the number of times specified by a *physician*
2. refills up to one (1) year from the date of order by a *physician*
3. a thirty (30) day supply for retail prescriptions

4. a ninety (90) day supply for mail-order prescriptions

Prescription drugs purchased from a *non-network pharmacy* or a *network pharmacy* when the *plan participant's* ID card is not used are not covered.

K. Prescription Drug Plan Exclusions

This benefit will not cover a charge for any of the following:

1. **Abortion.** Drugs that induce abortion such as Mifepristone (RU-486).
2. **Administration.** Any charge for the administration of a covered *prescription drug*.
3. **Appetite Suppressants/Dietary Supplements.** A charge for appetite suppressants, dietary supplements, or vitamin supplements, except for prenatal vitamins requiring a prescription or prescription vitamin supplements containing fluoride.
4. **Consumed on Premises.** Any drug or medicine that is consumed or administered at the place where it is dispensed.
5. **COVID-19 Home Tests.** Over-the-counter (OTC) tests for COVID-19.
6. **Devices.** 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.
7. **Drugs Used for Cosmetic Purposes.** Charges for drugs used for cosmetic purposes, such as anabolic steroids, Retin A, or medications for hair growth or removal.
8. **Experimental/Investigational.** *Experimental/investigational* drugs and medicines, even though a charge is made to the *plan participant*. A drug or medicine labeled: "Caution: Federal law prohibits dispensing without prescription."
9. **FDA.** Any drug not approved by the Food and Drug Administration.
10. **Growth Hormones.** Charges for drugs to enhance physical growth or athletic performance or appearance.
11. **Impotence.** A charge for impotence medication.
12. **Infertility.** A charge for *infertility* medication.
13. **Injectable.** A charge for hypodermic syringes and/or needles, injectables, or any prescription directing administration by injection (other than for insulin).
14. **Inpatient Medication.** A drug or medicine that is to be taken by the *plan participant*, in whole or in part, while *hospital* confined. This includes being confined in any *institution* that has a facility for the dispensing of drugs and medicines on its premises.
15. **Medical Exclusions.** A charge excluded under the Medical Plan Exclusions subsection, unless specifically covered in this **Prescription Drug Benefits** section.
16. **No Charge.** A charge for *prescription drugs* which may be properly received without charge under local, state, or federal programs.
17. **Non-Legend Drugs.** A charge for FDA-approved drugs that are prescribed for non-FDA-approved uses.
18. **Over-the-Counter Drugs.** Charges for over-the-counter drugs or medicines, regardless of whether purchased on the advice of a *physician*, unless required by law. A drug or medicine that can legally be bought without a written prescription. This does not apply to injectable insulin.
19. **Refills.** Any refill that is requested more than one (1) year after the prescription was written or any refill that is more than the number of refills ordered by the *physician*.
20. **VIVIO Health Specialty Drugs.** Specialty Drugs covered under the VIVIO Health Program are not covered under the MedOne Prescription Benefits. Please see the **VIVIO Health Program** section for information on the coverage of VIVIO Health specialty drugs.

SECTION XI—VIVIO HEALTH PROGRAM

This section is for your specialty drug plan ("Program"). This Program is separate from your pharmacy and medical benefit plans.

This Program provides you with coverage for certain specialty drugs. The list of managed drugs is available upon request by calling 1-800-470-4034.

This Program does not include a network of pharmacies or providers. You will be directed to use a specific pharmacy or provider that has agreed to accept the Program's offered pricing for Managed Drugs. The use of any other pharmacy or provider generally will not be reimbursed unless approved by VIVIO.

A. Glossary of Prescription Drug Terms

In this document you will see several key terms, which are defined below:

1. **Managed Drug.** A specialty drug that is on the list of the managed drugs. The list of Managed Drugs is available upon request by calling 1-800-470-4034. Benefits for Managed Drugs are only available through this Program and are not Managed by any other offering of [Plan Sponsor] group health plan. The Managed Drugs list may also contain specialty drugs for which coverage is excluded for clinical, financial or plan design reasons.
2. **Program.** The specialty drug program offered by the sponsor which is administered by VIVIO.

B. Qualification for Program Benefits

Terms of Specialty Drug Coverage

To be eligible for coverage under the Program, the drug must be prescribed by a licensed prescriber who is qualified to evaluate and treat the disease or condition for which the drug is prescribed. Qualification to prescribe Managed Drugs does not require the prescriber to hold any specific Board certification; however, a determination of appropriateness by the Program may include a review of the physician's competency to treat your condition and prescribe a Managed Drug.

The Program only covers certain drugs approved by the FDA for marketing and use in the USA. Since the FDA does not have objective standards on efficacy and effectiveness of drug therapies, determinations of investigational or experimental classification are made by VIVIO using their proprietary algorithms and methods. Medical foods that are voluntarily filed with the FDA are not covered. Drugs, biologics or cellular-based therapies that are approved or licensed with only orphan, breakthrough or limited population pathway designations are generally not covered due to the fact that these approvals were based on lower standards of evidence than a standard approval and may be excluded until their manufacturer provides data from additional randomized controlled trials.

Separate Program from Plan Sponsor's Medical Benefits and Prescription Drug Benefits

The VIVIO Program is separate from the network arrangement of this Plan's Medical Benefits and Prescription

Drug Benefits. Plan participants are automatically enrolled in VIVIO Program coverage when enrolling in medical coverage under this Plan. Specialty drugs on the VIVIO list of managed drugs are only covered when approved through the VIVIO Program whether administered at home, pharmacy, physician office, ambulatory center or other outpatient location.

How Coverage Decisions Are Made

Authorization is required for all Managed Drugs unless this requirement is specifically waived by the Program. The Program will contact your prescribing physician to initiate the VIVIO therapy planning process. Any authorization that is issued as a result of the therapy planning process may be specific to a pharmacy, provider, a period of time, dosing frequency, maximum dose quantity, reimbursement limits, outcome measurements, and/or specific warranties required of the drug manufacturer.

The Program may make its coverage determination using any combination of the following methods:

1. a documented medical coverage policy
2. externally referenceable standards of clinical practice
3. clinical trial data supplied by manufacturers
4. disease specific clinical models developed by VIVIO

Coverage may only be provided for a preferred drug for the treatment of your condition, or, your physician may be required to provide data to prove that a preferred drug is not appropriate for the treatment of your condition before another drug may be considered for coverage. In addition, the Program will require ongoing disease activity measures to assess whether ongoing therapies are effective in moving toward remission or managing disease progression.

Therapy Costs

VIVIO uses its proprietary dynamic market-based reference pricing model to set fair market value for the drugs acquired on behalf of the Employer sponsored plan. Generally, VIVIO considers manufacturer sponsored program(s) such as copay assistance, and other similar programs as reductions to the price of the drug, lowering its fair market value. When such programs exist, VIVIO reference prices a drug to a maximum of 50% of the drug cost until those discounts are exhausted. VIVIO does not consider any costs that are above fair market value in the accumulation of deductibles, coinsurance, co-payment or out-of-pocket maximums. VIVIO may also use other factors such as pricing of alternative therapies, clinical trial and real-world effectiveness data in its price computation algorithms.

A member can only accumulate out-of-pocket costs for specialty drug therapies approved by the VIVIO Health program. Any direct reimbursement for out-of-pocket costs for a specialty drug by that drug's manufacturer or affiliated company provided to the member is considered outside of and a violation of the health plan. If such reimbursement is accepted by the member, then no portion of the drug will be covered by the plan and if any portion was paid, the member must reimburse any plan paid portions. In addition, the member may be subject to income tax on those reimbursements as they are outside of the health plan and should report those earnings to the IRS.

Non-Duplication of Benefits

Non-duplication of benefits applies to Managed Drugs under this Program. When benefits are provided for a Managed Drug through this Program, the same drug is not Managed by any other offering of the Kyrene Employee Benefit Trust, unless approved by VIVIO.

Pre-certification Requirement

All VIVIO covered specialty drugs must be pre-certified through VIVIO.

Benefit Exclusions

This Program will not cover a charge for any of the following:

1. Drugs used in a clinical trial
2. Experimental and/or Investigational drugs
3. Non-Participating Pharmacy (Pharmacies not identified for usage through the VIVIO Program)
4. Not medically necessary

C. How You Can Obtain Specialty Drugs

Contact VIVIO to obtain a Managed Drug through the Program using the information below under **Program Contact Information**.

D. What You Pay for Managed Drugs

Your share of the cost for Managed Drugs may vary based on our proprietary dynamic pricing model. Generally, VIVIO considers manufacturer sponsored program(s) such as copay assistance, and other similar programs as reductions to the price of the drug, lowering its fair market value. When such programs exist, VIVIO reference prices a drug to a maximum of 50% of the drug cost until those discounts are exhausted. VIVIO does not consider any costs that are above fair market value in the accumulation of deductibles, coinsurance, copay towards out-of-pocket maximums. VIVIO may

also use other factors such as pricing of alternative therapies, clinical trial and real-world effectiveness data in its price computation algorithms.

If you pay for a drug out-of-pocket, at a pharmacy other than the one you are directed to by the Program, you may not be reimbursed for your expense.

E. Day Supply and Refill Limits

Specialty Drugs are subject to a "per fill" days' supply limit that will not exceed a thirty (30) day supply of medication, except by special request or as clinically necessary. The supply quantity for each prescription fill is determined by the dosing instructions that are included on the physician's prescription. In most cases, it is required that you have not more than a seven (7) day supply of medication on hand before your prescription can be refilled.

F. Appeals Process

Your plan offers you an appeals process if you have been denied care. You may call VIVIO for details at 1-800-470-4034 or find the details at **MyVIVIO.com**.

If you or your physician requests an appeal and additional information is provided, it is reviewed and evaluated by the VIVIO appeals unit to determine if the drug use meets coverage conditions specified or intended by your employer according to the procedures set forth below:

1. **Level 1:** The VIVIO Appeals Unit
2. **Level 2:** The VIVIO Appeals Unit or external third-party review organization
3. **Level 3:** Review by Independent Review Organization (IRO)

Appeal procedures apply to appeals of adverse benefit determinations of appropriateness, effectiveness and experimental classification of a specialty drug therapy. Appeals related to eligibility to participate in the plan are coordinated by your employer.

G. Program Contact Information

VIVIO Health
Concierge: 1-800-470-4034
Fax: 1-888-677-6754
Program Website: **MyVIVIO.com**
Email: **concierge@MyVIVIO.com**

SECTION XII—CLAIMS AND APPEALS

A. Introduction

This section contains the *claims* and *appeals* procedures and requirements for the Kyrene Employee Benefit Trust.

TIME LIMIT FOR FILING CLAIMS

All *claims* must be received by the *Plan* within twelve (12) months from the date of *incurring* the expense, or in accordance with applicable federal government regulations. The *Plan* will accept *network* adjustments of *claims* that are within the *network's* established guidelines.

The *Plan's* representatives will follow administrative processes and safeguards designed to ensure and to verify that benefit *claim* determinations are made in accordance with governing plan documents and that where appropriate the *Plan* provisions have been applied consistently with respect to similarly situated *claimants*.

The following types of *claims* are covered by the procedures in this section:

1. **Pre-Service Claim.** Some *Plan* benefits are payable without a financial penalty only if the *Plan* approves services **before** services are rendered. These benefits are referred to as *pre-service claims* (also known as *pre-certification* or prior authorization). The services that require *pre-certification* are listed in the **Health Care Management Program** section of this document.
2. **Urgent Care Claim.** An *urgent care claim* is a *claim* (request) for medical care or treatment in which:
    a. applying the time periods for *pre-certification* could seriously jeopardize the life or health of the individual or the ability of the individual to regain maximum function
    b. in the opinion of a *physician* with knowledge of the individual's medical condition, would subject the individual to severe pain that cannot be adequately managed without the care or treatment that is the subject of the *claim*
    c. the *claim* involves urgent care
3. **Concurrent Care Claim.** A *concurrent care claim* refers to a *Plan* decision to reduce or terminate a pre-approved ongoing course of treatment before the end of the approved treatment. A *concurrent care claim* also refers to a request by you to extend a pre-approved course of treatment. Individuals will be given the opportunity to argue in favor of uninterrupted continuity of care before treatment is cut short.
4. **Post-Service Claim.** *Post-service claims* are *claims* that involve only the payment or reimbursement of the cost of the care that has already been provided. A standard *claim* and an electronic bill, submitted for payment after services have been provided, are examples of *post-service claims*. A *claim* regarding rescission of coverage will be treated as *post-service claim*.

Following is a description of how the *Plan* processes *claims* for benefits and reviews the *appeal* of any *claim* that is denied.

If a *claim* is denied, in whole or in part, or if *Plan* coverage is rescinded retroactively for fraud or misrepresentation, the denial is known as an *adverse benefit determination*.

A *claimant* has the right to request a review of an *adverse benefit determination*. This request is an *appeal*. If the *claim* is denied at the end of the *appeal* process, as described later in this section, the *Plan's* final decision is known as a *final internal adverse benefit determination*. If the *claimant* receives *notice* of a *final internal adverse benefit determination*, or if the *Plan* does not follow the *appeal* procedures properly, the *claimant* then has the right to request an independent *external review*. The *external review* procedures are also described later in this section.

Both the *claims* and the *appeal* procedures are intended to provide a full and fair review. This means, among other things, that *claims* and *appeals* will be decided in a manner designed to ensure the independence and impartiality of the persons involved in making these decisions.

A *claimant* must follow all *claims* and *appeals* procedures, both internal and external, before they can file a lawsuit. However, this rule may not apply if the *Plan Administrator* has not complied with the procedures described in this section. If a lawsuit is brought, it must be filed within two (2) years after the final determination of an *appeal*.

Any of the authority and responsibilities of the *Plan Administrator* under the *claims* and *appeals* procedures or the *external review* process, including the discretionary authority to interpret the terms of the *Plan*, may be delegated to a third party. If you have any questions regarding these procedures, please contact the *Plan Administrator*, as outlined in the Quick Reference Information Chart.

B. Timeframes for Claim and Appeal Processes

	Post-Service Claims	Pre-Service Claim Types		
		Urgent Care Claim	Concurrent Care Claim	Other Pre-Service Claim
Claimant must submit *claim* for benefit determination within:	twelve (12) months	twenty-four (24) hours		
Plan must make initial *benefit determination* as soon as possible but no later than:	thirty (30) days	seventy-two (72) hours	before the benefit is reduced or treatment terminated	fifteen (15) days
Extension permitted during initial *benefit determination*:	fifteen (15) days	no	no	fifteen (15) days
First-level *appeal* review must be submitted to the *Plan* within:	one hundred eighty (180) days	one hundred eighty (180) days	one hundred eighty (180) days	one hundred eighty (180) days
Plan must make first *appeal benefit determination* as soon as possible but no later than:	thirty (30) days	thirty-six (36) hours	before the benefit is reduced or treatment terminated	fifteen (15) days
Extension permitted during *appeal* review:	no	no	no	no
Second-level appeal must be submitted in writing within:	sixty (60) days	sixty (60) days	sixty (60) days	sixty (60) days
Plan must make second *appeal benefit determination* as soon as possible but no later than:	thirty (30) days	thirty-six (36) hours	thirty (30) days	fifteen (15) days
Appeal for external review must be submitted after a final adverse benefit determination within:	four (4) months	four (4) months	four (4) months	four (4) months
Plan will complete preliminary review of *IRO* request within:	five (5) business days	five (5) business days	five (5) business days	five (5) business days
Plan will *notify claimant* of preliminary review within:	one (1) business day	one (1) business day	one (1) business day	one (1) business day
IRO determination and *notice* within:	forty-five (45) days	seventy-two (72) hours	seventy-two (72) hours	forty-five (45) days

C. Types of Claims Managed by the Medical Management Administrator

The following types of *claims* are managed by the *Medical Management Administrator*:

1. *urgent care claims*
2. *concurrent care claims*
3. other *pre-service claims*

The process and procedures for each *pre-service claim* type are listed below.

D. Urgent Care Claims

Any *pre-service claim* for medical care or treatment which, if subject to the normal timeframes for *Plan* determination, could seriously jeopardize the *claimant's* life, health, or ability to regain maximum function or which, in the opinion of a *physician* with knowledge of the *claimant's* medical condition, would subject the *claimant* to severe pain that cannot be adequately managed without the care or treatment that is the subject of the *claim*. Whether a *claim* is an *urgent care claim* will be determined by an individual acting on behalf of the *Plan* applying the judgment of a prudent layperson who possesses an average knowledge of health and medicine. However, any *claim* that a *physician,* with knowledge of the *claimant's* medical condition, determines is an *urgent care claim* (as described herein) shall be treated as an *urgent care claim* under the *Plan*. *Urgent care claims* are a subset of *pre-service claims*.

How to File Urgent Care Claims

In order to file an *urgent care claim*, you or your *authorized representative* must call the *Medical Management Administrator* or VIVIO Health for specialty drugs covered under the VIVIO Health Program and provide the following:

1. information sufficient to determine whether, or to what extent, benefits are covered under the *Plan*
2. a description of the medical circumstances that give rise to the need for expedited review

If you or your *authorized representative* fail to provide the *Plan* with the above information, the *Plan* will provide *notice* as soon as reasonably possible, but no later than the timeframe shown in the Timeframes for Claim and Appeal Processes after receipt of your *claim*. You will be afforded a reasonable amount of time under the circumstance, but no less than the timeframe shown in the Timeframes for Claim and Appeal Processes, to provide the specified information.

Notification of Benefit Determination of Urgent Care Claims

Notice of a *benefit determination* (whether adverse or not) will be provided as soon as possible, taking into account the medical circumstances, but no later than the deadline shown in the Timeframes for Claim and Appeal Processes subsection. However, if the *Plan* gives you *notice* of an incomplete *claim*, the *notice* will include a time period of no less than forty-eight (48) hours for you to respond with the requested specified information. The *Plan* will then provide you with the *notice* of *benefit determination* within forty-eight (48) hours after the earlier of:

1. receipt of the specified information
2. the end of the period of time given you to provide the information

If the *benefit determination* is provided orally, it will be followed in writing no later than three (3) days after the oral *notice*.

If the *urgent care claim* involves a concurrent care decision, a *notice* of the *benefit determination* (whether adverse or not) will be provided as soon as possible, but no later than the timeframe shown in the Timeframes for Claim and Appeal Processes after receipt of your *claim* for extension of treatment or care, as long as the *claim* is made within the timeframe shown in the Timeframes for Claim and Appeal Processes before the prescribed period of time expires or the prescribed number of treatments ends.

Notification of Adverse Benefit Determination of Urgent Care Claims

If an *urgent care claim* is denied in whole or in part, the denial is considered to be an *adverse benefit determination*. The *Plan Administrator's notification* of an *adverse benefit determination* may be oral followed by written or electronic *notification* within three (3) days of the oral *notification*. The *notice* will state in a culturally and linguistically appropriate manner and in a manner calculated to be understood by the *claimant*:

1. identification of the *claim*, including date of service, name of provider, *claim* amount (if applicable), and a statement that the diagnosis code(s) and treatment code(s) and their corresponding meaning(s) will be provided to the *claimant* as soon as feasible upon request
2. the specific reason(s) for the *adverse benefit determination*, including the denial code(s) and corresponding meaning(s), and the *Plan's* standard, if any, used in denying the *claim*
3. reference to the specific *Plan* provisions on which the determination was based
4. a description of any additional information or material needed from you to complete the *claim* and an explanation of why such material or information is necessary
5. if an internal rule, guideline, protocol, or other similar criterion was relied upon in making the *adverse benefit determination*, either the specific rule, guideline, protocol, or other similar criterion; or a statement that such a rule, guideline, protocol, or other similar criterion was relied upon in the *adverse benefit determination* and that a copy of the rule, guideline, protocol, or other criterion will be provided free of charge to you, upon request
6. if the *adverse benefit determination* is based on the *medical necessity* or *experimental* or *investigational* treatment or similar exclusion or limit, an explanation of the scientific or clinical judgment for the determination, applying the terms of the *Plan* to the *claimant's* medical circumstances, or a statement that such an explanation will be provided free of charge, upon request
7. a description of the expedited review process applicable to the *claim*
8. a description of the *Plan's* review or *appeal* procedures, including applicable time limits

9. information about the availability of and contact information for any applicable office of health insurance consumer assistance or ombudsman established under applicable federal law to assist individuals with the internal *claims* and *appeals* and *external review* process

How to File an Appeal of an Urgent Care Claim

You may *appeal* any *adverse benefit determination* to the *Third Party Administrator*. The *Plan Administrator* is the sole *fiduciary* of the *Plan* and exercises all discretionary authority and control over the administration of the *Plan* and has sole discretionary authority to determine eligibility for *Plan* benefits and to construe the terms of the *Plan*. Refer to the timeframe shown in the Timeframes for Claim and Appeal Processes for when a claimant may file a written request for an *appeal* of the decision upon *notification* of an *adverse benefit determination*. However, for *concurrent care claims*, the *claimant* must file the *appeal* prior to the scheduled reduction or termination of treatment. For a *claim* based on rescission of coverage, the *claimant* must file the *appeal* within the timeframe shown in the Timeframes for Claim and Appeal Processes. A *claimant* may submit written comments, documents, records, and other information relating to the *claim*.

