# Unified School District #428 Employee Benefits Plan

## Group No.: 25971

## Plan Document
## and
## Summary Plan Description

**Originally Effective: October 1, 1997**

**Amended and Restated Effective: October 1, 2026**

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# ESTABLISHMENT OF THE PLAN

Unified School District #428 (the "Employer" or the "Plan Sponsor") has adopted this amended and restated Plan Document and Summary Plan Description effective as of October 1, 2026, for the Unified School District #428 Employee Benefits Plan (hereinafter referred to as the "Plan" or "Summary Plan Description"), as set forth herein for the exclusive benefit of its Employees and their eligible Dependents. The Plan was originally adopted by the Employer effective as of October 1, 1997.

**Purpose of the Plan**
The Plan Sponsor has established the Plan for your benefit and for the benefit of your eligible Dependents, on the terms and conditions described herein. The Plan Sponsor's purpose in establishing the Plan is to help to protect you and your family by offsetting some of the financial problems that may arise from an Injury or Illness. To accomplish this purpose, the Plan Sponsor must attempt to control health care costs through effective plan design and the Plan Administrator must abide by the terms of the Plan Document and Summary Plan Description, to allow the Plan Sponsor to allocate the resources available to help those individuals participating in the Plan to manage their healthcare costs.

The Plan is not a contract of employment between you and your Employer and does not give you the right to be retained in the service of your Employer.

The purpose of this Plan is to set forth the terms and provisions of the Plan that provide for the payment or reimbursement of all or a portion of certain health care expenses. This Plan is maintained by the Plan Administrator and may be inspected at any time during normal working hours by you or your eligible Dependents.

**Adoption of this Plan Document and Summary Plan Description**
The Plan Sponsor, as the settlor of the Plan, hereby adopts this Plan Document and Summary Plan Description (SPD) as the written description of the Plan. This Plan represents both the Plan Document and the Summary Plan Description. This Plan Document and SPD amends and replaces any prior statement of the health care coverage contained in the Plan or any predecessor to the Plan.

IN WITNESS WHEREOF, the Plan Sponsor has caused this Plan Document and Summary Plan Description to be executed as of the date set forth below.

Unified School District #428

Dated: 8/10/26

By: 

Name: John Popp

Title: Assistant Superintendent

# GENERAL OVERVIEW OF THE PLAN

The Plan Administrator has entered into an agreement that provides access to one or more networks of Participating Providers called “Networks”. Available Networks are identified on the Employee identification card. These Networks offer your health care services at discounted rates. Using a Network provider will normally result in a lower cost to the Plan as well as a lower cost to you. There is no requirement for anyone to seek care from a provider who participates in the Network. The choice of provider is entirely up to you. You are also not required to designate a Primary Care Physician (PCP), but the Plan encourages you to designate a PCP to help manage your care.

**Non-Participating Provider Exceptions**
Unless otherwise described herein, covered services rendered by a Non-Participating Provider will be paid at the Participating Provider level subject to the Usual and Customary provision of the Plan when a:

(1) Covered Person has an Emergency Medical Condition requiring immediate care.*

(2) Covered Person receives services by a Non-Participating Provider who is under agreement with a Network facility.*

(3) Participating Provider submits a specimen to a Non-Participating Provider laboratory.

(4) Covered Person receives services from a Network surgeon who uses a non-Network Assistant Surgeon.

(5) Participating Provider is not available within a 75-mile radius of the Covered Person’s residence.

***NOTE:** In the case of a Surprise Bill for covered services from a Non-Participating Provider who is under agreement with a Network facility and the Covered Person had no control of the Non-Participating Providers participation in their care or when a Covered Person seeks Emergency Services for an Emergency Medical Condition from a Non-Participating Provider, the cost share will be based on the median contract rate.

The above exceptions do not apply to your dental benefits under the Plan.

Not all providers based in Network Hospitals or medical facilities are Participating Providers. It is important when you enter a Hospital or medical facility that you request that ALL Physician services be performed by Participating Providers. By doing this, you will always receive the greater Participating Provider level of benefits.

A current list of Participating Providers is available, without charge, through the Third Party Administrator at www.meritain.com. If you do not have access to a computer at your home, you may contact your Employer or the Network at the phone number on the Employee identification card.

You have a free choice of any provider and you, together with your provider, are ultimately responsible for determining the appropriate course of medical treatment, regardless of whether the Plan will pay for all or a portion of the cost of such care. Participating Providers are independent contractors; neither the Plan nor the Plan Administrator makes any warranty as to the quality of care that may be rendered by any Participating Provider.

**Transitional Care**
Certain Covered Expenses may be paid at the applicable Participating Provider benefit level subject to the Usual and Customary provision of the Plan if the Covered Person is currently under a treatment plan by a Physician or other health care provider or facility that was a member of this Plan’s previous Network but who is not a member of this Plan’s current Network. In order to ensure continuity of care for certain medical conditions already under treatment, the Participating Provider benefit level may continue for 180 days for conditions approved as transitional care. Examples of medical conditions appropriate for consideration for transitional care include, but are not limited to:

(1) Cancer if under active treatment with chemotherapy and/or radiation therapy.

(2) Organ transplant patients if under active treatment (seeing a Physician on a regular basis, on a transplant waiting list, ready at any time for transplant).

(3) If the Covered Person is Inpatient in a Hospital on the effective date.

(4) Post-acute Injury or Surgery within the past 3 months.

(5) Pregnancy in the second or third trimester and up to 8 weeks postpartum.

(6) Behavioral Health – any previous treatment.

You or your Dependent must call the Plan Administrator prior to the effective date or within 4 weeks after the effective date to see if you or your Dependents are eligible for this benefit.

Routine procedures, treatment for stable chronic conditions, minor Illnesses and elective Surgical Procedures will not be covered by transitional level benefits.

**Continuity of Care** (Keeping a provider you go to now)
You may have to find a new provider when:

(1) The Plan's Network changes and the provider you have now is not in the new Network; or

(2) You are already enrolled in the Plan and your provider stops participating in the Plan's Network.

However, in some cases, you may be able to keep going to your current provider to complete a treatment or to have treatment that was already scheduled. This is called continuity of care. If you are pregnant and have entered your second trimester, this will include the time required for postpartum care directly related to the delivery. Routine procedures, minor Illnesses and elective Surgical Procedures generally are not covered under this provision.

Contact the phone number on the back of your identification card to obtain further information on how to submit a request for continuity of care. If your request is approved to keep going to your current provider, you will be informed how long you can continue to see the provider. Reimbursement for approved continuity of care will be at the applicable Participating Provider benefit level subject to the Usual and Customary provision of the Plan.

**Costs**
You must pay for a certain portion of the cost of Covered Expenses under the Plan, including (as applicable) any Copay, Deductible and Coinsurance percentage that is not paid by the Plan, up to the Out-of-Pocket Maximum set by the Plan.

**Coinsurance**
Coinsurance is the percentage of eligible expenses the Plan and the Covered Person are required to pay. The amount of Coinsurance a Covered Person is required to pay is the difference from what the Plan pays as shown in the Medical Schedule of Benefits.

There may be differences in the Coinsurance percentage payable by the Plan depending upon whether you are using a Participating Provider or a Non-Participating Provider. These payment levels are also shown in the Medical Schedule of Benefits.

**Copay**
A Copay is the portion of the medical expense that is your responsibility, as shown in the Medical Schedule of Benefits. A Copay is applied for each occurrence of such covered medical service and is not applied toward satisfaction of the Deductible.

**Deductible**
***NOTE: This section only applies to medical benefits under the Plan. Please refer to the Dental Expenses section of the Plan for the Deductible, if any, applicable to those benefits.***

A Deductible is the total amount of eligible expenses as shown in the Medical Schedule of Benefits, which must be Incurred by you during any Plan Year before Covered Expenses are payable under the Plan. The family Deductible maximum, as shown in the Medical Schedule of Benefits, is the maximum amount which must be Incurred by the covered family members during a Plan Year. However, each individual in a family is not required to contribute more than one individual Deductible amount to a family Deductible.

**Out-of-Pocket Maximum**
An Out-of-Pocket Maximum is the maximum amount you and/or all of your family members will pay for eligible expenses Incurred during a Plan Year before the percentage payable under the Plan increases to 100%.

The single Out-of-Pocket Maximum applies to a Covered Person with single coverage. When a Covered Person reaches his or her Out-of-Pocket Maximum, the Plan will pay 100% of additional eligible expenses for that individual during the remainder of that Plan Year.

The family Out-of-Pocket Maximum applies collectively to all Covered Persons in the same family. The family Out-of-Pocket Maximum is the maximum amount that must be satisfied by covered family members during a Plan Year. When selecting family coverage, the entire family Out-of-Pocket Maximum must be satisfied; however, each individual in a family is not required to contribute more than the single Out-of-Pocket amount to the family Out-of-Pocket Maximum before the Plan will pay 100% of Covered Expenses for any Covered Person in the family during the remainder of that Plan Year.

Your Out-of-Pocket Maximum may be higher for Non-Participating Providers than for Participating Providers. Please note, however, that not all Covered Expenses are eligible to accumulate toward your Out-of-Pocket Maximum. The types of expenses, which are not eligible to accumulate toward your Out-of-Pocket Maximum, ("non-accumulating expenses") include:

(1) Charges over Usual and Customary Charges for Non-Participating Providers.

(2) Charges this Plan does not cover.

(3) Charges that are considered penalty amounts.

(4) Dental benefits, other than those dental expenses paid under the major medical component of the Plan.

Reimbursement for any eligible non-accumulating expenses will continue at the percentage payable shown in the Schedule of Benefits, subject to the Plan maximums.

The Plan will not reimburse any expense that is not a Covered Expense. In addition, you must pay any expenses that are in excess of the Usual and Customary Charges for Non-Participating Providers. This could result in you having to pay a significant portion of your claim. None of these amounts will accumulate toward your Out-of-Pocket Maximum.

Once you have paid the Out-of-Pocket Maximum for eligible expenses Incurred during a Plan Year, the Plan will reimburse additional eligible expenses Incurred during that year at 100%.

If you have any questions about whether an expense is a Covered Expense or whether it is eligible for accumulation toward your Out-of-Pocket Maximum, please contact your Plan Administrator for assistance.

**Integration of Deductibles and Out-of-Pocket Maximums**
***NOTE: This section only applies to medical benefits under the Plan. Please refer to the Dental Expenses section of the Plan for the integration of Deductibles applicable to those benefits.***

If you use a combination of Participating Providers and Non-Participating Providers, your total Deductible amount and Out-of-Pocket Maximum amount required to be paid are separate amounts and do not integrate. In other words, you will be required to satisfy the Deductible amount and Out-of-Pocket Maximum amount for Participating Providers and Non-Participating Providers separately.

All other maximum amounts (e.g., Plan Year or Lifetime) are combined.

**Essential and Non-Essential Health Benefits**
Essential Health Benefit has the meaning found in section 1302(b) of the Patient Protection and Affordable Care Act and as may be further defined by the Secretary of the United States Department of Health and Human Services. Essential Health Benefits includes the following general categories and the items and services covered within such categories: ambulatory patient services; Emergency Services; hospitalization; maternity and newborn care; mental health and substance use disorder services (including behavioral health treatment); Prescription Drugs; rehabilitative and habilitative services and devices; laboratory service; preventive and wellness services and chronic disease management; and pediatric services, including oral and vision care.

The Plan considers the following items or services to be non-Essential Health Benefits:

(1) Hearing aids

(2) Wigs

**No Surprises Act Protections**
The No Surprises Act (Title I of Division BB of the Consolidated Appropriations Act, 2021) (the "No Surprises Act") protects Covered Persons from surprise medical billing in certain situations. For No Surprises Act purposes, a Surprise Bill is generally a bill you receive for covered services in the following circumstances: (1) certain Emergency Services performed by a Non-Participating Provider; (2) certain non-Emergency Services performed by a Non-Participating Provider at a Participating Provider that is a Health Care Facility; and (3) air ambulance services performed by a Non-Participating Provider.

The No Surprises Act includes special reimbursement rules that apply to Surprise Bills when determining the amount that the Plan is required to pay to the Non-Participating Provider. When these provisions apply to Emergency Services, the Non-Participating Provider generally is prohibited from balance billing you for amounts exceeding your cost-sharing amount (e.g., your Copay, Deductible or Coinsurance) under the Plan. That is, if the No Surprises Act provisions apply, such a provider generally cannot directly bill you the difference between the amount the provider charges and the amount the Plan will pay plus your cost-sharing (i.e., balance billing). Any cost-sharing payments you make with respect to items or services covered by the No Surprises Act will count towards any Participating Provider Deductible and Out-of-Pocket Maximum. These special reimbursement rules also apply to the following covered non-Emergency Services when performed by a Non-Participating Provider at a Participating Provider that is a Health Care Facility (to the extent required under the No Surprises Act):

(1) Covered items and services related to emergency medicine, anesthesiology, pathology, radiology, and neonatology (whether provided by a physician or a non-Physician practitioner);

(2) Covered items and services provided by Assistant Surgeons, hospitalists and intensivists;

(3) Diagnostic services, including radiology and laboratory services;

(4) Covered items and services performed by a Non-Participating Provider when a Participating Provider is unavailable at the time the health care services are performed at a Participating Provider that is a Health Care Facility; and

(5) Covered items or services performed by a Non-Participating Provider as a result of unforeseen, urgent medical issues that arise at the time such items or service is performed.

Notwithstanding the preceding, in accordance with and to the extent permitted by the No Surprises Act, the Surprise Billing protections do not include a bill for medical items or services when a Participating Provider is available and you elect to receive items or services from a Non-Participating Provider or, with respect to non-Emergency Services (other than those specified above) performed by a Non-Participating Provider at a Participating Provider (that is a Health Care Facility) if the Non-Participating Provider has obtained your consent to receive the items or services after providing you with required notice. That is, in certain cases if the Non-Participating Provider follows the "notice and consent" procedures under the No Surprises Act and you consent, the Plan's normal reimbursement rules with respect to Non-Participating Providers will apply (to the extent permitted under the No Surprises Act) and you may be balance billed. Note that the "notice and consent" procedures do not apply to Non-Participating Providers of air ambulance services and do not apply in certain other circumstances (e.g., where a Non-Participating Provider

provides items or services due to unforeseen urgent medical needs in certain cases, etc.) unless otherwise provided under the No Surprises Act and/or other binding, authoritative guidance under the No Surprises Act.

For any Surprise Bills, the Plan will reimburse the Non-Participating Provider an initial payment equal to the Recognized Amount and you will not be responsible for any Non-Participating Provider charges for items and services (pursuant to the Surprise Bill) in excess of your cost-sharing (e.g., your Copay, Deductible or Coinsurance) for Participating Providers based on that Recognized Amount.

Where air ambulance services are rendered by a Non-Participating Provider, to the extent necessary to comply with the No Surprises Act, the Plan shall apply the same cost-sharing (e.g., your Copay, Deductible or Coinsurance) to air ambulance services when rendered by a Non-Participating Provider as the cost-sharing that is applied to such services when rendered by a Participating Provider. For this purpose, air ambulance services generally means medical transport by a rotary wing air ambulance (e.g., helicopter), or fixed wing air ambulance (e.g., airplane).

# MEDICAL MANAGEMENT PROGRAM

Medical Management is a program designed to help ensure that you and your eligible Dependents receive necessary and appropriate healthcare while avoiding unnecessary expenses. 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 healthcare provider. The Medical Management Program Administrator contact information for this Plan is identified on the Employee identification card and also on the General Plan Information page of this Plan.

**Precertification**
Before you or your eligible Dependents are admitted to a medical facility or receive items or services from the list below, the Medical Management Program Administrator will, based on clinical information from the provider or facility, certify the care according to the Medical Management Program Administrator's policies, procedures, and guidelines. Once an Inpatient setting has been precertified, working directly with your Physician, the Medical Management Program Administrator will identify and approve the most appropriate and cost-effective setting for the treatment as it progresses. The Medical Management Program Administrator will also assist and coordinate the initial implementation of any services you will need post hospitalization (called discharge planning) with the attending Physician and the facility. This could include registering you for specialized programs or case management when appropriate.

**Case Management**
Depending on the level of care needed, 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. All parties involved (e.g., the Plan, attending Physician, and patient) must all agree to the alternate individually tailored treatment plan. Each treatment plan is specific to that patient and should not be seen as appropriate or recommended for any other patient, even one with the same diagnosis. Case management is a voluntary service. There are no reductions of benefits or penalties if you or your eligible Dependents choose not to participate.

**Important Timeframes to Know**
You, your Physician, the facility, or someone acting on your behalf, must call the Medical Management Program Administrator (at the number listed on your Employee identification card or the General Plan Information page of this Plan) within the following time frames for a:

| | |
|---|---|
| Non-emergency admission | 48 hours before the scheduled admission |
| Non-emergency services | 48 hours before you are scheduled to receive the services |
| Emergency admission | Within 48 hours or if later, the next business day after you are admitted |

If the attending Physician feels that it is Medically Necessary for a patient to receive services for a greater length of time than initially precertified, the attending Physician or the medical facility must request the additional service or days as soon as reasonably possible, but no later than the final authorized day.

(1) Covered Expenses will be reduced by $250 per occurrence. The amount of the precertification penalty is not covered by the Plan and will not accumulate toward your Out-of-Pocket Maximum.

If the Plan's required review procedures are not followed, a retrospective review will be conducted by the Medical Management Program Administrator to determine if the services provided met all other Plan provisions and requirements. If the review concludes the services were Medically Necessary and would have been approved had the required phone call been made, benefits will be considered subject to the penalty outlined above. However, any charges not deemed Medically Necessary will be denied.

**List of Items and/or Services that Require Precertification**
The below items and/or services, if Covered Expenses under the Plan, must be precertified (except as otherwise specifically stated within the Plan) before any medical services are provided. To determine whether a benefit is covered or excluded, please review the Eligible Medical Expenses and/or General Exclusions and Limitations sections of your Plan.

***NOTE: Precertification requirements and penalties do not apply to outpatient surgical and non-surgical treatment provided through Valenz Health.***

**All Inpatient Admissions:**

- Acute
- Long-Term Acute Care
- Mental Disorders/Substance Use Disorder
- Obstetric – Prenotification only (precertification only required if days exceed federal mandate)
- Rehabilitation
- Residential Treatment Facility
- Skilled Nursing Facility
- Transplant (excluding cornea and those covered under separate transplant policy)

**Outpatient and Physician – Surgery:**

- Autologous Chondrocyte Implantation, Carticel
- Back Surgeries
- Balloon Sinuplasty
- Hysterectomy (including prophylactic)
- Osteochondral Allograft, Knee
- Sleep Apnea related Surgeries, limited to:
  - Radiofrequency Ablation (Coblation, Somnoplasty)
  - Uvulopalatopharyngoplasty (UPPP) (including laser-assisted procedures)
- Transplant (excluding cornea and those covered under separate transplant policy)

**Outpatient and Physician – Potentially Cosmetic Procedures:**

- Abdominoplasty
- Blepharoplasty
- Facial Skin Lesions (Photo Therapy, Laser Therapy - excluding MOHS)
- Hernia Repair, abdominal and incisional (only when associated with a Cosmetic procedure)
- IDET (thermal intradiscal procedures)
- Liposuction/Lipectomy
- Mammoplasty, augmentation, and reduction (including removal of implant)
- Mastectomy (including gynecomastia and prophylactic)
- Morbid Obesity Procedures
- Orthognathic Procedures (e.g., Genioplasty, LeFort osteotomy, Mandibular ORIF, TMJ)
- Otoplasty
- Panniculectomy
- Rhinoplasty
- Rhytidectomy
- Scar Revisions
- Septoplasty
- Varicose Vein Surgery/Sclerotherapy

**Outpatient and Physician – Diagnostic Services:**

- Capsule Endoscopy
- Genetic Testing, including BRCA (excluding tumor markers)
- PET (including SPECT)
- Sleep Study

**Outpatient and Physician – Continuing Care Services:**

- Chemotherapy
- Durable Medical Equipment, limited to electric/motorized scooters or wheelchairs and pneumatic compression devices
- Gene Therapies
- Hyperbaric Oxygen Therapy (HBOT)
- Home Health Care
- Oncology and transplant related injections (except those covered under separate transplant policy), infusions and treatments (e.g. CAR-T, endocrine and immunotherapy), excluding supportive drugs (e.g. antiemetic and antihistamine)
- Radiation Therapy

**High-Cost Drugs – Medications Processed Under the Medical Benefit:**

- Injectable medications or infusion therapies that cost $2,000 or more per dose per month, unless on an exception list maintained by the Medical Management vendor (excluding acute oncology or transplant treatments)
- Gene therapy drugs

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**Important Notes:**

❖ Precertification is NOT REQUIRED for a maternity delivery admission unless the stay extends past 48 hours for vaginal delivery or 96 hours for a cesarean section. A Hospital stay begins at the time of delivery or for deliveries outside the Hospital, the time the newborn or mother is admitted to a Hospital following birth, in connection with childbirth. If a newborn remains hospitalized beyond the time frames specified, the confinement must be precertified with the Medical Management Program Administrator or a penalty will be applied. Please refer to the penalty section above.

❖ High Cost Drugs are drugs that are covered under the medical benefits section of the Plan. This requirement does not apply to drugs covered under the Prescription Drug Card Program.

**Recommended List of Items and/or Services for Prenotification**
The below items and/or services, if Covered Expenses under the Plan, should be prenotified before any medical services are provided. To determine whether a benefit is covered or excluded, please review the Eligible Medical Expenses and/or General Exclusions and Limitations sections of this document.

- Biopsies (excluding skin)
- Creation and revision of Arteriovenous Fistula (AV Fistula) or Vessel to Vessel Cannula for Dialysis
- CT for non-orthopedic (including CTAs)
- Dialysis
- MRI for non-orthopedic (including MRAs)
- Oophorectomy, unilateral and bilateral
- Open Prostatectomy
- Thyroidectomy, partial or complete
- Transplant evaluation (excluding cornea and those covered under separate transplant policy)
- Vascular access devices for the infusion of chemotherapy (e.g. PICC and Central Lines)

Prenotification is used to inform the Medical Management program of upcoming services. It is a data-entry process and does not require judgment or interpretation for Medical Necessity. Prenotification is set in motion by a telephone call from you, the patient, or a representative acting on your behalf or on behalf of the patient. There are no reductions of benefits or penalties if prenotification is not performed.

**Precertification Does Not Guarantee Payment**
Precertification of the above benefits ensures the service being rendered is Medically Necessary and appropriate. All benefits/payments are subject to the patient's eligibility for benefits under the Plan. For benefit payment, services rendered must be considered a Covered Expense and are subject to all other provisions of the Plan.

**To File a Complaint or Request an Appeal to a Non-Certification**
If it is determined that the item and/or services are not Medically Necessary, the notification you receive will explain why. Verbal appeal requests and information regarding the appeal process should be directed to the Medical Management Program Administrator as identified on the General Plan Information page of this Plan.

**High Cost Drug Management**
The primary objective of the High Cost Drug Management program is to provide assistance when you or eligible Dependents have been prescribed a high cost drug that exceeds $2,000 per month and is covered under the medical benefits section of the Plan.

The High Cost Drug Management program helps coordinate the most effective way to reduce expenses associated with the high cost drug. Specially trained case managers will make recommendations based on the terms of the Plan to ensure the medication is being obtained through the most cost effective method.

If you or your eligible Dependents are not currently utilizing the most cost effective method, the case manager will make a recommendation to how to obtain the medication from the most cost efficient Participating Provider. The program includes 1-on-1 coaching based on Plan provisions, support, and education to improve adherence and avoid complications.

This is a voluntary service. There are no reductions of benefits or penalties if the Covered Person and family choose not to participate or comply with recommendations or suggestion provided by case managers.