The *Third Party Administrator* will conduct a full and fair review of all benefit *appeals*, independently from the individual(s) who made the *adverse benefit determination* or anyone who reports to such individual(s) and without affording deference to the *adverse benefit determination*. You will, upon request and free of charge, be given reasonable access to, and copies of, all documents, records, and other information relevant to your *claim* for benefits, including your *claim* file. You will also have the opportunity to submit to the *Third Party Administrator* written comments, documents, records, and other information relating to your *claim* for benefits. You may also present evidence and testimony should you choose to do so; however, a formal hearing may not be allowed. The *Third Party Administrator* will take into account all this information regardless of whether it was considered in the *adverse benefit determination*.

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

1. was relied upon in making the *benefit determination*
2. was submitted, considered, or generated in the course of making the *benefit determination*, without regard to whether it was relied upon in making the *benefit determination*
3. demonstrated compliance with the administrative processes and safeguards designed to ensure and to verify that *benefit determinations* are made in accordance with plan documents and *Plan* provisions have been applied consistently with respect to all *claimants*
4. constituted a statement of policy or guidance with respect to the *Plan* concerning the denied treatment option or benefit

The period of time within which a *benefit determination* on *appeal* is required to be made shall begin at the time of receipt of a written *appeal* in accordance with the procedures of the *Plan*. This timing is without regard to whether all the necessary information accompanies the filing.

Before the *Third Party Administrator* issues its *final internal adverse benefit determination* based on a new or additional rationale or evidence, the *claimant* must be provided, free of charge, with a copy of the rationale. The rationale must be provided as soon as possible and sufficiently in advance of the time within which a final determination on *appeal* is required to allow the *claimant* time to respond.

If the *adverse benefit determination* was based, in whole or in part, on a medical judgment, including determinations that treatments, drugs, or other services are *experimental/investigational*, or not *medically necessary* or appropriate, the *Third Party Administrator* will consult with a health care professional who has appropriate training and experience in the field of medicine involved in the medical judgment, and who was neither consulted in connection with the *adverse benefit determination* nor is a subordinate of any such individual.

Upon request, you will be provided the identification of the medical or vocational expert(s) whose advice was obtained on behalf of the *Plan* in connection with the *adverse benefit determination*, whether or not the advice was relied upon to make the *adverse benefit determination*.

Form and Timing of Appeals of Denied Urgent Care Claims

You or your *authorized representative* must file an *appeal* of an *adverse benefit determination* within the timeframe shown in the Timeframes for Claim and Appeal Processes after receiving *notification* of the *adverse benefit determination*.

Requests for *appeal* which do not comply with the above requirement will not be considered.

You may *appeal* an *adverse benefit determination* of an *urgent care claim* on an expedited basis, either orally or in writing. You may *appeal* orally by calling the *Medical Management Administrator*. All necessary information, including the *Medical Management Administrator's benefit determination* on review, will be transmitted between the *Medical Management Administrator* and you by telephone, facsimile, or other available similarly expeditious method.

Time Period for Deciding Appeals of Urgent Care Claims

Appeals of *urgent care claims* will be decided by the *Plan Administrator* or its designee as soon as possible, taking into account the *medical emergencies*, but no later than the timeframe shown in the Timeframes for Claim and Appeal Processes after the *Plan Administrator* or its designee receives the *appeal*. A decision communicated orally will be followed-up in writing.

Notification of Appeal Denials of Urgent Care Claims

The *Third Party Administrator* shall provide *notification* of the decision on an *urgent care claim* orally, but a follow-up written *notification* will be provided no later than the timeframe shown in the Timeframes for Claim and Appeal Processes after the oral *notice*. The *notice* will state in a culturally and linguistically appropriate manner and in a manner calculated to be understood by the *claimant*:

1. identification of the *claim*, including date of service, name of provider, *claim* amount (if applicable), and a statement that the diagnosis code(s) and treatment code(s) and their corresponding meaning(s) will be provided to the *claimant* as soon as feasible upon request
2. the specific reason(s) for the *adverse benefit determination*, including the denial code(s) and corresponding meaning(s), and the *Plan's* standard, if any, used in denying the *claim*
3. reference to the specific *Plan* provisions on which the *adverse benefit determination* was based
4. a statement regarding your right, upon request and free of charge, to access and receive copies of documents, records, and other information that are relevant to the *claim*

   You and your *Plan* may have other voluntary alternative dispute resolution options, such as mediation. One (1) way to find out what may be available is to contact your local U.S. Department of Labor Office.
5. if an internal rule, guideline, protocol, or other similar criterion was relied upon in denying the *appeal*, either the specific rule, guideline, protocol, or other similar criterion; or a statement that such a rule, guideline, protocol, or other similar criterion was relied upon in denying the *appeal* and that a copy of the rule, guideline, protocol, or other criterion will be provided free of charge to you upon request
6. if the denied *appeal* was based on a *medical necessity*, *experimental/investigational*, or similar exclusion or limit, either an explanation of the scientific or clinical judgment for the denial, applying the terms of the *Plan* to your medical circumstances, or a statement that such an explanation will be provided free of charge upon request
7. a description of any additional material or information necessary for the *claimant* to perfect the *claim* and an explanation of why such material or information is necessary
8. a description of the *Plan's* internal and *external review* procedures and the time limits applicable to such procedures
9. a statement describing any additional *appeal* procedures offered by the *Plan* and your right to obtain information about such procedures
10. information about the availability of and contact information for any applicable office of health insurance consumer assistance or ombudsman established under applicable federal law to assist individuals with the internal *claims* and *appeals* and *external review* process

E. Concurrent Care Claims

Your *claim* for medical care or treatment is a *concurrent care claim* if your *claim* has been approved to provide an ongoing course of treatment over a period of time, which either involves a reduction or termination by the *Plan* of such course of treatment (other than by *Plan* amendment or termination), or a request by you or on your behalf to extend or expand your treatment.

If your request involves concurrent care (the continuation/reduction of an ongoing course of treatment), you may file the *claim* by writing (orally for an expedited review) to the *Medical Management Administrator*.

1. If a decision is made to reduce or terminate an approved course of treatment, you will be provided *notification* of the termination or reduction sufficiently in advance of the reduction or termination to allow you to *appeal* and obtain a determination of that *adverse benefit determination* before the benefit is reduced or terminated.
2. The *Plan* will provide you free of charge with any new or additional evidence considered, relied upon, or generated by the *Plan* (or at the direction of the *Plan*) in connection with the denied *claim*. Such evidence will be provided as soon as possible (and sufficiently in advance of the date on which the *notice* of *adverse benefit determination* on review is required to be provided) to give you a reasonable opportunity to respond prior to that date. Additionally, before the *Plan* issues an *adverse benefit determination* or review based on a new or additional rationale, you will be provided, free of charge, with the rationale. The rationale will be provided as soon as possible (and sufficiently in advance of the date on which the *notice* of *adverse benefit determination* on review is required to be provided) to give you a reasonable opportunity to respond prior to that date.
3. A *concurrent care claim* that involves urgent care will be processed according to the initial review and *appeals* procedures and timeframes noted under the Urgent Care Claims subsection (above).
4. If a *concurrent care claim* does not involve urgent care, the request may be treated as a new benefit *claim* and decided within the timeframe appropriate to the type of *claim* (i.e., as a *pre-service claim* or a *post-service claim*). Such *claims* will be processed according to the initial review and *appeals* procedures and timeframes applicable to the claim-type, as noted under the Other Pre-Service Claims subsection (below) or the Post-Service Claims subsection listed later in this section.
5. If the *concurrent care claim* is approved, you will be *notified* orally followed by written (or electronic, as applicable) *notice* provided no later than the timeframe shown in the Timeframes for Claim and Appeal Processes after the oral *notice*

F. Other Pre-Service Claims

Claims that require *Plan* approval prior to obtaining medical care for the *claimant* to receive full benefits under the *Plan* are considered *other pre-service claims* (e.g. a request for *pre-certification* under the health care management program). Refer to the **Heath Care Management Program** section to review the list of services that require *pre-certification*.

How to File Other Pre-Service Claims

Typically, other *pre-service claims* are made on a *claimant's* behalf by the treating *physician*. However, it is the *claimant's* responsibility to ensure that the other *pre-service claim* has been filed. The *claimant* can accomplish this by having their health care provider contact the *Medical Management Administrator* to file the *other pre-service claim* on behalf of the *claimant*.

Other *pre-service claims* must include the following information:

1. the name of this *Plan*
2. the identity of the *claimant* (name, address, and date of birth)
3. the proposed date(s) of service
4. the name and credentials of the health care *provider*
5. an order or request from the health care provider for the requested service
6. the proposed place of service
7. a specific diagnosis
8. a specific proposed service code for which approval or payment is requested [current Healthcare Common Procedure Coding System (HCPCS) or Current Procedural Terminology (CPT) format]
9. clinical information for this *Plan* to make a *medical necessity* determination

Under certain circumstances provided by federal law, if you or your *authorized representative* fail to follow the *Plan's* procedures for filing other *pre-service claims*, the *Plan* will provide *notice* of the failure and the proper procedures to be followed. This *notification* will be provided as soon as reasonably possible, but no later than five (5) days after receipt of the *claim*. You will then have up to forty-five (45) days from receipt of the *notice* to follow the proper procedures.

Notification of Benefit Determination of Other Pre-Service Claims

Notice of a *benefit determination* (whether adverse or not) will be provided in writing within a reasonable period appropriate to the medical circumstances, but no later than the timeframe shown in the Timeframes for Claim and Appeal Processes after receipt of the *claim*. However, this period may be extended one (1) time by the *Plan* for up to the timeframe shown in the Timeframes for Claim and Appeal Processes if the *Plan* both determines that such an extension is necessary due to matters beyond its control and provides you written *notice*, prior to the end of the original time period, of the circumstances requiring the extension and the date by which the *Plan* expects to render a decision. Refer to the Incomplete Claims subsection if such an extension is necessary due to your failure to submit the information necessary to decide the *claim*.

Notification of Adverse Benefit Determination of Other Pre-Service Claims

If the other *pre-service claim* is denied in whole or in part, the denial is considered to be an *adverse benefit determination*. The *Third Party Administrator* shall provide written or electronic *notification* of the *adverse benefit determination*. This *notice* will state in a culturally and linguistically appropriate manner and in a manner calculated to be understood by the *claimant*:

1. identification of the *claim*, including date of service, name of provider, *claim* amount (if applicable), and a statement that the diagnosis code(s) and treatment code(s) and their corresponding meaning(s) will be provided to the *claimant* as soon as feasible upon request
2. the specific reason(s) for the *adverse benefit determination*, including the denial code(s) and corresponding meaning(s), and the *Plan's* standard, if any, used in denying the *claim*
3. reference to the specific *Plan* provisions on which the determination was based
4. a description of any additional information or material needed from you to complete the *claim* and an explanation of why such material or information is necessary
5. if an internal rule, guideline, protocol, or other similar criterion was relied upon in making the *adverse benefit determination*, either the specific rule, guideline, protocol, or other similar criterion; or a statement that such a rule, guideline, protocol, or other similar criterion was relied upon in the *adverse benefit determination* and that a copy of the rule, guideline, protocol, or other criterion will be provided free of charge to you, upon request
6. if the *adverse benefit determination* is based on the *medical necessity* or *experimental* or *investigational* treatment or similar exclusion or limit, an explanation of the scientific or clinical judgment for the determination, applying the terms of the *Plan* to the *claimant's* medical circumstances, or a statement that such an explanation will be provided free of charge, upon request
7. a description of the *Plan's* review or *appeal* procedures, including applicable time limits
8. information about the availability of and contact information for any applicable office of health insurance consumer assistance or ombudsman established under applicable federal law to assist individuals with the internal *claims* and *appeals* and *external review* process

How to File an Appeal of Other Pre-Service Claims

You may *appeal* any *adverse benefit determination* to the *Third Party Administrator*. The *Plan Administrator* is the sole *fiduciary* of the *Plan* and exercises all discretionary authority and control over the administration of the *Plan* and has sole discretionary authority to determine eligibility for *Plan* benefits and to construe the terms of the *Plan*. Refer to the timeframe shown in the Timeframes for Claim and Appeal Processes in which a *claimant* may file a written request for an *appeal* of the decision after receiving *notification* of an *adverse benefit determination*. However, for *concurrent care claims*, the *claimant* must file the *appeal* prior to the scheduled reduction or termination of treatment. For a *claim* based on rescission of coverage, the *claimant* must file the *appeal* within the timeframe shown in the Timeframes for Claim and Appeal Processes. A *claimant* may submit written comments, documents, records, and other information relating to the *claim*.

The *Third Party Administrator* will conduct a full and fair review of all benefit *appeals*, independently from the individual(s) who made the *adverse benefit determination* or anyone who reports to such individual(s), and without affording deference to the *adverse benefit determination*. You will, upon request and free of charge, be given reasonable access to, and copies of, all documents, records, and other information relevant to your *claim* for benefits, including your *claim* file. You will also have the opportunity to submit to the *Plan Administrator* or its designee written comments, documents, records, and other information relating to your *claim* for benefits. You may also present evidence and testimony should you choose to do so; however, a formal hearing may not be allowed. The *Third Party Administrator* will take into account all this information regardless of whether it was considered in the *adverse benefit determination*.

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

1. was relied upon in making the *benefit determination*
2. was submitted, considered, or generated in the course of making the *benefit determination*, without regard to whether it was relied upon in making the *benefit determination*
3. demonstrated compliance with the administrative processes and safeguards designed to ensure and to verify that *benefit determinations* are made in accordance with plan documents and *Plan* provisions have been applied consistently with respect to all *claimants*
4. constituted a statement of policy or guidance with respect to the *Plan* concerning the denied treatment option or benefit

The period of time within which a *benefit determination* on *appeal* is required to be made shall begin at the time of receipt of a written *appeal* in accordance with the procedures of the *Plan*. This timing is without regard to whether all the necessary information accompanies the filing.

Before the *Third Party Administrator* issues its *final internal adverse benefit determination* based on a new or additional rationale or evidence, the *claimant* must be provided, free of charge, with a copy of the rationale. The rationale must be provided as soon as possible and sufficiently in advance of the time within which a final determination on *appeal* is required to allow the *claimant* time to respond.

If the *adverse benefit determination* was based, in whole or in part, on a medical judgment, including determinations that treatments, drugs, or other services are *experimental/investigational*, or not *medically necessary* or appropriate, the *Third Party Administrator* will consult with a health care professional who has appropriate training and experience in the field of medicine involved in the medical judgment, and who was neither consulted in connection with the *adverse benefit determination* nor is a subordinate of any such individual.

Upon request, you will be provided the identification of the medical or vocational expert(s) whose advice was obtained on behalf of the *Plan* in connection with the *adverse benefit determination*, whether or not the advice was relied upon to make the *adverse benefit determination*.

Form and Timing of Appeals of Denied Other-Pre-Service Claims

You or your *authorized representative* must file an *appeal* of an *adverse benefit determination* within the timeframe shown in the Timeframes for Claim and Appeal Processes after receiving *notification* of the *adverse benefit determination*.

Requests for *appeal* which do not comply with the above requirement will not be considered.

All requests for a review of a denied *pre-service claim* (other than *urgent care claim*) must be in writing and should include a copy of the *adverse benefit determination*, if applicable, and any other pertinent information that you wish the *Medical Management Administrator* to review in conjunction with your *appeal*. Send all information to the *Medical Management Administrator* as listed in the Quick Reference Information Chart.

Time Period for Deciding Appeals of Other Pre-Service Claims

Appeals of other *pre-service claims* will be decided by the *Third Party Administrator* within a reasonable period of time appropriate to the medical circumstances, but no later than the timeframe shown in the Timeframes for Claim and Appeal Processes after the *Third Party Administrator* receives the *appeal*. The *Third Party Administrator's* decision will be provided to you in writing.

Notification of Appeal Denials of Other Pre-Service Claims

If your *appeal* is denied, in whole or in part, the *Third Party Administrator* will provide written *notification* of the *adverse benefit determination* on *appeal*. The *notice* will state in a culturally and linguistically appropriate manner and in a manner calculated to be understood by the *claimant*:

1. identification of the *claim*, including date of service, name of provider, *claim* amount (if applicable), and a statement that the diagnosis code(s) and treatment code(s) and their corresponding meaning(s) will be provided to the *claimant* as soon as feasible upon request
2. the specific reason(s) for the *adverse benefit determination*, including the denial code(s) and corresponding meaning(s), and the *Plan's* standard, if any, used in denying the *claim*
3. reference to the specific *Plan* provisions on which the *adverse benefit determination* was based
4. a statement regarding your right, upon request and free of charge, to access and receive copies of documents, records, and other information that are relevant to the *claim*

You and your *Plan* may have other voluntary alternative dispute resolution options, such as mediation. One way to find out what may be available is to contact your local U. S. Department of Labor Office.

5. if an internal rule, guideline, protocol, or other similar criterion was relied upon in denying the *appeal*, either the specific rule, guideline, protocol, or other similar criterion; or a statement that such a rule, guideline, protocol, or other similar criterion was relied upon in denying the *appeal* and that a copy of the rule, guideline, protocol, or other criterion will be provided free of charge to you upon request
6. if the denied *appeal* was based on a *medical necessity*, *experimental/investigational*, or similar exclusion or limit, either an explanation of the scientific or clinical judgment for the denial, applying the terms of the *Plan* to your medical circumstances, or a statement that such an explanation will be provided free of charge upon request
7. a description of any additional material or information necessary for the *claimant* to perfect the *claim* and an explanation of why such material or information is necessary
8. a description of the *Plan's* internal and *external review* procedures and the time limits applicable to such procedures
9. a statement describing any additional *appeal* procedures offered by the *Plan* and your right to obtain information about such procedures
10. information about the availability of and contact information for any applicable office of health insurance consumer assistance or ombudsman established under applicable federal law to assist individuals with the internal *claims* and *appeals* and *external review* process

G. Second Level Appeals Process for Urgent Care, Concurrent Care, and Other Pre-Service Claims

If your *appeal* of a *claim* is denied, you or your *authorized representative* may request further review by the *Third Party Administrator*. This request for a second-level *appeal* must be made in writing within the timeframe shown in the Timeframes for Claim and Appeal Processes.

The *Third Party Administrator* will promptly conduct a full and fair review of your *appeal*, independently from the individual(s) who considered your first-level *appeal* or anyone who reports to such individual(s) and without affording deference to the initial denial. You will again have access to all relevant records and other information and the opportunity to submit written comments and other information.

If the *adverse benefit determination* was based, in whole or in part, on a medical judgment, including determinations that treatments, drugs, or other services are *experimental/investigational*, or not *medically necessary* or appropriate, the *Third Party Administrator* will consult with a health care professional who has appropriate training and experience in the field of medicine involved in the medical judgment, and who was consulted neither in connection with the *adverse benefit determination* nor the initial *appeal* denial and who is not a subordinate of any such individuals.

Second-level *appeals* of *claims* will be decided by the *Third Party Administrator* within a reasonable period of time, but no later than the timeframe shown in the Timeframes for Claim and Appeal Processes after the *Third Party Administrator* receives the *appeal*. The *Third Party Administrator's* decision will be provided to you in writing, and if the decision is a second denial, the *notification* will include all of the information described in the subsection entitled Notification of Appeal Denials above.

H. External Review of Pre-Service Claims

Refer to the External Review of Claims section for the full description of the *external review* process under the *Plan*.

I. Incomplete Claims

Incomplete *pre-service claims* and/or *post-service claims* can be addressed through the extension of time described herein. (Refer to *Clean Claim* in the **Defined Terms** section.) If the reason for the extension is the failure to provide necessary information and the *claimant* is appropriately *notified*, this *Plan's* period of time to make a decision is suspended from the date upon which *notification* of the missing necessary information is sent until the date upon which the *claimant* responds or should have responded.

The *notification* will include a timeframe of at least forty-five (45) days in which the necessary information must be provided. Once the necessary information has been provided, this *Plan* will decide the *claim* within the extension described herein.

However, if the time period for the *benefit determination* is extended due to your failure to submit information necessary to decide a *claim*, the time period for making the *benefit determination* will be suspended from the date the *notice* of extension is sent to you until the earlier of:

1. the date on which you respond to the request for additional information
2. the date established by the *Plan* for the furnishing of the requested information (shown in the Timeframes for Claim and Appeal Processes)

If the requested information is not provided within the time specified, the *claim* may be denied. If your *claim* is denied based on your failure to submit information necessary to decide the *claim*, the *Plan* may, in its sole discretion, renew its consideration of the denied *claim* if the *Plan* receives the additional information within one hundred eighty (180) days after original receipt of the *claim*. In such circumstances, you will be *notified* of the *Plan's* reconsideration and subsequent *benefit determination*.

J. Post-Service Claims

The *Claims Administrator* manages the *claims*, first, and second level *appeal* process of *post-service claims*.

Post-service claims are *claims* that involve only the payment or reimbursement of the cost of the care that has already been provided. A standard *claim* and an electronic bill, submitted for payment after services have been provided, are examples of *post-service claims*. A *claim* regarding rescission of coverage will be treated as *post-service claim*.