# MEDICAL SCHEDULE OF BENEFITS – POS PLAN

| POS PLAN | PARTICIPATING PROVIDERS | NON-PARTICIPATING PROVIDERS (Subject to Usual and Customary Charges) |
|---|---|---|
| **LIFETIME MAXIMUM BENEFIT** | Unlimited | |
| **PLAN YEAR MAXIMUM BENEFIT** | Unlimited | |
| **PLAN YEAR DEDUCTIBLE** | | |
| Single | $1,500 | $3,000 |
| Family | $3,000 | $6,000 |
| **PLAN YEAR OUT-OF-POCKET MAXIMUM** (includes Deductible, Coinsurance and Copays – combined with Prescription Drug Card) | | |
| Single | $5,000 | Unlimited |
| Family | $10,000 | Unlimited |
| **MEDICAL BENEFITS** | | |
| **Accident Benefit** (within 90 days of Accident) | 100%; Deductible waived for the first $300; thereafter is 70% after Deductible | 50% after Deductible |
| **Ambulance Services** | 70% after Deductible | Paid at the Participating Provider level of benefits |
| **Ambulatory Surgical Center** | 70% after Deductible | 50% after Deductible |
| **Chemotherapy (Outpatient – includes all related charges)** | 70% after Deductible | 50% after Deductible |
| **Chiropractic Care/Spinal Manipulation** | 70% after Deductible | Paid at the Participating Provider level of benefits |
| **Diagnostic Testing, X-Ray, and Lab Services (Outpatient)** | 70% after Deductible | 50% after Deductible |
| Advanced Imaging (MRI, MRA, CT and PET Scans, Bone Density, Scintimammography, Capsule Endoscopy, Nuclear Medicine) | 70% after Deductible | 50% after Deductible |
| **NOTE:** Diagnostic testing, x-ray and lab services (except advanced imaging) received in the office are payable as shown under the office visit benefit under Physician's Services. | | |
| **Durable Medical Equipment (DME)** | 70% after Deductible | 50% after Deductible |
| **Emergency Services/Emergency Room Services** | $150 Copay, then 70% after Deductible | Paid at the Participating Provider level of benefits |
| **NOTE:** The Copay will be waived if the person is admitted directly as an Inpatient to the Hospital. | | |
| **Hearing Aids** | 70% after Deductible | 50% after Deductible |
| Maximum Benefit | 1 aid per ear up to $750 per ear every 3 Plan Years | |
| **Home Health Care** | 70% after Deductible | 50% after Deductible |
| Plan Year Maximum Benefit | 20 visits | |
| **NOTE:** Visit limits will not apply to Mental Disorders or Substance Use Disorders. | | |

| POS PLAN | PARTICIPATING PROVIDERS | NON-PARTICIPATING PROVIDERS (Subject to Usual and Customary Charges) |
|---|---|---|
| **Hospice Care** | 70% after Deductible | 50% after Deductible |
| **Hospital Expenses or Long-Term Acute Care Facility/Hospital (facility charges)** | | |
| Inpatient | 70% after Deductible | 50% after Deductible |
| Room and Board Allowance* | Semi-Private Room Rate* | Semi-Private Room Rate* |
| Intensive Care Unit | ICU/CCU Room Rate | ICU/CCU Room Rate |
| Miscellaneous Services & Supplies | 70% after Deductible | 50% after Deductible |
| Outpatient | 70% after Deductible | 50% after Deductible |
| * A private room will be considered eligible when Medically Necessary. Charges made by a Hospital having only single or private rooms will be considered at the least expensive rate for a single or private room. | | |
| **Infusion Therapy (Outpatient)** | 70% after Deductible | 50% after Deductible |
| **Maternity (non-facility charges)*** | | |
| Preventive Prenatal and Breastfeeding Support (other than lactation consultations) | 100%; Deductible waived | 50% after Deductible |
| Lactation Consultations | 100%; Deductible waived | 100%; Deductible waived |
| All Other Prenatal and Postnatal Care | 100%; Deductible waived | 50% after Deductible |
| Delivery | 70% after Deductible | 50% after Deductible |
| * See Preventive Services under Eligible Medical Expenses for limitations. | | |
| **Mental Disorders and Substance Use Disorders** | | |
| Inpatient | 70% after Deductible | 50% after Deductible |
| Outpatient | | |
| Office Visits | $35 Copay then 100%; Deductible waived | 50% after Deductible |
| All Other Outpatient Care | 70% after Deductible | 50% after Deductible |
| **NOTE:** Any visit maximums regarding home health care and outpatient therapies (as applicable) will not apply to Mental Disorders or Substance Use Disorders. | | |
| **NOTE:** Emergency care (ambulance and Emergency Services/Room) will be paid the same as the benefits for ambulance services and Emergency Services/Room listed above in the Medical Schedule of Benefits, however, the Participating Provider level of benefits will always apply regardless of the provider utilized. | | |
| **MinuteClinic** | 100%; Deductible waived | Not Applicable |
| **Morbid Obesity (Surgery)** | 70% after Deductible | 50% after Deductible |
| Lifetime Maximum Benefit | 1 Surgical Procedure | |
| **Outpatient Therapies** (physical, speech/hearing, occupational) | 70% after Deductible | 50% after Deductible |
| Combined Plan Year Maximum Benefit | 60 visits | |

| POS PLAN | PARTICIPATING PROVIDERS | NON-PARTICIPATING PROVIDERS (Subject to Usual and Customary Charges) |
|---|---|---|
| **Physician's Services** | | |
| Inpatient/Outpatient Services | 70% after Deductible | 50% after Deductible |
| Office Visits: | | |
| Primary Care Physician (PCP) | $35 Copay* then 100%; Deductible waived | 50% after Deductible |
| Specialist | $35 Copay* then 100%; Deductible waived | 50% after Deductible |
| Physician Office Surgery | 70% after Deductible | 50% after Deductible |
| *Copay applies to the Physician office visit component only. All other services are paid subject to any Deductible and Coinsurance percentages. | | |
| **Preventive Services and Routine Care** | | |
| Preventive Services (includes the office visit and any other eligible item or service received at the same time, whether billed at the same time or separately) | 100%; Deductible waived | 50% after Deductible |
| Routine Care (includes any routine care item or service not otherwise covered under the preventive services provision above) | 100%; Deductible waived | 50% after Deductible |
| Routine Eye Exam to Age 19 (including refractions) | 100%; Deductible waived | 100%; Deductible waived |
| Plan Year Maximum Benefit | 1 exam | |
| **Radiation Therapy (Outpatient – includes all related charges)** | 70% after Deductible | 50% after Deductible |
| **Skilled Nursing Facility and Rehabilitation Facility** | 70% after Deductible | 50% after Deductible |
| Combined Plan Year Maximum Benefit | 60 days | |
| **Teladoc Network Providers** | | |
| General Medical Consultations | 100%; Deductible waived | Not Applicable |
| Behavioral Health Consultations | $35 Copay, then 100%; Deductible waived | Not Applicable |
| **Telemedicine** | | |
| Mental Disorders & Substance Use Disorders | Paid same as office visit benefit for Mental Disorders and Substance Use Disorders | Paid same as office visit benefit for Mental Disorders and Substance Use Disorders |
| All Other Provider Services | Paid based on provider billing for telemedicine (subject to any applicable maximums and exclusions for the services provided) | Paid based on provider billing for telemedicine (subject to any applicable maximums and exclusions for the services provided) |

| POS PLAN | PARTICIPATING PROVIDERS | NON-PARTICIPATING PROVIDERS (Subject to Usual and Customary Charges) |
|---|---|---|
| **Transplants** | | |
| Transplants covered by the Certificate of Coverage under a separate Fully Insured Transplant Services Policy | Not Covered<br>Please contact the Plan Administrator for details on the Fully Insured Transplant Policy | |
| Cornea transplants; and<br>Services determined to be outside the benefit period as defined in the Certificate of Coverage under the Fully Insured Transplant Services Policy; and<br>Transplants not covered by the Fully Insured Transplant Services Policy | 70% after Deductible | 50% after Deductible |
| **Urgent Care Clinic** | $35 Copay* then 100%; Deductible waived | 50% after Deductible |
| *Copay applies to the Physician office visit component only. All other services are paid subject to any Deductible and Coinsurance percentages. | | |
| **Valenz Health**<br>Outpatient surgical and non-surgical treatment provided by Valenz Health providers. | 100%; Deductible waived | |
| **NOTE:** Please refer to the Valenz Health section of this Plan for a more detailed description of this benefit. Covered Expenses include facility and professional fees, supplies and equipment Incurred at a Valenz Health contracted facility. If treatment is received from providers outside of Valenz Health, standard Plan benefits will apply as outlined in the Medical Schedule of Benefits. | | |
| **Wig (see Eligible Medical Expenses)** | 70% after Deductible | 50% after Deductible |
| Plan Year Maximum Benefit | 1 wig up to $500 | |
| **All Other Eligible Medical Expenses** | 70% after Deductible | 50% after Deductible |

# PRESCRIPTION DRUG SCHEDULE OF BENEFITS – POS PLAN

***NOTE: Certain Prescription Drugs MUST be obtained directly through the Payer Matrix Program offered by the Employer. For a list of drugs subject to the Payer Matrix Program, please contact Payer Matrix at (877) 305-6202. Benefits listed below are payable only for those medications that fall outside of the Payer Matrix Program.***

| BENEFIT DESCRIPTION | BENEFIT |
|---|---|
| **PLAN YEAR OUT-OF-POCKET MAXIMUM**<br>(includes Copays – combined with major medical Out-of-Pocket) | |
| Single | $5,000 |
| Family | $10,000 |
| **Retail Pharmacy: 30-day supply** | |
| Generic Drug | $15 Copay* |
| Preferred Drug | $40 Copay* |
| Non-Preferred Drug | $64 Copay* |
| Preventive Drug (Prescription Drugs classified as a Preventive Drug by HHS) | $0 Copay (100% paid) |
| Immunization / Vaccination | $0 Copay (100% paid) |
| ***NOTE:** Prescription Drugs received from a non-Network pharmacy will be paid at a 50% Copay. | |
| **Specialty Pharmacy Network: 30-day supply** | |
| Generic Drug | $15 Copay |
| Preferred Drug | $40 Copay |
| Non-Preferred Drug | $64 Copay |
| **NOTE:** Specialty Drugs MUST be obtained from the specialty pharmacy network. Refer to the Prescription Drug Card Program Administrator for full details. | |
| **Retail Pharmacy: 90-day supply** | |
| Generic Drug | $30 Copay* |
| Preferred Drug | $80 Copay* |
| Non-Preferred Drug | $128 Copay* |
| Preventive Drug (Prescription Drugs classified as a Preventive Drug by HHS) | $0 Copay (100% paid) |
| ***NOTE:** Prescription Drugs received from a non-Network pharmacy will be paid at a 50% Copay. | |
| **Mail Order Pharmacy: 90-day supply** | |
| Generic Drug | $30 Copay |
| Preferred Drug | $80 Copay |
| Non-Preferred Drug | $128 Copay |
| Preventive Drug (Prescription Drugs classified as a Preventive Drug by HHS) | $0 Copay (100% paid) |

***NOTE: Certain Prescription Drug classes are subject to Step Therapy. (See the Prescription Drug Card Program section for further details regarding Step Therapy.)***

**Dispense as Written**
The Plan requires pharmacies dispense Generic Drugs when available unless the Physician specifically prescribes a Preferred or Non-Preferred Drug and marks the script "Dispense as Written" (DAW). Should a Covered Person choose a Preferred or Non-Preferred Drug rather than the Generic equivalent when the Physician allowed a Generic Drug to be dispensed, the Covered Person will also be responsible for the cost difference between the Generic and Preferred or Non-Preferred Drug. The cost difference is considered a penalty and is not covered by the Plan and will not accumulate toward your Out-of-Pocket Maximum.

**Advanced Control Specialty Formulary**
Advanced Control Specialty Formulary (ACSF) is a moderately aggressive approach and presents specialty trend management. The formulary utilizes formulary exclusions, new-to-market (NTM) drug management and tiering strategies to help ensure clinically appropriate utilization and cost-effectiveness of specialty therapies.

**CVS True Accumulation Program**
Some Specialty Drugs may qualify for third-party copayment assistance programs that could lower your out of-pocket costs for those products. For any such Specialty Drug where third-party copayment assistance is used, the Covered Person shall not receive credit toward their maximum Out-of-Pocket or Deductible for any Copay or Coinsurance amounts that are applied to a manufacturer coupon or rebate.

**Payer Matrix Program**
Prescription Drug assistance through Payer Matrix is offered as part of your Plan's Prescription Drug Card Program benefit. Payer Matrix advocates will help you pursue drug manufacturer assistance programs and/or patient assistance programs. With many of these programs, your responsibility toward your Prescription Drug Copay may be reduced. Coverage for certain Prescription Drugs is only available if Payer Matrix advocates are unable to obtain assistance programs for eligible Prescription Drugs. If your prescribed medication does not have an assistance program available and the Prescription Drug is deemed Medically Necessary, the standard Prescription Drug Copay will apply as shown in the Prescription Drug Schedule of Benefits. For a list of drugs subject to the Payer Matrix Program, please contact Payer Matrix at (877) 305-6202.

Prescription Drugs, designated by Payer Matrix, must be obtained directly through the Payer Matrix Program. Under this program, Specialty Drugs are not available at retail or mail order pharmacies and there are no grace fills provided to Covered Persons. If necessary, one fill of non-Specialty Drugs at a Participating Pharmacy may be covered under the Prescription Drug Card Program.

For additional information about the Payer Matrix Program and a list of eligible drugs, please call Payer Matrix at (877) 305-6202 or contact the Prescription Drug Card Program Administrator.

**Specialty Pharmacy Network**
Self-administered Specialty Drugs that do not require administration under the direct supervision of a Physician must be obtained from the specialty pharmacy network. For additional information, please contact the Prescription Drug Card Program Administrator.

Specialty Drugs that must be administered in a Physician's office, infusion center or other clinical setting, or the Covered Person's home by a third party, will be considered under the Medical Benefits section of the Plan. Those drugs that can be self-administered and do not require the direct supervision of a Physician are only eligible under the Prescription Drug Program.

**Rx Smart Savings Program**
The Rx Smart Savings Program works with the Plan, your Physician, and pharmacies to improve your quality of care and identify possible savings in your Prescription Drug coverage. From time to time, you may be contacted by a program representative who will speak with you about possible alternatives to your current prescribed drugs. The decision to switch to a different prescribed drug is up to you and your Physician.

**Preventive Drug** means items which have been identified by the U.S. Department of Health and Human Services (HHS) as a preventive service. You may view the guidelines established by HHS by visiting the following website:

https://www.healthcare.gov/what-are-my-preventive-care-benefits

For a list of Preventive Drugs, contact the Prescription Drug Card Program Administrator identified in the General Plan Information section of this Plan.

# MEDICAL SCHEDULE OF BENEFITS – HDHP PLAN

| HDHP PLAN | PARTICIPATING PROVIDERS | NON-PARTICIPATING PROVIDERS (Subject to Usual and Customary Charges) |
|---|---|---|
| **LIFETIME MAXIMUM BENEFIT** | Unlimited | |
| **PLAN YEAR MAXIMUM BENEFIT** | Unlimited | |
| **PLAN YEAR DEDUCTIBLE** (combined with Prescription Drug Card) | | |
| Single | $3,400 | $6,800 |
| Family | $6,800 | $13,600 |
| **PLAN YEAR OUT-OF-POCKET MAXIMUM** (includes Deductible, Coinsurance and Copays – combined with Prescription Drug Card) | | |
| Single | $4,200 | Unlimited |
| Family | $8,400 | Unlimited |
| **MEDICAL BENEFITS** | | |
| **Accident Benefit** | 70% after Deductible | 50% after Deductible |
| **Ambulance Services** | 70% after Deductible | Paid at the Participating Provider level of benefits |
| **Ambulatory Surgical Center** | 70% after Deductible | 50% after Deductible |
| **Chemotherapy (Outpatient – includes all related charges)** | 70% after Deductible | 50% after Deductible |
| **Chiropractic Care/Spinal Manipulation** | 70% after Deductible | Paid at the Participating Provider level of benefits |
| **Diagnostic Testing, X-Ray, and Lab Services (Outpatient)** | 70% after Deductible | 50% after Deductible |
| Advanced Imaging (MRI, MRA, CT and PET Scans, Bone Density, Scintimammography, Capsule Endoscopy, Nuclear Medicine) | 70% after Deductible | 50% after Deductible |
| **NOTE:** Diagnostic testing, x-ray and lab services (except advanced imaging) received in the office are payable as shown under the office visit benefit under Physician's Services. | | |
| **Durable Medical Equipment (DME)** | 70% after Deductible | 50% after Deductible |
| **Emergency Services/Emergency Room Services** | 100% after Deductible | Paid at the Participating Provider level of benefits |
| **Hearing Aids** | 70% after Deductible | 50% after Deductible |
| Maximum Benefit | 1 aid per ear up to $750 per ear every 3 Plan Years | |
| **Home Health Care** | 70% after Deductible | 50% after Deductible |
| Plan Year Maximum Benefit | 20 visits | |
| **NOTE:** Visit limits will not apply to Mental Disorders or Substance Use Disorders. | | |
| **Hospice Care** | 70% after Deductible | 50% after Deductible |

| HDHP PLAN | PARTICIPATING PROVIDERS | NON-PARTICIPATING PROVIDERS (Subject to Usual and Customary Charges) |
|---|---|---|
| **Hospital Expenses or Long-Term Acute Care Facility/Hospital (facility charges)** | | |
| Inpatient | 70% after Deductible | 50% after Deductible |
| Room and Board Allowance* | Semi-Private Room Rate* | Semi-Private Room Rate* |
| Intensive Care Unit | ICU/CCU Room Rate | ICU/CCU Room Rate |
| Miscellaneous Services & Supplies | 70% after Deductible | 50% after Deductible |
| Outpatient | 70% after Deductible | 50% after Deductible |
| * A private room will be considered eligible when Medically Necessary. Charges made by a Hospital having only single or private rooms will be considered at the least expensive rate for a single or private room. | | |
| **Infusion Therapy (Outpatient)** | 70% after Deductible | 50% after Deductible |
| **Maternity (non-facility charges)*** | | |
| Preventive Prenatal and Breastfeeding Support (other than lactation consultations) | 100%; Deductible waived | 50% after Deductible |
| Lactation Consultations | 100%; Deductible waived | 100%; Deductible waived |
| All Other Prenatal, Delivery and Postnatal Care | 70% after Deductible | 50% after Deductible |
| * See Preventive Services under Eligible Medical Expenses for limitations. | | |
| **Mental Disorders and Substance Use Disorders** | | |
| Inpatient | 70% after Deductible | 50% after Deductible |
| Outpatient | 70% after Deductible | 50% after Deductible |
| **NOTE:** Any visit maximums regarding home health care and outpatient therapies (as applicable) will not apply to Mental Disorders or Substance Use Disorders. | | |
| **NOTE:** Emergency care (ambulance and Emergency Services/Room) will be paid the same as the benefits for ambulance services and Emergency Services/Room listed above in the Medical Schedule of Benefits, however, the Participating Provider level of benefits will always apply regardless of the provider utilized. | | |
| **MinuteClinic** | 100% after Deductible (Deductible waived for preventive services and routine care) | Not Applicable |
| **Morbid Obesity (Surgery)** | 70% after Deductible | 50% after Deductible |
| Lifetime Maximum Benefit | 1 Surgical Procedure | |
| **Outpatient Therapies** (physical, speech/hearing, occupational) | 70% after Deductible | 50% after Deductible |
| Combined Plan Year Maximum Benefit | 60 visits | |
| **Physician's Services** | | |
| Inpatient/Outpatient Services | 70% after Deductible | 50% after Deductible |
| Office Visits: | | |
| Primary Care Physician (PCP) | 70% after Deductible | 50% after Deductible |
| Specialist | 70% after Deductible | 50% after Deductible |
| Physician Office Surgery | 70% after Deductible | 50% after Deductible |

| HDHP PLAN | PARTICIPATING PROVIDERS | NON-PARTICIPATING PROVIDERS (Subject to Usual and Customary Charges) |
|---|---|---|
| **Preventive Services and Routine Care** | | |
| Preventive Services (includes the office visit and any other eligible item or service received at the same time, whether billed at the same time or separately) | 100%; Deductible waived | 50% after Deductible |
| Routine Care (includes any routine care item or service not otherwise covered under the preventive services provision above) | 100%; Deductible waived | 50% after Deductible |
| Routine Eye Exam to Age 19 (including refractions) | 100%; Deductible waived | 100%; Deductible waived |
| Plan Year Maximum Benefit | 1 exam | |
| **Radiation Therapy (Outpatient – includes all related charges)** | 70% after Deductible | 50% after Deductible |
| **Skilled Nursing Facility and Rehabilitation Facility** | 70% after Deductible | 50% after Deductible |
| Combined Plan Year Maximum Benefit | 60 days | |
| **Teladoc Network Providers** | | |
| General Medical Consultations | 100%; Deductible waived | Not Applicable |
| Behavioral Health Consultations | $35 Copay, then 100%; Deductible waived | Not Applicable |
| **Telemedicine** | | |
| Mental Disorders & Substance Use Disorders | Paid same as office visit benefit for Mental Disorders and Substance Use Disorders | Paid same as office visit benefit for Mental Disorders and Substance Use Disorders |
| All Other Provider Services | Paid based on provider billing for telemedicine (subject to any applicable maximums and exclusions for the services provided) | Paid based on provider billing for telemedicine (subject to any applicable maximums and exclusions for the services provided) |
| **Transplants** | | |
| Transplants covered by the Certificate of Coverage under a separate Fully Insured Transplant Services Policy | Not Covered<br>Please contact the Plan Administrator for details on the Fully Insured Transplant Policy | |
| Cornea transplants; and<br>Services determined to be outside the benefit period as defined in the Certificate of Coverage under the Fully Insured Transplant Services Policy; and<br>Transplants not covered by the Fully Insured Transplant Services Policy | 70% after Deductible | 50% after Deductible |

| HDHP PLAN | PARTICIPATING PROVIDERS | NON-PARTICIPATING PROVIDERS (Subject to Usual and Customary Charges) |
|---|---|---|
| **Urgent Care Clinic** | 70% after Deductible | 50% after Deductible |
| **Valenz Health** (with rebates)<br>Outpatient surgical and non-surgical treatment provided by Valenz Health providers. | 100% after Deductible* | |
| *For Employees with single coverage, they only have to meet the minimum annual Deductible amount for single coverage; and for Employees with family coverage, an individual within a family only has to satisfy the minimum family Deductible for an HSA Qualified High Deductible Health Plan (QHDHP) per IRS guidelines before the Plan begins to pay for services rendered through Valenz Health.<br><br>**NOTE:** Please refer to the Valenz Health section of this Plan for a more detailed description of this benefit. Covered Expenses include facility and professional fees, supplies and equipment Incurred at a Valenz Health contracted facility. If treatment is received from providers outside of Valenz Health, standard Plan benefits will apply as outlined in the Medical Schedule of Benefits. | | |
| **Wig (see Eligible Medical Expenses)** | 70% after Deductible | 50% after Deductible |
| Plan Year Maximum Benefit | 1 wig up to $500 | |
| **All Other Eligible Medical Expenses** | 70% after Deductible | 50% after Deductible |

# PRESCRIPTION DRUG SCHEDULE OF BENEFITS – HDHP PLAN

***NOTE: Certain Prescription Drugs MUST be obtained directly through the Payer Matrix Program offered by the Employer. For a list of drugs subject to the Payer Matrix Program, please contact Payer Matrix at (877) 305-6202. Benefits listed below are payable only for those medications that fall outside of the Payer Matrix Program.***

| BENEFIT DESCRIPTION | BENEFIT |
|---|---|
| **PLAN YEAR DEDUCTIBLE**<br>(combined with major medical Deductible)<br>Single<br>Family | <br><br>$3,400<br>$6,800 |
| **PLAN YEAR OUT-OF-POCKET MAXIMUM**<br>(includes Deductible and Copays – combined with major medical Out-of-Pocket)<br>Single<br>Family | <br><br><br>$4,200<br>$8,400 |
| **Retail Pharmacy: 30-day supply** | |
| Generic Drug | Deductible, then 30% Copay* |
| Preferred Drug | Deductible, then 30% Copay* |
| Non-Preferred Drug | Deductible, then 30% Copay* |
| Preventive Drug (Prescription Drugs classified as a Preventive Drug by HHS) | $0 Copay; Deductible waived (100% paid) |
| Immunization / Vaccination | $0 Copay; Deductible waived (100% paid) |
| ***NOTE:** Prescription Drugs received from a non-Network pharmacy will be subject to the Deductible, then paid at a 50% Copay. | |
| **Specialty Pharmacy Network: 30-day supply** | |
| Specialty Drug | Deductible, then 30% Copay |
| **NOTE:** Specialty Drugs MUST be obtained from the specialty pharmacy network. Refer to the Prescription Drug Card Program Administrator for full details. | |
| **Retail Pharmacy: 90-day supply** | |
| Generic Drug | Deductible, then 30% Copay* |
| Preferred Drug | Deductible, then 30% Copay* |
| Non-Preferred Drug | Deductible, then 30% Copay* |
| Preventive Drug (Prescription Drugs classified as a Preventive Drug by HHS) | $0 Copay; Deductible waived (100% paid) |
| ***NOTE:** Prescription Drugs received from a non-Network pharmacy will be subject to the Deductible, then paid at a 50% Copay. | |
| **Mail Order Pharmacy: 90-day supply** | |
| Generic Drug | Deductible, then 30% Copay |
| Preferred Drug | Deductible, then 30% Copay |
| Non-Preferred Drug | Deductible, then 30% Copay |
| Preventive Drug (Prescription Drugs classified as a Preventive Drug by HHS) | $0 Copay; Deductible waived (100% paid) |

***NOTE: Certain Prescription Drug classes are subject to Step Therapy. (See the Prescription Drug Card Program section for further details regarding Step Therapy.)***

**Dispense as Written**
The Plan requires pharmacies dispense Generic Drugs when available unless the Physician specifically prescribes a Preferred or Non-Preferred Drug and marks the script "Dispense as Written" (DAW). Should a Covered Person choose a Preferred or Non-Preferred Drug rather than the Generic equivalent when the Physician allowed a Generic Drug to be dispensed, the Covered Person will also be responsible for the cost difference between the Generic and Preferred or Non-Preferred Drug. The cost difference is considered a penalty and is not covered by the Plan and will not accumulate toward your Out-of-Pocket Maximum.

**Advanced Control Specialty Formulary**
Advanced Control Specialty Formulary (ACSF) is a moderately aggressive approach and presents specialty trend management. The formulary utilizes formulary exclusions, new-to-market (NTM) drug management and tiering strategies to help ensure clinically appropriate utilization and cost-effectiveness of specialty therapies.

**CVS True Accumulation Program**
Some Specialty Drugs may qualify for third-party copayment assistance programs that could lower your out of-pocket costs for those products. For any such Specialty Drug where third-party copayment assistance is used, the Covered Person shall not receive credit toward their maximum Out-of-Pocket or Deductible for any Copay or Coinsurance amounts that are applied to a manufacturer coupon or rebate.

**Payer Matrix Program**
Prescription Drug assistance through Payer Matrix is offered as part of your Plan's Prescription Drug Card Program benefit. Payer Matrix advocates will help you pursue drug manufacturer assistance programs and/or patient assistance programs. With many of these programs, your responsibility toward your Prescription Drug Copay may be reduced. Coverage for certain Prescription Drugs is only available if Payer Matrix advocates are unable to obtain assistance programs for eligible Prescription Drugs. If your prescribed medication does not have an assistance program available and the Prescription Drug is deemed Medically Necessary, the standard Prescription Drug Copay will apply as shown in the Prescription Drug Schedule of Benefits. For a list of drugs subject to the Payer Matrix Program, please contact Payer Matrix at (877) 305-6202.

Prescription Drugs, designated by Payer Matrix, must be obtained directly through the Payer Matrix Program. Under this program, Specialty Drugs are not available at retail or mail order pharmacies and there are no grace fills provided to Covered Persons. If necessary, one fill of non-Specialty Drugs at a Participating Pharmacy may be covered under the Prescription Drug Card Program.

For additional information about the Payer Matrix Program and a list of eligible drugs, please call Payer Matrix at (877) 305-6202 or contact the Prescription Drug Card Program Administrator.

**Specialty Pharmacy Network**
Self-administered Specialty Drugs that do not require administration under the direct supervision of a Physician must be obtained from the specialty pharmacy network. For additional information, please contact the Prescription Drug Card Program Administrator.

Specialty Drugs that must be administered in a Physician's office, infusion center or other clinical setting, or the Covered Person's home by a third party, will be considered under the Medical Benefits section of the Plan. Those drugs that can be self-administered and do not require the direct supervision of a Physician are only eligible under the Prescription Drug Program.

**Rx Smart Savings Program**
The Rx Smart Savings Program works with the Plan, your Physician, and pharmacies to improve your quality of care and identify possible savings in your Prescription Drug coverage. From time to time, you may be contacted by a program representative who will speak with you about possible alternatives to your current prescribed drugs. The decision to switch to a different prescribed drug is up to you and your Physician.

**Preventive Drug** means items which have been identified by the U.S. Department of Health and Human Services (HHS) as a preventive service. You may view the guidelines established by HHS by visiting the following website:

https://www.healthcare.gov/what-are-my-preventive-care-benefits

For a list of Preventive Drugs, contact the Prescription Drug Card Program Administrator identified in the General Plan Information section of this Plan.

# DENTAL SCHEDULE OF BENEFITS

| BENEFIT DESCRIPTION | BENEFIT<br>(Subject to Usual and Customary Charges) |
|---|---|
| **LIFETIME DEDUCTIBLE**<br>Per Person | $100 |
| **CLASS A, B AND C EXPENSES COMBINED PLAN YEAR MAXIMUM BENEFIT** | $1,200 per Covered Person |
| **DENTAL BENEFITS** | |
| Class A-Preventive Services | 100%; Deductible waived |
| Class B-Basic Services | 80% after Deductible |
| Class C-Major Services | 50% after Deductible |

**Late Enrollment Restriction**
If you and your eligible Dependent(s) fail to enroll for Employee or Dependent coverage during your original 45-day eligibility period or due to a Special Enrollment Event or Status Change Event or later terminate coverage and subsequently re-enroll, coverage will be limited as follows:

(1) During the first 12 months, coverage will be limited to Class A-Preventive Services and Class B-Basic Services only.

***NOTE: The dental benefits provided under this Plan are limited-scope benefits and are offered separately from any medical coverage offered under the Plan. You have a separate right to enroll in the dental benefits under the Plan. If you choose to enroll in such dental benefit, you may be charged an employee contribution amount that is separate from what you are charged for any other benefit offered under the Plan. The amount of a required employee contribution, if any, will be communicated to you by the Plan Administrator prior to the annual open enrollment period.***

# ELIGIBILITY FOR PARTICIPATION

**Employee Eligibility**
A Full-Time Employee of the Employer who regularly works 30 or more Hours of Service per week will be eligible to enroll for coverage under this Plan once he/she completes a waiting period of 45 days from the first day he or she reports for employment with the Employer. Participation in the Plan will begin as of the first day of the month following completion of the waiting period provided all required election and enrollment forms are properly submitted to the Plan Administrator.

You are not eligible to participate in the Plan if you are a part-time, temporary, leased or Seasonal Employee, an independent contractor or a person performing services pursuant to a contract under which you are designated an independent contractor (regardless of whether you might later be deemed a common law employee by a court or governmental agency), or a person covered by a collective bargaining agreement that does not provide for participation in this Plan.

**Dependent Eligibility**
Your Dependents are eligible for participation in this Plan provided he/she is:

(1) Your Spouse.

(2) Your Child until the end of the month in which he/she attains age 26.

(3) Your Child age 26 or older, who is unable to be self-supporting by reason of mental or physical handicap and is incapacitated, provided the Child suffered such incapacity prior to the end of the month in which he/she attained age 26. Your Child must be unmarried and primarily dependent upon you for support. The Plan Sponsor may require subsequent proof of your Child's disability and dependency, including a Physician's statement certifying your Child's physical or mental incapacity.

(4) A Child for whom you are required to provide health coverage due to a Qualified Medical Child Support Order (QMCSO). Procedures for determining a QMCSO may be obtained from the Plan Administrator at no cost.

The below terms have the following meanings:

"Spouse" means any person who is lawfully married to you under any state law. Specifically excluded from this definition is a spouse by reason of common law marriage, whether or not permitted in your state. The Plan Administrator may require documentation proving a legal marital relationship.

"Child" means your natural born son, daughter, stepson, stepdaughter, legally adopted Child (or a Child placed with you in anticipation of adoption), or a Child for whom you are the Legal Guardian. Coverage for a Child for whom you are the Legal Guardian will remain in effect until such Child no longer meets the age requirements of an eligible Dependent under the terms of the Plan, regardless of whether or not such Child has attained age 18 (or any other applicable age of emancipation of minors).

"Child placed with you in anticipation of adoption" means a Child that you intend to adopt, whether or not the adoption has become final, who would otherwise be eligible for enrollment if the Child was your natural born Child. The term "placed" means the assumption and retention by you 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.

"Legal Guardian" means 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 an individual that is placed with such person by judgment, decree, or other order of any court of competent jurisdiction.

The Plan Administrator, in its sole discretion, shall have the right to require documentation necessary to establish an individual's status as an eligible Dependent.

**When You and Your Dependents are Covered Employees**
When both you and your Spouse and/or Child are covered Employees, each of you must choose coverage as either an Employee or as a Dependent of an Employee. You may not be covered under this Plan as both an Employee and a Dependent. Eligible Dependent Children of 2 covered Employees may not be enrolled as Dependents of both Employees, whether the Employees are married or unmarried.

**Court Ordered Coverage for a Child**
Federal law requires the Plan, under certain circumstances, to provide coverage for your Children. The details of these requirements are summarized below.

The Plan Administrator shall enroll for immediate coverage under this Plan any Child, who is the subject of a "qualified medical child support order" ("QMCSO"). If you are ordered to provide such coverage for a Child and you are not enrolled in the Plan at the time the Plan Administrator receives a QMCSO, the Plan Administrator shall also enroll you for immediate coverage under this Plan. Coverage under the Plan will be effective as of the later of the date specified in the order or the date the Plan Administrator determines that the order is a QMCSO. Any required contribution for coverage pursuant to this section will be deducted from your pay in accordance with the Employer's payroll schedule and policies.

A QMCSO is defined as a child support decree or order issued by a court (or a state administrative agency that has the force and effect of law under applicable state law) that obligates you to support or provide health care coverage to your Child and includes certain information concerning such coverage. The Plan Administrator will determine whether any child support order it receives constitutes a QMCSO. Except for QMCSO's, no Child is eligible for Plan coverage, even if you are required to provide coverage for that Child under the terms of a separation agreement or court order, unless the Child is an eligible Child under this Plan. Procedures for determining a QMCSO may be obtained, free of charge, by contacting the Plan Administrator.

**Retiree Eligibility (This section shall be construed and applied in a manner consistent with the requirements of Kansas Statutes Annotated 12-5040)**
You are eligible for coverage under this Plan as a Retiree if you have 10 or more years of service with the Employer and were covered under the Plan as of the date of your retirement. You may also elect to continue coverage for your Spouse and any eligible Dependents.

At the time of retirement, you may elect to enroll in COBRA Continuation Coverage in lieu of Retiree coverage. If you elect COBRA Continuation Coverage in lieu of Retiree coverage for yourself and any eligible Dependents or if you fail to make any election under the Plan, you and/or your Dependents will not be eligible to enroll in the Retiree coverage under the Plan at a later time. If, however, you elect Retiree coverage in lieu of COBRA Continuation Coverage, the Retiree coverage under the Plan will be treated as alternative coverage and you will not be eligible to continue coverage under COBRA once Retiree coverage under the Plan has ended.

If you decide to enroll yourself and your eligible Dependents in Retiree coverage, you must enroll by completing all required election and enrollment forms and submitting them to the Plan Administrator within 63 days after your retirement date. Participation in the Plan will begin for you and any eligible Dependents as of your date of retirement provided all required election and enrollment forms are properly submitted to the Plan Administrator.You may be required to contribute toward the cost of Retiree coverage for yourself and any eligible Dependents in accordance with the policies and procedures established by the Plan Sponsor. The amount of any required contribution will be communicated to you prior to the date of your retirement.

**Timely Enrollment**
Once you are eligible to participate in the Plan, you must enroll for coverage by completing all election and enrollment forms and submitting them to the Plan Administrator within 30 days after satisfaction of the eligibility requirements. If you are required to contribute towards the cost of coverage you must complete and submit a payroll deduction authorization for the Plan Administrator to deduct the required contribution from your pay. In addition, as part of the enrollment requirements, you will be required to provide your social security number, as well as the social security numbers of your Dependents. The Plan Administrator may request this information at any time for continued eligibility under the Plan. Failure to provide the required social security numbers may result in loss of eligibility or loss of continued eligibility under the Plan.

If you decline enrollment for you and/or your Dependents, you must provide notification to the Plan Administrator indicating that the reason you are declining enrollment is due to other health coverage. If you lose such other health coverage, it may constitute a Special Enrollment Event (described below) that gives you and/or your Dependents a right to enroll in the Plan mid-year due to such loss of coverage. However, if you failed to submit such notification when initially eligible, you will lose your right to this special mid-year enrollment opportunity.

If you fail to complete and submit the appropriate election and enrollment forms within the 30-day period described above, you will not be eligible to enroll in the Plan until the next open enrollment period or unless you experience a Special Enrollment Event or a Status Change Event.

**Open Enrollment Period**
You and your Dependents may enroll for coverage during the Plan's open enrollment period, designated by the Plan Sponsor and communicated to you prior to such open enrollment period. During this time, you will be permitted to make changes to any existing benefit elections. Benefit elections made during the open enrollment period will be effective as of October 1 and will remain in effect until the next open enrollment period unless you or your Dependent experiences a Special Enrollment Event or Status Change Event.

**Late Enrollment**
If you did not enroll during your original 30-day eligibility period, you may do so by making written application to the Plan Administrator during the annual open enrollment period (refer to annual open enrollment period section above). In these circumstances, you and/or your eligible Dependents will be considered Late Enrollees.

**Special Enrollment Event**
A special enrollment event occurs when you or your Dependents suffer a loss of other health care coverage, when you become eligible for a state premium assistance subsidy or acquire a new Dependent as a result of marriage, birth, adoption, or placement for adoption. In these circumstances, you and/or your eligible Dependents will be considered Special Enrollees.

Each special enrollment event is more fully described below:

(1) **Loss of Other Coverage (other than under Medicaid or SCHIP).** If you declined enrollment for yourself or your Dependents (including your Spouse) because you or your Dependents had other health coverage (including coverage under a group health plan sponsored by a governmental or educational institution, a medical care program of the Indian Health Service or of a tribal organization), you may enroll for coverage for yourself and/or your Dependents under this Plan if the other health coverage is lost as a result of one of the following provided, however, you submitted notification to the Plan Administrator when you and/or your Dependents were initially eligible stating that other health coverage was the reason for declining enrollment under this Plan:

   (a) The other health coverage was under COBRA and the maximum continuation period available under COBRA has been exhausted;

   (b) Loss of eligibility under the other health coverage for reasons other than non-payment of the required contribution or premium, making a fraudulent claim or intentional misrepresentation of a material fact in connection with the other plan; or

   (c) Employer contributions cease for the other health coverage.

   If you are already enrolled in a benefit option available under the Plan and your Dependent lost his or her other health coverage, you may enroll in a different benefit option available under the Plan due to the special enrollment event of your Dependent.

   You must submit the appropriate election and enrollment forms to the Plan Administrator within 30 days after the date the other health coverage was lost. Coverage under the Plan will become effective on the first day of the month following the date you submit the appropriate election and enrollment forms to the Plan Administrator.

(2) **Loss of Coverage under Medicaid or SCHIP or Eligibility for a State Premium Assistance Subsidy.** If you or your Dependents did not enroll in the Plan when initially eligible because you and/or your Dependents were covered under Medicaid or a state sponsored Children's Health Insurance Program (SCHIP) and your coverage terminates because you or your Dependents are no longer eligible for Medicaid or SCHIP or you or your Dependents become eligible for a state premium assistance subsidy under Medicaid or SCHIP, you may enroll for coverage under this Plan for yourself and your Dependents after Medicaid or SCHIP coverage terminates or after you or your Dependents' eligibility for a state assistance subsidy under Medicaid or SCHIP is determined.

You must submit the appropriate election and enrollment forms to the Plan Administrator within 60 days after coverage under Medicaid or SCHIP terminates or within 60 days after eligibility for a state premium assistance subsidy under Medicaid or SCHIP is determined. Coverage under the Plan will become effective on the first day of the month following the date you submit the appropriate election and enrollment forms to the Plan Administrator.

(3) **Acquisition of a New Dependent.** If you acquire a new Dependent as a result of marriage, birth, adoption, or placement for adoption, you may be able to enroll for coverage under this Plan for yourself and your Dependents. You must submit the appropriate election and enrollment forms to the Plan Administrator within 30 days after the date you acquire such Dependent.

(a) Coverage becomes effective for a Dependent Child who is born after the date your coverage becomes effective as of such Child's date of birth provided you complete and submit the required election and enrollment forms (including a payroll deduction authorization, if applicable) within 30 days after the Child's birth. Failure to enroll in the Plan within this 30-day period will result in no coverage under the Plan.

(b) Coverage for a newly acquired Dependent due to marriage will be effective on the first day of the month following the date of marriage provided you complete and submit the required election and enrollment forms (including a payroll deduction authorization, if applicable) within 30 days after your date of marriage. Failure to enroll in the Plan within the 30-day period described above will result in no coverage under the Plan.

(c) Coverage for a newly acquired Dependent due to adoption (or placement with you in anticipation of adoption) will be effective as of the date of adoption (or placement in anticipation of adoption) provided you complete and submit the required election and enrollment forms (including a payroll deduction authorization, if applicable) within 30 days after adoption or placement in anticipation of adoption, as applicable. Failure to enroll in the Plan within the 30-day period described above will result in no coverage under the Plan.

**Status Change Event**

Generally, your election under the Plan will remain in effect for the entire Plan Year unless you experience a Special Enrollment Event (described above) or a Status Change Event (as permitted by the Employer's Section 125 Plan). If a Status Change Event occurs, you may make a new election under the Plan provided your new election is consistent with the Status Change Event.

You must submit the appropriate election and enrollment forms to the Plan Administrator within 30 days after the Status Change Event. Coverage under the Plan will become effective on the first day of the month following the date you submit the appropriate election and enrollment forms to the Plan Administrator.

# TERMINATION OF COVERAGE

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

(1) The date the Plan terminates, in whole or in part.

(2) If you fail to make any contribution when it is due, the beginning of the period for which a required contribution has not been paid.

(3) The date you report to active duty military service unless coverage is continued through the Uniformed Services Employment and Reemployment Rights Act (USERRA) as explained below.

(4) The end of the month in which you cease to be eligible for coverage under the Plan.

(5) The end of the month in which you terminate employment or cease to be included in an eligible class of Employees.

(6) The date you (or any person seeking coverage on your behalf) performs an act, practice or omission that constitutes fraud.

(7) The date you (or any person seeking coverage on your behalf) makes an intentional misrepresentation of a material fact.

**Termination of Dependent Coverage**
Coverage under the Plan will terminate on the earliest of the following dates:

(1) The date the Plan terminates, in whole or in part.

(2) The date the Plan discontinues coverage for Dependents.

(3) The date your Dependent becomes covered as an Employee under the Plan.

(4) The date coverage terminates for the Employee.

(5) If you and/or your Dependents fail to make any contribution when it is due, the beginning of the period for which a required contribution has not been paid.

(6) The date the Dependent Spouse of an Employee reports to active duty military service.

(7) The end of the month in which a Dependent ceases to be a Dependent as defined by the Plan.

(8) The date your Dependent (or any person seeking coverage on behalf of your Dependent) performs an act, practice or omission that constitutes fraud.

(9) The date your Dependent (or any person seeking coverage on behalf of your Dependent) makes an intentional misrepresentation of a material fact.

**Termination of Retiree Coverage (This section shall be construed and applied in a manner consistent with the requirements of Kansas Statutes Annotated 12-5040)**
Coverage under the Plan will terminate for you and any Dependents on the earliest of the following dates:

(1) The end of the month in which you attain age 65;

(2) The end of the month in which a required contribution has not been paid;

(3) The date the Plan terminates or no longer provides Retiree coverage;

(4) The date you or any eligible Dependent become eligible for Medicare. Coverage will terminate only for the Medicare eligible person;

(5) The date the Covered Person becomes covered, or becomes eligible to be covered, under another employer's group health plan.

(6) The end of the month in which a Dependent no longer satisfies the eligibility requirements as a Dependent under the terms of the Plan;

(7) The end of the month of a Retiree's death;

(8) The date you or your Dependent (or any person seeking coverage on behalf of you or your Dependent) performs an act, practice or omission that constitutes fraud;

(9) The date you or your Dependent (or any person seeking coverage on behalf of you or your Dependent) makes an intentional misrepresentation of a material fact.

**Retroactive Termination of Coverage**
Except in cases where you and/or your covered Dependents fail to pay any required contribution to the cost of coverage, the Plan will not retroactively terminate coverage under the Plan unless you and/or your covered Dependents (or a person seeking coverage on behalf of you and/or your covered Dependents) performs an act, practice or omission that constitutes fraud with respect to the Plan or unless the individual makes an intentional misrepresentation of material fact. In such cases, the Plan will provide at least 30 days advance written notice to you or your covered Dependent who is affected before coverage will be retroactively terminated. As provided above, coverage may be retroactively terminated in cases where required Employee contributions have not been paid by the applicable deadline. In those cases, no advance written notice is required.

**Continuation of Plan Coverage due to Disability**
Medical, Prescription Drug and dental coverage will be continued by your Employer for you and your Dependents in the event of your disability. Coverage will continue for the period of time you are receiving benefits under the Employer's short term disability plan and paying any required contributions.

Coverage under this provision will continue in accordance with the same terms and conditions of an active Employee. If a COBRA qualifying event occurs, any period of continued coverage under this section will not reduce the maximum time for which you may elect to continue coverage under COBRA. Please refer to the COBRA Continuation Coverage section of the Plan.

**Continuation of Plan Coverage due to Approved Leave of Absence**
Medical, Prescription Drug and dental coverage will be continued by your Employer for you and your Dependents in the event of an approved Leave of Absence. Coverage will continue as follows:

(1) In the event of an approved Leave of Absence, your coverage may continue for up to 60 days.

If your leave qualifies under the Family and Medical Leave Act (FMLA), any continuation of coverage provided under this provision will run concurrent with FMLA.

Coverage under this provision will continue in accordance with the same terms and conditions of an active Employee. If a COBRA qualifying event occurs, any period of continued coverage under this section will not reduce the maximum time for which you may elect to continue coverage under COBRA. Please refer to the COBRA Continuation Coverage section of the Plan.

**Continuation of Coverage under the Family and Medical Leave Act (FMLA)**
The Plan shall at all times comply with the Family and Medical Leave Act of 1993 (FMLA), as amended, and as promulgated in regulations issued by the Department of Labor.

During any leave taken under the FMLA, you may maintain coverage under the Plan on the same conditions as coverage would have been provided if you had been continuously employed during the leave period. Failure to

make required payments within 30 days of the due date established by your Employer may result in the termination of coverage for you and/or your eligible Dependents.

If you fail to return to work after the FMLA leave, the Employer may have the right to recover its contributions toward the cost of coverage during the FMLA leave.

If coverage under the Plan terminates during the FMLA leave, coverage will be reinstated for you and your covered Dependents if you return to work at the end of the FMLA leave.

**Continuation of Coverage under State Family and Medical Leave Laws**
To the extent this Plan is required to comply with a state family and medical leave law that is more generous than the FMLA, continuation of coverage under this Plan will be provided in accordance with such state family and medical leave law, as well as under FMLA.

**Continuation of Coverage under USERRA**
You may elect to continue Plan coverage under the Uniformed Services Employment and Reemployment Rights Act (USERRA) if you are absent from work due to military service in the Uniformed Services (as defined under USERRA). You may elect to continue coverage for yourself and any of your Dependents that were covered under the Plan at the time of your leave. Your eligible Dependents do not have an independent right to elect coverage under USERRA; therefore, unless you elect to continue coverage on their behalf, your eligible Dependents will not be permitted to continue coverage under USERRA separately.

To elect coverage under USERRA, you must submit your election to continue coverage under USERRA, on a form prescribed by the Plan Administrator to the Plan Administrator within 60 days after the date of your leave. Coverage under the Plan will become effective as of the date of your leave and will continue for the lesser of (a) 24 months (beginning on the date your absence begins); or (b) the period of time beginning on the date your absence begins and ending on the day after the date you return to employment with the Employer or fail to apply for or return to employment with the Employer within the time limit applicable under USERRA.

If your leave is 31 days or more, you will be required to pay up to 102% of the full contribution under the Plan. If your leave is 30 days or less, you will not be required to pay more than the amount (if any) you would have paid had you remained an active Employee of the Employer. Your Employer will notify you of the procedures for making payments under this Plan.

Continuation coverage provided under USERRA counts towards the maximum coverage period under COBRA continuation coverage.

An Employee returning from USERRA-covered military leave who participated in the Plan immediately before going on USERRA leave has the right to resume coverage under the Plan upon return from USERRA leave, as long as the Employee resumes employment within the time limit that applies under USERRA. No waiting period will apply to an Employee returning from USERRA leave (within the applicable time period) unless the waiting period would have applied to the Employee if the Employee had remained continuously employed during the period of military leave.

# ELIGIBLE MEDICAL EXPENSES

Eligible expenses shall be the charges actually made for services provided to the Covered Person and will be considered eligible only if the expenses are:

(1) Routine care or preventive services provided such services are ordered and performed by a Physician and not otherwise excluded under the Plan; or

(2) Due to Illness or Injury provided such services are ordered and performed by a Physician, Medically Necessary and not otherwise excluded under the Plan.

Reimbursement for eligible expenses will be made directly to the provider of the service, unless a receipt showing payment is submitted. All eligible expenses Incurred at a Participating Provider will be reimbursed to the provider.

(1) **Accident Benefit:** Benefits are payable for eligible medical expenses Incurred as a result of an Accidental Injury. Expenses must be Incurred within 90 days of the date of the Accident. Eligible expenses include charges Incurred upon the recommendation and approval of a duly qualified Physician and:

   (a) Medical or surgical treatment rendered or prescribed by a Physician;

   (b) Hospital room and board, services, and supplies; and

   (c) X-ray or laboratory examinations.

   Any expenses Incurred in excess of the maximum amount shall be payable according to the service rendered under the benefits otherwise provided by the Plan. Eligible expenses will be payable as shown in the Medical Schedule of Benefits.

(2) **Allergy Services:** Allergy testing, serum, and injections. Some allergy services may be payable under the Physician office visit benefit.

(3) **Ambulance Service:** Professional ambulance service to transport the Covered Person:

   (a) To the nearest Hospital equipped to treat the specific Illness or Injury in an emergency situation; or

   (b) To another Hospital in the area when the first Hospital did not have services required and/or facilities to treat the Covered Person; or

   (c) To and from a Hospital during a period of Hospital confinement to another facility for special services which are not available at the first Hospital; or

   (d) From the Hospital to the patient's home or to a Skilled Nursing Facility, Rehabilitation Facility, or any other type of convalescent facility nearest to the patient's home when there is documentation the patient required ambulance transportation.

   Professional ambulance charges for convenience are not covered.

   Eligible expenses will be payable as shown in the Medical Schedule of Benefits.

(4) **Ambulatory Surgical Center:** Services and supplies provided by an Ambulatory Surgical Center. Eligible expenses will be payable as shown in the Medical Schedule of Benefits.

(5) **Anesthetics:** Anesthetics and their professional administration.

(6) **Blood and Blood Derivatives:** Blood, blood plasma or blood components not donated or replaced.

(7) **Cardiac Rehabilitation:** Cardiac rehabilitation services which are rendered: (a) under the supervision of a Physician; and (b) in connection with a myocardial infarction, coronary occlusion or coronary bypass Surgery or any other medical condition if medically appropriate; and (c) initiated within 12 weeks after other treatment for the medical condition ends; and (d) in a medical care facility.

Expenses in connection with Phase III or Phase IV cardiac rehabilitation, including, but not limited to occupational therapy or work hardening programs will not be considered eligible. Phase III and Phase IV is defined as the general maintenance level of treatment, with no further medical improvements being made and exercise therapy that no longer requires the supervision of medical professionals.

(8) **Chemotherapy:** Services and supplies related to chemotherapy. Eligible expenses will be payable as shown in the Medical Schedule of Benefits.

(9) **Chiropractic Care/Spinal Manipulation:** Skeletal adjustments, manipulation, or other treatment in connection with the correction by manual or mechanical means of structural imbalance or subluxation in the human body, including x-rays. Eligible expenses will be payable as shown in the Medical Schedule of Benefits.

(10) **Circumcision:** Services and supplies related to circumcision. Circumcision performed while Hospital confined following birth will be considered as a newborn expense.

(11) **Cleft Palate and Cleft Lip:** Services and supplies related to cleft palate and cleft lip. Cleft palate is defined as a birth deformity in which the palate (the roof of the mouth) fails to close, and cleft lip is defined as a birth deformity in which the lip fails to close. Eligible expenses include the following when provided by a Physician, or other professional provider:

(a) Oral and facial Surgery, surgical management and follow-up care by plastic surgeons and oral surgeons.

(b) Medically Necessary speech/hearing therapy.

(c) Otolaryngology treatment.

(d) Audiological assessments and treatment.

(e) Orthodontic Treatment.

(f) Prosthodontic treatment.

(g) Prosthetic treatment such as obturators, speech appliances and feeding appliances.

(12) **Cochlear Implants:** Services and supplies related to cochlear implants when Medically Necessary, and the related maintenance and adjustments.

Benefits include post-cochlear implant aural therapy under the recommendation of a Physician.

(13) **Cognitive Therapy:** Restorative or rehabilitative cognitive therapy under the recommendation of a Physician.