How to File Post-Service Claims

All *claims* must be received by the *Plan* within the timeframe shown in the Timeframes for Claim and Appeal Processes from the date of the expense and must include the following information:

1. the *plan participant's* name, Social Security Number, and address
2. the covered *employee's* name, Social Security Number, and address if different from the *plan participant's*
3. the provider's name, tax identification number, address, degree, and signature
4. date(s) of service
5. diagnosis
6. procedure codes (describes the treatment or services rendered)
7. *assignment of benefits*, signed (if payment is to be made to the provider)
8. release of information statement, signed
9. coordination of benefits (COB) information if another plan is the primary payer
10. sufficient medical information to determine whether and to what extent the expense is a covered benefit under the *Plan*

Send complete information to:

AmeriBen
P.O. Box 7186
Boise, ID 83707

Notification of Benefit Determination of Post-Service Claims

The *Plan* will *notify* you or your *authorized representative* of its *benefit determination* (whether adverse or not) no later than the timeframe shown in the Timeframes for Claim and Appeal Processes after receipt of the *claim*. However, this period may be extended one (1) time by the *Plan* for up to the timeframe shown in the Timeframes for Claim and Appeal Processes if the *Plan* both determines that such an extension is necessary due to matters beyond its control and provides you written *notice*, prior to the end of the original time period, of the circumstances requiring the extension and the date by which the *Plan* expects to render a decision.

The applicable time period for the *benefit determination* begins when your *claim* is filed in accordance with the reasonable procedures of the *Plan*, even if you haven't submitted all the information necessary to make a *benefit determination*. Refer to the Incomplete Claims subsection for information regarding incomplete *claims*.

Notification of Adverse Benefit Determination of Post-Service Claims

If a *post-service claim* is denied in whole or in part, the denial is considered to be an *adverse benefit determination*. The *Third Party Administrator* shall provide written or electronic *notification* of the *adverse benefit determination*. This *notice* will state in a culturally and linguistically appropriate manner and in a manner calculated to be understood by the *claimant*:

1. identification of the *claim*, including date of service, name of provider, *claim* amount (if applicable), and a statement that the diagnosis code(s) and treatment code(s) and their corresponding meaning(s) will be provided to the *claimant* as soon as feasible upon request
2. the specific reason(s) for the *adverse benefit determination*, including the denial code(s) and corresponding meaning(s), and the *Plan's* standard, if any, used in denying the *claim*
3. reference to the specific *Plan* provisions on which the determination was based
4. a description of any additional information or material needed from you to complete the *claim* and an explanation of why such material or information is necessary
5. if an internal rule, guideline, protocol, or other similar criterion was relied upon in making the *adverse benefit determination*, either the specific rule, guideline, protocol, or other similar criterion; or a statement that such a rule, guideline, protocol, or other similar criterion was relied upon in the *adverse benefit determination* and that a copy of the rule, guideline, protocol, or other criterion will be provided free of charge to you, upon request
6. if the *adverse benefit determination* is based on the *medical necessity* or *experimental* or *investigational* treatment or similar exclusion or limit, an explanation of the scientific or clinical judgment for the determination, applying the terms of the *Plan* to the *claimant's* medical circumstances, or a statement that such an explanation will be provided free of charge, upon request
7. a description of the *Plan's* review or *appeal* procedures, including applicable time limits
8. information about the availability of and contact information for any applicable office of health insurance consumer assistance or ombudsman established under applicable federal law to assist individuals with the internal *claims* and *appeals* and *external review* process

How to File an Appeal of Post-Service Claims

You may *appeal* any *adverse benefit determination* to the *Third Party Administrator*. The *Plan Administrator* is the sole *fiduciary* of the *Plan* and exercises all discretionary authority and control over the administration of the *Plan* and has sole discretionary authority to determine eligibility for *Plan* benefits and to construe the terms of the *Plan*. Refer to the timeframe shown in the Timeframes for Claim and Appeal Processes in which a *claimant* may file a written request for an *appeal* of the decision after receiving *notification* of an *adverse benefit determination*. However, for *concurrent care claims*, the *claimant* must file the *appeal* prior to the scheduled reduction or termination of treatment. For a *claim* based on rescission of coverage, the *claimant* must file the *appeal* within the timeframe shown in the Timeframes for Claim and Appeal Processes. A *claimant* may submit written comments, documents, records, and other information relating to the *claim*.

The *Third Party Administrator* will conduct a full and fair review of all benefit *appeals*, independently from the individual(s) who made the *adverse benefit determination* or anyone who reports to such individual(s) and without affording deference to the *adverse benefit determination*. You will, upon request and free of charge, be given reasonable access to, and copies of, all documents, records, and other information relevant to your *claim* for benefits, including your *claim* file. You will also have the opportunity to submit to the *Plan Administrator* or its designee written comments, documents, records, and other information relating to your *claim* for benefits. You may also present evidence and testimony should you choose to do so; however, a formal hearing may not be allowed. The *Plan Administrator* or its designee will take into account all this information regardless of whether it was considered in the *adverse benefit determination*.

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

1. was relied upon in making the *benefit determination*
2. was submitted, considered, or generated in the course of making the *benefit determination*, without regard to whether it was relied upon in making the *benefit determination*
3. demonstrated compliance with the administrative processes and safeguards designed to ensure and to verify that *benefit determinations* are made in accordance with plan documents and *Plan* provisions have been applied consistently with respect to all *claimants*
4. constituted a statement of policy or guidance with respect to the *Plan* concerning the denied treatment option or benefit

The period of time within which a *benefit determination* on *appeal* is required to be made shall begin at the time of receipt of a written *appeal* in accordance with the procedures of the *Plan*. This timing is without regard to whether all the necessary information accompanies the filing.

Before the *Third Party Administrator* issues its *final internal adverse benefit determination* based on a new or additional rationale or evidence, the *claimant* must be provided, free of charge, with a copy of the rationale. The rationale must be provided as soon as possible and sufficiently in advance of the time within which a final determination on *appeal* is required to allow the *claimant* time to respond.

If the *adverse benefit determination* was based, in whole or in part, on a medical judgment, including determinations that treatments, drugs, or other services are *experimental/investigational*, or not *medically necessary* or appropriate, the *Plan Administrator* or its designee will consult with a health care professional who has appropriate training and experience in the field of medicine involved in the medical judgment, and who was neither consulted in connection with the *adverse benefit determination* nor is a subordinate of any such individual.

Upon request, you will be provided the identification of the medical or vocational expert(s) whose advice was obtained on behalf of the *Plan* in connection with the *adverse benefit determination*, whether or not the advice was relied upon to make the *adverse benefit determination*.

Form and Timing of Appeals of Denied Post-Service Claims

You or your *authorized representative* must file an *appeal* of an *adverse benefit determination* within the timeframe shown in the Timeframes for Claim and Appeal Processes after receiving *notification* of the *adverse benefit determination*.

Requests for *appeal* which do not comply with the above requirement will not be considered.

All requests for a review of a denied *post-service claim* must be in writing and should include a copy of the *adverse benefit determination* and any other pertinent information that you wish the *Third Party Administrator* to review in conjunction with your *appeal*. Send all information to:

AmeriBen
Attention: Appeals Coordination
P.O. Box 7186
Boise, ID 83707

Time Period for Deciding Appeals of Post-Service Claims

Appeals of *post-service claims* will be decided by the *Third Party Administrator* within a reasonable period of time, but no later than the timeframe shown in the Timeframes for Claim and Appeal Processes after the *Third Party Administrator* receives the *appeal*. The *Third Party Administrator's* decision will be provided to you in writing.

Notification of Appeal Denials of Post-Service Claims

If your *appeal* is denied, in whole or in part, the *Third Party Administrator* will provide written *notification* of the *adverse benefit determination* on *appeal*. The *notice* will state in a culturally and linguistically appropriate manner and in a manner calculated to be understood by the *claimant*:

1. identification of the *claim*, including date of service, name of provider, *claim* amount (if applicable), and a statement that the diagnosis code(s) and treatment code(s) and their corresponding meaning(s) will be provided to the *claimant* as soon as feasible upon request
2. the specific reason(s) for the *adverse benefit determination*, including the denial code(s) and corresponding meaning(s), and the *Plan's* standard, if any, used in denying the *claim*
3. reference to the specific *Plan* provisions on which the *adverse benefit determination* was based

4. a statement regarding your right, upon request and free of charge, to access and receive copies of documents, records, and other information that are relevant to the *claim*

   You and your *Plan* may have other voluntary alternative dispute resolution options, such as mediation. One (1) way to find out what may be available is to contact your local U.S. Department of Labor Office.

5. if an internal rule, guideline, protocol, or other similar criterion was relied upon in denying the *appeal*, either the specific rule, guideline, protocol, or other similar criterion; or a statement that such a rule, guideline, protocol, or other similar criterion was relied upon in denying the *appeal* and that a copy of the rule, guideline, protocol, or other criterion will be provided free of charge to you upon request

6. if the denied *appeal* was based on a *medical necessity*, *experimental/investigational*, or similar exclusion or limit, either an explanation of the scientific or clinical judgment for the denial, applying the terms of the *Plan* to your medical circumstances, or a statement that such an explanation will be provided free of charge upon request

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

8. a description of the *Plan's* internal and *external review* procedures and the time limits applicable to such procedures

9. a statement describing any additional *appeal* procedures offered by the *Plan* and your right to obtain information about such procedures

10. information about the availability of and contact information for any applicable office of health insurance consumer assistance or ombudsman established under applicable federal law to assist individuals with the internal *claims* and *appeals* and *external review* process

K. Second-Level Appeal Process of Post-Service Claims

The *Third Party Administrator* manages the second-level *appeal* process for *post-service claim* decisions.

The *Third Party Administrator* will be identified in the *notification* of denial of your first-level *appeal* and will not be the individual who made the original decision regarding the denial of your first-level *appeal* or a subordinate of such individual.

If your *appeal* of a *post-service claim* is denied, you or your *authorized representative* may request further review by the *Third Party Administrator*. This request for a second-level *appeal* must be made in writing within the timeframe shown in the Timeframes for Claim and Appeal Processes.

The *Third Party Administrator* will promptly conduct a full and fair review of your *appeal*, independently from the individual(s) who considered your first-level *appeal* or anyone who reports to such individual(s) and without affording deference to the initial denial. You will again have access to all relevant records and other information and the opportunity to submit written comments and other information, as described in more detail under the subsection entitled Post-Service Claims above.

If the *adverse benefit determination* was based, in whole or in part, on a medical judgment, including determinations that treatments, drugs, or other services are *experimental/investigational*, or not *medically necessary* or appropriate, the *Third Party Administrator* will consult with a health care professional who has appropriate training and experience in the field of medicine involved in the medical judgment, and who was consulted neither in connection with the *adverse benefit determination* nor the initial *appeal* denial and who is not a subordinate of any such individuals.

Second-level *appeals* of *post-service claims* will be decided by the *Plan Administrator* or its designee within a reasonable period of time, but no later than the timeframe shown in the Timeframes for Claim and Appeal Processes after the *Third Party Administrator* receives the *appeal*. The *Third Party Administrator's* decision will be provided to you in writing, and if the decision is a second denial, the *notification* will include all of the information described in the provision entitled Notification of Appeal Denials of Post-Service Claims above.

L. External Review Rights

If your final *appeal* for a *claim* is denied, you will be *notified* in writing that your *claim* is eligible for an *external review*, and you will be informed of the time frames and the steps necessary to request an *external review*. You must complete all levels of the internal *claims* and *appeals* procedures before you can request a voluntary *external review*.

If you decide to seek *external review*, an *independent review organization (IRO)* will be assigned your *claim*, and the *IRO* will work with a neutral, independent clinical reviewer with appropriate medical expertise. The *IRO* does not have to give deference to any earlier *claims* and *appeals* decisions, but it must observe the written terms of the plan document. In other words, the *IRO* is not bound by any previous decision made on your *claim*. The ultimate decision of the *IRO* will be binding on you, the *Third Party Administrator*, and the *Plan*.

M. External Review of Claims

The *external review* process is available only where the *final internal adverse benefit determination* is denied on the basis of any of the following:

1. a medical judgment (which includes but is not limited to *Plan* requirements for *medical necessity*, appropriateness, health care setting, level of care, or effectiveness of a covered benefit)
2. a determination that a treatment is *experimental* or *investigational*
3. a rescission of coverage

If your *appeal* is denied, you or your *authorized representative* may request further review by an *independent review organization (IRO)*. This request for *external review* must be made, in writing, within the timeframe shown in the Timeframes for Claims and Appeals Processes beginning the date you are *notified* of an *adverse benefit determination* or *final internal adverse benefit determination*.

The *Plan* will complete a preliminary review of the request within the timeframe shown in the Timeframes for Claim and Appeal Processes following the date of receipt of the *external review* request to determine whether:

1. the *claimant* is or was covered under the *Plan* at the time the health care item or service was requested or, in the case of a retrospective review, was covered under the *Plan* at the time the health care item or service was provided
2. the *adverse benefit determination* or the *final internal adverse benefit determination* does not relate to the *claimant's* failure to meet the requirements for eligibility under the terms of the group health plan (e.g., worker classification or similar determination)
3. the *claimant* has exhausted the *Plan's* internal *appeal* process
4. the *claimant* has provided all the information and forms required to process an *external review*

The *Plan* will *notify* the *claimant* within the timeframe shown in the Timeframes for Claim and Appeal Processes following completion of its preliminary review if either:

1. the request is complete but not eligible for *external review*, in which case the *notice* will include the reasons for its ineligibility, and contact information for the Employee Benefits Security Administration [toll-free number 1-866-444-EBSA (3272)]
2. the request is not complete, in which case the *notice* will describe the information or materials needed to make the request complete, and allow the *claimant* to perfect the request for *external review* within the timeframe shown in the Timeframes for Claim and Appeal Processes or within the forty-eight (48) hour period following receipt of the *notification*, whichever is later

NOTE: If the *adverse benefit determination* or *final internal adverse benefit determination* relates to a *plan participant's* or beneficiary's failure to meet the requirements for eligibility under the terms of the *Plan*, it is not within the scope of the *external review* process, and no *external review* may be taken.

If the request is complete and eligible, the *Plan Administrator* or its designee will assign the request to an *IRO*. Once that assignment is made, the following procedure will apply:

1. The assigned *IRO* will utilize legal experts where appropriate to make coverage determinations under the *Plan*.
2. The assigned *IRO* will timely *notify* the *claimant* in writing of the request's eligibility and acceptance for *external review*. This *notice* will include a statement that the *claimant* may submit in writing to the assigned *IRO*, within the timeframe shown in the Timeframes for Claim and Appeal Processes following the date of receipt of the *notice*, additional information that the *IRO* must consider when conducting the *external review*.

The *IRO* is not required to, but may, accept and consider additional information submitted after ten (10) business days.

3. Within the timeframe shown in the Timeframes for Claim and Appeal Processes after the date of assignment of the *IRO*, the *Plan* must provide to the assigned *IRO* the documents and any information considered in making the *adverse benefit determination* or *final internal adverse benefit determination*. Failure by the *Plan* to timely provide the documents and information must not delay the conduct of the *external review*. If the *Plan* fails to timely provide the documents and information, the assigned *IRO* may terminate the *external review* and make a decision to the *adverse benefit determination* or *final internal adverse benefit determination*. The *IRO* must *notify* the *claimant* and the *Plan* within the timeframe shown in the Timeframes for Claim and Appeal Processes after making the decision.
4. Upon receipt of any information submitted by the *claimant*, the assigned *IRO* must forward the information to the *Plan* within the timeframe shown in the Timeframes for Claim and Appeal Processes. Upon receipt of any such information, the *Plan* may reconsider its *adverse benefit determination* or *final internal adverse benefit determination* that is the subject of the *external review*. Reconsideration by the *Plan* must not delay the *external review*. The *external review* may be terminated as a result of the reconsideration only if the *Plan* decides, upon completion of its reconsideration, to reverse its *adverse benefit determination* or *final internal adverse benefit determination* and provide coverage or payment. The *Plan* must provide written *notice* of its decision to the *claimant* and the assigned *IRO* within the timeframe shown in the Timeframes for Claim and Appeal Processes. The assigned *IRO* must terminate the *external review* upon receipt of the *notice* from the *Plan*.
5. The *IRO* will review all of the information and documents timely received. In reaching a decision, the assigned *IRO* will review the *claim* de novo and not be bound by any decisions or conclusions reached during the *Plan's* internal *claims* and *appeals* process. In addition to the documents and information provided, the assigned *IRO*, to the extent the information or documents are available and the *IRO* considers them appropriate, will consider the following in reaching a decision:
    a. the *claimant's* medical records
    b. the attending health care professional's recommendation
    c. reports from appropriate health care professionals and other documents submitted by the *Plan*, *claimant*, or the *claimant's* treating provider
    d. the terms of the *claimant's Plan* to ensure that the *IRO's* decision is not contrary to the terms of the *Plan*, unless the terms are inconsistent with applicable law
    e. appropriate practice guidelines, which must include applicable evidence-based standards and may include any other practice guidelines developed by the federal government, national or professional medical societies, boards, and associations
    f. any applicable clinical review criteria developed and used by the *Plan*, unless the criteria are inconsistent with the terms of the *Plan* or with applicable law
    g. the opinion of the *IRO's* clinical reviewer or reviewers after considering the information described in this *notice* to the extent the information or documents are available
6. The assigned *IRO* must provide written *notice* of the final *external review* decision within the timeframe shown in the Timeframes for Claim and Appeal Processes after the *IRO* receives the request for the *external review*. The *IRO* must deliver the *notice* of *final external review decision* to the *claimant* and the *Plan*.
7. The assigned *IRO's* decision *notice* will contain:
    a. a general description of the reason for the request for *external review*, including information sufficient to identify the *claim* [including the date or dates of service, the health care provider, the *claim* amount (if applicable), the diagnosis code and its corresponding meaning, the treatment code and its corresponding meaning, and the reason for the previous denial]
    b. the date the *IRO* received the assignment to conduct the *external review* and the date of the *IRO* decision
    c. the references to the evidence or documentation, including the specific coverage provisions and evidence-based standards, considered in reaching its decision
    d. a discussion of the principal reason(s) for its decision, including the rationale for its decision and any evidence-based standards that were relied on in making its decision

e. a statement that the determination is binding except to the extent that other remedies may be available under state or federal law to either the group health *Plan* or to the *claimant*

f. a statement that judicial review may be available to the *claimant*

g. current contact information, including phone number, for any applicable office of health insurance consumer assistance or ombudsman

Generally, a *claimant* must exhaust the *Plan's claims* and *appeals* procedures in order to be eligible for the *external review* process. However, in some cases the *Plan* provides for an expedited *external review* if either:

1. The *claimant* receives an *adverse benefit determination* that involves a medical condition for which the time for completion of the *Plan's* internal *claims* and *appeals* procedures would seriously jeopardize the *claimant's* life, health, or ability to regain maximum function, and the *claimant* has filed a request for an expedited internal review.
2. The *claimant* receives a *final internal adverse benefit determination* that involves a medical condition where the time for completion of a standard *external review* process would seriously jeopardize the *claimant's* life or health or the *claimant's* ability to regain maximum function, or if the *final internal adverse benefit determination* concerns an admission, availability of care, continued stay, or health care item or service for which the *claimant* received *emergency services*, but has not been discharged from a facility.

Immediately upon receipt of a request for expedited *external review*, the *Plan* must determine and *notify* the *claimant* whether the request satisfies the requirements for expedited review, including the eligibility requirements for *external review* listed above. If the request qualifies for expedited review, it will be assigned to an *IRO*. The *IRO* must make its determination and provide a *notice* of the decision as expeditiously as the *claimant's* medical condition or circumstances require, but in no event more than the timeframe shown in the Timeframes for Claim and Appeal Processes after the *IRO* receives the request for an expedited *external review*. If the original *notice* of its decision is not in writing, the *IRO* must provide written confirmation of the decision within the timeframe shown in the Timeframes for Claim and Appeal Processes to both the *claimant* and the *Plan*.

N. Designation of Authorized Representative

A *plan participant* is permitted to appoint an *authorized representative* to act on behalf of the *plan participant* with respect to a benefit *claim* or *appeal* of a denial. In connection with a *claim* involving urgent care, the *Plan* will permit a health care professional with knowledge of the *plan participant's* medical condition to act as the *plan participant's authorized representative*. In the event a *plan participant* designates an *authorized representative*, all future communications from the *Plan* will be with the representative, rather than the *plan participant*, unless the *plan participant* directs the *Plan Administrator*, in writing, to the contrary. If you wish to change/alter your authorized representative, or the time frame, you will need to submit these changes in writing.

O. Physical Examinations

The *Plan* reserves the right to have a *physician* of its own choosing examine any *plan participant* whose condition, *illness*, or *injury* is the basis of a *claim*. All such examinations shall be at the expense of the *Plan*. This right may be exercised when and as often as the *Plan* may reasonably require during the pendency of a *claim*. The *plan participant* must comply with this requirement as a necessary condition to coverage.

P. Autopsy

The *Plan* reserves the right to have an autopsy performed upon any deceased *plan participant* whose condition, *illness*, or *injury* is the basis of a *claim*. This right may be exercised only where not prohibited by law.

Q. Payment of Benefits

All benefits under this *Plan* are payable, in U.S. dollars, to the *plan participant* whose *illness* or *injury*, or whose covered *dependent's illness* or *injury*, is the basis of a *claim*. In the event of the death or incapacity of a *plan participant*, and in the absence of written evidence to this *Plan* of the qualification of a guardian for their estate, this *Plan* may, in its sole discretion, make any and all such payments to the individual or *institution* which, in the opinion of this *Plan*, is or was providing the care and support of such *employee*.

R. Assignments

Benefits for medical expenses covered under this *Plan* may be assigned by a *plan participant* to the provider as consideration in full for services rendered; however, if those benefits are paid directly to the *employee*, the *Plan* shall be deemed to have fulfilled its obligations with respect to such benefits. The *Plan* will not be responsible for determining whether any such assignment is valid. Payment of benefits which have been assigned will be made directly to the assignee unless a written request not to honor the assignment, signed by the *plan participant* and the assignee, has been received before the proof of loss is submitted.

No *plan participant* shall at any time, either during the time in which they are a *plan participant* in the *Plan*, or following their termination as a *plan participant*, in any manner, have any right to assign their right to sue to recover benefits under the *Plan*, to enforce rights due under the *Plan*, or to any other causes of action which they may have against the *Plan* or its fiduciaries.

A provider which accepts an *assignment of benefits*, in accordance with this *Plan* as consideration in full for services rendered, is bound by the rules and provisions set forth within the terms of this document.

S. Non-U.S. Providers

Medical expenses for care, supplies, or services which are rendered by a provider whose principal place of business or address for payment is located outside the United States (non-U.S. provider) are payable under the *Plan*, subject to all *Plan* exclusions, limitations, maximums, and other provisions, under the following conditions:

1. Benefits may not be assigned to a non-U.S. provider.
2. The *plan participant* is responsible for making all payments to non-U.S. providers and submitting receipts to the *Plan* for reimbursement.
3. Benefit payments will be determined by the *Plan* based upon the exchange rate in effect on the *incurred* date.
4. The non-U.S. provider shall be subject to, and in compliance with, all U.S. and other applicable licensing requirements.
5. *Claims* for benefits must be submitted to the *Plan* in English.

T. Recovery of Payments

Occasionally, benefits are paid more than once; are paid based upon improper billing or a misstatement in a proof of loss or enrollment information; are not paid according to the *Plan's* terms, conditions, limitations, or exclusions; or should otherwise not have been paid by the *Plan*. As such, this *Plan* may pay benefits that are later found to be greater than the *maximum allowable charge*. In this case, this *Plan* may recover the amount of the overpayment from the source to which it was paid, primary payers, or from the party on whose behalf the charge(s) were paid. As such, whenever the *Plan* pays benefits exceeding the amount of benefits payable under the terms of the *Plan*, the *Plan Administrator* has the right to recover any such erroneous payment directly from the person or entity who received such payment and/or from other payers and/or the *plan participant* or *dependent* on whose behalf such payment was made.

A *plan participant*, *dependent*, provider, another benefit plan, insurer, or any other person or entity who receives a payment exceeding the amount of benefits payable under the terms of the *Plan* or on whose behalf such payment was made, shall return or refund the amount of such erroneous payment to the *Plan* within thirty (30) days of discovery or demand. The *Plan Administrator* shall have no obligation to secure payment for the expense for which the erroneous payment was made or to which it was applied.

The person or entity receiving an erroneous payment may not apply such payment to another expense. The *Plan Administrator* shall have the sole discretion to choose who will repay the *Plan* for an erroneous payment and whether such payment shall be reimbursed in a lump sum. When a *plan participant* or other entity does not comply with the provisions of this section, the *Plan Administrator* shall have the authority, in its sole discretion, to deny payment of any *claims* for benefits by the *plan participant* and to deny or reduce future benefits payable (including payment of future benefits for other *injuries* or *illnesses*) under the *Plan* by the amount due as reimbursement to the *Plan*. The *Plan Administrator* may also, in its sole discretion, deny or reduce future benefits (including future benefits for other *injuries* or *illnesses*) under any other group benefits plan maintained by the *Plan Sponsor*. The reductions will equal the amount of the required reimbursement.

Providers and any other person or entity accepting payment from the *Plan* or to whom a right to benefits has been assigned, in consideration of services rendered, payments, and/or rights, agrees to be bound by the terms of this *Plan* and agree to submit *claims* for reimbursement in strict accordance with their state's health care practice acts, ICD-10

or CPT standards, *Medicare* guidelines, HCPCS standards, or other standards approved by the *Plan Administrator* or insurer. Any payments made on *claims* for reimbursement not in accordance with the above provisions shall be repaid to the *Plan* within thirty (30) days of discovery or demand or *incur* prejudgment interest of 1.5% per month. If the *Plan* must bring an action against a *plan participant*, provider, or other person or entity to enforce the provisions of this section, then that *plan participant*, provider, or other person or entity agrees to pay the *Plan's* attorneys' fees and costs, regardless of the action's outcome.

Further, *plan participants* and/or their *dependents*, beneficiaries, estate, heirs, guardian, personal representative, or assigns (*plan participant*) shall assign or be deemed to have assigned to the *Plan* their right to recover said payments made by the *Plan*, from any other party and/or recovery for which the *plan participant(s)* are entitled, for or in relation to facility-acquired condition(s), provider error(s), or damages arising from another party's act or omission for which the *Plan* has not already been refunded.

The *Plan* reserves the right to deduct from any benefits properly payable under this *Plan* the amount of any payment which has been made:

1. in error
2. pursuant to a misstatement contained in a proof of loss or a fraudulent act
3. pursuant to a misstatement made to obtain coverage under this *Plan* within two (2) years after the date such coverage commences
4. with respect to an ineligible person
5. in anticipation of obtaining a recovery if a *plan participant* fails to comply with the *Plan's* **Reimbursement, Subrogation, and Recovery Provisions**
6. pursuant to a *claim* for which benefits are recoverable under any policy or act of law providing for coverage for occupational *injury* or *disease* to the extent that such benefits are recovered

   This provision (6) shall not be deemed to require the *Plan* to pay benefits under this *Plan* in any such instance.

The deduction may be made against any *claim* for benefits under this *Plan* by a *plan participant* or by any of their covered *dependents* if such payment is made with respect to the *plan participant* or any person covered or asserting coverage as a *dependent* of the *plan participant*.

If the *Plan* seeks to recoup funds from a provider due to a *claim* being made in error, a *claim* being fraudulent on the part of the provider, and/or a *claim* that is the result of the provider's misstatement, said provider shall, as part of its *assignment of benefits* from the *Plan*, abstain from billing the *plan participant* for any outstanding amount.

SECTION XIII—COORDINATION OF BENEFITS

A. Coordination of the Benefit Plans

Coordination of benefits sets out rules for the order of payment of *covered charges* when two (2) or more plans, including *Medicare*, are paying. When a *plan participant* is covered by this *Plan* and another plan, or the *plan participant's* spouse is covered by this *Plan* and by another plan, or the couple's covered children are covered under two (2) or more plans, the plans will coordinate benefits when a *claim* is received.

Non-Duplication/Maintenance of Benefits

The plan that pays first according to the rules will pay as if there were no *other plan* involved. The secondary will pay up to its own plan formula minus whatever the primary plan paid.

Example: Assume all *deductibles* are met, billed services are considered *covered charges* under both plans, the primary plan pays 80% of the *allowable amount*, and the secondary plan pays 90% of the *allowable amount*. A *plan participant* incurs a *claim* with a *network* provider in which the *allowable amount* is $1,000.

Primary Plan	$800
Secondary Plan	$100
Patient Responsibility	$100
Total Amount Paid	$1,000

If the *plan participant* is *Medicare* primary, *claims* are coordinated with the *Plan* according to the *Medicare* allowed amounts. The coordination of these *claims* is standard coordination of benefits. The plan that pays first according to the rules will pay as if there were no *other plan* involved. The secondary and subsequent plans will pay the balance due up to 100% of the total *allowable charges*.

B. Excess Insurance

If at the time of *injury*, *illness*, *disease*, or disability there is available, or potentially available, any coverage (including, but not limited to, coverage resulting from a judgment at law or settlements), the benefits under this *Plan* shall apply only as an excess over such other sources of coverage.

The *Plan's* benefits will be excess to, whenever possible:

1. any primary payer besides the *Plan*
2. any first-party insurance through medical payment coverage, personal injury protection, *no-fault auto insurance* coverage, uninsured or underinsured motorist coverage
3. any policy of insurance from any insurance company or guarantor of a third party
4. workers' compensation or other liability insurance company
5. any other source, including, but not limited to, crime victim restitution funds, medical, disability, school insurance coverage, or other benefit payment

C. Allowable Charge

For a charge to be allowable it must be within the *Plan's maximum amount* and at least part of it must be covered under this *Plan*.

In the case of HMO (health maintenance organization) or other *network* only plans, this *Plan* will not consider any charges in excess of what an HMO or *network* provider has agreed to accept as payment in full. Also, when an HMO or *network* plan is primary and the *plan participant* does not use an HMO or *network* provider, this *Plan* will not consider as an *allowable charge* any charge that would have been covered by the HMO or *network* plan had the *plan participant* used the services of an HMO or *network* provider.

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

D. General Limitations

When medical payments are available under any other insurance source, the *Plan* shall always be considered the secondary carrier.

E. Application to Benefit Determinations

The plan that pays first according to the rules in the subsection entitled Benefit Plan Payment Order will pay as if there were no *other plan* involved. The secondary will pay up to its own plan formula minus whatever the primary plan paid. When there is a conflict in the rules, this *Plan* will never pay more than 50% of *allowable charges* when paying secondary. Benefits will be coordinated as referenced in the Claims Determination Period subsection.

When medical payments are available under automobile insurance, this *Plan* will pay excess benefits only, without reimbursement for automobile plan *deductibles*. This *Plan* will always be considered the secondary carrier regardless of the individual's election under personal injury protection (PIP) coverage with the automobile insurance carrier.

In certain instances, the benefits of the *other plan* will be ignored for the purposes of determining the benefits under this *Plan*. This is the case when either:

1. the *other plan* would, according to its rules, determine its benefits after the benefits of this *Plan* have been determined
2. the rules in the subsection entitled Benefit Plan Payment Order would require this *Plan* to determine its benefits before the *other plan*

F. Benefit Plan Payment Order

When two (2) or more plans provide benefits for the same *allowable charge*, benefit payment will adhere to these rules in the following order:

1. Plans that do not have a coordination provision, or one like this, will pay first. Plans with such a provision will be considered after those without one.
2. Plans with a coordination provision will pay their benefits up to the *allowable charge*:
    a. The benefits of the plan which covers the person directly (that is, as an *employee*, member, or subscriber) are determined before those of the plan which covers the person as a *dependent*.
    b. The benefits of a benefit plan which covers a person as an *employee* who is neither laid off nor retired are determined before those of a benefit plan which covers that person as a laid-off or retired *employee*. The benefits of a benefit plan which covers a person as a *dependent* of an *employee* who is neither laid off nor retired are determined before those of a benefit plan which covers a person as a *dependent* of a laid off or retired *employee*. If the other benefit plan does not have this rule, and if, as a result, the plans do not agree on the order of benefits, this rule does not apply.
    c. The benefits of a benefit plan which covers a person as an *employee* who is neither laid off nor retired or a *dependent* of an *employee* who is neither laid off nor retired are determined before those of a plan which covers the person as a COBRA beneficiary.
    d. When a child is covered as a *dependent* and the parents are not separated or divorced, these rules will apply:
        i. The benefits of the benefit plan of the parent whose birthday falls earlier in a year are determined before those of the benefit plan of the parent whose birthday falls later in that year.
        ii. If both parents have the same birthday, the benefits of the benefit plan which has covered the patient for the longer time are determined before those of the benefit plan which covers the other parent.
    e. When a *child's* parents are divorced or legally separated, these rules will apply:
        i. This rule applies when the parent with custody of the child has not remarried. The benefit plan of the parent with custody will be considered before the benefit plan of the parent without custody.
        ii. This rule applies when the parent with custody of the child has remarried. The benefit plan of the parent with custody will be considered first. The benefit plan of the stepparent that covers

the *child* as a *dependent* will be considered next. The benefit plan of the parent without custody will be considered last.

iii. This rule will be in place of items (i.) and (ii.) immediately above when it applies. A court decree may state which parent is financially responsible for medical and dental benefits of the child. In this case, the benefit plan of that parent will be considered before *other plans* that cover the child as a *dependent*.

iv. If the specific terms of the court decree state that the parents shall share joint custody, without stating that one (1) of the parents is responsible for the health care expenses of the child, the plans covering the child shall follow the order of *benefit determination* rules outlined above when a child is covered as a *dependent* and the parents are not separated or divorced.

v. For parents who were never married to each other, the rules apply as set out above, as long as paternity has been established.

f. If there is still a conflict after these rules have been applied, the benefit plan which has covered the patient for the longer time will be considered first. When there is a conflict in coordination of benefit rules, the *Plan* will never pay more than 50% of *allowable charges* when paying secondary.

g. When a married *dependent* child is covered as a *dependent* on both a spouse's plan and a parent's plan, and the policies are both effective on the same day, the benefits of the policy holder whose birthday falls earlier in a year are determined before those of the policy holder whose birthday falls later in that year.

3. *Medicare* will pay primary, secondary, or last to the extent stated in federal law. Refer to the *Medicare* publication Your Guide to Who Pays First at **https://www.medicare.gov/supplements-other-insurance/how-medicare-works-with-other-insurance/which-insurance-pays-first**. When *Medicare* would be the primary payer if the person had enrolled in *Medicare*, this *Plan* will base its payment upon benefits that would have been paid by *Medicare* under Parts A and B, regardless of whether or not the person was enrolled under any of these parts. The *Plan* reserves the right to coordinate benefits with respect to *Medicare* Part D. The *Plan Administrator* will make this determination based on the information available through Centers for Medicare & Medicaid Services (CMS). If CMS does not provide sufficient information to determine the amount *Medicare* would pay, the *Plan Administrator* will make *reasonable* assumptions based on published *Medicare* fee schedules.

4. If a *plan participant* is under a disability extension from a previous benefit plan, that benefit plan will pay first, and this *Plan* will pay second.

5. When an adult *dependent* is covered by their spouse's plan and is also covered by a parent's plan, the benefits of the benefit plan which has covered the patient for the longest time are determined before those of the *other plan*.

6. When an adult *dependent* is covered by multiple parents' plans, the benefits of the benefit plan of the parent whose birthday falls earlier in the year are determined before those of the benefit plan of the parent whose birthday falls later in that year. Should both/all parents have the same birthday, the benefits of the benefit plan which has covered the patient the longest shall be determined first.

7. The *Plan* will pay primary to a state *Children's Health Insurance Plan* to the extent required by federal law.

8. The *Plan*, including COBRA coverage, will pay primary to Tricare to the extent required by federal law.

NOTE: Tricare pays after all other health insurance (including Medicare) with the exception of Medicaid, Tricare supplements, state victims of crime compensation programs, and other federal government programs as identified by the Director, Defense Health Agency (such as Indian Health Service). For more information please visit **https://www.tricare.mil/Plans/OHI**.

G. Coordination with Government Programs

1. **Medicaid/IHS.** If a *plan participant* is covered by both this *Plan* and Medicaid or Indian Health Services (IHS), this *Plan* pays first and Medicaid or IHS pays second.

2. **Veterans Affairs or Military Medical Facility Services.** If a *plan participant* receives services in a U.S. Department of Veterans Affairs Hospital or Military Medical Facility on account of a military-service-related *illness* or *injury*, benefits are not covered by this *Plan*. If a *plan participant* receives services in a U.S. Department of Veterans Affairs Hospital or Military Medical Facility on account of any other condition that is not a military-service-related *illness* or *injury*, benefits are covered by the *Plan* to the extent those services are *medically necessary* and the charges are within this *Plan's maximum allowable charge*.

3. **Other Coverage Provided by State or Federal Law.** If you are covered by both this *Plan* and any other coverage (not already mentioned above) that is provided by any other state or federal law, the coverage provided by any other state or federal law pays first and this *Plan* pays second, unless applicable law dictates otherwise.

H. Claims Determination Period

Benefits will be coordinated on a *plan year* basis. This is called the claims determination period.

I. Right to Receive or Release Necessary Information

For the purpose of determining the applicability of and implementing the terms of this provision or any provision of similar purpose of any *other plan*, this *Plan* may, without the consent of or *notice* to any person, release to or obtain from any insurance company, or other organization or individual, any information with respect to any person, which the *Plan* deems to be necessary for such purposes. Any person claiming benefits under this *Plan* shall furnish to the *Plan* such information as may be necessary to implement this provision.

J. Facility of Payment

Whenever payments which should have been made under this *Plan* in accordance with this provision have been made under any *other plans*, the *Plan Administrator* may, in its sole discretion, pay any organizations making such other payments any amounts it shall determine to be warranted in order to satisfy the intent of this provision, and amounts so paid shall be deemed to be benefits paid under this *Plan* and, to the extent of such payments, this *Plan* shall be fully discharged from liability. This *Plan* may repay *other plans* for benefits paid that the *Plan Administrator* determines it should have paid. That repayment will count as a valid payment under this *Plan*.

K. Right of Recovery

In accordance with the **Claims and Appeals** section, Recovery of Payments subsection, whenever payments have been made by this *Plan* with respect to *allowable charges* in a total amount, at any time, in excess of the *maximum amount* of payment necessary at that time to satisfy the intent of this article, the *Plan* shall have the right to recover such payments, to the extent of such excess, from any one (1) or more of the following as this *Plan* shall determine: any person to or with respect to whom such payments were made, or such person's legal representative, any insurance companies, or any other individuals or organizations which the *Plan* determines are responsible for payment of such *allowable charges*, and any future benefits payable to the *plan participant* or their *dependents*. Please see the Recovery of Payments subsection for more details.

L. Exception to Medicaid

The *Plan* shall not take into consideration the fact that an individual is eligible for or is provided medical assistance through Medicaid when enrolling an individual in the *Plan* or making a determination about the payments for benefits received by a *plan participant* under the *Plan*.

SECTION XIV—MEDICARE

A. Application to Active Employees and Their Spouses

An active *employee* and their spouse (when eligible for *Medicare*) may, at the option of such *employee*, elect or reject coverage under this *Plan*. If such *employee* elects coverage under this *Plan*, the benefits of this *Plan* shall be determined before any benefits provided by *Medicare*. If coverage under this *Plan* is rejected by such *employee*, benefits listed herein will not be payable even as secondary coverage to *Medicare*.

B. Applicable to All Other Participants Eligible for Medicare Benefits

To the extent required by federal regulations, this *Plan* will pay before any *Medicare* benefits. There are some circumstances under which *Medicare* would be required to pay its benefits first. In these cases, benefits under this *Plan* would be calculated as the secondary payer (as described under the section entitled **Coordination of Benefits**). The *plan participant* will be assumed to have full *Medicare* coverage (that is, both Parts A & B) whether or not the *plan participant* has enrolled for the full coverage. If the provider accepts assignment with *Medicare*, *covered charges* will not exceed the *Medicare* approved expenses.

SECTION XV—REIMBURSEMENT, SUBROGATION AND RECOVERY PROVISIONS

The *Plan* has a right to subrogation and reimbursement. References to "you" or "your" in this section shall include you, your estate and your heirs and beneficiaries unless otherwise stated.

Subrogation applies when the *plan* has paid benefits on your behalf for an *[illness] or injury* for which any third party is alleged to be responsible. The right to subrogation means that the *Plan* is substituted to and shall succeed to any and all legal claims that you may be entitled to pursue against any third party for the benefits that the *Plan* has paid that are related to the *[illness] or injury* for which any third party is considered responsible.

Example: Suppose you are injured in a car accident that is not your fault, and you receive benefits under the *Plan* to treat your injuries. Under subrogation, the *Plan* has the right to take legal action in your name against the driver who caused the accident and that driver's insurance carrier to recover the cost of those benefits.

The right to reimbursement means that if it is alleged that any third party caused or is responsible for a *[illness] or injury* for which you receive a settlement, judgment, or other recovery from any third party, you must use those proceeds to fully return to the *Plan* 100% of any benefits you receive for that *[illness] or injury*. The right of reimbursement shall apply to any benefits received at any time until the rights are extinguished, resolved or waived in writing.

Example: Suppose you are injured in a boating accident that is not your fault, and you receive Benefits under the Plan as a result of your injuries. In addition, you receive a settlement in a court proceeding from the individual who caused the accident. You must use the settlement funds to return to the plan 100% of any benefits you received to treat your injuries.

A. Third Parties

The following persons and entities are considered third parties:

1. A person or entity alleged to have caused you to suffer a *[illness], injury* or damages, or who is legally responsible for the *[illness*], *injury* or damages.
2. Any insurer or other indemnifier of any person or entity alleged to have caused or who caused the [*illness*], *injury* or damages.
3. The *Plan Sponsor* in a workers' compensation case or other matter alleging liability.
4. Any person or entity who is or may be obligated to provide benefits or payments to you, including benefits or payments for underinsured or uninsured motorist protection, no-fault or traditional auto insurance, medical payment coverage (auto, homeowners or otherwise), workers' compensation coverage, other insurance carriers or third-party administrators.
5. Any person or entity against whom you may have any claim for professional and/or legal malpractice arising out of or connected to a [*illness]* or *injury* you allege or could have alleged were the responsibility of any third party.
6. Any person or entity that is liable for payment to you on any equitable or legal liability theory.