(14) **Contraceptives:** Contraceptive procedures and medications other than those considered preventive services, including, but not limited to: orals, patches, injections, diaphragms, intrauterine devices (IUD), implants and any related office visit. Some contraceptives may be available under the Prescription Drug Card Program. The Plan does not cover contraceptive supplies or devices available without a Physician's prescription or contraceptives provided over-the-counter (unless the expense qualifies as a preventive service).

(15) **Cosmetic Procedures/Reconstructive Surgery:** Cosmetic procedures or Reconstructive Surgery will be considered eligible only under the following circumstances:

(a) For the correction of a Congenital Anomaly for a Dependent Child.

(b) Any other Medically Necessary Surgery related to an Illness or Injury.

(c) Charges for reconstructive breast Surgery following a mastectomy will be eligible as follows:

(i) Reconstruction of the breast on which the mastectomy has been performed;

(ii) Surgery and reconstruction of the other breast to produce symmetrical appearance;

(iii) Chest wall reconstruction with aesthetic flat closure; and

(iv) Coverage for prostheses and physical complications of all stages of mastectomy, including lymphedemas.

The manner in which breast reconstruction is performed will be determined in consultation with the attending Physician and the Covered Person.

(16) **Dental Care:** Dental services and x-rays rendered by Dentist or dental surgeon for:

(a) Excision of tumors and cysts of the jaws, cheeks, lips, tongue, roof, and floor of the mouth.

(b) Emergency repair due to Injury to sound natural teeth, including the emergency replacement of sound natural teeth.

(c) Surgery needed to correct Accidental Injuries to the jaws, cheeks, lips, tongue, floor, and roof of the mouth.

(d) Excision of benign bony growths of the jaw and hard palate.

(e) External incision and drainage of cellulitis.

(f) Incision of sensory sinuses, salivary glands, or ducts.

(g) Removal of impacted teeth.

General anesthesia and Hospital expenses are covered for eligible dental care services that would require the service be performed in a Hospital to monitor the patient due to a serious underlying medical condition, such as heart condition, blood disorder, etc.; or is necessary due to Accidental Injury to sound natural teeth; or your Physician has certified the service cannot be performed in the Dentist's office due to age or condition of the Covered Person.

(17) **Diabetic Education:** The following diabetic education and self-management programs: diabetes outpatient self-management training and education, including medical nutrition therapy that is provided by a certified, registered, or licensed healthcare professional working in a program consistent with the national standards of diabetes self-management education as established by the American Diabetes Association. Coverage is provided for individuals with diabetes.

(18) **Diabetic Supplies:** All Physician-prescribed medically appropriate and necessary equipment and supplies used in the management and treatment of diabetes that are not covered under the Prescription Drug Card Program.

(19) **Diagnostic Testing, X-ray, and Laboratory Services:** Diagnostic testing, x-ray and laboratory services, and services of a professional radiologist or pathologist. Dental x-rays are not eligible expenses, except as specified under Dental Care.

Eligible expenses will be payable as shown in the Medical Schedule of Benefits.

(20) **Dialysis:** Treatment of a kidney disorder by dialysis as an Inpatient in a Hospital or other facility or for expenses in an outpatient facility or in the Covered Person’s home, including the training of one attendant to perform kidney dialysis at home. The attendant may be a family member. When home care replaces Inpatient or outpatient dialysis treatments, the Plan will pay for rental of dialysis equipment and expendable medical supplies for use in the Covered Person’s home as shown under the Durable Medical Equipment benefit.

(21) **Durable Medical Equipment:** The rental of oxygen, wheelchairs, walkers, special Hospital beds, iron lungs and other Durable Medical Equipment subject to the following:

(a) The equipment must be prescribed by a Physician and Medically Necessary; and

(b) The equipment will be provided on a rental basis; however, such equipment may be purchased at the Plan's option. Any amount paid to rent the equipment will be applied towards the purchase price. In no case will the rental cost of Durable Medical Equipment exceed the purchase price of the item (oxygen equipment is not limited to the purchase price); and

(c) Benefits will be limited to standard models as determined by the Plan; and

(d) The Plan will pay benefits for only one of the following unless Medically Necessary due to growth of the Covered Person or if changes to the Covered Person's medical condition requires a different product, as determined by the Plan: a manual wheelchair, motorized wheelchair, or motorized scooter; and

(e) If the equipment is purchased, benefits will be payable for subsequent repairs, excluding batteries, necessary to restore the equipment to a serviceable condition. If such equipment cannot be restored to a serviceable condition, replacement will be considered eligible subject to prior approval by the Plan. In all cases, repairs, or replacement due to abuse or misuse, as determined by the Plan, are not covered; and

(f) Expenses for the rental or purchase of any type of air conditioner, air purifier or any other device or appliance will not be considered eligible.

Eligible expenses will be payable as shown in the Medical Schedule of Benefits.

(22) **Emergency Services/Emergency Room:** When you experience an Emergency Medical Condition, coverage for Emergency Services will continue until your condition is Stabilized and:

(a) Your attending Physician determines that you are medically able to travel or to be transported, by non-medical or non-emergency medical transportation, to another provider if you need more care; and

(b) You are in a condition to be able to receive from the Non-Participating Provider delivering services the notice and consent criteria with respect to the services; and

(c) Your Non-Participating Provider delivering the services meets the notice and consent criteria with respect to the services.

If you go to an emergency room for what is not an Emergency Medical Condition, the Plan may not cover your expenses. See the Medical Schedule of Benefits and the General Exclusions and Limitations for specific Plan details. If your Physician decides you need to stay in the Hospital (emergency admission) or receive follow-up care, these are not Emergency Services. Different benefits and requirements apply.

Eligible expenses will be payable as shown in the Medical Schedule of Benefits.

(23) **Gene Therapy:** Gene therapy products and services directly related to their administration when Medically Necessary. Gene therapy is a category of pharmaceutical products approved by the U.S. Food and Drug Administration (FDA) to treat or cure a disease by:

(a) Replacing a disease-causing gene with a healthy copy of the gene;

(b) Inactivating a disease-causing gene that may not be functioning properly; or

(c) Introducing a new or modified gene into the body to help treat a disease.

Each gene therapy product is specific to a particular disease and is administered in a specialized manner. The Plan determines which products are in the category of gene therapy, based in part on the nature of the treatment and how it is distributed and administered.

Coverage includes the cost of the gene therapy product; medical, surgical, professional and facility services directly related to administration of the gene therapy product.

(24) **Genetic Testing:** Diagnostic testing of Genetic Information and counseling when Medically Necessary. Genetic testing is covered in addition to and to the extent it is not otherwise included for coverage under the preventive services section of the Plan.

(25) **Habilitative Services:** Testing and Medically Necessary treatment of habilitative services, including habilitative occupational, physical and speech/hearing therapy when Medically Necessary or when required due to a developmental delay. Any habilitative services that meet the definition of a Mental Disorder or Substance Use Disorder are paid under the separate Mental Disorder and Substance Use Disorder benefits.

(26) **Hearing Aids:** Hearing aids (including the fitting thereof) and related supplies. For purposes of this Plan, cochlear implants are not considered a hearing aid and will be paid under the cochlear benefit. Eligible expenses will be payable as shown in the Medical Schedule of Benefits.

(27) **Home Health Care:** Services provided by a Home Health Care Agency to a Covered Person in the home. The following are considered eligible home health care services:

(a) Home nursing care;

(b) Services of a home health aide or licensed practical nurse (L.P.N.), under the supervision of a registered nurse (R. N.);

(c) Visits provided by a medical social worker (MSW);

(d) Physical, occupational, speech/hearing, or respiratory/pulmonary therapy if provided by the Home Health Care Agency;

(e) Medical supplies, drugs and medications prescribed by a Physician;

(f) Laboratory services; and

(g) Nutritional counseling by a licensed dietician.

For the purpose of determining the benefits for home health care available to a Covered Person, each visit by a member of a Home Health Care Agency shall be considered as one home health care visit and each 4 hours of home health aide services shall be considered as one home health care visit.

In no event will the services of a Close Relative, transportation services, housekeeping services and meals, etc., be considered an eligible expense.

Eligible expenses will be payable as shown in the Medical Schedule of Benefits.

(28) **Hospice Care:** Hospice care on either an Inpatient or outpatient basis for a terminally ill person rendered under a Hospice treatment plan. The Hospice treatment plan must certify that the person is terminally ill with a life expectancy of 6 months or less.

Covered services include:

(a) Room and board charges by the Hospice.

(b) Other Medically Necessary services and supplies.

(c) Nursing care by or under the supervision of a registered nurse (R.N.).

(d) Home health care services furnished in the patient's home by a Home Health Care Agency for the following:

(i) health aide services consisting primarily of caring for the patient (excluding housekeeping, meals, etc.); and

(ii) physical, occupational, speech/hearing, or respiratory/pulmonary therapy.

(e) Counseling services by a licensed social worker or a licensed pastoral counselor for the patient's immediate family.

(f) Nutritional counseling by a licensed dietician.

(g) Respite care.

(h) Bereavement counseling services by a licensed social worker or a licensed pastoral counselor for the patient's immediate family within 6 months after the patient's death. For the purposes of bereavement counseling, the term "Patient's Immediate Family" means the patient's spouse, parents of a Dependent Child and/or Dependent Children who are covered under the Plan.

Eligible expenses will be payable as shown in the Medical Schedule of Benefits.

(29) **Hospital Services or Long-Term Acute Care Facility/Hospital:**

(a) Inpatient

Room and board, including all regular daily services in a Hospital or Long-Term Acute Care Facility/Hospital. Care provided in an Intensive Care Unit (including cardiac care (CCU) and burn units).

Miscellaneous services and supplies, including any additional Medically Necessary nursing services furnished while being treated on an Inpatient basis.

(b) Outpatient

Services and supplies furnished while being treated on an outpatient basis.

Eligible expenses will be payable as shown in the Medical Schedule of Benefits.

(30) **Infertility:** Diagnosis and testing of infertility (the inability to conceive) and the correction of an underlying medical condition. All other treatment or procedures for the promotion of conception will not be considered eligible (e.g., in vitro fertilization, GIFT, artificial insemination, etc.).

(31) **Infusion Therapy:** Services, supplies, and equipment necessary for infusion therapy provided:

(a) By a free-standing facility;

(b) By an outpatient department of a Hospital;

(c) By a Physician in his/her office; or

(d) In your home.

Infusion therapy is the intravenous or continuous administration of medications or solutions that are a part of your course of treatment. Charges for the following outpatient infusion therapy services and supplies are Covered Expenses:

(a) The pharmaceutical when administered in connection with infusion therapy and any medical supplies, equipment and nursing services required to support the infusion therapy;

(b) Professional services;

(c) Total parenteral nutrition (TPN);

(d) Chemotherapy;

(e) Drug therapy (includes antibiotic and antivirals);

(f) Pain management (narcotics); and

(g) Hydration therapy (includes fluids, electrolytes, and other additives).

Infusion therapy provided by a Home Health Care Agency will not be subject to the Home Health Care maximum benefit.

Eligible expenses will be payable as shown in the Medical Schedule of Benefits.

(32) **Lenses:** Initial pair of eyeglasses, contact lenses or an intraocular lens following a Medically Necessary Surgical Procedure to the eye or for aphakic patients. Soft lenses or sclera shells intended for use as corneal bandages.

(33) **Maternity:** Expenses Incurred by all Covered Persons for:

(a) Pregnancy.

(b) Preventive prenatal and breastfeeding support as identified under the preventive services section below.

(c) Services provided by a Birthing Center.

(d) Amniocentesis testing when Medically Necessary.

(e) Up to 2 ultrasounds per pregnancy (more than 2 only when it is determined to be Medically Necessary).

(f) When not prohibited by state or local laws, elective induced abortions in the case of fetal abnormality, when the pregnancy is the result of documented rape or incest, or when carrying the fetus to full term would seriously endanger the life of the mother.

If complications arise after the performance of any abortion for any Covered Person, any expenses Incurred to treat those complications will be eligible, whether the abortion was eligible or not.

Hospital stays in connection with childbirth for either the mother or newborn may not be limited to less than 48 hours following a vaginal delivery or 96 hours following a cesarean section. These requirements can only be waived by the attending Physician in consultation with the mother. The Covered Person or provider is not required to precertify the maternity admission unless the stay extends past the applicable 48 or 96 hour stay. A Hospital stay begins at the time of delivery or for deliveries outside the Hospital, the time the newborn or mother is admitted to a Hospital following birth, in connection with childbirth.

If the mother is discharged earlier, the Plan will pay for one home visit after delivery by a health care provider.

If a newborn remains hospitalized beyond the time frames specified above, the confinement must be precertified or a penalty may be applied.

Eligible expenses will be payable as shown in the Medical Schedule of Benefits.

(34) **Medical and Surgical Supplies:** Crutches, ostomy supplies, prescribed compression garments, dressings and other Medically Necessary supplies ordered by a Physician.

(35) **Mental Disorders:** Care, supplies and treatment of a Mental Disorder including, but not limited to treatment for autism (including applied behavioral analysis) and family counseling. Eligible expenses will be payable as shown in the Medical Schedule of Benefits.

(36) **MinuteClinic:** Eligible virtual visits provided through MinuteClinic Virtual Care. Walk-in clinic health services provided at MinuteClinic for:

(a) Scheduled and unscheduled visits for minor Illnesses and Injuries;

(b) Routine vaccinations and immunizations administered with the scope of the clinic's license; and

(c) Screening and monitoring services.

Expenses for health examinations needed for employment, to go to a school, camp, or sporting event, or to join in a sport or other recreational activity will not be covered under the MinuteClinic benefit but may be payable under other provisions of the Plan.

Eligible expenses will be payable as shown in the Medical Schedule of Benefits.

(37) **Morbid Obesity:** Care and treatment of Morbid Obesity (including surgical treatment).

Non-Surgical: Non-surgical treatment of Morbid Obesity includes but is not limited to the following expenses:

(a) An initial medical history and physical exam;

(b) Physician office visits; and

(c) Diagnostic tests (i.e. lab services and other diagnostic testing).

Commercial weight loss programs such as Jenny Craig, Weight Watchers or other similar types of weight loss programs will not be considered eligible.

Surgical Treatment: Surgical treatment for Morbid Obesity will only be covered if all the following conditions are met:

(a) The Covered Person has either (1) a body mass index (BMI) of 40 or greater or (2) a BMI of 35 or greater in conjunction with a severe co-morbidity, such as obesity hypoventilation, sleep apnea, diabetes, hypertension, cardiomyopathy, or musculoskeletal dysfunction.

(b) The Covered Person has at least a 24-month history of Morbid Obesity as documented in such person's medical records.

(c) The Covered Person does not have an underlying diagnosed medical condition that would cause Morbid Obesity (e.g., an endocrine disorder) that can be corrected by means other than surgical treatment.

(d) The Covered Person has completed full growth (18 years old or supporting documentation of complete bone growth).

(e) The Covered Person has failed to achieve and maintain significant weight loss and such person has participated in a Physician-supervised nutrition and exercise program for at least 6 months (occurring within the 24-month period prior to the proposed surgical treatment) and such participation is documented in his or her medical records.

(f) The Covered Person must be evaluated by a licensed professional counselor, psychologist, or psychiatrist within 12 months prior to the proposed surgical treatment. The evaluation should document the following:

(i) that there is no significant psychological problem that would limit the ability of the Covered Person to understand the procedure and comply with any medical and/or surgical recommendations;

(ii) any psychological co-morbidities that may be contributing to the Covered Person's inability to lose weight or a diagnosed eating disorder; and

(iii) the Covered Person's willingness to comply with the preoperative and postoperative treatment plans.

The Plan does not cover Experimental and/or Investigational treatment of Morbid Obesity, including but not limited to:

(a) Loop gastric bypass;

(b) Gastroplasty, more commonly known as "stomach stapling" (not to be confused with vertical band gastroplasty); and

(c) Mini gastric bypass.

Eligible expenses will be payable as shown in the Medical Schedule of Benefits.

(38) **Nutritional Counseling:** Services related to nutritional counseling for medical and mental health conditions (e.g., eating disorders such as bulimia and anorexia, diabetes mellitus, gastro-intestinal disorders, chronic obstructive pulmonary disease), in which dietary adjustment has a therapeutic role, when furnished by a provider (e.g., licensed nutritionist, registered dietician, or other qualified licensed health professionals such as nurses who are trained in nutrition) recognized under the Plan. Medically Necessary nutritional counseling is covered in addition to and to the extent it is not otherwise included for coverage under the preventive services section of the Plan.

(39) **Nutritional Supplements:** Physician-prescribed nutritional supplements or other enteral supplementation necessary to sustain life for Covered Persons who are or will become malnourished or suffer from disorders, which left untreated will cause chronic disability or intellectual disability. Covered Expenses include rental or purchase of equipment used to administer nutritional supplements or other enteral supplementation, and special dietary treatment when prescribed by a Physician for Covered Persons with inherited metabolic diseases, such as phenylketonuria (PKU), branched-chain ketonuria, galactosemia and homocystinuria.

Over-the-counter nutritional supplements or infant formulas will not be considered eligible even if prescribed by a Physician.

(40) **Occupational Therapy:** Rehabilitative occupational therapy rendered by a qualified Physician or a licensed occupational therapist under the recommendation of a Physician. Expenses for Maintenance Therapy or therapy primarily for recreational or social interaction will not be considered eligible. Eligible expenses will be payable as shown in the Medical Schedule of Benefits.

(41) **Off-Label Drug Use:** Services and supplies related to Off-Label Drug Use (the use of a drug for a purpose other than that for which it was approved by the FDA) will be eligible for coverage when all of the following criteria have been satisfied:

(a) The named drug is not specifically excluded under the General Exclusions and Limitations section of the Plan; and

(b) The named drug has been approved by the FDA; and

(c) The Off-Label Drug Use is appropriate and generally accepted by the medical community for the condition being treated; and

(d) If the drug is used for the treatment of cancer, The American Hospital Formulary Service Drug Information or NCCN Drugs and Biologics Compendium recognize it as an appropriate treatment for that form of cancer.

(42) **Orthotics:** Splints, trusses, braces, and other medical orthotics ordered by a Physician. Benefits also include orthopedic shoes when an integral part of a leg brace.

The purchase, fitting and repair of custom-fitted foot orthotics will be eligible for coverage when determined to be Medically Necessary by the attending Physician.

(43) **Physical Therapy:** Physical therapy rendered by a qualified Physician or a licensed physical therapist under the recommendation of a Physician. This includes Medically Necessary aquatic therapy (hydrotherapy or pool therapy) for musculoskeletal conditions when provided by a physical therapist or other recognized, licensed provider. Eligible expenses include the professional charges for physical therapy modalities administered in a pool, which require direct one-on-one patient contact. Charges for aquatic exercise programs or separate charges for use of a pool are not covered. Maintenance Therapy will not be considered eligible. Eligible expenses will be payable as shown in the Medical Schedule of Benefits.

(44) **Physician's Services:** Services of a Physician for medical care or Surgery.

(a) Services performed in a Physician's office on the same day for the same or related diagnosis. Services include, but are not limited to: examinations, supplies, injections, x-ray, and laboratory tests (including the reading or processing of the tests), cast application and minor Surgery. If more than one Physician is seen in the same clinic on the same day, only one Copay will apply.

(b) For multiple or bilateral surgeries performed during the same operative session which are not incidental or not part of some other procedure and which add significant time or complexity (all as determined by the Plan) to the complete procedure, the charge considered will be: (i) 100% for the primary procedure; (ii) 50% for the secondary procedure, including any bilateral procedure; and (iii) 50% for each additional covered procedure. This applies to all Surgical Procedures, except as determined by the Plan.

(c) For surgical assistance by an Assistant Surgeon, the charge will be 25% of the corresponding Surgery.

Eligible expenses will be payable as shown in the Medical Schedule of Benefits.

(45) **Podiatry:** Treatment for the following foot conditions: (a) bunions when an open cutting operation is performed; (b) non-routine treatment of corns or calluses; (c) toenails when at least part of the nail root is removed or treatment of ingrown toenails; (d) any Medically Necessary Surgical Procedure required for a foot condition. For foot orthotics, refer to the Orthotics benefit.

(46) **Pre-Admission Testing:** Outpatient pre-admission testing performed prior to a scheduled Inpatient hospitalization or Surgery.

(47) **Prescription Drugs:** Prescription Drugs, injectables or supplies used for the treatment of a covered Illness or Injury, which are dispensed through the Physician's office, infusion center or other clinical setting, the Covered Person's home by a third party, or take-home Prescription Drugs from a Hospital are covered under the major medical benefits of this Plan and separate from the Prescription Drug Card Program benefits. Benefits will be paid the same as "All Other Eligible Expenses" listed in the Medical Schedule of Benefits.

Your Prescription Drug Card Program Administrator may have certain provisions regarding Specialty Drug coverage. In those cases, those drugs will only be payable under the major medical benefits if those drugs fall outside any specialty pharmacy network requirements, as applicable (as noted in the Prescription Drug Card Program section).

(48) **Preventive Services and Routine Care:** The following preventive services and routine care are paid as shown in the Medical Schedule of Benefits:

(a) Preventive Services

(i) Evidence-Based Preventive Services

Evidence-based items or services that have in effect a rating of "A" or "B" in the current recommendations of the United States Preventive Services Task Force (the "Task Force") with respect to the individual involved, except that with respect to breast cancer screening, mammography and prevention of breast cancer, the recommendations of the Task Force will be considered the current recommendations until further guidance is issued by the Task Force or the Health Resources and Services Administration.

(ii) Routine Vaccines

Immunizations that have in effect a recommendation from the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention with respect to the individual involved.

(iii) Prevention for Children

With Respect to infants, children and adolescents, evidence-informed preventive care and screenings provided for in the comprehensive guidelines supported by the Health Resources and Services Administration.

(iv) Prevention for Women

With respect to women, such additional preventive care, and screenings, not otherwise addressed by the Task Force, as provided for in current comprehensive guidelines supported by the Health Resources and Services Administration (or any applicable subsequent guidelines or guidance requiring any additional women's preventive services). Those guidelines generally include the following:

(A) Well-woman visits. Well-woman preventive care visits annually for adult women to obtain the recommended preventive services that are age and developmentally appropriate, including preconception and prenatal care. The inclusion of a well-woman visit is not meant to limit the coverage for any other preventive service described elsewhere in this Plan document that might be administered as part of the well-woman visit.

Coverage for prenatal care is limited to pregnancy-related Physician office visits including the initial and subsequent history and physical exams of the pregnant woman. In the event a provider bills a "maternity global rate", the portion of the claim that will be considered for prenatal visits and therefore, preventive care, is 40% of the "maternity global rate". As a result, 60% of the "maternity global rate" will be considered for delivery and postnatal care and the normal cost-sharing provisions would apply. Items not considered preventive (and therefore subject to normal cost-sharing provisions) include Inpatient admissions, high risk specialist units, ultrasounds, amniocentesis, fetal stress tests, delivery including anesthesia and certain pregnancy diagnostic lab tests.

(B) Screening for gestational diabetes.

(C) Human papillomavirus (HPV) testing. High-risk HPV DNA testing in women with normal cytology results. Screening is limited to women age 30 or older and is limited to 1 screening every 3 Plan Years.

(D) Counseling annually for sexually transmitted infections (including for the human immunodeficiency virus (HIV)) and screening annually for HIV for all sexually active women. Limited to 2 counseling sessions per Plan Year.

(E) Screening and counseling annually for interpersonal and domestic violence.

(F) Contraceptive methods and counseling, as prescribed by your Physician. All FDA approved contraceptive methods (see Preventive Drugs section below), sterilization procedures and patient education and counseling for women with reproductive capacity. Contraceptive counseling is limited to 2 visits per 12-month period.

For purposes of the above, the sterilization procedures to be considered preventive include any FDA approved sterilization implants and surgical sterilization either abdominally, vaginally, or laparoscopically. Complications arising following a sterilization procedure are not covered as preventive services.

(G) Breastfeeding support, supplies, and counseling in conjunction with each birth, including the following:

(1) Comprehensive lactation support and counseling by a trained provider during pregnancy and/or in the postnatal period (60 days from baby's date of birth). Lactation consultation is limited to 6 cumulative visits per 12-month period.

(2) Breastfeeding equipment will be covered, subject to the following:

(i) Rental of a Hospital grade electric pump while the baby is Hospital confined; and

(ii) Breastfeeding equipment and supplies including, but not limited to, double electric breast pumps (including pump parts and maintenance) and breast milk storage supplies if requested during pregnancy or during the duration of breastfeeding, provided the Covered Person remains continuously enrolled in the Plan.

(3) For women using a breast pump from a prior pregnancy, one new set of breast pump supplies will be covered at 100% with each subsequent pregnancy for initiation or continuation of breastfeeding.

For a detailed listing of women's preventive services, please visit the U.S. Department of Health and Human Services website at: https://www.hrsa.gov/womens-guidelines. For a paper copy, please contact the Plan Administrator. To the extent the above does not cover any preventive service required to be covered under the current guidelines published by the Health Resources and Services Administration (or any applicable subsequent guidelines or guidance requiring any additional women's preventive services), the above shall be deemed to be amended to cover such preventive services to the extent required by such guidelines.

(v) Preventive Drugs means items which have been identified by the U.S. Department of Health and Human Services (HHS) as a preventive service. You may view the guidelines established by HHS by visiting the following website:

https://www.healthcare.gov/what-are-my-preventive-care-benefits

For a list of Preventive Drugs, contact the Prescription Drug Card Program Administrator identified in the General Plan Information section of this Plan.

For a detailed listing of preventive services, please visit the U.S. Department of Health and Human Services website at: https://www.healthcare.gov/what-are-my-preventive-care-benefits. For a paper copy, please contact the Plan Administrator. To the extent the above does not cover any preventive service required to be covered by the U.S. Department of Health and Human Services (HHS) the above shall be deemed to be amended to cover such preventive service to the extent required by the HHS.

(b) Routine Care

Routine care including, but not limited to, the office visit, lab tests, x-rays, routine testing, vaccinations or immunizations (including flu vaccines), well child care, pap smears, breast cancer screenings, routine eye exams (including refraction) to age 19, colon exams and PSA testing. If a diagnosis is indicated after a routine exam, the exam will still be payable under the routine care benefit, however, all charges related to the diagnosis (except the initial exam) will be payable as any other Illness.