B. Participant Agreement

You will cooperate with the *Plan* in protecting its legal and equitable rights to subrogation and reimbursement in a timely manner, including, but not limited to:

1. notifying the *Plan*, in writing, of any potential legal claim(s) you may have against any third party for acts which caused Benefits to be paid or become payable
2. providing any relevant information requested by the *Plan*
3. signing and/or delivering such documents as the *Plan* or its agents reasonably request to secure the subrogation and reimbursement claim
4. responding to requests for information about any accident or injuries.
5. making court appearances

6. obtaining the *Plan's* consent or its agents' consent before releasing any party from liability or payment of medical expenses
7. complying with the terms of this section

In the event that you do not abide by the terms of the *Plan* pertaining to reimbursement, the *Plan Administrator* may terminate benefits to you, your dependents or the participant, deny future benefits, take legal action against you, and/or set off from any future benefits the value of benefits the *Plan* has paid relating to any *illness or injury* alleged to have been caused or caused by any third party to the extent not recovered by the *Plan* due to your failure to abide by the terms of the *Plan*. If the *Plan* incurs attorneys' fees and costs in order to collect third party settlement funds held by you or your representative, the Plan has the right to recover those fees and costs from you. You will also be required to pay interest on any amounts you hold which should have been returned to the *Plan*.

C. Subrogation and Right of Reimbursement

The *Plan* has a first priority right to receive payment on any claim against any third party before you receive payment from that third party. Further, the *Plan's* first priority right to payment is superior to any and all claims, debts or liens asserted by any medical providers, including but not limited to hospitals or emergency treatment facilities, that assert a right to payment from funds payable from or recovered from an allegedly responsible third party and/or insurance carrier.

The *Plan's* subrogation and reimbursement rights apply to full and partial settlements, judgments, or other recoveries paid or payable to you or your representative, your estate, your heirs and beneficiaries, no matter how those proceeds are captioned or characterized. Payments include, but are not limited to, economic, non-economic, pecuniary, consortium and punitive damages. The *Plan* is not required to help you to pursue your claim for damages or personal injuries and no amount of associated costs, including attorneys' fees, shall be deducted from the *Plan's* recovery without the *Plan's* express written consent. No so-called "Fund Doctrine" or "Common Fund Doctrine" or "Attorney's Fund Doctrine" shall defeat this right.

Regardless of whether you have been fully compensated or made whole, the *Plan* may collect from you the proceeds of any full or partial recovery that you or your legal representative obtain, whether in the form of a settlement (either before or after any determination of liability) or judgment, no matter how those proceeds are captioned or characterized. Proceeds from which the *Plan* may collect include, but are not limited to, economic, non-economic, and punitive damages. No "collateral source" rule, any "Made-Whole Doctrine" or "Make-Whole Doctrine," claim of unjust enrichment, nor any other equitable limitation shall limit the Plan's subrogation and reimbursement rights.

Benefits paid by the *Plan* may also be considered to be benefits advanced.

If you receive any payment from any party as a result of *illness or injury*, and the *Plan* alleges some or all of those funds are due and owed to the *Plan*, you and/or your representative shall hold those funds in trust, either in a separate bank account in your name or in your representative's trust account.

No allocation of damages, settlement funds or any other recovery, by you, your estate, the personal representative of your estate, your heirs, your beneficiaries or any other person or party, shall be valid if it does not reimburse the Plan for 100% of its interest unless the Plan provides written consent to the allocation.

The provisions of this section apply to the parents, guardian, or other representative of a *dependent* child who incurs a *illness or injury* caused by any third party. If a parent or guardian may bring a claim for damages arising out of a minor's *illness or Injury*, the terms of this subrogation and reimbursement clause shall apply to that claim.

If a third party causes or is alleged to have caused you to suffer an *illness or injury* while you are covered under this *Plan*, the provisions of this section continue to apply, even after you are no longer covered.

The *Plan* and all administrators administering the terms and conditions of the *Plan's* subrogation and reimbursement rights have such powers and duties as are necessary to discharge its duties and functions, including the exercise of its discretionary authority to:

1. construe and enforce the terms of the *Plan's* subrogation and reimbursement rights, and
2. make determinations with respect to the subrogation amounts and reimbursements owed to the *Plan*.

D. Assignment of Benefits

By participating in and accepting benefits from the *Plan*, you agree to assign to the *Plan* any benefits, claims or rights of recovery you have under any automobile policy - including no-fault benefits, PIP Benefits and/or medical payment benefits - other coverage or against any third party, to the full extent of the benefits the *Plan* has paid for the *illness or injury*. By agreeing to provide this assignment in exchange for participating in and accepting benefits, you acknowledge and recognize the *Plan's* right to assert, pursue and recover on any such claim, whether or not you choose to pursue the claim, and you agree to this assignment voluntarily.

The *Plan* may, at its option, take necessary and appropriate action to preserve its rights under these provisions, including but not limited to, providing or exchanging medical payment information with an insurer, the insurer's legal representative or other third party; filing an ERISA reimbursement lawsuit to recover the full amount of medical benefits you receive for the *illness or injury* out of any settlement, judgment or other recovery from any third party considered responsible and filing suit in your name or your estate's name, which does not obligate the Plan in any way to pay you part of any recovery the *Plan* might obtain. Any ERISA reimbursement lawsuit stemming from a refusal to refund benefits as required under the terms of the *Plan* is governed by a six-year statute of limitations.

You may not accept any settlement that does not fully reimburse the Plan, without its written approval.

E. Death of Participant

In the case of your death, giving rise to any wrongful death or survival claim, the provisions of this section apply to your estate, the personal representative of your estate, and your heirs or beneficiaries. In the case of your death the *Plan's* right of reimbursement and right of subrogation shall apply if a claim can be brought on behalf of you or your estate that can include a claim for past medical expenses or damages. The obligation to reimburse the Plan is not extinguished by a release of claims or settlement agreement of any kind.

F. Language Interpretation

The *Plan* has the authority and discretion to resolve all disputes regarding the interpretation of the language stated herein.

SECTION XVI—CONTINUATION COVERAGE RIGHTS UNDER COBRA

Under federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA), as Amended, certain *employees* and their families covered under the Kyrene Employee Benefit Trust (*Plan*) will be entitled to the opportunity to elect a temporary extension of health coverage (called COBRA continuation coverage) where coverage under the *Plan* would otherwise end. This *notice* is intended to inform *plan participants* and beneficiaries, in summary fashion, of their rights and obligations under the continuation coverage provisions of COBRA, as amended and reflected in final and proposed regulations published by the Department of the Treasury. This *notice* is intended to reflect the law and does not grant or take away any rights under the law.

Refer to the Quick Reference Information Chart for the COBRA Administrator's contact information. Complete instructions on COBRA, as well as election forms and other information, will be provided by the *Plan Administrator* or its designee to *plan participants* who become qualified beneficiaries under COBRA.

There may be other options available 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 thirty (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*.

A. COBRA Continuation Coverage

COBRA continuation coverage is the temporary extension of group health plan coverage that must be offered to certain *plan participants* and their eligible family members (called qualified beneficiaries) at group rates. The right to COBRA continuation coverage is triggered by the occurrence of a life event that results in the loss of coverage under the terms of the *Plan* (the qualifying event). The coverage must be identical to the *Plan* coverage that the qualified beneficiary had immediately before the qualifying event, or if the coverage has been changed, the coverage must be identical to the coverage provided to similarly situated active *employees* who have not experienced a qualifying event (in other words, similarly situated non-COBRA beneficiaries).

COBRA continuation coverage does not run concurrent with the coverage under the terms of the *Plan*.

B. Qualified Beneficiary

In general, a qualified beneficiary can be:

1. Any individual who, on the day before a qualifying event, is covered under a *Plan* by virtue of being on that day either a covered *employee*, the spouse of a covered *employee*, or a *dependent* child of a covered *employee*. If, however, an individual who otherwise qualifies as a qualified beneficiary is denied or not offered coverage under the *Plan* under circumstances in which the denial or failure to offer constitutes a violation of applicable law, then the individual will be considered to have had the *Plan* coverage and will be considered a qualified beneficiary if that individual experiences a qualifying event.
2. Any child who is born to or placed for adoption or foster care with a covered *employee* during a period of COBRA continuation coverage, and any individual who is covered by the *Plan* as an *alternate recipient* under a *Qualified Medical Child Support Order*. If, however, an individual who otherwise qualifies as a qualified beneficiary is denied or not offered coverage under the *Plan* under circumstances in which the denial or failure to offer constitutes a violation of applicable law, then the individual will be considered to have had the *Plan* coverage and will be considered a qualified beneficiary if that individual experiences a qualifying event.
3. A covered *employee* who retired on or before the date of substantial elimination of *Plan* coverage which is the result of a bankruptcy proceeding under Title 11 of the U.S. Code with respect to the *employer*, as is the spouse, surviving spouse, or *dependent* child of such a covered *employee* if, on the day before the bankruptcy qualifying event, the spouse, surviving spouse, or *dependent* child was a beneficiary under the *Plan*.

The term 'covered *employee*' includes any individual who is provided coverage under the *Plan* due to their performance of services for the *employer* sponsoring the *Plan*, self-employed individuals, independent contractor, or corporate director. However, this provision does not establish eligibility of these individuals. Eligibility for *Plan* coverage shall be determined in accordance with *Plan's* **Eligibility, Effective Date, and Termination Provisions** section.

An individual is not a qualified beneficiary if the individual's status as a covered *employee* is attributable to a period in which the individual was a nonresident alien who received from the individual's *employer* no earned income that constituted income from sources within the United States. If, on account of the preceding reason, an individual is not a qualified beneficiary, then a spouse or *dependent* child of the individual will also not be considered a qualified beneficiary by virtue of the relationship to the individual.

A domestic partner and their children are not qualified beneficiaries and do not have an independent right to elect COBRA continuation coverage. However, if an *employee* who is a qualified beneficiary elects COBRA continuation coverage, they may also elect to continue coverage for their domestic partner and children or qualified *dependents* if they are covered under the *Plan* on the day before the qualifying event.

Each qualified beneficiary (including a child who is born to or placed for adoption or foster care with a covered *employee* during a period of COBRA continuation coverage) must be offered the opportunity to make an independent election to receive COBRA continuation coverage.

C. Qualifying Event

The following are considered to be qualifying events if they would cause the *plan participant* to lose coverage (i.e., cease to be covered under the same terms and conditions as in effect immediately before the qualifying event) in the absence of COBRA continuation coverage:

1. the death of a covered *employee*
2. the termination (other than by reason of the *employee's* gross misconduct), or reduction of hours, of a covered *employee's* employment
3. the divorce or legal separation of a covered *employee* from the *employee's* spouse

   If the *employee* reduces or eliminates the *employee's* spouse's *Plan* coverage in anticipation of a divorce or legal separation, and a divorce or legal separation later occurs, then the divorce or legal separation may be considered a qualifying event even though the spouse's coverage was reduced or eliminated before the divorce or legal separation.
4. a covered *employee's* enrollment in any part of the *Medicare* program
5. a *dependent* child's ceasing to satisfy the *Plan's* requirements for a *dependent* child (for example, attainment of the maximum age for dependency under the *Plan*)

If the qualifying event causes the covered *employee*, or the covered spouse or a *dependent* child of the covered *employee*, to cease to be covered under the *Plan* under the same terms and conditions as in effect immediately before the qualifying event [or in the case of the bankruptcy of the *employer*, any substantial elimination of coverage under the *Plan* occurring within twelve (12) months before or after the date the bankruptcy proceeding commences], the persons losing such coverage become qualified beneficiaries under COBRA if all the other conditions of the COBRA are also met. For example, any increase in contribution that must be paid by a covered *employee*, the spouse, or a *dependent* child of the covered *employee*, for coverage under the *Plan* that results from the occurrence of one (1) of the events listed above is a loss of coverage.

The taking of leave under the Family and Medical Leave Act of 1993 (FMLA) does not constitute a qualifying event. A qualifying event will occur, however, if an *employee* does not return to employment at the end of the *FMLA leave* and all other COBRA continuation coverage conditions are present. If a qualifying event occurs, it occurs on the last day of *FMLA leave,* and the applicable maximum coverage period is measured from this date (unless coverage is lost at a later date and the *Plan* provides for the extension of the required periods, in which case the maximum coverage date is measured from the date when the coverage is lost). Note that the covered *employee* and family members will be entitled to COBRA continuation coverage even if they failed to pay the *employee* portion of premiums for coverage under the *Plan* during the *FMLA leave*.

D. Notice of Unavailability of Continuation Coverage

The *Plan* may sometimes deny a request for COBRA coverage, including an extension of coverage, when the *Plan Administrator* determines the *plan participant* is not entitled to receive it.

When a *Plan Administrator* makes the decision to deny a request for COBRA coverage from a *plan participant*, the *Plan* must give the *plan participant* a *notice* of unavailability of COBRA coverage. The *notice* must be provided within fourteen (14) days after the request is received relating to a qualifying event, second qualifying event, or determination of disability by the Social Security Administration, and the *notice* must explain the reason for denying the request.

E. Factors to Consider in Electing COBRA Continuation Coverage

When considering options for health coverage, qualified beneficiaries should consider:

1. **Premiums.** This *Plan* can charge up to 102% of total plan premiums for COBRA coverage. Other options, like coverage on a spouse's plan or through the marketplace, may be less expensive. Qualified beneficiaries have special enrollment rights under federal law (HIPAA). They have the right to request special enrollment in another group health plan for which they are otherwise eligible (such as a plan sponsored by a spouse's *employer*) within thirty (30) days after *Plan* coverage ends due to one (1) of the qualifying events listed above.
2. **Provider Networks.** If a qualified beneficiary is currently getting care or treatment for a condition, a change in health coverage may affect access to a particular health care provider. You may want to check to see if your current health care providers participate in a *network* in considering options for health coverage.
3. **Drug Formularies.** For qualified beneficiaries taking medication, a change in health coverage may affect costs for medication—and in some cases, the medication may not be covered by another plan. Qualified beneficiaries should check to see if current medications are listed in drug formularies for other health coverage.
4. **Severance Payments.** If COBRA rights arise because the *employee* has lost their job and there is a severance package available from the *employer*, the former *employer* may have offered to pay some or all of the *employee's* COBRA payments for a period of time. This can affect the timing of coverage available in the marketplace. In this scenario, the *employee* may want to contact the Department of Labor at 1-866-444-3272 to discuss options.
5. **Service Areas.** If benefits under the *Plan* are limited to specific service or coverage areas, benefits may not be available to a qualified beneficiary who moves out of the area.
6. **Other Cost-Sharing.** In addition to premiums or contributions for health coverage, the *Plan* requires *participants* to pay *co-payments*, *deductibles*, *co-insurance*, or other amounts as benefits are used. Qualified beneficiaries should check to see what the cost-sharing requirements are for other health coverage options. For example, one option may have much lower monthly premiums, but a much higher *deductible* and higher *co-payments*.

Other Coverage Options

Instead of enrolling in COBRA continuation coverage, there may be other coverage options for qualified beneficiaries through the Health Insurance Marketplace, Medicaid, or other group health plan coverage options (such as a spouse's plan) through what is called a special enrollment period. Some of these options may cost less than COBRA continuation coverage. You can learn more about many of these options at **www.healthcare.gov**.

F. Procedure for Obtaining COBRA Continuation Coverage

The *Plan* has conditioned the availability of COBRA continuation coverage upon the timely election of such coverage. An election is timely if it is made during the election period.

G. The Election Period

The election period is the timeframe within which the qualified beneficiary must elect COBRA continuation coverage under the *Plan*. The election period must begin no later than the date the qualified beneficiary would lose coverage on account of the qualifying event, and ends sixty (60) days after the later of the date the qualified beneficiary would lose coverage on account of the qualifying event or the date *notice* is provided to the qualified beneficiary of their right to elect COBRA continuation coverage. If coverage is not elected within the sixty (60) day period, all rights to elect COBRA continuation coverage are forfeited.

H. Responsibility for Informing the Plan Administrator of the Occurrence of a Qualifying Event

The *Plan* will offer COBRA continuation coverage to qualified beneficiaries only after the *Plan Administrator* or its designee has been timely *notified* that a *qualifying event* has occurred. The *employer* (if the *employer* is not the *Plan Administrator*) will *notify* the *Plan Administrator* of the *qualifying event* within thirty (30) days following the date coverage ends when the qualifying event is any of the following:

1. the end of employment or reduction of hours of employment

2. death of the *employee*
3. commencement of a proceeding in bankruptcy with respect to the *employer*
4. enrollment of the *employee* in any part of *Medicare*

IMPORTANT:

For the 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 or someone on your behalf must notify the Plan Administrator or its designee in writing within sixty (60) days after the qualifying event occurs, using the procedures specified below. If these procedures are not followed, or if the notice is not provided in writing to the Plan Administrator or its designee during the sixty (60) day notice period, any spouse or dependent child who loses coverage will not be offered the option to elect continuation coverage. You must send this notice to the Plan Sponsor.

Notice Procedures

Any *notice* that you provide must be in writing. Oral *notice*, including *notice* by telephone, is not acceptable. You must mail, fax, or hand-deliver your *notice* to the person, department, or firm listed below, at the following address:

Kyrene School District
8700 S. Kyrene Rd.
Tempe, AZ 85284
1-480-541-1302

If mailed, your *notice* must be postmarked no later than the last day of the required *notice* period. Any *notice* you provide must state all of the following:

1. the name of the plan or plans under which you lost or are losing coverage
2. the name and address of the *employee* covered under the *Plan*
3. the name(s) and address(es) of the qualified beneficiary(ies)
4. the qualifying event and the date it happened

If the qualifying event is a **divorce or legal separation**, your *notice* must include a **copy of the divorce decree or the legal separation agreement.**

Be aware that there are other *notice* requirements in other contexts, for example, in order to qualify for a disability extension.

Once the *Plan Administrator* or its designee receives timely *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 for their spouses, and parents may elect COBRA continuation coverage on behalf of their children. For each qualified beneficiary who elects COBRA continuation coverage, COBRA continuation coverage will begin on the date that *Plan* coverage would otherwise have been lost. If you or your spouse or *dependent* children do not elect continuation coverage within the sixty (60) day election period described above, the right to elect continuation coverage will be lost.

I. Waiver Before the End of the Election Period

If, during the election period, a qualified beneficiary waives COBRA continuation coverage, the waiver can be revoked at any time before the end of the election period. Revocation of the waiver is an election of COBRA continuation coverage. However, if a waiver is later revoked, coverage need not be provided retroactively (that is, from the date of the loss of coverage until the waiver is revoked). Waivers and revocations of waivers are considered made on the date they are sent to the *Plan Administrator* or its designee, as applicable.

J. If a Qualified Beneficiary Has Other Group Health Plan Coverage or Medicare

Qualified beneficiaries who are entitled to elect COBRA continuation coverage may do so even if they are covered under another group health plan or are entitled to *Medicare* benefits on or before the date on which COBRA is elected. However, a qualified beneficiary's COBRA coverage will terminate automatically if, after electing COBRA, they become entitled to *Medicare* or become covered under other group health plan coverage.

K. When a Qualified Beneficiary's COBRA Continuation Coverage Can be Terminated

During the election period, a qualified beneficiary may waive COBRA continuation coverage. Except for an interruption of coverage in connection with a waiver, COBRA continuation coverage that has been elected for a qualified beneficiary must extend for at least the period beginning on the date of the qualifying event and ending not before the earliest of the following dates:

1. the last day of the applicable maximum coverage period
2. the first day for which *timely payment* is not made to the *Plan* with respect to the qualified beneficiary
3. the date upon which the *employer* ceases to provide any group health plan (including a successor plan) to any *employee*
4. the date, after the date of the election, that the qualified beneficiary first becomes covered under any *other plan*
5. the date, after the date of the election, that the qualified beneficiary first enrolls in the *Medicare* program (either Part A or Part B, whichever occurs earlier)
6. in the case of a qualified beneficiary entitled to a disability extension, the later of:
    a. twenty-nine (29) months after the date of the qualifying event
    b. the first day of the month that is more than thirty (30) days after the date of a final determination under Title II or XVI of the Social Security Act that the disabled qualified beneficiary whose disability resulted in the qualified beneficiary's entitlement to the disability extension is no longer disabled, whichever is earlier
    c. the end of the maximum coverage period that applies to the qualified beneficiary without regard to the disability extension

The *Plan* can terminate for cause the coverage of a qualified beneficiary on the same basis that the *Plan* terminates for cause the coverage of similarly situated non-COBRA beneficiaries, for example, for the submission of a fraudulent *claim*.

In the case of an individual who is not a qualified beneficiary and who is receiving coverage under the *Plan* solely because of the individual's relationship to a qualified beneficiary, if the *Plan's* obligation to make COBRA continuation coverage available to the qualified beneficiary ceases, the *Plan* is not obligated to make coverage available to the individual who is not a qualified beneficiary.

When the *Plan* terminates COBRA coverage early for any of the reasons listed above, the *Plan Administrator* must give the qualified beneficiary a *notice* of early termination. The *notice* must be given as soon as practicable after the decision is made, and it must describe all of the following:

1. the date of termination of COBRA coverage
2. the reason for termination
3. any rights the qualified beneficiary may have under the plan or applicable law to elect alternative group or individual coverage, such as a right to convert to an individual policy

L. Maximum Coverage Periods for COBRA Continuation Coverage

The maximum coverage periods are based on the type of the qualifying event and the status of the qualified beneficiary, as shown below.