The above routine care items are covered in addition to and to the extent they are not otherwise included for coverage under the Preventive Services section of the Plan.

(49) **Prosthetics:** Artificial limbs, eyes, or other prosthetic devices when necessary due to an Illness or Injury. This benefit includes any necessary repairs to restore the prosthesis to a serviceable condition. If such prosthesis cannot be restored to a serviceable condition, replacement will be considered eligible, subject to prior approval by the Plan. In all cases, repairs, or replacement due to abuse or misuse, as determined by the Plan, are not covered.

(50) **Qualified Clinical Trial Expenses:** Please refer to the CancerCARE for Life Program section of the Plan for information related to Qualified Clinical Trial Expenses for cancer.

For all other Qualified Clinical Trials, eligible expenses are, except as excluded below, healthcare items and services for the treatment of cancer or any other life threatening condition for a qualifying individual enrolled in a Qualified Clinical Trial that are otherwise consistent with the terms of the Plan and would be covered if the Covered Person did not participate in the Qualified Clinical Trial.

For purposes of this section, a “life threatening condition” means any condition or disease from which the likelihood of death is probable unless the course of the disease or condition is interrupted; and a “qualifying individual” means any Covered Person who is eligible to participate in a Qualified Clinical Trial according to the trial protocol for treatment of cancer or any other life threatening condition that makes his or her participation in the program appropriate, as determined based on either (i) a conclusion of a referring health care professional or (ii) medical and scientific information provided by the Covered Person.

Notwithstanding the above, Qualified Clinical Trial expenses do not include any of the following:

(a) Costs associated with managing the research associated with the Qualified Clinical Trial; or

(b) Costs that would not be covered for non-Experimental and/or Investigational treatments; or

(c) Any item or service that is clearly inconsistent with widely accepted and established standards of care for a particular diagnosis.

(51) **Radiation Therapy:** Radium and radioactive isotope therapy treatment. Eligible expenses will be payable as shown in the Medical Schedule of Benefits.

(52) **Reconstructive Surgery:** See Cosmetic Procedures/Reconstructive Surgery.

(53) **Rehabilitation Facility:** Inpatient care in a Rehabilitation Facility provided such confinement: (a) is under the recommendation and general supervision of a Physician; (b) is for the purpose of receiving medical care necessary for convalescence from the conditions causing or contributing to the precedent Hospital or Skilled Nursing Facility confinement; and (c) is not for Custodial Care.

See the Skilled Nursing Facility benefit for services and supplies provided for confinements in a Skilled Nursing Facility.

Eligible expenses will be payable as shown in the Medical Schedule of Benefits.

(54) **Respiratory/Pulmonary Therapy:** Respiratory/pulmonary therapy under the recommendation of a Physician.

(55) **Routine Newborn Care:** Routine newborn care including Hospital nursery expenses and routine pediatric care while confined following birth will be considered as part of the newborn's expense.

If the newborn is ill, suffers an Injury or requires care other than routine care, benefits will be provided on the same basis as any other eligible expense.

(56) **Second Surgical Opinion:** Voluntary second surgical opinions for elective, non-emergency Surgery when recommended for a Covered Person.

Benefits for the second opinion will be payable only if the opinion is given by a specialist who: (a) is certified in the field related to the proposed Surgery; and (b) is not affiliated in any way with the Physician recommending the Surgery.

If the second opinion conflicts with the first opinion, the Covered Person may obtain a third opinion, although this is not required.

(57) **Skilled Nursing Facility:** Skilled nursing care in a Skilled Nursing Facility provided such confinement: (a) is under the recommendation and general supervision of a Physician; (b) is for the purpose of receiving medical care necessary for convalescence from the conditions causing or contributing to the precedent Hospital or Rehabilitation Facility confinement; and (c) is not for Custodial Care.

See the Rehabilitation Facility benefit for services and supplies provided for confinements in a Rehabilitation Facility.

Eligible expenses will be payable as shown in the Medical Schedule of Benefits.

(58) **Sleep Disorders:** Sleep disorder treatment and sleep studies that are Medically Necessary.

(59) **Speech/Hearing Therapy:** Restorative or rehabilitative speech or hearing therapy rendered by a qualified Physician or a licensed speech or hearing therapist under the recommendation of a Physician. Eligible expenses will be payable as shown in the Medical Schedule of Benefits.

(60) **Sterilization:** Elective sterilization procedures (this does not include reversal of sterilization). Elective sterilization procedures are covered in addition to and to the extent they are not otherwise included for coverage under the preventive services section of the Plan.

(61) **Substance Use Disorders:** Care, supplies, and treatment of a Substance Use Disorder, including smoking and tobacco cessation and family counseling. Eligible expenses will be payable as shown in the Medical Schedule of Benefits.

(62) **Teladoc Network Providers:** Teladoc provides 24/7/365 access to a national network of U.S. board-certified Physicians who can resolve many of your medical issues. Teladoc services involve the delivery of clinical medicine via real-time telecommunications such as telephone, the Internet, or other communication networks or devices that do not involve direct patient contact.

Coverage under this benefit does not include consults from your regular Physician; it only includes coverage for consults to the extent the Physician who is consulted participates in the Teladoc program. To learn more about Teladoc, see the Teladoc contact information under General Plan Information section of the Plan.

Teladoc benefits include:

- 24/7/365 access to a Physician online or by phone
- Fast treatment
- Talk to a Teladoc Physician from anywhere at home, work, or while traveling
- Save money by avoiding expensive urgent care or emergency room visits

Call Teladoc:

- When you need care now
- If you're considering the emergency room or urgent care center for non-emergency issues
- On vacation, on a business trip, or away from home
- For short-term prescription refills

Teladoc providers treat a broad range of clinical conditions. Covered services depend on the selection made by the Plan Administrator. Register for a Teladoc account at www.teladochealth.com to see the list of services available or call Teladoc at (800) 835-2362. For any questions with respect to Teladoc, please contact the Plan Administrator.

Eligible expenses will be payable as shown in the Medical Schedule of Benefits.

(63) **Telemedicine:** Services related to the delivery of clinical medicine via real-time telecommunications such as telephone, the Internet, or other communication networks or devices that do not involve direct patient contact by a covered provider. Eligible expenses will be payable as shown in the Medical Schedule of Benefits.

(64) **Temporomandibular Joint Dysfunction (TMJ):** Surgical and non-surgical treatment of Temporomandibular Joint Dysfunction (TMJ).

The treatment of jaw joint disorders (TMJ) includes conditions of structures linking the jawbone and skull and complex muscles, nerves and other tissues related to the temporomandibular joint. Treatment shall include but is not limited to: orthodontics; physical therapy; and any appliance that is attached to or rests on the teeth.

(65) **Transplants:**

**Solid Organ and Bone Marrow:** Services determined to be outside the benefit period as defined in the Certificate of Coverage under the Fully Insured Transplant Services Policy or transplants not covered by the Fully Insured Transplant Services Policy (e.g., cornea transplants) may be covered under the self-funded health plan, subject to all other plan provisions including Medical Necessity and Experimental and/or Investigational criteria.

Eligible services and supplies in connection with Medically Necessary non-Experimental and/or Investigational transplant procedures are covered subject to the following conditions:

(a) If both the donor and the recipient are covered under this Plan, eligible expenses Incurred by each person will be treated separately for each person.

(b) If the recipient is covered under this Plan and the donor is not covered, eligible expenses Incurred by the donor will be considered eligible if not covered by the donor's plan.

(c) If the donor is covered under this Plan and the recipient is not covered, eligible expenses Incurred by the donor will not be covered.

(d) The Usual and Customary fee of securing an organ from the designated live donor, a cadaver or tissue bank, including the surgeon's fees, anesthesiology, radiology, and pathology fees for the removal of the organ and a Hospital's charge for storage or transportation of the organ.

Eligible expenses will be payable as shown in the Medical Schedule of Benefits.

Exclusions:

(a) Non-human and artificial organ transplants.

(b) The purchase price of bone marrow, any organ, tissue, or any similar items which are sold rather than donated.

(c) Transplants which are not medically recognized and are Experimental and/or Investigational in nature.

(d) Lodging expenses, including meals.

(e) Expenses related to the Covered Person’s travel.

(66) **Urgent Care Clinic:** Services and supplies provided by an Urgent Care Clinic. Eligible expenses will be payable as shown in the Medical Schedule of Benefits.

(67) **Wigs:** Purchase of a scalp hair prosthesis when necessitated by hair loss due to the medical condition known as alopecia areata or as the result of hair loss due to chemotherapy or radiation. Eligible expenses will be payable as shown in the Medical Schedule of Benefits.

# VALENZ HEALTH

Valenz Health includes services and supplies rendered for certain outpatient surgical and non-surgical treatment for a medical condition. Expenses include a bundled cost for facility and professional charges, supplies and equipment Incurred at a Valenz Health-contracted facility. Selecting a Valenz Health provider for non-emergency procedures and services may result in a lower cost to the Plan as well as a lower cost to you. The choice of provider is entirely up to you.

You and your eligible Dependents may seek services through Valenz Health and receive care and treatment at no cost. If you are required to satisfy a Deductible amount, prior to receiving services through this Plan, you may be eligible for a cash incentive distributed through Valenz Health.

Expenses Incurred by a Valenz Health provider are considered eligible expenses when such services are Medically Necessary and not otherwise excluded under the Plan. Outpatient procedures and services available through Valenz Health include, but are not limited to:

- Colonoscopies
- Orthopedic Surgeries
- General Surgeries
- MRIs, CT, and PET Scans

Valenz Health advocates can provide details regarding medical procedures and services offered through the program. You may call (877) 438-5479 for more information.

Valenz Health does not offer:

- Pediatric services
- Travel and lodging reimbursement

# CANCERCARE FOR LIFE PROGRAM

The Plan provides benefit coverage for evidence-based cancer care services provided at local, regional, and national cancer programs. To be eligible for enhanced Plan benefits, all Covered Persons with a cancer diagnosis must as soon as reasonably possible call the CancerCARE for Life program at (877) 640-9610 or visit the CancerCARE for Life website at https://cancercareprogram.com and complete registration.

| CancerCARE for Life Benefits – POS Plan | |
|---|---|
| **Compliant Benefit – Participating Providers** | **Non-Compliant Benefit** |
| • Standard Plan Benefits apply as outlined within the Medical Schedule of Benefits<br>• Covered Persons choosing not to travel to a COE Network Provider for complex care, but receiving care in concordance to a Value Pathway<br>• Clinical Trials as defined below<br>• Covered Persons receiving cancer care when a Value Pathway does not exist if Clear Value Participation has been achieved with NCCN Guideline® concordance or Plan-approved deviation<br>• CancerCARE for Life Second Opinion Benefits at 100% of CancerCARE for Life Allowable, Deductible does not apply<br>• Travel Benefits at 100%, Deductible does not apply | • Standard Plan Benefits apply as outlined within the Medical Schedule of Benefits |

| CancerCARE for Life Benefits – HDHP Plan | |
|---|---|
| **Compliant Benefit – Participating Providers** | **Non-Compliant Benefit** |
| • Standard Plan Benefits apply as outlined within the Medical Schedule of Benefits<br>• Covered Persons choosing not to travel to a COE Network Provider for complex care, but receiving care in concordance to a Value Pathway<br>• Clinical Trials as defined below<br>• Covered Persons receiving cancer care when a Value Pathway does not exist if Clear Value Participation has been achieved with NCCN Guideline® concordance or Plan-approved deviation<br>• CancerCARE for Life Second Opinion Benefits at 100% of CancerCARE for Life Allowable, Deductible applies<br>• Travel Benefits at 100%, Deductible applies | • Standard Plan Benefits apply as outlined within the Medical Schedule of Benefits |

**Case Management Recommendation:** Should an alternate site of care be identified for a recommended treatment where there is no reduction in the quality of care and the cost is less than the current site, CancerCARE for Life must work with the patient and provider to transfer to the alternate site of care. In these instances, alternate providers will be reimbursed at the applicable benefit level currently in effect with the existing provider. If medical and pharmacy benefits are utilized to obtain medications otherwise provided in a provider's office, normal Copays or Coinsurance may be waived if savings to the Plan are realized and the Covered Person has paid any applicable Deductible. Genetic testing is a covered service when coordinated by a CancerCARE for Life Program Nurse.

**DEFINITIONS**

**CancerCARE for Life Program:** A comprehensive cancer management program operated by INTERLINK, which employs care coordinator nurses to monitor care and coordinate care at Cancer COE Providers for appropriate Covered Persons.

**CancerCOE Provider:** A cancer center, hospital or other institution, Physician or ancillary provider that has been designated by the CancerCARE for Life Program to provide complex cancer care services. CancerCOE Providers must have their designation as a National Cancer Institute (NCI) Cancer Center or NCCN® member institution and be a member of the Aetna Network.

**Clear Value Participation:** In order to determine courses of care, testing occurs, and the results of those tests (Clinical Facts) are used to determine any applicable Value Pathways. Clear Value Participation requires the provider to: (1) submit Clinical Facts to CancerCARE for Life when care is being planned; (2) consider Value Pathways as treatment options; and (3) confirm with CancerCARE for Life the optimal Value Pathway course of care will be utilized.

**COE Referral:** CancerCARE for Life provides benefits and support for all cancer diagnoses, but Covered Persons with a diagnosis or condition that is considered rare, aggressive, or complex will be evaluated for referral to a CancerCOE Provider. Such diagnoses or conditions are evaluated and determined by the CancerCARE for Life Medical Team in consultation with a Medical Advisory Board and other relevant medical literature. These diagnoses and conditions are reviewed and revised periodically, please contact CancerCARE for Life for details regarding what cancer diagnoses or conditions are currently considered rare, aggressive, or complex.

**Compliant Benefit Level:** A Covered Person status obtained when the Covered Person: (1) has completely registered into the CancerCARE for Life Program; (2) the treatment is deemed concordant to a Value Pathway; and (3) the provider's office has achieved Clear Value Participation. If all the above conditions have been met, and there is no Value Pathway available, treatment must be concordant with NCCN Guidelines®, or the care plan must be deemed consistent with evidence-based medicine by CancerCARE for Life. Covered Persons that are directed by CancerCARE for Life to receive care from a COE Network Provider shall be deemed Compliant. This status is reported by the CancerCARE for Life Triage Center to the Plan.

**Non-Compliant Benefit:** If the Covered Person does not comply with the requirements of the CancerCARE for Life Program, achieve a Compliant Benefit Level, or attend a Participating Provider, the Plan's standard benefits apply as outlined within the Medical Schedule of Benefits.

**Value Pathway:** Optimal course of treatment created by the input of patient specific clinical facts into the McKesson Clear Value Plus application which utilizes NCCN Guidelines®. Each Value Pathway has been based on efficacy, toxicity, and cost, providing value to the Covered Person and the Plan.

**ADDITIONAL PROVISIONS**

**Registration Requirement:** Upon diagnosis of cancer of any type, Covered Persons must register with the CancerCARE for Life Program at (877) 640-9610 or visit the CancerCARE for Life website at https://cancercareprogram.com. Failure to register with the CancerCARE for Life Program will prevent the Covered Person from receiving enhanced CancerCARE for Life benefits outlined within this section.

**COE Travel Benefits:** The Plan provides a maximum travel and lodging benefit up to $10,000 per Covered Person per lifetime. Travel benefits will only apply for Covered Persons with cancer diagnoses or conditions as described within the COE Referral provision that have been directed to a CancerCOE Provider by the CancerCARE for Life Program. The CancerCOE Provider location must be at least 50 miles from the Covered Person's home. Travel and lodging assistance shall be coordinated by the CancerCARE for Life Program. While receiving care at a CancerCOE Provider, the Plan will reimburse lodging, meals, and incidentals. The Plan covers travel costs (coach air, train, or mileage at Internal Revenue Service "IRS" Standard Mileage Rate for travel by car) for the Covered Persons plus one companion if the Covered Person is an adult (18 or older), or up to 2 companions if the Covered Person is less than 18. The benefit is subject to INTERLINK's CancerCARE for Life Program coordination and approval guidelines.

**CancerCARE for Life Second Opinion:** The Plan provides coverage for a CancerCARE for Life Second Opinion through utilization of the CancerCOE Providers, which may include a review of the diagnosis, review of the treatment plan or both. Second Opinions may require travel to a CancerCOE Provider to qualify for benefits. A Second Opinion may consist solely of having pathology slides reviewed by a specialized lab or may include other services.

**CancerCARE for Life High Risk Procedures:** In the event a Covered Person requires a cancer-related transplant, CAR-T, cancer-related gene therapy, or any other cancer-related high risk procedure, a CancerCARE for Life nurse may recommend the Covered Person's transfer care to an authorized treatment center and the COE Travel Benefits provision will apply to that Covered Person's travel/lodging.

**Clinical Trial Benefits:** The Plan provides Clinical Trial coverage for Routine Patient Costs consistent with the terms within this Summary Plan Description. Covered Persons will be able to access COE Travel Benefits for Clinical Trials, provided that the Clinical Trial: (1) is provided at a CancerCOE Provider; and (2) is approved and coordinated by a CancerCARE for Life nurse. Covered Persons are encouraged to contact CancerCARE for Life at (877) 640-9610 for further information on cancer-related clinical trial coverage.

**Questions:** If there are any questions regarding coverage or a specific provision of the CancerCARE for Life Program, please contact the Plan Administrator or the CancerCARE for Life Program at (877) 640-9610.

# ALTERNATE BENEFITS

In addition to the benefits specified, the Plan may elect to offer benefits for services furnished by any provider pursuant to a Plan-approved alternate treatment plan, in which case those charges Incurred for services provided to a Covered Person under an alternate treatment plan to its end, will be more cost effective than those charges to be Incurred for services to be provided under the current treatment plan to its end.

The Plan shall provide such alternate benefits at its sole discretion and only when and for so long as it determines that alternate treatment plan is Medically Necessary and cost effective. If the Plan elects to provide alternate treatment plan benefits for a Covered Person in one instance, it shall not be obligated to provide the same or similar benefits for such Covered Person in any other instance or for other Covered Persons under this Plan in any other instance, nor shall it be construed as a waiver of the Plan Administrator's rights to administer this Plan thereafter in strict accordance with its express terms.

# GENERAL EXCLUSIONS AND LIMITATIONS

No payment will be eligible under any portion of this Plan for expenses Incurred by a Covered Person for the expenses or circumstances listed below. If an expense is paid that is found to be excluded or limited as shown below, the Plan has the right to collect that amount from the payee, the Covered Person or from future benefits and any such payment does not waive the written exclusions, limitations, or other terms of the Plan.

(1) **Abortions:** Expenses related to elective abortions will not be considered eligible, except as specified under the Maternity benefit under Eligible Medical Expenses.

(2) **Acupuncture:** Expenses for acupuncture will not be considered eligible.

(3) **Administrative Services:** Expenses for completion of claim forms and shipping and handling will not be considered eligible.

(4) **Adoption:** Expenses related to adoption will not be considered eligible.

(5) **After Termination Date:** Expenses which are Incurred after the termination date of your coverage under the Plan will not be considered eligible.

(6) **Biofeedback:** Expenses related to biofeedback will not be considered eligible.

(7) **Cardiac Rehabilitation:** Expenses in connection with Phase III or Phase IV cardiac rehabilitation, including, but not limited to occupational therapy or work hardening programs will not be considered eligible. Phase III and Phase IV is defined as the general maintenance level of treatment, with no further medical improvements being made and exercise therapy that no longer requires the supervision of medical professionals.

(8) **Chelation Therapy:** Expenses for chelation therapy will not be considered eligible, unless due to heavy metal poisoning.

(9) **Close Relative:** Expenses for services, care or supplies provided by a person who normally resides in the Covered Person's home or by a Close Relative will not be considered eligible.

(10) **Complications:** Expenses for care, services or treatment required as a result of complications from a treatment or procedure not covered under the Plan will not be considered eligible. This exclusion does not apply to complications from abortions as specified under Eligible Medical Expenses.

(11) **Convenience Items:** Expenses for personal hygiene and convenience items will not be considered eligible.

(12) **Cosmetic Procedures:** Expenses for Cosmetic and reconstructive procedures will not be considered eligible, except as specified under Eligible Medical Expenses.

(13) **Counseling:** Expenses for religious, marital, or relationship counseling will not be considered eligible, except as specified under Eligible Medical Expenses.

(14) **Custodial Care:** Expenses for Custodial Care will not be considered eligible, except as specified under the Home Health Care and Hospice Care benefits.

(15) **Dental Care:** Expenses Incurred in connection with dental care, treatment, x-rays, implants, general anesthesia, or Hospital expenses will not be considered eligible, except as specified under Eligible Medical Expenses.

(16) **Exercise Programs:** Expenses for exercise programs for treatment of any condition will not be considered eligible, except for Physician-supervised cardiac rehabilitation and occupational or physical therapy covered by the Plan.

(17) **Experimental and/or Investigational:** Expenses for treatment, procedures, devices, drugs or medicines which are determined to be Experimental and/or Investigational, including any related complications will not be considered eligible, except for Off-Label Drug Use or when such expenses are considered Qualified Clinical Trial Expenses.

(18) **Foot Care:** Expenses for routine foot care, treatment of weak, unstable, or flat feet will not be considered eligible, unless for metabolic or peripheral vascular disease, including diabetes.

(19) **Gender Reassignment:** Expenses in connection with gender reassignment will not be considered eligible.

(20) **Governmental Agency:** Expenses for services and supplies which are provided by any governmental agency for which the Covered Person is not liable for payment will not be considered eligible. In the case of a state-sponsored medical assistance program, benefits payable under this Plan will be primary. Benefits payable under this Plan will also be primary for any Covered Person eligible under TRICARE (the government sponsored program for military dependents).

(21) **Hair Loss:** Expenses for hair loss, hair transplants, wigs or any drug that promises hair growth, whether or not prescribed by a Physician, will not be considered eligible, except as specified under Eligible Medical Expenses. This exclusion does not apply to the Medically Necessary treatment of alopecia areata.

(22) **Hearing Exams:** Expenses for routine hearing examinations will not be considered eligible. This exclusion does not apply to any expenses otherwise covered as a preventive service under the Eligible Medical Expenses section of the Plan.

(23) **Home Birth:** Expenses related to home births will not be considered eligible.

(24) **Homeopathic Treatment:** Expenses for naturopathic and homeopathic treatments, services and supplies will not be considered eligible.

(25) **Hypnotherapy:** Expenses for hypnotherapy will not be considered eligible.

(26) **Illegal Occupation/Felony:** Expenses for or in connection with an Injury or Illness arising out of an illegal occupation or commission of a felony will not be considered eligible. This exclusion will not apply to Injuries and/or Illnesses sustained due to a medical condition (physical or mental) or due to an act of domestic violence.

(27) **Infertility:** Expenses for confinement, treatment or services related to infertility (the inability to conceive) or the promotion of conception will not be considered eligible, except diagnosis and testing of infertility and the correction of an underlying medical condition as specified under Eligible Medical Expenses.

Nothing in this section is intended to exclude coverage for any infertility counseling or treatment required to be covered (if any) as a preventive service under the guidelines published by the Health Resources and Services Administration on August 1, 2011 (or any applicable subsequent guidelines).

(28) **Maintenance Therapy:** Expenses for Maintenance Therapy of any type when the individual has reached the maximum level of improvement will not be considered eligible.

(29) **Massage Therapy:** Expenses for massage therapy or Rolfing will not be considered eligible.

(30) **Medically Necessary:** Expenses which are determined not to be Medically Necessary will not be considered eligible.

(31) **Missed Appointments:** Expenses for missed appointments will not be considered eligible.

(32) **No Legal Obligation:** Expenses for services provided for which the Covered Person has no legal obligation to pay will not be considered eligible. This exclusion will not apply to eligible expenses that may be covered by state Medicaid coverage where federal law requires this Employer's Plan to be primary.

(33) **Non-Covered Procedures:** Expenses for services related to a non-covered Surgery or procedure will not be considered eligible regardless of when the Surgery or procedure was performed.

(34) **Not Performed Under the Direction of a Physician:** Expenses for services and supplies which are not prescribed or performed by or under the direction of a Physician will not be considered eligible.

(35) **Not Recommended by a Physician:** Expenses by a Hospital or covered residential treatment center if hospitalization is not recommended or approved by a legally qualified Physician will not be considered eligible.

(36) **Nutritional Supplements:** Expenses for nutritional supplements or other enteral supplementation will not be considered eligible, except as otherwise covered as a preventive service and as specified under the Eligible Medical Expenses section of the Plan. Over-the-counter nutritional supplements or infant formulas will not be considered eligible even if prescribed by a Physician.

(37) **Obesity:** Expenses for surgical and non-surgical care and treatment of obesity including weight loss, whether or not it is in any case a part of a treatment plan for another Illness, will not be considered eligible.

This exclusion does not apply to any services that are otherwise covered as preventive services as specified under the Eligible Medical Expenses section of the Plan.

(38) **Occupational Therapy:** Expenses for occupational therapy primarily for recreational or social interaction will not be considered eligible.

(39) **Operated by the Government:** Expenses for treatment at a facility owned or operated by the government will not be considered eligible unless the Covered Person is legally obligated to pay. This does not apply to Covered Expenses rendered by a Hospital owned or operated by the United States Veteran's Administration when services are provided to a Covered Person for a non-service related Illness or Injury.

(40) **Outside the United States (U.S.):** Expenses for services or supplies if the Covered Person leaves the U.S. or the U.S. Territories for the express purpose of receiving medical treatment will not be considered eligible.

(41) **Over-the-Counter (OTC) Medication:** Expenses for any over-the-counter medication will not be considered eligible. Expenses for drugs and medicines not requiring a prescription by a licensed Physician and not dispensed by a licensed pharmacist will not be considered eligible, except as otherwise covered as a preventive service under the Eligible Medical Expenses section of the Plan.

(42) **Plan Maximums:** Expenses for charges in excess of Plan maximums will not be considered eligible.

(43) **Prior to Effective Date:** Expenses which are Incurred prior to the effective date of your coverage under the Plan will not be considered eligible.

(44) **Private Duty Nursing:** Expenses for private duty nursing will not be considered eligible, except those nursing services which are considered eligible under the Home Health Care and Hospice Care benefits.

(45) **Radioactive Contamination:** Expenses Incurred as the result of radioactive contamination or the hazardous properties of nuclear material will not be considered eligible.

(46) **Recreational and Educational Therapy:** Expenses for recreational and educational services; learning disabilities; behavior modification services; vocational testing or training; any form of non-medical self-care or self-help training, including any related diagnostic testing; music therapy; health club memberships; will not be considered eligible. Diabetic education is considered eligible as specified under Eligible Medical Expenses. This exclusion will not apply to services that are considered Mental Disorders or Substance Use Disorders.

(47) **Refractive Errors:** Expenses for radial keratotomy, Lasik Surgery, or any Surgical Procedure to correct refractive errors of the eye will not be considered eligible.

(48) **Required by Law:** In any case where an individual is required by law to maintain insurance coverage (or to maintain any other security or reserve amount in lieu of insurance coverage), expenses of a Covered Person that would be paid by such insurance coverage are not eligible expenses, regardless of whether the individual is in fact covered under such coverage. For purposes of any required automobile, motorcycle or other vehicle coverage, otherwise eligible expenses below the minimum required coverage or the actual coverage elected, whichever is higher, will be excluded from coverage under this Plan.

(49) **Riot/Revolt:** Expenses resulting from a Covered Person's participation in a riot or revolt will not be considered eligible. This exclusion will not apply to Injuries and/or Illnesses sustained due to a medical condition (physical or mental) or domestic violence.

(50) **Services Not Permitted Under Applicable State or Local Laws:** Some state or local laws restrict the scope of health care services that a provider may render. In such cases, the Plan will not cover such health care services.

(51) **Sexual Dysfunction/Impotence:** Expenses for services, supplies or drugs related to sexual dysfunction/ impotence not related to organic disease will not be considered eligible except as specified under the Prescription Drug Card Program. Expenses for sex therapy will not be considered eligible.

(52) **Sleep Therapy:** Expenses for treatment, services and supplies for sleep therapy will not be considered eligible.

(53) **Stand-by Physician:** Expenses for technical medical assistance or stand-by Physician services will not be considered eligible.

(54) **Sterilization:** Expenses for the reversal of elective sterilization will not be considered eligible.

(55) **Surrogate:** Expenses relating to a surrogate pregnancy of any person who is not covered under this Plan for maternity benefits will not be considered eligible, including but not limited to pre-pregnancy, conception, prenatal, childbirth and postnatal expenses.

(56) **Transplants:** Expenses for benefits which are payable under the Certificate of Coverage under the Fully Insured Transplant Services Policy will not be considered eligible under the self-funded health plan, except as specified under the Medical Schedule of Benefits and Eligible Medical Expenses.

(57) **Travel:** Expenses for travel will not be considered eligible, except as specified under the CancerCARE for Life Program and under the Eligible Medical Expenses section of the Plan.

(58) **Usual and Customary Charge:** Expenses in excess of the Usual and Customary Charge will not be considered eligible.

(59) **Vision Care:** Expenses for vision care, including routine eye exams (age 19 and over), professional services for the fitting and/or supply of lenses, frames, contact lenses and other fabricated optical devices will not be considered eligible, except routine eye exams up to age 19 as specified under Eligible Medical Expenses. However, benefits will be provided for the necessary initial placement of a pair of eyeglasses, contact lenses or an intraocular lens following a Medically Necessary Surgical Procedure to the eye. This exclusion does not apply to aphakic patient and soft lenses or sclera shells intended for use as corneal bandages and as otherwise covered as a preventive service under the Eligible Medical Expense section of the Plan.

(60) **Wage or Profit:** Expenses for or in connection with any Injury or Illness which arises out of or in the course of any occupation for wage or profit (including self-employment) will not be considered eligible.

(61) **War:** Expenses for the treatment of Illness or Injury resulting from actively participating in a war or any act of war or terrorism, whether declared or undeclared, civil war, hostilities, or invasion, or while in the armed forces of any country or international organization will not be considered eligible.

(62) **Weekend Admissions:** Expenses for care and treatment billed by a Hospital for non-Emergency Medical Condition admissions on a Friday, Saturday or Sunday will not be considered eligible, unless Surgery is scheduled within 24 hours.

(63) **Workers' Compensation:** Expenses for or in connection with any Injury or Illness which arises out of or in the course of any occupation for which the Covered Person would be entitled to compensation under any Workers' Compensation Law or occupational disease law or similar legislation will not be considered eligible.

Expenses for Injuries or Illness which were eligible for payment under Workers' Compensation or similar law and have reached the maximum reimbursement paid under Workers' Compensation or similar law will not be eligible for payment under this Plan.

# PRESCRIPTION DRUG CARD PROGRAM

Eligible expenses include Prescription Drugs and medicines prescribed by a Physician or authorized prescriber and dispensed by a licensed pharmacist, which are deemed necessary for treatment of an Illness or Injury including but not limited to: insulin; hypodermic needles or syringes, but only when dispensed upon a written prescription of a licensed Physician; diabetic supplies; smoking/tobacco deterrents; sexual dysfunction/impotence medication; growth hormones; and contraceptives (regardless of intended use). See the Prescription Drug Schedule of Benefits for any cost-sharing provisions, if applicable.

When your prescription is filled at a retail pharmacy, the maximum amount or quantity of Prescription Drugs covered per Copay is a 90-day supply.

When using the mail order program, the maximum amount or quantity of Prescription Drugs covered per Copay is a 90-day supply.

Expenses for certain medications that are not covered under the Prescription Drug Card Program and are Medically Necessary for the treatment of a covered Illness or Injury will be payable under the medical benefits section of the Plan subject to any applicable major medical Deductibles and Coinsurance as well as any coverage limitations and exclusions applicable to the major medical component of the Plan. Please refer to the Eligible Medical Expenses and the General Limitations and Exclusions section of the Plan.

***NOTE: Coverage, limitations and exclusions for Prescription Drugs will be determined through the Prescription Drug Card Program elected by the Plan Sponsor and will not be subject to any limitations and exclusions under the major medical component of the Plan (except for certain medications that are not covered under the Prescription Drug Card Program). For a complete listing of Prescription Drugs available under the Prescription Drug Card Program, as well as any exclusions or limitations that may apply, please contact the Prescription Drug Card Program Administrator identified in the General Plan Information section of this Plan.***

**Dispense as Written**
The Plan requires pharmacies dispense Generic Drugs when available unless the Physician specifically prescribes a Preferred or Non-Preferred Drug and marks the script "Dispense as Written" (DAW). Should a Covered Person choose a Preferred or Non-Preferred Drug rather than the Generic equivalent when the Physician allowed a Generic Drug to be dispensed, the Covered Person will also be responsible for the cost difference between the Generic and Preferred or Non-Preferred Drug. The cost difference is considered a penalty and is not covered by the Plan and will not accumulate toward your Out-of-Pocket Maximum.

**Advanced Control Specialty Formulary**
Advanced Control Specialty Formulary (ACSF) is a moderately aggressive approach and presents specialty trend management. The formulary utilizes formulary exclusions, new-to-market (NTM) drug management and tiering strategies to help ensure clinically appropriate utilization and cost-effectiveness of specialty therapies.

**CVS True Accumulation Program**
Some Specialty Drugs may qualify for third-party copayment assistance programs that could lower your out of-pocket costs for those products. For any such Specialty Drug where third-party copayment assistance is used, the Covered Person shall not receive credit toward their maximum Out-of-Pocket or Deductible for any Copay or Coinsurance amounts that are applied to a manufacturer coupon or rebate.

**Payer Matrix Program**
Prescription Drug assistance through Payer Matrix is offered as part of your Plan’s Prescription Drug Card Program benefit. Payer Matrix advocates will help you pursue drug manufacturer assistance programs and/or patient assistance programs. With many of these programs, your responsibility toward your Prescription Drug Copay may be reduced. Coverage for certain Prescription Drugs is only available if Payer Matrix advocates are unable to obtain assistance programs for eligible Prescription Drugs. If your prescribed medication does not have an assistance program available and the Prescription Drug is deemed Medically Necessary, the standard Prescription Drug Copay will apply as shown in the Prescription Drug Schedule of Benefits. For a list of drugs subject to the Payer Matrix Program, please contact Payer Matrix at (877) 305-6202.

Prescription Drugs, designated by Payer Matrix, must be obtained directly through the Payer Matrix Program. Under this program, Specialty Drugs are not available at retail or mail order pharmacies and there are no grace fills provided to Covered Persons. If necessary, one fill of non-Specialty Drugs at a Participating Pharmacy may be covered under the Prescription Drug Card Program.

For additional information about the Payer Matrix Program and a list of eligible drugs, please call Payer Matrix at (877) 305-6202 or contact the Prescription Drug Card Program Administrator.

**Specialty Pharmacy Network**
Self-administered Specialty Drugs that do not require administration under the direct supervision of a Physician must be obtained from the specialty pharmacy network. For additional information, please contact the Prescription Drug Card Program Administrator.

Specialty Drugs that must be administered in a Physician's office, infusion center or other clinical setting, or the Covered Person's home by a third party, will be considered under the Medical Benefits section of the Plan. Those drugs that can be self-administered and do not require the direct supervision of a Physician are only eligible under the Prescription Drug Program.

**Rx Smart Savings Program**
The Rx Smart Savings Program works with the Plan, your Physician, and pharmacies to improve your quality of care and identify possible savings in your Prescription Drug coverage. From time to time, you may be contacted by a program representative who will speak with you about possible alternatives to your current prescribed drugs. The decision to switch to a different prescribed drug is up to you and your Physician.

**Step Therapy**

**What is Step Therapy?**
Certain Prescription Drug classes are subject to Step Therapy. Step Therapy is a type of prior authorization. In most cases, you must first try a less expensive drug on the formulary (also called a drug list) that has been proven effective for most people with your condition before you can move up a "step" to a more expensive drug. This might mean trying a similar, more affordable Brand Name Drug. The more affordable drugs in the first phase are known as "Step 1" Prescription Drugs. Please note the formulary may change at any time. You will receive notice when necessary.

However, if you have already tried the more affordable drug and it didn't work or if your Physician believes it is Medically Necessary for you to be on a more expensive drug, he or she can contact the Plan Administrator to request an exception. If your Physician's request is approved, the Plan will cover the more expensive drug. The more expensive drugs are known as "Step 2" Prescription Drugs.

Step Therapy is a program especially for people who take Prescription Drugs regularly for ongoing conditions like arthritis and high blood pressure.

In Step Therapy, drugs are grouped in categories based on cost:

- Front-line drugs - the first step - are Generic Drugs proven to be safe, effective, and affordable. These drugs should be tried first because they can provide the same health benefit as more expensive drugs, at a lower cost.

- Back-up drugs - Step 2 and Step 3 drugs - are Brand Name Drugs. There are lower-cost brand drugs (Step 2) and higher-cost brand drugs (Step 3). Back-up drugs typically cost more than front-line drugs.

**How does Step Therapy work?**
The next time the Physician writes a prescription, ask the Physician if a Generic Drug listed by the Plan as a front-line drug is appropriate. It makes good sense to ask for these drugs first because, for most everyone, they work as well as Brand Name Drugs - and they almost always cost less.

If the Covered Person already tried a front-line drug, or his or her Physician decides one of these drugs isn't appropriate, then the Covered Person's Physician can prescribe a back-up drug. The Covered Person should ask his or her Physician if one of the lower-cost Brand Name Drugs (Step 2 drugs) listed by the Plan is appropriate.

Remember, the Covered Person can always get a higher-cost Brand Name Drug at a higher Copay if the front-line or Step 2 back-up drugs are not appropriate.

If on January 1, 2027, the Covered Person is currently using a medication that requires Step Therapy he or she may continue using that medication. If the Covered Person is trying to fill a medication for the first time in 6 months, he or she may be required to use the first-line therapy before the Step Therapy medication can be filled. Please contact the Prescription Drug Card Program Administrator for more information on the Step Therapy program.

Failure to use the Step Therapy program may result in the Covered Person being responsible for the entire cost of the drug.

**Brand Name Drug**: Means a trade name medication.

**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.

**Non-Preferred Drug:** Any Brand Name Drugs that do not appear on the list of Preferred Drugs.

**Preferred Drug**: A list of Brand Name Drugs that has been developed by a Pharmacy and Therapeutics Committee comprised of Physicians, Pharmacists, and other health care professionals. The list of Brand Name Drugs is subject to periodic review and modification based on a variety of factors such as, but not limited to, Generic Drug availability, Food and Drug Administration (FDA) changes, and clinical information. The Prescription Drug Card Program Administrator will have a list of Preferred Drugs available.

**Prescription Drug**: Any of the following: (a) 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”; (b) injectable insulin; or (c) 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.

**Preventive Drug** means items which have been identified by the U.S. Department of Health and Human Services (HHS) as a preventive service. You may view the guidelines established by HHS by visiting the following website:

https://www.healthcare.gov/what-are-my-preventive-care-benefits

For a list of Preventive Drugs, contact the Prescription Drug Card Program Administrator identified in the General Plan Information section of this Plan.

**Specialty Drug** means those Prescription Drugs, medicines, agents, substances, and other therapeutic products that include one or more of the following particular characteristics:

(1) Address complex, chronic diseases with many associated co-morbidities (e.g., cancer, rheumatoid arthritis, hemophilia, multiple sclerosis);

(2) Require a greater amount of pharmaceutical oversight and clinical monitoring for side effect management and to limit waste;

(3) Limited pharmaceutical supply chain distribution as determined by the applicable drug’s manufacturer; and/or

(4) Relative expense.

# DENTAL EXPENSES

If a Covered Person incurs expenses for a service on the list of "Eligible Dental Expenses," such charges are covered to the extent that they meet all of the following conditions:

(1) Constitute Dentally Necessary treatment.

(2) Are Incurred while covered under this Plan.

(3) Are Usual and Customary Charges for Non-Participating Providers.

The Plan will pay for such eligible expenses as shown in the Dental Schedule of Benefits.

Reimbursement for eligible expenses will be made directly to the provider of the service, unless a receipt showing payment is submitted.

**Deductible**
A Deductible is the total amount of eligible expenses as shown in the Dental Schedule of Benefits, which must be Incurred by you during any Plan Year before Covered Expenses are payable under the Plan.

**Date Expenses are Incurred**
An expense is Incurred when the service is performed, except that it is deemed to be Incurred:

(1) When the impression is taken in the case of dentures or fixed bridgework;

(2) When the pulp chamber is opened in the case of root canal therapy.

**Pre-Determination of Benefits**
When the total cost of eligible dental expenses is expected to exceed the Pre-Determination Limit as shown in the Dental Schedule of Benefits, the Dentist's treatment plan should be sent to the Third Party Administrator before the first date of treatment. Based on the treatment plan, the Third Party Administrator will estimate the amount of the benefit available if treatment is performed and inform the Dentist of the determination. The treatment plan should:

(1) Show the Dentist's proposed course of treatment;

(2) Show the total charge for the treatment;

(3) Include x-rays, study models and any other data requested by the Third Party Administrator; and

(4) Show how long the treatment will take.

Pre-determination is not necessary when eligible dental expenses are Incurred for emergency dental care or Accidental dental Injuries.

Pre-treatment review is not a guarantee of the benefits that will be payable. It tells the Covered Person and the Dentist, in advance, what is payable for the eligible dental services named in the treatment plan. But payment is conditioned on:

(1) The work being done as proposed and while the Covered Person is covered under this Plan; and

(2) The Deductible and payment limit provisions listed in the Dental Schedule of Benefits and all of the other terms of this Plan.

**Alternative Treatment**
The Plan has an "alternative treatment" clause that limits the Plan's payment to the most cost effective treatment of a dental condition that provides a professionally acceptable result as determined by national standards of dental practice. If a Covered Person chooses a more expensive treatment according to accepted standards of dental practice to correct a dental condition, the Plan's payment will be based on the treatment that provides professionally satisfactory results at the most cost-effective level.

**Eligible Dental Expenses**

**Class A-Preventive Services:**
(1) Routine oral exams and prophylaxis. This includes the cleaning, scaling and polishing of teeth. Limit of 2 exams per Covered Person each Plan Year.

(2) Dental imaging services required to treat or diagnose diseases or abnormalities of the teeth, surrounding tissue, and cavity detection, including those provided in association with a covered dental implant limited as follows:

(a) Bitewing x-ray series limited to once every 6 months.

(b) One full-mouth or panoramic x-ray limited to once in every 3 Plan Year periods.

(c) All other dental imaging services as Dentally Necessary.

(3) Sealants for Dependent Children once every 3 years for permanent first and second molars. Recall visits for checking sealant application are not covered.

(4) Topical application of fluoride for Dependent Children under age 17 each Plan Year.

(5) Space maintainers for covered Dependent Children under age 14 to replace primary teeth. No payment will be made for duplicate space maintainers.

(6) Emergency palliative treatment for pain.

(7) Fixed and removable appliances to inhibit thumb sucking and other harmful habits for Dependent Children under age 16 and limited to appliance only - allowance includes all adjustments in the first 6 months after installation.

**Class B-Basic Services:**
(1) Extractions. This includes local anesthesia and routine post-operative care.

(2) Silver (amalgam), silicate, acrylic, synthetic, resin, porcelain and composite filling to restore diseased or accidentally broken teeth. Gold foil restorations are not eligible.

(3) General and local anesthetics, upon demonstration of Medical Necessity.

(4) Diagnostic casts, laboratory tests and other diagnostic exams.

(5) Biopsy and examination of oral tissue.

(6) Antibiotic drugs administered in an office setting.

(7) Problem-focused exams.

(8) Re-cementing bridges, crowns or inlays.

(9) Oral surgery, limited to removal of teeth, preparation of the mouth for dentures and removal of tooth-generated cysts of less than ¼ inch.

**Class C-Major Services:**

(1) Gold restorations, including inlays, onlays, and foil fillings. The cost of gold restorations in excess of the cost for amalgam, synthetic porcelain or plastic materials will be included only when the teeth must be restored with gold.

(2) Endodontic Treatment including root canal work.

(3) Periodontics (gum treatment)

(4) Repair of crowns, bridgework and removable dentures.

(5) Installation of crowns.

(6) Installing precision attachments for removable dentures.

(7) Installing partial, full or removable dentures to replace one or more natural teeth. This service also includes all adjustments made during a 6-month period following the installation.

(8) Addition of clasp or rest to existing partial removable dentures.

(9) Initial installation of fixed bridgework to replace one or more natural teeth.

(10) Rebasing or relining of removable dentures.

(11) Replacing an existing full or partial removable denture, new bridgework, or the addition of teeth to an existing full or partial removable denture or bridgework. However, only replacement and additions that meet the "Prosthesis Replacement Rule" below will be covered.

**Prosthesis Replacement Rule**

This rule requires that satisfactory evidence be furnished to show that one of the following criteria applies:

(1) The replacement or addition of teeth is required to replace teeth that were extracted after the existing denture was installed and while the individual was covered under the Plan;

(2) The existing denture cannot be made serviceable and was installed at least 5 years prior to its replacement; or

(3) The existing denture is an immediate temporary denture which cannot be made permanent and replacement by a permanent denture is required and takes place within 12 months from the date of the initial installation of the immediate temporary denture.

# DENTAL EXCLUSIONS AND LIMITATIONS

In addition to the General Exclusions and Limitations section of this Plan, no payment will be eligible under any portion of this Plan for Dental Expenses Incurred by a Covered Person for the expenses or circumstances listed below. If an expense is paid that is found to be excluded or limited as shown below, the Plan has the right to collect that amount from the payee, the Covered Person or from future benefits and any such payment does not waive the written exclusions, limitations, or other terms of the Plan.

(1) **Alternative Treatment:** If a Covered Person chooses a more expensive treatment according to accepted standards of dental practice to correct a dental condition, the Plan's payment will be based on the treatment which provides professionally satisfactory results at the most cost-effective level.

(2) **American Dental Association:** Expenses that do not meet the standards of dental practices accepted by the American Dental Association will not be considered eligible.

(3) **Athletic Mouth Guards:** Expenses for athletic mouth guards will not be considered eligible.

(4) **Bite Registration:** Expenses for bite registration, equilibration, or occlusal analysis will not be considered eligible.

(5) **Bone Grafts:** Expenses for bone grafts for alveolar ridge augmentation will not be considered eligible.

(6) **Chemotherapeutic Agent:** Expenses for chemotherapeutic agent(s) inserted into a periodontal pocket will not be considered eligible.

(7) **Cosmetic:** Expenses for services or supplies partially or wholly Cosmetic in nature will not be considered eligible.

(8) **Duplicate Devices:** Expenses for duplicate prosthetic devices or appliances; expenses for a lost or stolen dental appliance; will not be considered eligible.

(9) **Harmful Habit Appliances:** Expenses for Harmful Habit appliances will not be considered eligible, except as specified in Eligible Dental Expenses.

(10) **Home Sealant Kits:** Expenses for home sealant kits will not be considered eligible.

(11) **Hospital Expenses:** Expenses for Hospital expenses will not be considered eligible.

(12) **Implants:** Expenses for implants, including any appliances and/or crowns and the surgical insertion or removal of implants will not be considered eligible.

(13) **Installation or Replacement:** Expenses for installation, replacement, or alteration of or addition to, dentures and fixed bridgework will not be considered eligible, except as shown in Eligible Dental Expenses.

(14) **Medical Plan:** Expenses covered under the medical portion of the Plan will not be considered eligible.

(15) **Missed Appointments:** Expenses for missed appointments will not be considered eligible.

(16) **Not Performed By a Dentist:** Expenses for treatment by other than a Dentist or Physician will not be considered eligible, except charges for treatment performed under the supervision and direction of a Dentist or Physician by any person duly licensed or certified to perform such treatment under applicable professional statutes and regulations.

(17) **Not Prescribed by a Dentist:** Expenses for services not prescribed as necessary by a Physician or Dentist will not be considered eligible.

(18) **Occlusion:** Expenses for restorations or procedures to splint, change vertical dimension or restore occlusion will not be considered eligible, except as shown in Eligible Dental Expenses.

(19) **Oral Hygiene:** Expenses for oral hygiene, dietary or plaque control programs or other educational programs will not be considered eligible.

(20) **Orthodontic Treatment:** Expenses for Orthodontic Treatment and appliances will not be considered eligible.

(21) **Orthognathic Surgery:** Expenses for Surgery to correct malposition in the bones of the jaw will not be considered eligible.

(22) **Personalization:** Expenses for personalization of dentures will not be considered eligible.

(23) **Replacement:** Expenses for replacement of lost or stolen appliances will not be considered eligible.

(24) **Take Home Items:** Expenses for take home items will not be considered eligible.

(25) **Temporary:** Expenses for temporary dental service will be considered an integral part of the final dental service rather than a separate service.

(26) **Temporary Prosthesis:** Expenses for a temporary full prosthesis or for adjustment or relining of a prosthesis within 6 months after the prosthesis is initially furnished will not be considered eligible.

(27) **Temporomandibular Joint Dysfunction (TMJ):** Expenses for appliances or restorations in connection with Temporomandibular Joint Dysfunction (TMJ) or myofunctional therapy will not be considered eligible.

(28) **Usual and Customary Charges:** Expenses in excess of the Usual and Customary Charge will not be considered eligible.

(29) **Veneers:** Expenses for Cosmetic veneers will not be considered eligible.

**Integration with Medical Benefits**
In the event benefits are available for the same expenses under both a medical plan offered by the Employer and the dental provisions of this Plan, such charges will first be considered for payment as a medical expense. The charges will be considered under the dental expenses only if the amount normally paid under the dental expenses exceeds the amount paid under the medical expenses and only up to the excess amount.

# COBRA CONTINUATION COVERAGE

The right to COBRA Continuation Coverage was created by a federal law known as the Consolidated Omnibus Budget Reconciliation Act of 1985, as amended ("COBRA"). COBRA Continuation Coverage can become available to you and/or your eligible Dependents when your coverage under the Plan ends because of a life event known as a "qualifying event".

**Qualified Beneficiary**
In general, you, your Spouse and any Dependent Child covered under the Plan on the day before a qualifying event that causes you to lose coverage under the Plan is considered a "qualified beneficiary".

In addition, any Dependent Child who is born to or placed for adoption with you during a period of COBRA continuation coverage is considered a "qualified beneficiary".

If the qualifying event is a bankruptcy proceeding under Title 11 of the U.S. Code with respect to the Employer, a covered Retiree and his or her covered Spouse, surviving Spouse or Dependent Child of such Retiree will also be considered qualified beneficiaries provided the bankruptcy results in the loss of their coverage under the Plan.

Each qualified beneficiary (including a child who is born to or placed for adoption with a covered Employee during a period of COBRA continuation coverage) is offered the opportunity to make an independent election to receive COBRA continuation coverage.

**Qualifying Event**
If you are a covered Employee, you, your Spouse and/or Dependent Child will become a qualified beneficiary if you lose your coverage under the Plan because of either one of the following qualifying events:

(1) Your hours of employment are reduced; or

(2) Your employment ends for any reason other than your gross misconduct.

You, your Spouse and/or Dependent Child may elect to continue coverage under the Plan for up to a maximum period of 18 months provided you elect to enroll in COBRA within 60 days following the later of (a) the date coverage under the Plan would end due to the qualifying event; or (b) the date you are given notice of your rights to elect COBRA Continuation Coverage.

You, your Spouse and Dependent Child have an independent right to elect COBRA Continuation Coverage. You and/or your Spouse may elect coverage on behalf of either one of you and parents may elect coverage on behalf of their Dependent Child.

If you are the Spouse and/or Dependent Child of a covered Employee, you will also become a qualified beneficiary if you lose your coverage under the Plan because of any of the following qualifying events:

(1) Your spouse/parent-Employee dies;

(2) Your spouse/parent-Employee becomes entitled to Medicare benefits (under Part A, Part B, or both); or

(3) You/your parents become divorced or legally separated.