1. In the case of a qualifying event that is a termination of employment or reduction of hours of employment, the maximum coverage period ends either:
    a. eighteen (18) months after the qualifying event if there is not a disability extension
    b. twenty-nine (29) months after the qualifying event if there is a disability extension
2. In the case of a covered *employee's* enrollment in the *Medicare* program before experiencing a qualifying event that is a termination of employment or reduction of hours of employment, the maximum coverage period for qualified beneficiaries other than the covered *employee* ends on the later of:
    a. thirty-six (36) months after the date the covered *employee* becomes enrolled in the *Medicare* program
    b. eighteen (18) months [or twenty-nine (29) months, if there is a disability extension] after the date of the covered *employee's* termination of employment or reduction of hours of employment
3. In the case of a qualified beneficiary who is a child born to or placed for adoption or foster care with a covered *employee* during a period of COBRA continuation coverage, the maximum coverage period is the maximum coverage period applicable to the qualifying event giving rise to the period of COBRA continuation coverage during which the child was born or placed for adoption or foster care.
4. In the case of any other qualifying event than that described above, the maximum coverage period ends thirty-six (36) months after the qualifying event.

M. Circumstances in Which the Maximum Coverage Period Can Be Expanded

If a qualifying event that gives rise to an eighteen (18) month or twenty-nine (29) month maximum coverage period is followed, within that eighteen (18) or twenty-nine (29) month period, by a second qualifying event that gives rise to a thirty-six (36) months maximum coverage period, the original period is expanded to thirty-six (36) months, but only for individuals who are qualified beneficiaries at the time of and with respect to both qualifying events. In no circumstance can the COBRA maximum coverage period be expanded to more than thirty-six (36) months after the date of the first qualifying event. The *Plan Administrator* must be *notified* of the second qualifying event within sixty (60) days of the second qualifying event. This *notice* must be sent to the *Plan Sponsor* in accordance with the procedures above.

N. How a Qualified Beneficiary Becomes Entitled to a Disability Extension

A disability extension will be granted if an individual (whether or not the covered *employee*) who is a qualified beneficiary in connection with the *qualifying event* that is a termination or reduction of hours of a covered *employee's* employment, is determined under Title II or XVI of the Social Security Act to have been disabled at any time during the first sixty (60) days of COBRA continuation coverage. To qualify for the disability extension, the qualified beneficiary must also provide the *Plan Administrator* with *notice* of the disability determination on a date that is both within sixty (60) days of the date of the determination and before the end of the original eighteen (18) month maximum coverage. Said *notice* shall be provided to the *Plan Administrator*, in writing, and should be sent to the *Plan Sponsor* in accordance with the procedures above.

O. Payment for COBRA Continuation Coverage

For any period of COBRA continuation coverage under the *Plan*, qualified beneficiaries who elect COBRA continuation coverage must pay for COBRA continuation coverage. Qualified beneficiaries will pay up to 102% of the applicable premium and up to 150% of the applicable premium for any expanded period of COBRA continuation coverage covering a disabled qualified beneficiary due to a disability extension. The *Plan* will terminate a qualified beneficiary's COBRA continuation coverage as of the first day of any period for which *timely payment* is not made.

The *Plan* must allow payment for COBRA continuation coverage to be made in monthly installments. The *Plan* is also permitted to allow for payment at other intervals.

P. Timely Payment for COBRA Continuation Coverage

Timely payment means a payment made no later than thirty (30) days after the first day of the coverage period. Payment that is made to the *Plan* by a later date is also considered *timely payment* if either under the terms of the *Plan*, covered *employees* or qualified beneficiaries are allowed until that later date to pay for their coverage for the period, or under the terms of an arrangement between the *employer* and the entity that provides *Plan* benefits on the *employer's* behalf, the *employer* is allowed until that later date to pay for coverage of similarly situated non-COBRA beneficiaries for the period.

Notwithstanding the above paragraph, the *Plan* does not require payment for any period of COBRA continuation coverage for a qualified beneficiary earlier than forty-five (45) days after the date on which the election of COBRA continuation coverage is made for that qualified beneficiary. Payment is considered made on the date on which it is postmarked to the *Plan*.

If *timely payment* is made to the *Plan* in an amount that is not significantly less than the amount the *Plan* requires to be paid for a period of coverage, then the amount paid will be deemed to satisfy the *Plan's* requirement for the amount to be paid, unless the *Plan notifies* the qualified beneficiary of the amount of the deficiency and grants a reasonable period of time for payment of the deficiency to be made. A reasonable period of time is thirty (30) days after the *notice* is provided. A shortfall in a *timely payment* is not significant if it is no greater than the lesser of $50 or 10% of the required amount.

Q. Non-Sufficient Funds Payments (NSF)

Non-Sufficient Funds (NSF) payments are payments that are received timely but are later returned by the bank. The following conditions will apply to NSF payments:

1. If *notification* that a *timely payment* is being returned as a NSF payment **within** the grace period for the month the payment was for, a replacement payment can be submitted before the end of the grace period.
2. If *notification* that a *timely payment* is being returned due to a NSF payment **after** the grace period has expired and a subsequent payment was not received timely, COBRA continuation coverage will be retro terminated.
3. If *notification* that a *timely payment* is being returned as a NSF payment **after** the grace period has expired and a subsequent payment was postmarked beyond the grace period for the month the NSF payment was for, the subsequent payment will be refunded and coverage will be retro terminated

R. Right to Enroll in a Conversion Health Plan at the End of the Maximum Coverage Period for COBRA Continuation Coverage

If a qualified beneficiary's COBRA continuation coverage under a group health plan ends as a result of the expiration of the applicable maximum coverage period, the *Plan* will, during the one hundred eighty (180) day period that ends on that expiration date, provide the qualified beneficiary with the option of enrolling under a conversion health plan if such an option is otherwise generally available to similarly situated non-COBRA beneficiaries under the *Plan*.

S. If You Have Questions

If you have questions about your COBRA continuation coverage, you should contact the *Plan Sponsor*. For more information about your rights including COBRA, the Health Insurance Portability and Accountability Act (HIPAA), 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). Addresses and phone numbers of regional and district EBSA offices are available through EBSA's website at **www.dol.gov/ebsa**.

T. Keep Your Plan Administrator Informed of Address Changes

In order to protect your family's rights, you should keep the *Plan Administrator* informed of 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*.

U. If You Wish to Appeal

In an effort to provide all qualified beneficiaries with a fair and thorough review process for COBRA related *claims*, all determinations regarding COBRA eligibility and coverage will be made in accordance with the **Continuation Coverage Rights Under COBRA** section of this governing plan document. Accordingly, if a qualified beneficiary wishes to *appeal* a COBRA eligibility or coverage determination made by the *Plan*, such *claims* must be submitted consistent with the *appeals* procedure set forth in the **Claims and Appeals** section of this document. The *Plan* will respond to all complete *appeals* in accordance with the *appeals* procedure set forth in the **Claims and Appeals** section of this document. The *Plan* offers two (2) levels of *appeal*. A qualified beneficiary who files an *appeal* with the *Plan* must exhaust the administrative remedies afforded by the *Plan* prior to pursuing civil action in federal court under COBRA.

SECTION XVII—FUNDING THE PLAN AND PAYMENT OF BENEFITS

For additional information on the terms of funding the *Plan* and payment of benefits under the *Plan*, please reference provisions within the Kyrene Employee Benefit Trust wrap document.

A. Payment for Coverage

The specific amount you must pay for coverage is announced each *plan year*. You pay your contributions for medical coverage on a **before-tax** basis. This means that your payments for these coverages come from your pay before federal, and in most cases, state taxes are withheld. That way, you should pay less in taxes.

The amount and frequency of that contribution is determined by Kyrene School District (within permissible government guidelines) and announced on an annual basis.

NOTE: If you elect coverage for a domestic partner and that domestic partner is not your tax-qualified *dependent*, the contributions you make toward the cost of this domestic partner coverage must be deducted on an after-tax basis, in accordance with IRS regulations. The amount your *employer* pays toward the cost of your domestic partner coverage must be imputed as income and therefore is taxable to you, the *employee*. If you have questions about the tax implications of covering a domestic partner, contact your financial or tax advisor. **Kyrene School District does not provide tax advice, and nothing in this paragraph should be construed as providing tax advice.**

B. Clerical Error

Any clerical error by the *Plan Administrator* or an agent of the *Plan Administrator* in keeping pertinent records, or a delay in making any changes, will not invalidate coverage otherwise validly in force or continue coverage validly terminated. An equitable adjustment of contributions will be made when the error or delay is discovered.

If an overpayment occurs in a *Plan* reimbursement amount, the *Plan* retains a contractual right to the overpayment. The person or *institution* receiving the overpayment will be required to return the amount paid in error. In the case of a *plan participant*, the amount of overpayment may be deducted from future benefits payable.

SECTION XVIII—STATE LAW RIGHTS

A. Enforce Your Rights

Plan participants may be entitled to certain rights and protections pursuant to Arizona's insurance regulations and/or insurance laws.

To further understand *participant* rights under state, local, or tribal law, please visit: **https://difi.az.gov**.

B. Assistance with Your Questions

If the *plan participant* has any questions about the *Plan*, they should contact the *Plan Administrator* as outlined in the Quick Reference Information Chart. If the *plan participant* has any questions about this statement or their rights under the law, including COBRA or the Health Insurance Portability and Accountability Act (HIPAA) and other laws affecting group health plans, that *plan participant* should contact either the nearest regional or district office of the U.S. Department of Labor's Employee Benefits Security Administration (EBSA) or visit the EBSA website at **www.dol.gov/ebsa**. Addresses and phone numbers of regional and district EBSA offices are available through EBSA's website.

SECTION XIX—FEDERAL NOTICES

A. Children's Health Insurance Program Reauthorization Act of 2009 (CHIPRA)

An *employee* or *dependent* who is eligible, but not enrolled in this *Plan*, may enroll if:

1. The *employee* or *dependent* is covered under a Medicaid plan under Title XIX of the Social Security Act or a state children's health insurance program (CHIP) under Title XXI of such Act, and coverage of the *employee* or *dependent* is terminated due to loss of eligibility for such coverage, and the *employee* or *dependent* requests enrollment in this *Plan* within sixty (60) days after such Medicaid or CHIP coverage is terminated.
2. The *employee* or *dependent* becomes eligible for assistance with payment of *employee* contributions to this *Plan* through a Medicaid or CHIP plan (including any waiver or demonstration project conducted with respect to such plan), and the *employee* or *dependent* requests enrollment in this *Plan* within sixty (60) days after the date the *employee* or *dependent* is determined to be eligible for such assistance.

If a *dependent* becomes eligible to enroll under this provision and the *employee* is not then enrolled, the *employee* must enroll in order for the *dependent* to enroll.

B. Genetic Information Nondiscrimination Act of 2008 (GINA)

GINA generally prohibits discrimination in group premiums based on *genetic information* and the use of *genetic information* as a basis for determining eligibility or setting premiums, and places limitations on genetic testing and the collection of *genetic information* in group health plan coverage. GINA provides clarification with respect to the treatment of *genetic information* under privacy regulations promulgated pursuant to the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

C. Mental Health Parity and Addiction Equity Act of 2008

In the case of a group health plan (or health insurance coverage offered in connection with such a plan) that provides both medical and surgical benefits and *mental health* or *substance use disorder* benefits, such plan or coverage shall ensure all of the following:

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

Regardless of any limitations on benefits for *mental disorders/substance use disorder* treatment otherwise specified in the *Plan*, any aggregate lifetime limit, annual limit, financial requirement, *non-network* exclusion, or treatment limitation on *mental disorders/substance use disorder* benefits imposed by the *Plan* shall comply with federal parity requirements, if applicable.

D. Newborns' and Mothers' Health Protection Act of 1996 (NMHPA)

Under federal law, group health plans and health insurance issuers offering group health insurance coverage generally may not do any of the following:

1. restrict benefits for any *hospital* length of stay in connection with childbirth for the mother or newborn child to less than forty-eight (48) hours following a vaginal delivery, or less than ninety-six (96) hours following a delivery by cesarean section

2. set the level of benefits or out-of-pocket costs so that any later portion of the forty-eight (48) or ninety-six (96) hours, as applicable, stay is treated in a manner less favorable to the mother or newborn than any earlier portion of the stay
3. require that a *physician* or other health care provider obtain authorization for prescribing a length of stay of up to forty-eight (48) or ninety-six (96) hours, as applicable

However, the plan or issuer may pay for a shorter stay than forty-eight (48) hours following a vaginal delivery, or ninety-six (96) hours following a delivery by cesarean section if the attending provider (e.g., your *physician*, nurse midwife, or *physician* assistant), discharges the mother or newborn after consultation with the mother.

E. Non-Discrimination Policy

This *Plan* will not discriminate against any *plan participant* based on race, color, religion, national origin, disability, gender, sexual orientation, or age. This *Plan* will not establish rules for eligibility based on health status, medical condition, *claims* experience, receipt of health care, medical history, evidence of insurability, *genetic information*, or disability.

This *Plan* intends to be nondiscriminatory and to meet the requirements under applicable provisions of the Internal Revenue Code of 1986. If the *Plan Administrator* determines before or during any *plan year* that this *Plan* may fail to satisfy any non-discrimination requirement imposed by the Code or any limitation on benefits provided to highly compensated individuals, the *Plan Administrator* shall take such action as the *Plan Administrator* deems appropriate, under rules uniformly applicable to similarly situated covered *employees*, to assure compliance with such requirements or limitation.

F. Uniformed Services Employment and Re-employment Rights Act of 1994 (USERRA)

Employees going into or returning from military service may elect to continue *Plan* coverage as mandated by the Uniformed Services Employment and Re-employment Rights Act of 1994 (USERRA) under the following circumstances. These rights apply only to *employees* and their *dependents* covered under the *Plan* immediately before leaving for military service.

1. The maximum period of coverage of a person and the person's *dependents* under such an election shall be the lesser of:
    a. the twenty-four (24) month period beginning on the date on which the person's absence begins
    b. the day after the date on which the person was required to apply for or return to a position of employment and fails to do so
2. A person who elects to continue health plan coverage must pay up to 102% of the full contribution under the *Plan*, except a person on active duty for thirty (30) days or less cannot be required to pay more than the *employee's* share, if any, for the coverage.
3. An exclusion or *waiting period* may not be imposed in connection with the reinstatement of coverage upon re-employment if one would not have been imposed had coverage not been terminated because of service. However, an exclusion or *waiting period* may be imposed for coverage of any *illness* or *injury* determined by the Secretary of Veterans Affairs to have been *incurred* in, or aggravated during, the performance of *uniformed service*.

If the *employee* wishes to elect this coverage or obtain more detailed information, contact the *Plan Administrator* as outlined in the Quick Reference Information Chart. The *employee* may also have continuation rights under *USERRA*. In general, the *employee* must meet the same requirements for electing *USERRA* coverage as are required under COBRA continuation coverage requirements. Coverage elected under these circumstances is concurrent, not cumulative. The *employee* may elect *USERRA* continuation coverage for the *employee* and their *dependents*. Only the *employee* has election rights. *Dependents* do not have any independent right to elect *USERRA* health plan continuation.

G. Women's Health and Cancer Rights Act of 1998 (WHCRA)

The Women's Health and Cancer Rights Act of 1998 (WHCRA) requires that you be informed of your rights to *surgery* and prostheses following a covered *mastectomy*.

The *Plan* will pay charges *incurred* for a *plan participant* who is receiving benefits in connection with a *mastectomy* and then elects breast reconstruction in connection with the *mastectomy*. Coverage will include:

1. reconstruction of the breast on which the *mastectomy* has been performed
2. *surgery* and reconstruction of the other breast to produce a symmetrical appearance
3. prosthesis and treatment of physical complications of all stages of *mastectomy*, including lymphedemas

SECTION XX—COMPLIANCE WITH HIPAA PRIVACY STANDARDS

For information on the *Plan's* Compliance with HIPAA Privacy Standards and the use and disclosure of PHI, please reference provisions within the Kyrene Employee Benefit Trust wrap document.

SECTION XXI—DEFINED TERMS

The following terms have special meanings and will be italicized when used in this *Plan*. The failure of a term to appear in italics does not waive the special meaning given to that term, unless the context requires otherwise.

Accident

A sudden and unforeseen event, or a deliberate act resulting in unforeseen consequences.

Accidental Injury (Accidental Injuries)

An objectively demonstrable impairment of bodily function caused by trauma from a sudden, unforeseen outside force or object, occurring at an identifiable time and place, and without the *plan participant's* foresight or expectation.

Active Employment

Performance by the *employee* of all the regular duties of their occupation at an established business location of the participating *employer*, or at another location to which they may be required to travel to perform the duties of their employment. An *employee* shall be deemed actively at work if the *employee* is absent from work due to a health factor. In no event will an *employee* be considered actively at work if they have effectively terminated employment.

Adoptive Cell Therapy

A type of immunotherapy in which T cells (a type of immune cell) are given to a patient to help the body fight diseases, such as cancer. In cancer therapy, T cells are usually taken from the patient's own blood or tumor tissue, grown in large numbers in the laboratory, and then given back to the patient to help the immune system fight the cancer. Sometimes, the T cells are changed in the laboratory to make them better able to target the patient's cancer cells and kill them. Types of adoptive cell therapy include, but not limited to, chimeric antigen receptor T-cell (CAR T-cell) therapy and tumor-infiltrating lymphocyte (TIL) therapy. Also called adoptive cell transfer, *cellular adoptive immunotherapy*, and T-cell transfer therapy.

Adverse Benefit Determination

Any of the following: a denial, reduction, rescission, or termination of a *claim* for benefits, or a failure to provide or make payment for such a *claim* (in whole or in part) including determinations of a *claimant's* eligibility, the application of any review under the Health Care Management Program, and determinations that an item or service is *experimental/investigational* or not *medically necessary* or appropriate.

Allowable Charges

The *maximum amount/maximum allowable charge* for any *medically necessary*, eligible item of expense, at least a portion of which is covered under a plan. When some *other plan* pays first in accordance with the Application to Benefit Determinations subsection in the **Coordination of Benefits** section herein, this *Plan's* allowable charges shall in no event exceed the *other plan's* allowable charges. When some *other plan* provides benefits in the form of services rather than cash payments, the *reasonable* cash value of each service rendered, in the amount that would be payable in accordance with the terms of the *Plan*, shall be deemed to be the benefit. Benefits payable under any *other plan* include the benefits that would have been payable had *claim* been duly made therefore.

Alternate Recipient

Any child of a *plan participant* who is recognized under a *medical child support order* as having a right to enrollment under this *Plan* as the *plan participant's* eligible *dependent*. For purposes of the benefits provided under this *Plan*, an alternate recipient shall be treated as an eligible *dependent*, but for purposes of the reporting and disclosure requirements under ERISA, an alternate recipient shall have the same status as a *plan participant*.

Ambulatory Surgical Center

A licensed facility that is used mainly for performing *outpatient surgery*, has a staff of *physicians*, has continuous *physician* and nursing care by registered nurses (R.N.s), and does not provide for overnight stays.

Appeal

A review by the *Plan* of an *adverse benefit determination*, as required under the *Plan's* internal *claims* and appeals procedures.

Applied Behavioral Analysis (ABA) Therapy

Applied Behavioral Analysis (ABA) Therapy is an umbrella term describing principles and techniques used in the assessment, treatment, and prevention of challenging behaviors and the promotion of new desired behaviors. The goal of ABA Therapy is to teach new skills, promote generalization of these skills, and reduce challenging behaviors with systematic reinforcement. ABA Therapy is a combination of services for adaptive behavior treatment, which applies the principles of how people learn and motivations to change behavior. ABA Therapy is designed to address multiple areas of behavior and function such as to increase language and communication, enhance attention and focus, and help with social skills and memory. It generally includes psychosocial interventions, should address factors that may exacerbate behavioral challenges, and is most effective when initiated as soon as feasible after diagnosis is made.

Approved Clinical Trial

A phase I, phase II, phase III, or phase IV clinical trial that is conducted in relation to the prevention, detection, or treatment of cancer or other *life-threatening disease or condition* and is described in **any** of the following subparagraphs:

1. The study or investigation is approved or funded by one (1) or more of the following:
    a. The National Institutes of Health
    b. The Centers for Disease Control and Prevention
    c. The Agency for Health Care Research and Quality
    d. The Centers for Medicare and Medicaid Services
    e. a cooperative group or center of any of the entities described in sub-clauses a. through d. above, the Department of Defense, or the Department of Veterans Affairs
    f. a qualified non-governmental research entity identified in the guidelines issued by the National Institutes of Health for center support grants
    g. any of the following if the following conditions are met: the study or investigation has been reviewed and approved through a system of peer review that the Secretary determines to be comparable to the system of peer review studies and investigations used by the National Institutes of Health, and assures unbiased review of the highest scientific standards by *qualified individuals* who have no interest in the outcome of the review.
        i. The Department of Veterans Affairs
        ii. The Department of Defense
        iii. The Department of Energy
2. The study or investigation is conducted under an *investigational* new drug application reviewed by the Food and Drug Administration.
3. The study or investigation is a drug trial that is exempt from having such an *investigational* new drug application.

Assignment of Benefits

An arrangement by which a patient may request that their health benefit payments under this *Plan* be made directly to a designated medical provider or facility. By completing an assignment of benefits, the *plan participant* authorizes the *Plan Administrator* to forward payment for a covered procedure directly to the treating medical provider or facility. The *Plan Administrator* expects an assignment of benefits form to be completed, as between the *plan participant* and the provider.

Authorized Representative

An authorized representative is a person or organization a *plan participant* has designated to act on their behalf to submit or *appeal* a *claim*. By authorizing a person or organization to act on your behalf, you are giving them permission to see your Protected Health Information (PHI) and act on all matters related to your *claim* and/or *appeal*. If you choose to authorize a person to act on your behalf, all future communications shall be with the designee. Where an *urgent care claim* is involved, a health care professional with knowledge of the medical condition will be permitted to act as a *claimant's* authorized representative without a prior written authorization.

Balance Bill/Surprise Bill

Balance bill refers to the difference between a *non-network provider's* total billed charges and the *allowable charges* off of which the *Plan* will base its reimbursement.

Non-network providers have no obligation to accept the *allowable charge* as payment in full. You are responsible to pay a *non-network provider's* billed charges, even though the *Plan's* reimbursement is based on the *allowable charge*. Any amounts paid for balance bills do not count toward the *deductible*, *co-insurance*, or *out-of-pocket limit*.

Refer to the **Consolidated Appropriations Act of 2021 and Transparency in Coverage Regulations** section for additional provisions pertaining to *non-network* services and billing.

Benefit Determination

The *Plan's* decision regarding the acceptance or denial of a *claim* for benefits under the *Plan*.

Birthing Center

Any freestanding health facility, place, professional office, or *institution* which is not a *hospital* or in a *hospital*, where births occur in a home-like atmosphere. This facility must be licensed and operated in accordance with the laws pertaining to birthing centers in the jurisdiction where the facility is located.

The birthing center must provide the following:

1. facilities for obstetrical delivery and short-term recovery after delivery
2. care under the full-time supervision of a *physician* and either a registered nurse (R.N.) or a licensed nurse-midwife
3. have a written agreement with a *hospital* in the same locality for immediate acceptance of patients who develop complications or require pre- or post-delivery confinement

Blue Distinction Center

Blue Distinction facilities have met or exceeded national quality standards for care delivery (quality only).

See also *Center of Excellence*.

Brand Name

A trade name medication.

Cellular Immunotherapy

A type of therapy that uses substances to stimulate or suppress the immune system to help the body fight cancer, infection, and other diseases. Some types of immunotherapy only target certain cells of the immune system. Others affect the immune system in a general way. Types of immunotherapy include cytokines, vaccines, bacillus Calmette-Guerin (BCG), and some monoclonal antibodies.

Center of Excellence

Medical care facilities that have met stringent criteria for quality care in the specialized procedures of organ transplantation. These centers have the greatest experience in performing transplant procedures and the best survival rates. The *Plan Administrator* shall determine what *network* Centers of Excellence are to be used.

Any *plan participant* in need of an organ transplant may contact the *Third Party Administrator* as outlined in the Quick Reference Information Chart to initiate the *pre-certification* process resulting in a referral to a Center of Excellence. The *Third Party Administrator* acts as the primary liaison with the Center of Excellence, patient, and attending *physician* for all transplant admissions taking place at a Center of Excellence.

Additional information about this option, as well as a list of Centers of Excellence, will be given to *plan participant(s)* and updated as requested.

Claim

Any request for a *Plan* benefit, made by a *claimant* or by a representative of a *claimant*, in accordance with a *Plan's* reasonable procedure for filing benefit claims.

Some requests made to the *Plan* are specifically not claims for benefits; for example:

1. an inquiry as to eligibility which does not request benefits
2. a request for prior approval where prior approval is not required by the *Plan*
3. casual inquiries about benefits such as verification of whether a service/item is a covered benefit or the estimated cost for a service

Claimant

Any *plan participant* or beneficiary making a *claim* for benefits. Claimants may file *claims* themselves or may act through an *authorized representative*. In this document, the words 'you' and 'your' are used interchangeably with 'claimant.'

Claims Administrator

See *Third Party Administrator*.

AmeriBen has been hired as the Claims Administrator by the *Plan Administrator* to perform *claims* processing and other specified administrative services in relation to the *Plan*. The Claims Administrator is not an insurer of health benefits under this *Plan*, is not a *fiduciary* of the *Plan*, and does not exercise any of the discretionary authority and responsibility granted to the *Plan Administrator*. The Claims Administrator is not responsible for *Plan* financing and does not guarantee the availability of benefits under this *Plan*.

Clean Claim

A *claim* that can be processed in accordance with the terms of this plan document without obtaining additional information from the service provider or a third party. It is a *claim* which has no defect, impropriety, or special circumstance that delays *timely payment*. A clean *claim* does not include:

1. *claims* under investigation for fraud and abuse
2. *claims* under review for *medical necessity*
3. fees under review for *usual* and *customariness* and *reasonableness*
4. any other matter that may prevent the expense(s) from being considered a *covered charge*

The claim form or electronic file record must include all required data elements and must be complete, legible, and accurate. A *claim* will not be considered to be a clean claim if the *participant* has failed to submit required forms or additional information to the *Plan* as well.

Co-Insurance

The portion of medical expenses (after the *deductible* has been satisfied) for which a *plan participant* is responsible.

Concurrent Care Claim

A *Plan* decision to reduce or terminate a pre-approved ongoing course of treatment before the end of the approved treatment. A concurrent care claim also refers to a request by you to extend a pre-approved course of treatment. Individuals will be given the opportunity to argue in favor of uninterrupted continuity of care before treatment is cut short.

Co-Payment

A specific dollar amount a *plan participant* is required to pay and is typically payable to the health care provider at the time services or supplies are rendered.

Cost Sharing Amounts

The dollar amount a *plan participant* is responsible for paying when covered services are received from a provider. Cost sharing amounts include *co-insurance*, *co-payments*, *deductible* amounts, and *out-of-pocket limits*. Providers may bill you directly or request payment of *co-insurance* and/or *co-payments* at the time services are provided. Refer to the applicable Schedules of Benefits for the specific cost sharing amounts that apply to this *Plan*.

Cosmetic

Procedures are considered cosmetic when intended to change a physical appearance that would be considered within normal human anatomic variation. Cosmetic services are often described as those that are primarily intended to preserve or improve appearance.

Courtesy Review

A pre-service review of requested services for benefits which are neither on the pre-certification list nor an exclusion of the *Plan*.

Covered Charges

The *maximum allowable charge* for a *medically necessary* service, treatment, or supply, meant to improve a condition or *plan participant's* health, which is eligible for coverage in this *Plan*. Covered charges will be determined based upon all other *Plan* provisions. When more than one (1) treatment option is available, and one (1) option is no more effective than another, the covered charge is the least costly option that is no less effective than any other option.

All treatment is subject to benefit payment maximums shown in the applicable Schedule of Medical Benefits section and as determined elsewhere in this document.

Custodial Care

Care (including *room and board* needed to provide that care) that is given principally for personal hygiene or for assistance in daily activities and can, according to generally accepted medical standards, be performed by persons who have no medical training. The following are examples of custodial care:

1. help in walking and getting out of bed
2. assistance in bathing, dressing, feeding, or supervision over medication which could normally be self-administered

Deductible

A specified portion of the *covered charges* that must be *incurred* by a *plan participant* before the *Plan* has any liability.

Dentist

A person who is properly trained and licensed to practice dentistry and who is practicing within the scope of such license.

Dependent

For information regarding eligibility for dependents, refer to the section entitled **Eligibility, Effective Date, and Termination Provisions**.

Developmental Delay

A delay in the appearance of normal developmental milestones achieved during infancy and early childhood, caused by organic, psychological, or environmental factors. Conditions are marked by delayed development or functional limitations especially in learning, language, communication, cognition, behavior, socialization, or mobility.

Diagnosis Related Grouping (DRG)

A method for reimbursing *hospitals* for *inpatient* services. A DRG amount can be higher or lower than the actual billed charge because it is based on an average for that grouping of diagnoses and procedures.

Diagnostic Service

A test or procedure performed for specified symptoms to detect or to monitor a *disease* or condition. It must be ordered by a *physician* or other professional provider.

Disease

Any disorder which does not arise out of, which is not caused or contributed to by, and which is not a consequence of, any employment or occupation for compensation or profit; however, if evidence satisfactory to the *Plan* is furnished showing that the individual concerned is covered as an *employee* under any workers' compensation law, occupational disease law, or any other legislation of similar purpose, or under the maritime doctrine of maintenance, wages, and cure, but that the disorder involved is one (1) not covered under the applicable law or doctrine, then such disorder shall, for the purposes of the *Plan*, be regarded as a *sickness*, *illness*, or disease.

Durable Medical Equipment (DME)

Equipment which can withstand repeated use, is primarily and customarily used to serve a medical purpose, generally is not useful to a person in the absence of an *illness* or *injury*, and is appropriate for use in the home.

Emergency

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

Emergency Medical Condition

A medical condition of recent onset and severity, including severe pain, such that the absence of immediate medical attention could reasonably be expected to result in serious impairment to bodily function, serious dysfunction of any bodily organ or part, or would place the person's health, or with respect to a pregnant woman, the health of the woman or her unborn child in serious jeopardy.

Emergency Services

A medical screening examination [as required under Section 1867 of the Social Security Act (EMTALA)] within the capability of the *hospital* emergency department, including routine ancillary services, to evaluate a *medical emergency* and such further medical examination and treatment as are within the capabilities of the staff and facilities of the *hospital* and required under EMTALA to stabilize the patient.

Employee

A person who is active on the regular payroll of the *employer*, has begun to perform the duties of their job with the *employer*, and is regularly scheduled to work for the *employer* on a full basis in an employee/*employer* relationship.

Employer

Kyrene School District

Enrollment Date

The first day of coverage, or if there is a *waiting period*, the first day of the *waiting period*.

Essential Health Benefits

Benefits set forth under the *Patient Protection and Affordable Care Act of 2010* (*PPACA*), including the categories listed in the state of Arizona benchmark plan.

Experimental/Investigational

Services, supplies, care, 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 and dental community or government oversight agencies at the time services were rendered.

The *Plan Administrator* must make an independent evaluation of the experimental/non-experimental standings of specific technologies. The *Plan Administrator* shall be guided by a reasonable interpretation of *Plan* provisions. The decisions shall be made in good faith and rendered following a detailed factual background investigation of the *claim* and the proposed treatment. The decision of the *Plan Administrator* will be final and binding on the *Plan*. The *Plan Administrator* will be guided by the following principles, any of which comprise a definition of experimental/investigational:

1. if the drug or device cannot be lawfully marketed without approval of the U.S. Food and Drug Administration, and approval for marketing has not been given at the time the drug or device is furnished
2. if the drug, device, medical treatment, or procedure, or the patient informed consent document utilized with the drug, device, treatment, or procedure, 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
3. if reliable evidence shows that the drug, device, medical treatment, or procedure is the subject of ongoing Phase I or Phase II clinical trials, is the research, experimental study, or investigational arm of ongoing Phase III clinical trials, or is otherwise under study to determine its maximum tolerated dose, its toxicity, its safety, its efficacy, or its efficacy as compared with a standard means of treatment or diagnosis
4. if reliable evidence shows that the 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, its efficacy, or its efficacy as compared with a 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(s) used by the treating facility, or the protocol(s) of another facility studying substantially the same drug, service, 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.

Drugs are considered experimental if they are not commercially available for purchase and/or they are not approved by the Food and Drug Administration for general use.

Benefits covered under the Clinical Trials provision are not considered experimental or investigational.

The *Plan Administrator* has the discretion to determine which drugs, services, supplies, care, and/or treatments are considered experimental, investigative, or unproven.

Explanation of Benefits (EOB)

A document sent to the *plan participant* by the *Third Party Administrator* after a *claim* for reimbursement has been processed. It includes the patient's name, claim number, type of service, provider, date of service, charges submitted for the services, amounts covered by this *Plan*, non-covered services, *cost sharing amounts*, and the amount of the charges that are the *plan participant's* responsibility. This form should be carefully reviewed and kept with other important records.

External Review

A review of an *adverse benefit determination*, including a *final internal adverse benefit determination*, under applicable state or federal external review procedures.

Family Unit

The covered *employee* and the family members who are covered as *dependents* under the *Plan*.

Fiduciary

A fiduciary exercises discretionary authority or control over management of the *Plan* or the disposition of its assets, renders investment advice to the *Plan*, or has discretionary authority or responsibility in the administration of the *Plan*.

Final Internal Adverse Benefit Determination

An *adverse benefit determination* that has been upheld by the *Plan* at completion of the *Plan's* internal *appeals* procedures; or an *adverse benefit determination* for which the internal *appeals* procedures have been exhausted under the deemed exhausted rule contained in the *appeals* regulations. For plans with two (2) levels of *appeals*, the second-level *appeal* results in a final internal *adverse benefit determination* that triggers the right to *external review*.

FMLA Leave

A *leave of absence* which the *employer* is required to extend to an *employee* under the provisions of the FMLA.

Formulary

A list of prescription medications compiled by the third-party payer of safe and effective therapeutic drugs specifically covered by this *Plan*.

Foster Child

A child under the limiting age shown in the **Eligibility, Effective Date, and Termination Provisions** section of this *Plan* for whom a covered *employee* has assumed a legal obligation in connection with the child's placement with a state, county, or private foster care agency.

A covered foster child is not a child temporarily living in the covered *employee's* home; one placed in the covered *employee's* home by a social service agency which retains control of the child; or whose natural parent(s) may exercise or share parental responsibility and control.

Gene Therapy

Human gene therapy seeks to modify or manipulate the expression of a gene or to alter the biological properties of living cells for therapeutic use. It is a technique that modifies a person's genes to treat or cure disease. Gene therapies can work by several mechanisms:

1. replacing a disease-causing gene with a healthy copy of the gene
2. inactivating a disease-causing gene that is not functioning properly
3. introducing a new or modified gene into the body to help treat a disease

Generic Drug

A *prescription drug* which has the equivalency of the *brand name* drug with the same use and metabolic disintegration. This *Plan* will consider as a generic drug any Food and Drug Administration approved generic pharmaceutical dispensed according to the professional standards of a licensed pharmacist and clearly designated by the pharmacist as being generic.

Genetic Information

Information about the genetic tests of an individual or their family members and information about the manifestations of *disease* or disorder in family members of the individual. A genetic test means an analysis of human DNA, RNA, chromosomes, proteins, or metabolites, which detects genotypes, mutations, or chromosomal changes. It does not mean an analysis of proteins or metabolites that is directly related to a manifested *disease*, disorder, or pathological condition that could reasonably be detected by a health care professional with appropriate training and expertise in the field of medicine involved. Genetic information does not include information about the age or gender of an individual.

The *Plan* complies with Title I of the Genetic Information Nondiscrimination Act of 2008 (GINA) as it applies to group health plans.

Habilitative Services/Habilitation Services

Treatment and services that help a *plan participant* keep, learn, or improve skills and functions for daily living that they may not be developing as expected for their age range. These services may include physical and occupational therapy, speech-language pathology, and other services for people with disabilities in a variety of *inpatient* and/or *outpatient* settings.

Health Savings Account (HSA)

A tax-exempt or custodial account that you set up with a qualified HSA trustee to pay or reimburse certain medical expenses you *incur*. You must be eligible to qualify for an HSA (refer to the **Schedule of Benefits** section of this document). Both *employer* and *employee* may contribute to an *HSA* in the same year. Annual contribution limits are subject to IRS guidelines. Participation in a qualified *high deductible health plan* is required for participation in an *HSA* program.

High Deductible Health Plan (HDHP)

A medical plan with lower premiums and a minimum *deductible* amount, set forth by federal law, which is higher than a traditional health plan *deductible*.

Home Health Care Agency

An organization that meets all of these tests: its main function is to provide *home health care services and supplies*; it is federally certified as a home health care agency; and it is licensed by the state in which it is located, if licensing is required.

Home Health Care Plan

Must meet these tests: it must be a formal written plan made by the patient's attending *physician* which is reviewed at least every thirty (30) days; it must state the diagnosis; it must certify that the home health care is in place of *hospital* confinement; and it must specify the type and extent of *home health care services and supplies* required for the treatment of the patient.

Home Health Care Services and Supplies

Include: part-time or intermittent nursing care by or under the supervision of a registered nurse (R.N.); part-time or intermittent home health aide services provided through a *home health care agency* (this does not include general housekeeping services); physical, occupational, and speech therapy; medical supplies; and laboratory services by or on behalf of the *hospital*.

Hospice Care Agency

An organization whose main function is to provide *hospice care services and supplies* and is licensed by the state in which it is located, if licensing is required.

Hospice Care Plan

A plan of terminal patient care that is established and conducted by a *hospice care agency* and supervised by a *physician*.

Hospice Care Services and Supplies

Provided through a *hospice care agency* and under a *hospice care plan* and includes *inpatient* care in a *hospice unit* or other licensed facility, and home health care, and family counseling during the bereavement period.

Hospice Unit

A facility or separate *hospital* unit that provides treatment under a *hospice care plan* and admits at least two (2) unrelated persons who are expected to die within six (6) months.

Hospital (Acute or Long-Term Acute Care Facility)

A provider licensed and operated as required by law, which provides all of the following and is fully accredited by The Joint Commission:

1. room, board, and nursing care
2. a staff with one (1) or more doctors on hand at all times
3. twenty-four (24) hour nursing service
4. all the facilities on site are needed to diagnose, care, and treat an *illness* or *injury*

The term hospital does not include a provider, or that part of a provider, used mainly for:

1. nursing care
2. rest care
3. convalescent care
4. care of the aged
5. *custodial care*
6. educational care
7. subacute care

Refer to the defined terms for *Residential Treatment Facility* and *Substance Use Disorder/Mental Health Treatment Center* for the specific requirements applicable to those facility types.

Illness

For a covered *employee* and covered spouse: a bodily disorder, congenital defect, *disease*, physical illness, or *mental disorder*. Illness includes *pregnancy*, childbirth, miscarriage, or complications of *pregnancy*.

For a covered dependent other than spouse: a bodily disorder, congenital defect, *disease*, physical illness, or *mental disorder*, not including *pregnancy* except for its complications.

Incurred

An expense for a service or supply is incurred on the date the service or supply is furnished. With respect to a course of treatment or procedure which includes several steps or phases of treatment, expenses are incurred for the various steps or phases as the services related to each step are rendered and not when services relating to the initial step or phase are rendered. More specifically, expenses for the entire procedure or course of treatment are not incurred upon commencement of the first stage of the procedure or course of treatment.

Independent Review Organization (IRO)

An entity that performs independent *external reviews* of *adverse benefit determinations* and *final internal adverse benefit determinations*.

Infertility

Incapable of producing offspring.

Injury

An *accidental bodily injury*, which does not arise out of, which is not caused or contributed by, and which is not a consequence of, any employment or occupation for compensation or profit.

In-Network

See *Network*.

Inpatient

Treatment in an approved facility during the period when charges are made for *room and board*.

Institution

A facility, operating within the scope of its license, whose purpose is to provide organized health care and treatment to individuals, such as a *hospital*, *ambulatory surgical center*, *psychiatric hospital*, community *mental health* center, *residential treatment facility*, psychiatric treatment facility, *substance use disorder treatment center*, alternative *birthing center*, home health care center, or any other such facility that the *Plan* approves.

Intensive Care Unit

A separate, clearly designated service area which is maintained within a *hospital* solely for the care and treatment of patients who are critically *ill*. This also includes what is referred to as a coronary care unit or an acute care unit. It has facilities for special nursing care not available in regular rooms and wards of the *hospital*; special lifesaving equipment which is immediately available at all times; at least two (2) beds for the accommodation of the critically *ill*; and at least one (1) registered nurse (R.N.) in continuous and constant attendance twenty-four (24) hours a day.

Investigational

See *Experimental/Investigational*.

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.

Legal Guardian

A person recognized by a court of law as having the duty of taking care of the person and managing the property and rights of a minor child.

Life-Threatening Disease or Condition

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

Long Term Acute Care Hospitals

Facilities that specialize in the treatment of patients with serious medical conditions that require care on an ongoing basis but no longer require intensive care or extensive diagnostic procedures.

Long Term Care

Generally refers to non-medical care for patients who need assistance with basic daily activities such as dressing, bathing, and using the bathroom. Long-term care may be provided at home or in facilities that include nursing homes and assisted livings.

Maintenance Care

Therapy or treatment intended primarily to maintain general physical condition, including, but not limited to routine, long-term, or maintenance care which is provided after the resolution of an acute medical problem. This includes services performed solely to preserve the present level of function or prevent regression for an *Illness*, *injury*, or condition that is resolved or stable.

Mastectomy

The surgical removal of all or part of a breast.

Maximum Amount or Maximum Allowable Charge

The benefit payable for a specific coverage item or benefit under the *Plan*. Maximum allowable charge(s) will be based on one (1) of the following options, depending on the circumstances of the *claim* and at the discretion of the *Plan Administrator*:

1. *network* allowed amount
2. *network non-participating provider* rate
3. 120% of the *Medicare* rate
4. the negotiated rate established in a contractual arrangement with a provider
5. the *usual and customary* and/or *reasonable* amount
6. the actual billed charges for the covered services

The maximum allowed amount for emergency care from a *non-network* provider will be determined using the median *Plan network* contract rate paid to *network* providers for the geographic area where the service is provided.

The *Plan* has the discretionary authority to decide if a *charge* is *usual and customary* and/or *reasonable* for a *medically necessary* service. The maximum allowable charge will not include any identifiable billing mistakes including, but not limited to, up-coding, duplicate charges, and charges for services not performed.