Your Spouse and/or Dependent Child may elect to continue coverage under the Plan for up to a maximum period of 36 months provided such Spouse and/or Dependent Child provide notice of the qualifying event to the Employer and elect to enroll in COBRA within 60 days following the later of (a) the date coverage under the Plan would end due to the qualifying event; or (b) the date they are given notice of their rights to elect COBRA Continuation Coverage and their obligation to provide such notice. Please see the section below entitled "Notice Requirement" for the requirements of such notice.

If you are a Dependent Child of a covered Employee, you will also become a qualified beneficiary if you lose coverage under the Plan because you cease to be eligible for coverage under the Plan as a Dependent Child. You may elect to continue coverage under the Plan for up to a maximum period of 36 months provided you provide

notice of the qualifying event to the Employer and elect to enroll in COBRA within 60 days following the later of; (a) the date coverage under the Plan would end due to the qualifying event; or (b) the date you are given notice of your rights to elect COBRA Continuation Coverage and your obligation to provide such notice. Please see the section below entitled "Notice Requirement" for the requirements of such notice.

**Extension of 18-Month Continuation Coverage Period**
If you, your Spouse or Dependent Child is determined to be disabled by the Social Security Act (SSA); you and all other qualified beneficiaries may be entitled to receive up to an additional 11 months of COBRA continuation coverage, for a total maximum of 29 months. The disability would have to have started at some time before the 61st day of COBRA continuation coverage and must last at least until the end of the 18-month period of COBRA continuation coverage. To qualify for this extension in coverage, notification must be given to your Employer on a date that is both within 60 days after the later of (a) the date of the SSA determination; (b) the date coverage under the Plan would end due to the qualifying event; or (c) the date you are given notice of your obligation to provide such notice and before the end of the initial 18-month period of coverage. If you are later determined not disabled by SSA, you must notify your Employer within 30 days following the later of (a) the date of the SSA determination; or (b) the date you are given notice of your obligation to provide such notice. Please see the section below entitled "Notice Requirement" for the requirements of such notice.

If your family experiences another qualifying event while receiving 18 months of COBRA continuation coverage, your Spouse and any Dependent Child in your family may be entitled to receive up to 18 additional months of COBRA continuation coverage, for a maximum of 36 months. To qualify for this extension in coverage, notification must be given to your Employer within 60 days after the later of (a) the date coverage under the Plan would end due to the qualifying event or (b) the date you are given notice of your obligation to provide such notice. Please see the section below entitled "Notice Requirement" for the requirements of such notice.

**Notice Requirement**
The notice must be postmarked (if mailed) or received by the COBRA Administrator (if hand delivered), by the deadline set forth above. If the notice is late, the opportunity to elect or extend COBRA continuation coverage is lost and if you are electing COBRA continuation coverage, your coverage under the Plan will terminate on the last date for which you are eligible under the terms of the Plan or if you are eligible for an extension of COBRA continuation coverage, such coverage will end on the last day of the initial 18-month COBRA continuation coverage period.

For qualifying events such as divorce or legal separation of the Employee and Spouse or a Dependent Child's loss of eligibility under the Plan, the notice must contain the following information:

(1) Name and address of the covered Employee or former Employee;

(2) Name and address of your Spouse, former Spouse, and any Dependent Children;

(3) Description of the qualifying event; and

(4) Date of the qualifying event.

In addition to the information above, if you, your Spouse, or any Dependent Child is determined by SSA to be disabled within 60 days after your COBRA continuation coverage begins, the notice must also contain the following information:

(1) Name of person deemed disabled;

(2) Date of disability determination; and

(3) Copy of SSA determination letter.

If you cannot provide a copy of the SSA's determination by the deadline, complete and provide the notice as instructed and submit the copy of the decree of divorce or the SSA's determination within 30 days after the deadline. The notice will be timely if you do so. However, no COBRA continuation coverage or extension of such coverage will be available until the copy of the SSA's determination is provided.

If the notice does not contain all of the required information, the COBRA Administrator may request additional information. If the individual fails to provide such information within the time period specified in the request, the notice may be rejected.

In addition to accepting a letter with the information described above, the Plan Administrator, in its discretion, may develop and make available a form, which may then be completed to provide the required notice. If such a form is available, a covered Employee or a covered Spouse may obtain a copy by requesting it from the Plan Administrator at the address provided in this notice.

Contact the COBRA Administrator below on how to submit notices:

Meritain Health, Inc.
ATTN: COBRA Department
P.O. Box 860093
Minneapolis, MN 55486-0093
Fax: (716) 319-5736
www.meritain.com

**Termination of COBRA Continuation Coverage**
COBRA continuation coverage automatically ends 18, 29 or 36 months (whichever is applicable) after the date of the qualifying event; however, coverage may end before the end of the maximum period on the earliest of the following events:

(1) The date the Plan Sponsor ceases to provide any group health plan coverage;

(2) The date on which the qualified beneficiary fails to pay the required contribution;

(3) The date that the qualified beneficiary first becomes, after the date of election, covered under any other group health plan (as an Employee or otherwise) or entitled to either Medicare Part A or Part B (whichever comes first); or

(4) The first day of the month that begins more than 30 days after the date of the SSA's determination that the qualified beneficiary is no longer disabled, but in no event before the end of the maximum coverage period that applied without taking into consideration the disability extension.

**Payment for COBRA Continuation Coverage**
Once COBRA continuation coverage is elected, you must pay for the cost of the initial period of coverage within 45 days. Payments then are due on the first day of each month to continue coverage for that month. If a payment is not received within 30 days of the due date, COBRA continuation coverage will be canceled and will not be reinstated. The amount you are required to pay for COBRA continuation coverage is 102% of the actual cost of coverage you elect unless you qualify for the 11-month period of extended coverage due to disability (as specified above). In the event of disability, you may be required to pay up to 150% of the actual cost of coverage you elect for the 11-month extension period.

**Additional Information**
Additional information about the Plan and COBRA continuation coverage is available from the Plan Administrator, who is identified on the General Plan Information page of this Plan.

**Current Addresses**
In order to protect your family's rights, you should keep the Plan Administrator informed of any changes in the addresses of family members.

# CLAIM PROCEDURES

You will receive an Employee identification card which will contain important information, including claim filing directions and contact information.

At the time you receive treatment, show the Employee identification card to your provider of service. In most cases, your provider will file your claim for you. You may file the claim yourself by submitting the required information to:

Meritain Health, Inc.
P.O. Box 853921
Richardson, TX 75085-3921
(800) 925-2272

Most claims under the Plan will be “post service claims.” A “post service claim” is a claim for a benefit under the Plan after the services have been rendered. Post service claims must include the following information in order to be considered filed with the Plan:

(1) The date of service;

(2) The name, address, telephone number and tax identification number of the provider of the services or supplies;

(3) The place where the services were rendered;

(4) The diagnosis and procedure codes;

(5) The amount of charges (including Network repricing information);

(6) The name of the Plan;

(7) The name of the covered Employee; and

(8) The name of the patient.

A call from a provider who wants to know if an individual is covered under the Plan or if a certain procedure or treatment is a Covered Expense before the treatment is rendered, is not a “claim” since an actual written claim for benefits is not being filed with the Plan. Likewise, presentation of a prescription to a pharmacy does not constitute a claim.

**Timely Filing**
All claims must be filed with the Third Party Administrator within 12 months following the date services were Incurred. Claims filed after this time period will be denied.

**Procedures for all Claims**
The Plan's claim procedures are intended to reflect the Department of Labor's claims procedures regulations and should be interpreted accordingly. In the event of any conflict between this Plan and those Regulations, those Regulations will control. In addition, any changes in those Regulations shall be deemed to amend this Plan automatically, effective as of the date of those changes.

To receive benefits under the Plan, the claimant (i.e., you and your covered Dependents) must follow the procedures outlined in this section. There are 4 different types of claims: (1) Urgent Care Claims; (2) Concurrent Care Claims; (3) Pre-Service Claims; and (4) Post-Service Claims. The procedures for each type of claim are more fully described below:

(1) **Urgent Care Claims.** If your claim is considered an urgent care claim, the Plan Administrator will notify you of the Plan's benefit determination (whether adverse or not) as soon as possible, taking into account the medical exigencies, but not later than 72 hours after the Plan receives the claim, unless you fail to provide sufficient information to determine whether or to what extent, benefits are covered or payable under the Plan. If you fail

to provide sufficient information for the Plan to decide your claim, the Plan Administrator will notify you as soon as possible, but not later than 24 hours after the Plan receives the claim, of the specific information necessary to complete the claim. The notification may be oral unless written notification is requested by you. You will be afforded a reasonable amount of time, taking into account the circumstances, but not less than 48 hours, to provide the specified information. The Plan Administrator will notify you of the Plan's determination as soon as possible, but in no case later than 48 hours after the earlier of (1) the Plan's receipt of the specified additional information or (2) the end of the period afforded the claimant to provide the specified additional information.

A claim for benefits is considered an urgent care claim if the application of the time periods for making non-urgent care determinations could seriously jeopardize your life or health or your ability to regain maximum function or, in the opinion of a Physician with knowledge of your medical condition, would subject you to severe pain that could not be adequately managed without the care or treatment which is the subject of the claim. In determining if the initial claim for benefits should be treated as an urgent care claim, the Plan will defer to a determination, if any, by an attending provider that the claim should be treated as an urgent care claim, if that determination is timely provided to the Plan.

(2) **Concurrent Care Claims.** If the Plan has approved an ongoing course of health care treatment to be provided over a period of time or number of treatments, any reduction or termination by the Plan of the previously approved course of treatment (other than by Plan amendment or termination) before the approved time period or number of treatments constitutes an adverse determination. In such a case, the Plan Administrator will notify you of the adverse determination at a time sufficiently in advance of the reduction or termination to allow you, the claimant, to appeal and obtain a determination on review of that adverse determination before reduction or termination of the benefit.

Any request by you to extend a previously approved course of urgent care treatment beyond the approved period of time or number of treatments shall be decided as soon as possible, taking into account the medical exigencies and the Plan Administrator will notify you of the benefit determination, whether adverse or not, within 24 hours after the Plan receives the claim provided that any such claim is made to the Plan at least 24 hours prior to the expiration of the prescribed period of time or number of treatments.

(3) **Pre-Service Claims.** For a pre-service claim, the Plan Administrator will notify you of the Plan's benefit determination (whether adverse or not) within a reasonable period of time appropriate to the medical circumstances, but not later than 15 days after the Plan receives the claim. If, due to matters beyond the control of the Plan, the Plan Administrator needs additional time to process a claim, the Plan Administrator may extend the time to notify you of the Plan's benefit determination for up to 15 days provided that the Plan Administrator notifies you within 15 days after the Plan receives the claim, of those special circumstances and of when the Plan Administrator expects to make its decision. However, if such an extension is necessary due to your failure to submit the information necessary to decide the claim, the notice of extension must specifically describe the required information and you will be afforded at least 45 days from receipt of the notice within which to provide the specified information.

A claim for benefits is considered a pre-service claim if the claim requires approval, in part or in whole, in advance of obtaining the health care in question.

(4) **Post-Service Claims.** For a post-service claim, the Plan Administrator will notify you of the Plan's adverse determination within a reasonable period of time, but not later than 30 days after receipt of the claim. If, due to special circumstances, the Plan Administrator needs additional time to process a claim, the Plan Administrator may extend the time for notifying you of the Plan's benefit determination on a one-time basis for up to 15 days provided that the Plan Administrator notifies you within 30 days after the Plan receives the claim, of those special circumstances and of the date by which the reviewer expects to make a decision. However, if such a decision is necessary due to your failure to submit the information necessary to decide the claim, the notice of extension will specifically describe the required information and you will be afforded at least 45 days from receipt of the notice within which to provide the specified information.

A claim for benefits is considered a post-service claim if it is a request for payment for services or other benefits that you have already received (or any other claim for health benefits that is not a pre-service claim or an urgent care claim).

**Manner and Content of Notice of Initial Adverse Determination**
If the Plan Administrator denies a claim, it must provide to you in writing or by electronic communication:

(1) An explanation of the specific reasons for the denial;

(2) A reference to the Plan provision or insurance contract provision upon which the denial is based;

(3) A description of any additional information or material that you must provide in order to perfect the claim;

(4) An explanation of why the additional material or information is necessary;

(5) Notice that you have the right to request a review of the claim denial and information on the steps to be taken if you wish to request a review of the claim denial along with the time limits applicable to a request for review;

(6) A statement describing your right to request an external review (or, if applicable, to request a second level appeal) or, if applicable, to bring an action for judicial review;

(7) A copy of any rule, guideline, protocol, or other similar criterion relied upon in making the adverse determination (or a statement that the same will be provided upon your request and without charge); and

(8) If the adverse determination is based on the Plan's Medical Necessity, Experimental treatment or similar exclusion or limit, either: (a) an explanation of the scientific or clinical judgment applying the exclusion or limit to your medical circumstances or (b) a statement that the same will be provided upon your request and without charge.

Any notice of adverse determination also will include the following information:

(1) Information sufficient to identify the claim involved, including the date of service, the health care provider, and the claim amount (if applicable);

(2) As part of the explanation of the determination, a discussion of the decision, as well as disclosure of any denial code used (and an explanation of its meaning) and a description of the Plan's standard, if any, that was used in denying the claim;

(3) A description of available internal appeals and external review processes, including information regarding how to initiate an appeal;

(4) Information (including contact information) about the availability of any applicable office of health insurance consumer assistance or ombudsmen established pursuant to the Patient Protection and Affordable Care Act (PPACA) to assist individuals with internal claims and appeals and external review processes; and

(5) A statement describing the availability, upon request, of any applicable diagnosis code (and an explanation of its meaning) and any applicable treatment code (and an explanation of its meaning).

For an adverse determination concerning an urgent care claim, the information described in this Section may be provided to you orally within the permitted time frame provided that a written or electronic notification in accordance with this section is furnished to you no later than 3 days after the oral notification.

**Internal Review of Initial Adverse Benefit Determination**
If you submit a claim for Plan benefits and it is initially denied under the procedures described above, you may request a review of that denial under the procedures described below.

You have 180 days after you receive notice of an initial adverse determination within which to request a review of the adverse determination. For a request for a second level appeal, you have 60 days after you receive notice of an adverse determination at the first level of appeal to request a second level appeal of the adverse determination.

If you request a review of an adverse determination within the applicable time period, the review will meet the following requirements:

(1) The Plan will provide a review that does not afford deference to the adverse determination that is being appealed and that is conducted by an appropriate named fiduciary of the Plan who did not make the adverse determination that is the subject of the appeal and who is not a subordinate of the individual who made that adverse determination.

(2) The appropriate named fiduciary of the Plan will consult with a health care professional who has appropriate training and experience in the field of medicine involved in the medical judgment before making a decision on review of any adverse determination based in whole or in part on a medical judgment, including determinations with regard to whether a particular treatment, drug or other item is Experimental and/or Investigational or not Medically Necessary or appropriate. The professional engaged for purposes of a consultation in the preceding sentence will be an individual who is neither an individual who was consulted in connection with the adverse determination that is the subject of the appeal, nor a subordinate of any such individual.

(3) The Plan will identify any medical or vocational experts whose advice is obtained on behalf of the Plan in connection with the Plan's review of an adverse determination, without regard to whether the advice is relied upon in making the adverse determination on review.

(4) For a requested review of an adverse determination involving an urgent care claim, the review process will meet the expedited deadlines described below. Your request for such an expedited review may be submitted orally or in writing and all necessary information, including the Plan's determination on review, will be transmitted between the Plan and you by telephone, facsimile, or other available similarly expeditious method.

(5) The reviewer will afford you an opportunity to review and receive, without charge, all relevant documents, information, and records relating to the claim and to submit issues and comments relating to the claim in writing to the Plan. The reviewer will take into account all comments, documents, records, and other information submitted by the claimant relating to the claim regardless of whether the information was submitted or considered in the initial benefit determination.

(6) You will be provided, free of charge, any new or additional evidence or rationale considered, relied upon, or generated by the Plan in connection with the claim. Such evidence or rationale will be provided as soon as possible and sufficiently in advance of the Plan's deadline for providing notice of its determination on review to give you a reasonable opportunity to respond prior to such determination.

(7) The Plan will ensure that all claims are adjudicated in a manner designed to ensure the independence and impartiality of the persons involved in making the decisions.

(8) The Plan will provide you with continued coverage pending the outcome of an internal appeal.

All requests for review of initial adverse benefit determinations (including all relevant information) must be submitted to the following address:

Meritain Health, Inc.
Appeals Department
P.O. Box 660908
Dallas, TX 75266-0908

**Deadline for Internal Review of Initial Adverse Benefit Determinations**

(1) Urgent Care Claims. The Plan provides for 2 levels of appeal for urgent care claims. For each level of appeal, the reviewer will notify you of the Plan's determination on review as soon as possible, taking into account the medical exigencies, but not later than 36 hours after the Plan receives your request for review of the initial adverse determination (or of the first-level appeal adverse determination).

(2) Pre-Service Claims. The Plan provides for 2 levels of appeal for a pre-service claim. At each level of appeal, the reviewer will notify you of the Plan's determination on review within a reasonable period of time appropriate to the medical circumstances, but in no event later than 15 days after the Plan receives your request for review of the initial adverse determination (or of the first-level appeal adverse determination).

(3) Post-Service Claims. The Plan provides for 2 levels of appeal for a post-service claim. At each level of appeal, the reviewer will notify you of the Plan's determination on review within a reasonable period of time appropriate to the medical circumstances, but in no event later than 30 days after the Plan receives your request for review of the initial adverse determination (or of the first-level appeal adverse determination).

**Manner and Content of Notice of Decision on Internal Review of Initial Adverse Benefit Determinations**
Upon completion of its review of an initial adverse determination (or a first-level appeal adverse determination), the reviewer will give you, in writing or by electronic notification, a notice of its benefit determination. For an adverse determination, the notice will include:

(1) A description of the Plan’s decision;

(2) The specific reasons for the decision;

(3) The relevant Plan provisions or insurance contract provisions on which its decision is based;

(4) A statement that you are entitled to receive, upon request and without charge, reasonable access to and copies of, all documents, records and other information in the Plan's files which is relevant to your claim for benefits;

(5) A statement describing your right to request an external review (or, if applicable, to request a second level appeal),or, if applicable, to bring an action for judicial review;

(6) If an internal rule, guideline, protocol, or other similar criterion was relied upon in making the adverse determination on review, a statement that a copy of the rule, guideline, protocol, or other similar criterion will be provided without charge to you upon request;

(7) If the adverse determination on review is based on a Medical Necessity, Experimental treatment or similar exclusion or limit, either: (a) an explanation of the scientific or clinical judgment on which the determination was based, applying the terms of the Plan to the claimant's medical circumstances or (b) a statement that such an explanation will be provided without charge upon request.

Any notice of adverse determination will include the following information:

(1) Information sufficient to identify the claim involved, including the date of service, the health care provider, and the claim amount (if applicable);

(2) As part of the explanation of the determination, a discussion of the decision, as well as disclosure of any denial code used (and an explanation of its meaning) and a description of the Plan's standard, if any, that was used in denying the claim;

(3) A description of available internal appeals and external review processes, including information regarding how to initiate an appeal;

(4) Information (including contact information) about the availability of any applicable office of health insurance consumer assistance or ombudsmen established pursuant to the Patient Protection and Affordable Care Act (PPACA) to assist individuals with internal claims and appeals and external review processes; and

(5) A statement describing the availability, upon request, of any applicable diagnosis code (and an explanation of its meaning) and any applicable treatment code (and an explanation of its meaning).

**Calculation of Time Periods**
For purposes of the time periods described in the Plan's claim procedures, the period of time during which a benefit determination is required to be made begins at the time a claim (or a request for review of an adverse benefit determination) is filed in accordance with the Plan procedures without regard to whether all the information necessary to make a decision accompanies the request. If a period of time is extended due to your failure to submit all information necessary for a claim for non-urgent care benefits, the period for making the determination is "frozen" from the date the notification requesting the additional information is sent to you until the date you respond or, if earlier, until 45 days from the date you receive (or were reasonably expected to receive) the notice requesting additional information.

**Adverse Determination**
For purposes of the Plan's claim procedures, an "adverse determination" is a denial, reduction or termination of or a failure to provide or make payment (in whole or in part) for, a benefit, including any such denial, reduction, termination or failure to provide or make payment that is based on a determination of an individual's eligibility to participate in the Plan and including a denial, reduction or termination of or a failure to provide or make payment (in whole or in part) for, a benefit resulting from the application of any utilization review, as well as a failure to cover an item or service for which benefits are otherwise provided because it is determined to be Experimental and/or Investigational or not Medically Necessary or appropriate. Adverse determination also includes any rescission of coverage, whether or not, in connection with the rescission, there is an adverse effect on any particular benefit at the time of rescission.

**Plan's Failure to Follow Procedures**
If the Plan fails to follow the claim procedures described above, you will be deemed to have exhausted the Plan internal claim procedures and you will be entitled to pursue any available remedy (including any available external review process) under state or federal law on the basis that the Plan has failed to provide a reasonable claims procedure that would yield a decision on the merits of the claim.

However, the Plan will not be treated as failing to follow its claim procedures and you will not be deemed to have exhausted the Plan's administrative remedies merely because of a failure by the Plan that would be considered (based on applicable regulations) a "*de minimis* violation" that does not cause and is not likely to cause prejudice or harm to you as long as the Plan can demonstrate that the violation was for good cause or due to matters beyond the control of the Plan and that the violation occurred in the context of an ongoing, good faith exchange of information between the Plan and you. You may request a written explanation of any violation by the Plan of these procedures. If you request such an explanation, the Plan will provide it within 10 days and, if applicable, the explanation will include a specific description of the Plan's reasons for asserting that the violation does not cause the Plan's internal claim procedures to be exhausted. If a court or external review rejects your request for an immediate review (based on a claim that you should be deemed to have exhausted the Plan's internal claim procedures), because the court or external reviewer determines that the "*de minimis* violation" exception applies, the Plan will provide to you a notice of your right to resubmit your internal appeal with a reasonable time (no longer than 10 days) after the court or external reviewer makes such a determination. Any applicable time limit for you to re-file your claim will begin to run when you receive that notice from the Plan.

**External Review of Adverse Benefit Determinations**
***NOTE: This provision does not apply to dental benefits.***

If you have exhausted the Plan's internal appeal process (or if you are eligible to request an external review for any other reason under the above procedures), you may request an external review of the Plan's final adverse determination for certain health benefit claims.

The Plan will provide for an external review process in accordance with applicable state law (if any). If no external review process exists under applicable state law or if the state law external review process does not meet certain minimum standards of the NAIC Uniform Health Carrier External Review Model Act (or the temporary "NAIC-similar" standards described in Department of Labor Technical Release 2011-02), the Plan will provide for an external review process that meets federal law requirements. Governmental plans that are not eligible to participate in a qualifying state process must elect to participate in a federal process administered by HHS or in the federal external review process that applies to ERISA-governed, self-funded Plans. If the Plan elects to participate in the federal

external review process that applies to an ERISA self-funded plan, the external review procedures described below will apply.

Note that the federal external review process (including the expedited external review process described later in these procedures) is not available for review of all internal adverse determinations. Specifically, federal external review is not available for review of an internal adverse determination that is based on a determination that a claimant fails to meet the eligibility requirements under the terms of the Plan. Also, the federal external review process is available only for:

(1) An adverse determination that involves medical judgment (including, but not limited to determinations based on the Plan's requirements for Medical Necessity, appropriateness, health care setting, level of care or effectiveness of a covered benefit; or the Plan's determination that a treatment is Experimental or Investigational), as determined by the external reviewer;

(2) A rescission of coverage;

(3) An adverse determination for Surprise Bills (medical and air ambulance bills), including determination of whether an adverse determination is subject to Surprise Bill provisions;

(4) An adverse determination involving whether a Covered Person is entitled to a reasonable alternative standard for a reward under the Plan’s wellness program (if any); and

(5) An adverse determination involving whether the Plan is complying with the nonquantitative treatment limitation provisions of the Mental Health Parity and Addiction Equity Act (MHPAEA) and its implementing regulations (if applicable and which generally require, among other things, parity in the application of medical management techniques).

For any adverse determination for which external review is available, the federal external review requirements are as follows:

(1) You have 4 months following the date you receive notice of the Plan’s final internal adverse determination within which to request an external review. The request for an external review must be submitted to the following address:

Meritain Health, Inc.
Appeals Department
P.O. Box 660908
Dallas, TX 75266-0908

(2) Within 5 business days following the date the Plan receives your external review request the Plan will complete a preliminary review. The Plan will notify you in writing within one business day after it completes the preliminary review whether the claim is eligible for the external review process:

   (a) If the request is complete, but the claim is not eligible for external review, the notice will describe the reasons it is not eligible and will provide contact information for the U.S. Department of Health and Human Services Health Insurance Assistance Team (HIAT).

   (b) If the request is not complete, the notice will describe information or materials needed to make the request complete. If the request is not complete and additional information or materials are needed to complete the preliminary review, you will have until the later of (i) 48 hours following the date of receipt of the notification or (ii) the end of the 4-month deadline described in (1) above to provide the necessary additional information or materials.

(3) Following the Plan’s preliminary review, if the request is eligible for external review, the Plan will assign an independent review organization (IRO) (as soon as administratively feasible) to make a determination on the request for external review. Within 5 business days following assignment of the IRO, the Plan will forward to the IRO all information and materials relevant to the final internal adverse determination.

(4) The assigned IRO will notify you in writing (within a reasonable period of time) of the request's eligibility and acceptance for external review. The notice will include a statement regarding your right to submit any additional information, within 10 business days from the date of receipt of the notice, for the IRO to consider as part of the external review process. Any such additional information received by the IRO will be forwarded on and shared with the Plan. The Plan, based upon any new information received, may reconsider its final internal adverse determination. Reconsideration by the Plan will not delay the external review process. If the Plan does not reconsider its final internal adverse benefits determination, the IRO will continue to proceed with the external review process.