Maximum Benefit

Any one (1) of the following, or any combination of the following:

1. the *maximum amount* paid by this *Plan* for any one (1) *plan participant* during the entire time they are covered by this *Plan*
2. the *maximum amount* paid by this *Plan* for any one (1) *plan participant* for a particular *covered charge*

   The *maximum amount* can be for either of the following:

   a. the entire time the *plan participant* is covered under this *Plan*
   b. a specified period of time, such as a *plan year*
3. the maximum number as outlined in the *Plan* as a *covered charge*

   The maximum number relates to the number of:

   a. treatments during a specified period of time
   b. days of confinement
   c. visits by a *home health care agency*

Medical Care Facility

A *hospital*, a facility that treats one (1) or more specific ailments, or any type of *skilled nursing facility*.

Medical Child Support Order

Any judgment, decree, or order (including approval of a domestic relations settlement agreement) issued by a court of competent jurisdiction that mandates one (1) of the following:

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

Medical Management Administrator

A team of medical care professionals selected to conduct *pre-certification* review, *emergency* admission review, continued stay review, discharge planning, patient consultation, and case management. For more information, see the **Health Care Management Program** section of this document.

Medical Non-Emergency Care

Care which can safely and adequately be provided other than in a *hospital*.

Medically Necessary/Medical Necessity

Care and treatment which is recommended or approved by a *physician*; is consistent with the patient's condition or accepted standards of good medical practice; is medically proven to be effective treatment of the condition; is not performed mainly for the convenience of the patient or provider of medical services; is not conducted for research purposes; and is the most appropriate level of services which can be safely provided to the patient.

All of these criteria must be met; merely because a *physician* recommends or approves certain care does not mean that it is medically necessary.

The *Plan Administrator* has the discretionary authority to decide whether care or treatment is medically necessary.

Medicare

The Health Insurance for the Aged and Disabled program under Title XVIII of the Social Security Act, as amended.

Mental Disorder and Nervous Disorders/Substance Use Disorder

Any *disease* or condition, regardless of whether the cause is organic, that is classified as a mental disorder in the current edition of *International Classification of Diseases*, published by the U.S. Department of Health and Human Services, or is listed in the current edition of *Diagnostic and Statistical Manual of Mental Disorders*, published by the American Psychiatric Association.

Mental Health or Substance Use Disorder Hold

An involuntary detainment, by an officer of the court, in an *inpatient facility*, of an individual who is either posing a danger to themselves or others, or determined to be gravely disabled due to a mental health condition. Typically lasting up to seventy-two (72) hours.

Network

An arrangement under which services are provided to *plan participants* through a select group of providers.

No-Fault Auto Insurance

The basic reparations provision of a law providing for payments without determining fault in connection with automobile *accidents*.

Non-Network

Services rendered by a *non-participating provider* within the designated *network* area.

Notice/Notify/Notification

The delivery or furnishing of information to a *claimant* as required by federal law.

Open Enrollment Period

The annual period during which you and your *dependents* are eligible to enroll for coverage or change benefit plan options.

Other Plan

Shall include but is not limited to:

1. any primary payer besides the *Plan*
2. any other group health plan
3. any other coverage or policy covering the *plan participant*
4. any first-party insurance through medical payment coverage, personal injury protection, *no-fault auto insurance* coverage, uninsured, or underinsured motorist coverage
5. any policy of insurance from any insurance company or guarantor of a responsible party

6. any policy of insurance from any insurance company or guarantor of a third party
7. workers' compensation or other liability insurance company
8. any other source, including, but not limited to, crime victim restitution funds, medical, disability, school insurance coverage, or other benefit payment

Out-of-Network

See *Non-Network*.

Out-of-Pocket Limit

A *Plan's* limit on the amount a *plan participant* must pay out of their own pocket for medical expenses *incurred* during *plan year*. Out-of-pocket limits accumulate on an individual, family, or combined basis. After a *plan participant* reaches the out-of-pocket limit, the *Plan* pays benefits at a higher rate.

Outpatient

Treatment including services, supplies, and medicines provided and used at a *hospital* under the direction of a *physician* to a person not admitted as a registered bed patient; or services rendered in a *physician's* office, laboratory, or x-ray facility, an *ambulatory surgical center*, or the patient's home.

Patient Protection and Affordable Care Act of 2010 (PPACA)

The Patient Protection and Affordable Care Act (P.L. 111-148), as amended by the Health Care and Education Reconciliation Act of 2010 (P.L. 111-152). Jointly, these laws are referred to as PPACA.

Pharmacy

A licensed establishment where covered *prescription drugs* are filled and dispensed by a pharmacist licensed under the laws of the state where they practice.

Physician

A Doctor of Medicine (M.D.), Doctor of Osteopathy (D.O.), Optometrist (O.D.), Doctor of Podiatry (D.P.M.), Audiologist, Certified Nurse Anesthetist, Licensed Professional Counselor, Licensed Professional Physical Therapist, Master of Social Work (M.S.W.), Midwife, Occupational Therapist, Doctor of Dental Surgery (D.D.S.), Physiotherapist, Psychiatrist, Psychologist (Ph.D.), Speech Language Pathologist, and any other practitioner of the healing arts who is licensed and regulated by a state or federal agency and is acting within the scope of their license.

Plan

Kyrene Employee Benefit Trust, which is a benefits plan for certain *employees* of Kyrene School District and is described in this document. Kyrene Employee Benefit Trust is a distinct entity, separate from the legal entity that is your *employer*.

Plan Administrator

Kyrene School District, which is the named *fiduciary* of the *Plan*, and exercises all discretionary authority and control over the administration of the *Plan* and the management and disposition of *Plan* assets.

Plan Participant/Participant

Any *employee* or *dependent* who is covered under this *Plan*.

Plan Sponsor

Kyrene School District

Plan Year/Benefit Year

The twelve (12) month period beginning on either the effective date of the *Plan* or on the day following the end of the first plan year which is a short plan year. All *deductibles* and benefit maximums accumulate during the plan year.

Post-Service Claim

Any *claim* for a benefit under the *Plan* related to care or treatment that the *plan participant* or beneficiary has already received.

Pre-Admission Tests/Testing

Those *diagnostic services* done prior to scheduled *surgery*, provided that all of the following conditions are met:

1. The tests are approved by both the *hospital* and the *physician*.
2. The tests are performed on an *outpatient* basis prior to *hospital* admission.
3. The tests are performed at the *hospital* into which confinement is scheduled, or at a qualified facility designated by the *physician* who will perform the *surgery*.

Pre-Certification/Pre-Certified

An evaluation conducted by a utilization review team through the Health Care Management Program to determine the *medical necessity* and *reasonableness* of a *plan participant's* course of treatment.

Pregnancy

Childbirth and conditions associated with pregnancy, including complications.

Prescription Drug

Any of the following: a Food and Drug Administration-approved drug or medicine which, under federal law, is required to bear the legend: "Caution: Federal law prohibits dispensing without prescription"; injectable insulin; hypodermic needles or syringes, but only when dispensed upon a written prescription of a licensed *physician*. Such drug must be *medically necessary* in the treatment of an *illness* or *injury*.

Pre-Service Claim

Any *claim* that requires *Plan* approval prior to obtaining medical care for the *claimant* to receive full benefits under the *Plan* (e.g. a request for *pre-certification* under the **Health Care Management Program**).

Preventive Care

Certain preventive services mandated under the *Patient Protection and Affordable Care Act of 2010 (PPACA)* which are available without cost sharing when received from a *network* provider. To comply with *PPACA*, and in accordance with the recommendations and guidelines, the *Plan* will provide *network* coverage for:

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

Copies of the recommendations and guidelines may be found here: **https://www.healthcare.gov/coverage/preventive-care-benefits/** or **http://www.uspreventiveservicestaskforce.org/Page/Name/uspstf-a-and-b-recommendations/**. For more information, you may contact the *Plan Administrator/employer* as outlined in the Quick Reference Information Chart.

Primary Care Physician (PCP)

Family practitioners, general practitioners, internists, OBGYNs, and pediatricians.

Charges from nurse practitioners and physician's assistants will be considered at the level of the provider they bill under.

Prior Plan

The coverage provided on a group or group-type basis by the group insurance policy, benefit plan, or service plan that was terminated on the day before the effective date of the *Plan* and replaced by the *Plan*.

Prior to Effective Date or After Termination Date

Dates occurring before a *plan participant* gains eligibility from the *Plan*, or dates occurring after a *plan participant* loses eligibility from the *Plan*, as well as charges *incurred* prior to the effective date of coverage under the *Plan* or after coverage is terminated, unless extension of benefits applies.

Privacy Standards

The standards of the privacy of individually identifiable health information, as pursuant to HIPAA.

Psychiatric Hospital

An *institution* constituted, licensed, and operated as set forth in the laws that apply to *hospitals*, which meets all of the following requirements:

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

The term psychiatric hospital does not include an *institution*, or that part of an *institution*, used mainly for nursing care, rest care, convalescent care, care of the aged, *custodial care*, or educational care.

Qualified Individual

An individual who is a covered *participant* or beneficiary in this *Plan* and who meets the following conditions:

1. the individual is eligible to participate in an *approved clinical trial* according to the trial protocol with respect to the treatment of cancer or other *life-threatening disease or condition*; and
2. either:
    a. The referring health care professional is a participating health care provider and has concluded that the individual's participation in such trial would be appropriate based upon the individual meeting the conditions described in item (1.), immediately above.
    b. The *participant* or beneficiary provides medical and scientific information establishing that the individual's participation in such trial would be appropriate based upon the individual meeting the conditions described in item (1.), immediately above.

Qualified Medical Child Support Order (QMCSO)

A *medical child support order* that creates or recognizes the existence of an *alternate recipient's* right to, or assigns to an *alternate recipient* the right to, receive benefits for which a *plan participant* or eligible *dependent* is entitled under this *Plan*.

Reasonable

In the *Plan Administrator's* discretion, services, supplies, or fees for services or supplies which are necessary for the care and treatment of *illness* or *injury* not caused by the treating provider. Determination that fee(s) or services are reasonable will be made by the *Plan Administrator*, taking into consideration unusual circumstances or complications requiring additional time, skill, and experience in connection with a particular service or supply; industry standards, and practices as they relate to similar scenarios; and the cause of *injury* or *illness* necessitating the services and/or charges.

This determination will consider, but will not be limited to, the findings and assessments of the following entities:

1. The National Medical Associations, societies, and organizations

2. The Food and Drug Administration

To be reasonable, services and/or fees must be in compliance with generally accepted billing practices for unbundling or multiple procedures. Services, supplies, care, and/or treatment that results from errors in medical care that are clearly identifiable, preventable, and serious in their consequence for patients, are not reasonable. The *Plan Administrator* retains discretionary authority to determine whether services and/or fees are reasonable based upon information presented to the *Plan Administrator*. A finding of provider negligence and/or malpractice is not required for services and/or fees to be considered not reasonable.

Charges and/or services are not considered to be reasonable, and as such are not eligible for payment (exceed the *maximum allowable charge*), when they result from provider error(s) and/or facility-acquired conditions deemed reasonably preventable through the use of evidence-based guidelines, taking into consideration but not limited to CMS guidelines.

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

Reconstructive

Procedures are considered reconstructive when intended to address a significant variation from normal related to accidental *injury*, *disease*, trauma, treatment of a *disease*, or a congenital defect.

Rehabilitation Hospital

An *institution* which mainly provides therapeutic and restorative services to *ill* or *injured* people. It is recognized as such if it meets the following criteria:

1. It carries out its stated purpose under all relevant federal, state, and local laws.
2. It is accredited for its stated purpose by either The Joint Commission or the Commission on Accreditation for Rehabilitation Facilities.

Residential Treatment Center/Facility

A facility which provides Mental Health Services or Substance-Related and Addictive Disorders Services treatment and meets all of the following requirements:

1. It is established and operated in accordance with applicable state law for Residential Treatment programs.
2. It provides a program of treatment approved by the Mental/Health Substance-Related and Addictive Disorders Services Administrator under the active participation and direction of a *physician*
3. It provides at least the following basic services in a twenty-four (24) per day structured setting:
    a. room and board
    b. evaluation and diagnosis
    c. counseling
    d. referral and orientation to specialized community resources

A Residential Treatment Center/Facility that qualifies as a *hospital* is considered a *hospital*.

Room and Board

A *hospital's* charge for:

1. room and linen service
2. dietary service, including meals, special diets, and nourishment
3. general nursing service
4. other conditions of occupancy which are *medically necessary*

Security Standards

The final rule implementing HIPAA's security standards for the Protection of Electronic PHI, as amended.

Sickness

See *Disease*.

Skilled Nursing Facility

A facility that fully meets all of these tests:

1. It is licensed to provide professional nursing services on an *inpatient* basis to persons recovering from an *injury* or *illness*. The service must be rendered by a registered nurse (R.N.) or by a licensed practical nurse (L.P.N.) under the direction of a registered nurse. Services to help restore patients to self-care in essential daily living activities must be provided.
2. Its services are provided for compensation and under the full-time supervision of a *physician*.
3. It provides twenty-four (24) hour per day nursing services by licensed nurses, under the direction of a full-time registered nurse.
4. It maintains a complete medical record on each patient.
5. It has an effective utilization review plan.
6. It is not, other than incidentally, a place for rest, the aged, *custodial care*, or educational care.

Sound Natural Tooth

A tooth that is stable, functional, free from decay and advanced periodontal *disease*, and in good repair at the time of the *accident*.

Specialty Drug

Specialty drugs are high-cost prescription medications used to treat complex, chronic conditions like cancer, rheumatoid arthritis, and multiple sclerosis. Specialty drugs sometimes require special handling and administration (typically injection or infusion), and patients using a specialty drug may need careful oversight from a health care provider who can watch for side effects and ensure that the medication is working as intended.

Spinal Manipulation/Chiropractic Care

Skeletal adjustments, manipulation, or other treatment in connection with the detection and correction by manual or mechanical means of structural imbalance or subluxation in the human body. Such treatment is done by a *physician* to remove nerve interference resulting from, or related to, distortion, misalignment, or subluxation of, or in, the vertebral column.

Substance Use Disorder/Mental Health Treatment Center

An *institution* which provides a program for the treatment of *substance use disorder* by means of a written treatment plan approved and monitored by a *physician*. This *institution* must be at least one (1) of the following:

1. affiliated with a *hospital* under a contractual agreement with an established system for patient referral
2. accredited as such a facility by The Joint Commission or CARF
3. licensed, certified, or approved as an alcohol or *substance use disorder* treatment program center, *psychiatric hospital*, or *facility* for *mental health* by a state agency having legal authority to do so
4. is a facility operating primarily for the treatment of *substance use disorder* and meets these tests:
    a. maintains permanent and full-time facilities for bed care and full-time confinement of at least twenty-four (24) hour-per-day nursing service by a registered nurse (R.N.)
    b. has a full-time psychiatrist or psychologist on the staff
    c. is primarily engaged in providing diagnostic and therapeutic services and facilities for treatment of *substance use disorder*

Substance Use Disorder

The DSM-5 definition is applied as follows: Substance use disorder describes a problematic pattern of using alcohol or another substance (whether obtained legally or illegally) that results in impairment in daily life or

noticeable distress. An individual must display two (2) of the following eleven (11) symptoms within twelve (12) months:

1. consuming more alcohol or other substance than originally planned
2. worrying about stopping or consistently failed efforts to control one's use
3. spending a large amount of time using drugs/alcohol, or doing whatever is needed to obtain them
4. use of the substance results in failure to fulfill major role obligations such as at home, work, or school
5. craving the substance (alcohol or drug)
6. continuing the use of a substance despite health problems caused or worsened by it

   This can be in the domain of *mental health* (psychological problems may include depressed mood, sleep disturbance, anxiety, or blackouts) or physical health.
7. continuing the use of a substance despite its having negative effects in relationships with others (for example, using even though it leads to fights or despite people's objecting to it)
8. repeated use of the substance in a dangerous situation (for example, when having to operate heavy machinery, when driving a car)
9. giving up or reducing activities in a person's life because of the drug/alcohol use
10. building up a tolerance to the alcohol or drug

    Tolerance is defined by the DSM-5 as either needing to use noticeably larger amounts over time to get the desired effect or noticing less of an effect over time after repeated use of the same amount.
11. experiencing withdrawal symptoms after stopping use

    Withdrawal symptoms typically include, according to the DSM-5: anxiety, irritability, fatigue, nausea/vomiting, hand tremor, or seizure in the case of alcohol.

Surgery/Surgical Procedure

Any of the following:

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

Temporomandibular Joint (TMJ)

The treatment of jaw joint disorders including conditions of structures linking the jaw bone and skull and the complex of muscles, nerves, and other tissues related to the temporomandibular joint.

Third Party Administrator

AmeriBen has been hired as the Third Party Administrator by the *Plan Administrator* to perform *claims* processing and other specified administrative services in relation to the *Plan*. The Third Party Administrator is not an insurer of health benefits under this *Plan*, is not a *fiduciary* of the *Plan*, and does not exercise any of the discretionary authority and responsibility granted to the *Plan Administrator*. The Third Party Administrator is not responsible for *Plan* financing and does not guarantee the availability of benefits under this *Plan*.

Timely Payment

As referenced in the section entitled **Continuation Coverage Rights Under COBRA**. Timely payment means a payment made no later than thirty (30) days after the first day of the coverage period.

Total Disability/Totally Disabled

In the case of a *dependent* child, the complete inability, as a result of *injury* or *illness*, to perform the normal activities of a person of like age and sex and in good health.

Uniformed Services

The Armed Forces, the Army National Guard, and the Air National Guard, when engaged in active duty for training, inactive duty training, or full-time National Guard duty; the commissioned corps of the Public Health Service; and any other category of persons designated by the President of the United States in time of war or *emergency*.

Urgent Care Claim

Any *pre-service claim* for medical care or treatment which, if subject to the normal timeframes for *Plan* determination, could seriously jeopardize the *claimant's* life, health, or ability to regain maximum function or which, in the opinion of a *physician* with knowledge of the *claimant's* medical condition, would subject the *claimant* to severe pain that cannot be adequately managed without the care or treatment that is the subject of the *claim*. Whether a *claim* is an urgent care claim will be determined by an individual acting on behalf of the *Plan* applying the judgment of a prudent layperson who possesses an average knowledge of health and medicine. However, any *claim* that a *physician* with knowledge of the *claimant's* medical condition determines is an urgent care claim as described herein shall be treated as an urgent care claim under the *Plan*. Urgent care claims are a subset of *pre-service claims*.

Urgent Care Facility

A free-standing facility, regardless of its name, at which a *physician* is in attendance at all times that the facility is open, that is engaged primarily in providing minor *emergency* and episodic medical care to a *plan participant*.

Usual and Customary Charge

Covered charges which are identified by the *Plan Administrator*, taking into consideration the fees which the provider most frequently charges (or accepts) for the majority of patients for the service or supply, the cost to the provider for providing the services, the prevailing range of fees charged in the same area by providers of similar training and experience for the service or supply, and the *Medicare* reimbursement rates. The term(s) 'same geographic locale' and/or 'area' shall be defined as a metropolitan area, county, or such greater area as is necessary to obtain a representative cross-section of providers, persons, or organizations rendering such treatment, services, or supplies for which a specific charge is made. To be usual and customary, fees must be in compliance with generally accepted billing practices for unbundling or multiple procedures.

The term 'usual' refers to the amount of a charge made or accepted for medical services, care, or supplies, to the extent that the charge does not exceed the common level of charges made by other medical professionals with similar credentials, or health care facilities, *pharmacies*, or equipment suppliers of similar standing, which are located in the same geographic locale in which the charge was *incurred*.

The term 'customary' refers to the form and substance of a service, supply, or treatment provided in accordance with generally accepted standards of medical practice to one (1) individual, which is appropriate for the care or treatment of an individual of the same sex, comparable age, and who has received such services or supplies within the same geographic locale.

The term 'usual and customary' does not necessarily mean the actual charge made (or accepted), nor the specific service or supply furnished to a *plan participant* by a provider of services or supplies, such as a *physician*, therapist, nurse, *hospital*, or pharmacist. The *Plan Administrator* will determine the usual charge for any procedure, service, or supply, and whether a specific procedure, service, or supply is customary.

Usual and customary charges may, at the *Plan Administrator's* discretion, alternatively be determined and established by the *Plan* using normative data such as, but not limited to, *Medicare* cost to charge ratios, average wholesale price (AWP) for prescriptions, and/or manufacturer's retail pricing (MRP) for supplies and devices.

Waiting Period

An interval of time during which the *employee* is in the continuous, *active employment* of their participating *employer*.

SECTION XXII—PLAN ADOPTION

A. Severability

In the event that any provision of this document is held by a court of competent jurisdiction to be excessive in scope or otherwise invalid or unenforceable, such provision shall be adjusted rather than voided, if possible, so that it is enforceable to the maximum extent possible, and the validity and enforceability of the remaining provisions of this document will not in any way be affected or impaired thereby.

B. Adoption

Kyrene School District, hereby adopts the provisions of this Kyrene Employee Benefit Trust, and its duly authorized officer has executed this plan document and summary plan description effective the first day of July 2024.

By: 

Date: May 22, 2024

Title: Chief Benefits Officer

If you have questions about your *Plan* benefits, please contact the *Third Party Administrator* at 1-855-961-5401.

P.O. Box 7186
Boise ID 83707