(5) Within 45 days after the IRO receives the external review request from the Plan, the IRO must provide written notice of its external review determination to you and the Plan. The IRO's notice is required to contain the following:

(a) A general description of the reason for the request for external review, including information sufficient to identify the claim, the diagnosis code and treatment code and the corresponding meaning for each 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) 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 or reasons 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 you;

(f) A statement that judicial review may be available to you; and

(g) Current contact information, including telephone number, for any applicable office of health insurance consumer assistance or ombudsman established under the Public Health Service Act Section 2793.

**Expedited External Review**
***NOTE: This provision does not apply to dental benefits.***

You may request an expedited external review if you have received:

(1) An initial internal adverse determination if the adverse determination involves a medical condition for which the time frame for completion of an expedited internal appeal under the Plan's internal claim procedures would seriously jeopardize your life or health or would jeopardize your ability to regain maximum function and you have filed a request for an expedited internal appeal; or

(2) A final internal adverse determination, if you have a medical condition where the timeframe for completion of a standard external review would seriously jeopardize your life or health or would jeopardize your ability to regain maximum function or if the final internal adverse determination concerns an admission, availability of care, continued stay or health care item or service for which you received Emergency Services but have not been discharged from a facility.

The following requirements apply to an expedited external review:

(1) Immediately following the date the Plan receives the external review request the Plan will complete a preliminary review. The Plan will notify you in writing immediately after completion of the preliminary review whether the request is eligible for the external review process.

(a) If the request is complete, but the claim is not eligible for external review, the notice will describe the reasons it is not eligible and will include contact information for the Employee Benefits Security Administration.

(b) If the request is not complete, the notice will describe any information or materials needed to make the request complete. If the request is not complete and additional information or materials is needed to complete the preliminary review, you will have until the later of (i) 48 hours following the date of receipt of the notification or (ii) the end of the 4-month deadline described in (1) above to provide the necessary additional information or materials.

(2) Following the Plan's preliminary review, if the request is eligible for external review, the Plan will assign an independent review organization (IRO) to make a determination on the request for external review. The Plan will promptly forward to the IRO, by any available expeditious method (e.g., telephone, facsimile, etc.), all information and materials relevant to the final internal adverse determination.

(3) The IRO must provide notice to the claimant and the Plan (either in writing or orally) as expeditiously as the claimant's medical condition or circumstance require and no later than 72 hours after it receives the expedited external review request from the Plan. If notice is not provided in writing, the IRO must provide written notice to you and the Plan as confirmation of the decision within 48 hours after the date of the notice. The IRO's notice is required to contain the following information:

(a) A general description of the reason for the request for external review, including information sufficient to identify the claim, the diagnosis code and treatment code and the corresponding meaning for each 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) 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 or reasons 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 you;

(f) A statement that judicial review may be available to you; and

(g) Current contact information, including telephone number, for any applicable office of health insurance consumer assistance or ombudsman established under the Public Health Service Act Section 2793.

**Effect of External Review Determination**
A determination on external review is binding on the Plan and the claimant, except to the extent that other remedies are available under applicable state or federal law. However, a decision by the external reviewer does not preclude the Plan from making payment or providing benefits on a claim at any time, including after a decision that denies the claim. When an external review decision requires the Plan to provide benefits or payment on a claim, the Plan will provide benefits or payment pursuant to the decision without unreasonable delay regardless of whether the Plan intends to seek judicial review of the decision, unless and until there is a judicial decision that provides otherwise.

**State Insurance Laws**
Nothing in the Plan's claims procedures will be construed to supersede any provision of any applicable state law.

**Statute of Limitations for Plan Claims**
Please note that no legal action may be commenced or maintained to recover benefits under the Plan more than 12 months after the final review/appeal decision by the Plan Administrator has been rendered (or deemed rendered).

**Appointment of Authorized Representative**
A Covered Person is permitted to appoint an authorized representative to act on his or her behalf with respect to a benefit claim or appeal of a denial. An assignment of benefits by a Covered Person to a provider will not constitute appointment of that provider as an authorized representative. To appoint such a representative, the Covered Person must complete a form which can be obtained from the Plan Administrator or the Third Party Administrator. However,

in connection with a claim involving urgent care or services rendered by a Participating Provider, the Plan will permit a health care professional with knowledge of the Covered Person's medical condition to act as the Covered Person's authorized representative without completion of this form. In the event a Covered Person designates an authorized representative, all future communications from the Plan will be with the representative, rather than the Covered Person, unless the Covered Person directs the Plan Administrator, in writing, to the contrary.

**Physical Examinations**
The Plan reserves the right to have a Physician of its own choosing examine any Covered Person whose Illness or Injury is the basis of a claim. All such examinations will be at the expense of the Plan. This right may be exercised when and as often as the Plan Administrator may reasonably require during the pendency of a claim. The Covered Person must comply with this requirement as a necessary condition for coverage.

# COORDINATION OF BENEFITS

**Benefits Subject to This Provision**
This provision applies to all benefits provided under any section of this Plan.

**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 the 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 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; or

(5) Any other source, including but not limited to crime victim restitution funds, any medical, disability or other benefit payments and school insurance coverage.

**Vehicle Limitation**
When medical payments are available (or, under applicable law should be available) under any vehicle insurance, the Plan shall pay excess benefits only, without reimbursement for vehicle plan and/or policy deductibles. This Plan shall always be considered secondary to such plans and/or policies. This applies to all forms of medical payments under vehicle plans and/or policies regardless of its name, title, or classification. If medical payments would have been available under a vehicle insurance policy if minimum legally required levels of coverage had been in effect, but the minimum level of coverage was not in effect, the Plan shall pay excess benefits only, determined as if the minimum legally required level of coverage had been in effect at the applicable time.

**Allowable Expenses**
"Allowable expenses" shall mean any Medically Necessary item of expense, at least a portion of which is covered under this Plan. 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.

In the case of HMO (Health Maintenance Organization) plans, this Plan will not consider any charges in excess of what an HMO provider has agreed to accept as payment in full. Further, when an HMO is primary and the Covered Person does not use an HMO provider, this Plan will not consider as allowable expenses any charge that would have been covered by the HMO had the Covered Person used the services of an HMO provider.

**Other Plan**
"Other Plan" means any of the following plans, other than this Plan, providing benefits or services for medical or dental care or treatment:

(1) Group, blanket, or franchise insurance coverage;

(2) Any group Hospital service prepayment, group medical or dental service prepayment, group practice or other group prepayment coverage;

(3) Any coverage under labor-management trusteed plans, union welfare plans, employer organization plans, school insurance or employee benefit organization plans;

(4) Coverage under Medicare and any other governmental program that the Covered Person is liable for payment, except state-sponsored medical assistance programs and TRICARE, in which case this Plan pays primary;

(5) Coverage under any Health Maintenance Organization (HMO); or

(6) Any mandatory automobile insurance (such as no-fault) providing benefits under a medical expense reimbursement provision for health care services because of Injuries arising out of a motor vehicle accident and any other medical and liability benefits received under any automobile policy.

**Application to Benefit Determinations**
The plan that pays first according to the rules in the section entitled “Order of Benefit Determination” will pay as if there were no other plan involved. When this Plan is secondary, this Plan will always pay either its benefits in full or a reduced amount which, when added to the benefits payable by the other plan or plans, will not exceed 100% of allowable expenses. When there is a conflict in the order of benefit determination, this Plan will never pay more than 50% of allowable expenses.

**Order of Benefit Determination**
For the purposes of the section entitled “Application to Benefit Determinations,” the rules establishing the order of benefit determination are listed below. The Plan will consider these rules in the order in which they are listed and will apply the first rule that satisfies the circumstances of the claim:

(1) A plan without a coordinating provision will always be the primary plan.

(2) The plan covering the person directly rather than as an employee's dependent is primary and the other plans are secondary.

(3) Active/laid-off employees or retirees: The plan which covers a person as an active employee (or as that employee’s dependent) determines its benefits before the plan which covers a person as a laid-off or retired employee (or as that employee’s dependent). If the plan which covers that person has not adopted this rule and if, as a result, the plans do not agree on the order of benefits, this rule will not apply.

(4) Dependent Children of parents not separated or divorced or unmarried parents living together: The plan covering the parent whose birthday falls earlier in the year pays first. The plan covering the parent whose birthday falls later in the year pays second. However, if the other plan does not have this rule but instead has a rule based upon the gender of the parent and if as a result the plans do not agree on the order of benefits, the rule in the other plan will determine the order of benefits.

(5) Dependent Children of separated or divorced parents or unmarried parents not living together: When parents are separated or divorced or unmarried and not living together, neither the male/female nor the birthday rules apply. Instead:

   (a) The plan of the parent with custody pays first;

   (b) The plan of the spouse of the parent with custody (the step-parent) pays next;

   (c) The plan of the parent without custody pays next; and

   (d) The plan of the spouse of the non-custodial parent pays last.

   Notwithstanding the above provisions, if there is a court decree that would otherwise establish financial responsibility for the Child’s health care expenses, the benefits of the plan that covers the Child as a dependent of the parent with such financial responsibility shall be determined before the benefits of any other plan that covers the child as a dependent child.

(6) If a person whose coverage is provided under a right of continuation pursuant to state or federal law (e.g., COBRA) is also covered under another plan, the plan covering the person as an employee, member, subscriber, or retiree (or as that person's dependent) is primary and the continuation coverage is secondary. If the other plan does not have this rule and if, as a result, the plans do not agree on the order of benefits, this rule is ignored.

When the rules above do not establish an order of benefit determination, the benefits of a plan which has covered the person on whose expenses claim is based for the longer period of time shall be determined before the benefits of a plan which has covered such person the shorter period of time.

**Right to Receive and Release Necessary Information**
For the purpose of determining the applicability of and implementing the terms of this coordination of benefits provision or any provision of similar purpose of any other plan, this Plan may, without 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 is deemed to consent to the release and receipt of such information and agrees to furnish to the Plan such information as may be necessary to implement this provision.

**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.

**Right of Recovery**
Whenever payments have been made by this Plan with respect to allowable expenses 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 provision, the Plan shall have the right to recover such payments, to the extent of such excess, in accordance with the Recovery of Payments provision of this Plan.

**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. This Plan may also inadvertently 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 person or entity to which it was paid, primary payers or from the party on whose behalf the charge(s) were paid. 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.

A Covered Person, 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 30 days of discovery or demand. The Plan Administrator shall have discretion in deciding whether to obtain 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 Covered Person 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 Covered Person and to deny or reduce future benefits payable (including payment of future benefits for any other Injury or Illness) 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 any other Injury or Illness) 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, agree 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, most recent edition of the ICD 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 30 days of discovery or demand or incur prejudgment interest of 1.5% per month. If the Plan must bring an action against a Covered Person, provider or other person or entity to enforce the provisions of this section, then that Covered Person, provider or other person or entity agrees to pay the Plan's attorneys' fees and costs, regardless of the action's outcome.

Further, a Covered Person and/or their dependents, beneficiaries, estate, heirs, guardian, personal representative or assigns ("Plan Participants") 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 reimbursed.

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 2 years after the date such coverage commences;

(4) With respect to an ineligible person;

(5) In anticipation of obtaining a recovery if a Covered Person fails to comply with the Plan's Subrogation, Third Party Recovery and Reimbursement provisions; or

(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 Covered Person if such payment is made with respect to the Covered Person.

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 the claim that is the result of the provider's misstatement, said provider shall, as part of its assignment to benefits from the Plan, abstain from billing the Covered Person for any outstanding amount(s).

**Medicaid Coverage**
You or your Dependent's eligibility for any state Medicaid benefits will not be taken into account in determining or making any payments for benefits to or on behalf of you or your Dependent. Any such benefit payments will be subject to the state's right to reimbursement for benefits it has paid on behalf of such person, as required by the state Medicaid program; and the Plan will honor any subrogation rights the state may have with respect to benefits which are payable under the Plan.

**Coordination of Benefits with Medicaid**
In all cases, benefits available through a state or federal Medicaid program will be secondary or subsequent to the benefits of this Plan.

**Coordination of Benefits with Medicare**
When Medicare is the primary payor, the Plan will base its payment upon benefits allowable by Medicare. If you or your Dependents(s) are enrolled in the Plan due to your Retiree coverage, and you and/or your Dependent(s) did not elect coverage under Medicare Parts A and/or B when eligible, the Plan will be secondary and coordinate with benefits that would have been provided by Medicare.

When you, your Spouse or Dependents (as applicable) are eligible for or entitled to Medicare and covered by the Plan, the Plan at all times will be operated in accordance with any applicable Medicare secondary payer and non-discrimination rules. These rules include, where applicable, but are not necessarily limited to, rules concerning individuals with end stage renal disease, rules concerning active employees age 65 or over and rules concerning working disabled individuals (as discussed below).

In accordance with federal law, the following rules apply in determining whether Medicare or Plan coverage is primary health care coverage:

(1) The Working Aged Rule: Medicare benefits are secondary to benefits payable under the Plan for individuals entitled to Medicare due to being age 65 or over and who have Plan coverage as a result of his or her current employment status (or the current employment status of a Spouse). When you or your Spouse become eligible for Medicare due to the attainment of age 65, you or your Spouse may still be eligible for benefits provided under the Plan based on your current employment status.

    If, as a result, you have or your Spouse has primary coverage under the Plan, the Plan will pay the portion of your Incurred expenses that are normally covered by the Plan. All or part of the remaining amount, if any, may be paid by Medicare if the expenses are covered expenses under Medicare and the portion of the expenses covered by Medicare exceeds the portion covered by the Plan. If the expenses are not covered by the Plan but are Medicare-covered expenses, then Medicare will process its payment of the expenses as if you do not have Plan coverage.

(2) The Working Disabled Rule: Medicare benefits are secondary to benefits payable under the Plan for covered individuals under age 65 entitled to Medicare on the basis of disability (other than end-stage renal disease) and who are covered under the Plan as a result of current employment status with an employer. That is, if you or your Dependents are covered by the Plan based on your current employment status, Medicare benefits are secondary for you or your covered Dependents entitled to Medicare on the basis of disability (other than end-stage renal disease). In this case the Plan is primary.

(3) End-Stage Renal Disease Rule: Medicare benefits are secondary to benefits payable under the Plan for covered individuals eligible for or entitled to Medicare benefits on the basis of end-stage renal disease ("ESRD") or entitlement to Medicare due to ESRD. (Special rules apply if you were entitled to Medicare based on age or disability prior to becoming eligible for Medicare due to ESRD.) Because an ESRD patient can have up to a 3-month wait to obtain Medicare coverage, the Plan's primary payment responsibility may vary up to 3 months. If the basis of your entitlement to Medicare changes from ESRD to age or disability, the Plan's primary payment responsibility may terminate on the month before the month in which the change is effective and the rules set forth above, if applicable, will apply. Your Employer can provide you with more detailed information on how this rule works.

**Medicare and COBRA**
For most COBRA beneficiaries (e.g., the working aged or disabled Medicare beneficiaries), Medicare rules state that Medicare will be primary to COBRA continuation coverage and this would apply to this Plan’s Continuation of Benefits (COBRA) coverage. For an ESRD-related Medicare beneficiary, COBRA continuation coverage (if elected) is generally primary to Medicare during the 30-month coordination period.

**Coordination of Benefits with TRICARE**
The Plan at all times will be operated in accordance with any applicable TRICARE secondary payer and non-discrimination rules issued by the Department of Defense.

# SUBROGATION, THIRD-PARTY RECOVERY AND REIMBURSEMENT

**Payment Condition**

(1) The Plan, in its sole discretion, may elect to conditionally advance payment of benefits in those situations where an Injury, Illness, disease or disability is caused in whole or in part by, or results from the acts or omissions of you and/or your Dependents, plan beneficiaries and/or their Dependents, beneficiaries, estate, heirs, guardian, personal representative, or assigns (collectively referred to hereinafter in this section as "Covered Person") or a third party, where any party besides the Plan may be responsible for expenses arising from an incident, and/or other insurance or other funds are available, including but not limited to no-fault, uninsured motorist, underinsured motorist, medical payment provisions, third party assets, third party insurance, and/or guarantor(s) of a third party (collectively "Coverage").

(2) The Covered Person, his or her attorney, and/or legal guardian of a minor or incapacitated individual agrees that acceptance of the Plan's conditional payment of medical benefits is constructive notice of these provisions in their entirety and agrees to maintain 100% of the Plan's conditional payment of benefits or the full extent of payment from any one or combination of first and third party sources in trust, without disruption except for reimbursement to the Plan or the Plan's assignee. By accepting benefits the Covered Person agrees the Plan shall have an equitable lien on any funds received by the Covered Person and/or their attorney from any source and said funds shall be held in trust until such time as the obligations under this provision are fully satisfied. The Covered Person agrees to include the Plan's name as a co-payee on any and all settlement drafts. Further, by accepting benefits the Covered Person understands that any recovery obtained pursuant to this section is an asset of the Plan to the extent of the amount of benefits paid by the Plan and that the Covered Person shall be a trustee over those Plan assets.

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

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

**Subrogation**

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

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

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

(4) The Covered Person authorizes the Plan to pursue, sue, compromise and/or settle any such claims in the Covered Persons and/or the Plan's name and agrees to fully cooperate with the Plan in the prosecution of any such claims if the Covered Person fails to file a claim or pursue damages against:

(a) The responsible party, its insurer, or any other source on behalf of that party;

(b) Any first party insurance through medical payment coverage, personal injury protection, no-fault coverage, uninsured or underinsured motorist coverage;

(c) Any policy of insurance from any insurance company or guarantor of a third party;

(d) Workers' Compensation or other liability insurance company; or

(e) Any other source, including but not limited to crime victim restitution funds, any medical, disability or other benefit payments and school insurance coverage.

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

**Right of Reimbursement**

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

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

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

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

(5) This provision shall not limit any other remedies of the Plan provided by law. These rights of subrogation and reimbursement shall apply without regard to the location of the event that led to or caused the applicable Illness, Injury, disease, or disability.

**Covered Person is a Trustee Over Plan Assets**

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

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

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

   (c) In circumstances where the Covered Person is not represented by an attorney, instruct the insurance company or any third party from whom the Covered Person obtains a settlement, judgment, or other source of Coverage to include the Plan or its authorized representative as a payee on the settlement draft; and,

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

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

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

**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, except as otherwise provided for under the Plan's "Coordination of Benefits" section.

The Plan's benefits shall be excess to any of the following:

(1) The responsible party, its insurer, or any other source on behalf of that party;

(2) Any first party insurance through medical payment coverage, personal injury protection, no-fault coverage, uninsured or underinsured motorist coverage;

(3) Any policy of insurance from any insurance company or guarantor of a third party;

(4) Workers' Compensation or other liability insurance company; or

(5) Any other source, including but not limited to crime victim restitution funds, any medical, disability or other benefit payments and school insurance coverage.

**Separation of Funds**

Benefits paid by the Plan, funds recovered by the Covered Person and funds held in trust over which the Plan has an equitable lien exist separately from the property and estate of the Covered Person, such that the death of the Covered Person or filing of bankruptcy by the Covered Person, will not affect the Plan's equitable lien, the funds over which the Plan has a lien or the Plan's right to subrogation and reimbursement.

**Wrongful Death**
In the event that the Covered Person dies as a result of his or her Injuries and a wrongful death or survivor claim is asserted against a third party or any Coverage, the Plan's subrogation and reimbursement rights shall still apply, and the entity pursuing said claim shall honor and enforce these Plan rights and terms by which benefits are paid on behalf of the Covered Person(s) and all others that benefit from such payment.

**Obligations**
(1) It is the Covered Person's obligation at all times, both prior to and after payment of medical benefits by the Plan:

(a) To cooperate with the Plan or any representatives of the Plan, in protecting its rights, including discovery, attending depositions, and cooperating in trial to preserve the Plan's rights;

(b) To provide the Plan with pertinent information regarding the Illness, disease, disability, or Injury, including Accident reports, settlement information and any other requested additional information;

(c) To take such action and execute such documents as the Plan may require facilitating enforcement of its subrogation and reimbursement rights;

(d) To do nothing to prejudice the Plan's rights of subrogation and reimbursement;

(e) To promptly reimburse the Plan when a recovery through settlement, judgment, award, or other payment is received;

(f) To notify the Plan or its authorized representative of any settlement prior to finalization of the settlement;

(g) To not settle or release, without the prior consent of the Plan, any claim to the extent that the Covered Person may have against any responsible party or coverage;

(h) To instruct his/her attorney to ensure that the Plan or its authorized representative is included as a payee on any settlement draft;

(i) In circumstances where the Covered Person is not represented by an attorney, instruct the insurance company or any third party from whom the Covered Person obtains a settlement to include the Plan or its authorized representative as a payee on the settlement draft; and

(j) To make good faith efforts to prevent disbursement of settlement funds until such time as any dispute between the Plan and Covered Person over settlement funds is resolved.

(2) If the Covered Person and/or his or her attorney fails to reimburse the Plan for all benefits paid or to be paid, as a result of said Injury or condition, out of any proceeds, judgment or settlement received, the Covered Person will be responsible for any and all expenses (whether fees or costs) associated with the Plan's attempt to recover such money from the Covered Person.

(3) The Plan's rights to reimbursement and/or subrogation are in no way dependent upon the Covered Persons' cooperation or adherence to these terms.

**Offset**
If timely repayment is not made, or the Covered Person and/or his or her attorney fails to comply with any of the requirements of the Plan, the Plan has the right, in addition to any other lawful means of recovery, to deduct the value of the Covered Person's amount owed to the Plan. To do this, the Plan may refuse payment of any future medical benefits and any funds or payments due under this Plan on behalf of the Covered Person in an amount equivalent to any outstanding amounts owed by the Covered Person to the Plan. This provision applies even if the Covered Person has disbursed settlement funds.

**Minor Status**

(1) In the event the Covered Person is a minor as that term is defined by applicable law, the minor's parents or court-appointed guardian shall cooperate in any and all actions by the Plan to seek and obtain requisite court approval to bind the minor and his or her estate insofar as these subrogation and reimbursement provisions are concerned.

(2) If the minor's parents or court-appointed guardian fail to take such action, the Plan shall have no obligation to advance payment of medical benefits on behalf of the minor. Any court costs or legal fees associated with obtaining such approval shall be paid by the minor's parents or court-appointed guardian.

**Language Interpretation**

The Plan Sponsor retains sole, full, and final discretionary authority to construe and interpret the language of this provision, to determine all questions of fact and law arising under this provision and to administer the Plan's subrogation and reimbursement rights.

**Severability**

In the event that any section of this provision is considered invalid or illegal for any reason, said invalidity or illegality shall not affect the remaining sections of this provision and Plan. The section shall be fully severable. The Plan shall be construed and enforced as if such invalid or illegal sections had never been inserted in the Plan.

Notwithstanding anything contained herein to the contrary, to the extent this Plan is not governed by ERISA, the Plan's right to subrogation and reimbursement may be subject to applicable state subrogation laws.

# DEFINITIONS

In this section you will find the definitions for the capitalized words found throughout this Plan. There may be additional words or terms that have a meaning that pertains to a specific section and those definitions will be found in that section provided, however, that any such capitalized word shall have such meaning when used in any other section. These definitions are not an indication that charges for particular care, supplies or services are eligible for payment under the Plan. Please refer to the appropriate sections of this Plan for that information.

**Accident** means a non-occupational sudden and unforeseen event, definite as to time and place or a deliberate act resulting in unforeseen consequences.

**Ambulatory Surgical Center** means a free-standing surgical center, which is not part of a Hospital and which: (1) has an organized medical staff of Physicians; (2) has permanent facilities that are equipped and operated primarily for the purpose of performing Surgical Procedures; (3) has continuous Physician's services and registered graduate nursing (R.N.) services whenever a patient is in the facility; (4) is licensed by the jurisdiction in which it is located; and (5) does not provide for overnight accommodations.

**Assistant Surgeon** means a Physician who actively assists the Physician in charge of a case in performing a Surgical Procedure. Depending on the type of Surgery to be performed, an operating surgeon may have one Assistant Surgeon, or 2 Assistant Surgeons if Medically Necessary. The technical aspects of the Surgery involved dictate the need for an Assistant Surgeon.

**Birthing Center** means a place accredited as a freestanding birth center by the Commission for the Accreditation of Birth Centers in the state. If the state does not have any accreditation, it must meet all of the following tests: (1) is primarily engaged in providing birthing services for low risk pregnancies; (2) is operated under the supervision of a Physician; (3) has at least one registered nurse (R.N.) certified as a nurse midwife in attendance at all times; (4) has a written agreement with a licensed ambulance for that service to provide immediate transportation of the Covered Person to a Hospital as defined herein if an emergency arises; and (5) has a written agreement with a Hospital located in the immediate geographical area of the Birthing Center to provide emergency admission of the Covered Person.

**Calendar Year** means January 1 – December 31.

**Close Relative** means a Covered Person's spouse, parent (including step-parents), sibling, child, grandparent, or in-law.

**COBRA** means the Consolidated Omnibus Budget Reconciliation Act of 1985, as may be amended from time to time.

**Coinsurance** has the same meaning as set forth in the section of this Plan entitled "General Overview of the Plan".

**Congenital Anomaly** means a physical developmental defect that is present at birth.

**Copay** has the same meaning as set forth in the section of this Plan entitled "General Overview of the Plan".

**Cosmetic** means any procedure which is primarily directed at improving an individual's appearance and does not meaningfully promote the proper function of the body or prevent or treat Illness or disease.

**Covered Expense** means:

(1) An item or service listed in the Plan as an eligible medical expense for which the Plan provides coverage.

(2) For Prescription Drug expenses, any Prescription Drugs, or medicines eligible for coverage under the Prescription Drug Card Program.

(3) For dental expenses, an item or service listed in the Plan as an eligible dental expense for which the Plan provides coverage.

**Covered Person** means, individually, a covered Employee or Retiree and each of his or her Dependents who are covered under the Plan.

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

**Dentally Necessary** means services or supplies, which are determined by the Plan Administrator to be:

(1) Appropriate and necessary for the symptoms, diagnosis or direct care and treatment of the dental condition, Injury, or Illness;

(2) Provided for the diagnosis or direct care and treatment of the dental condition, Injury, or Illness;

(3) Within standards of good dental practice within the organized dental community;

(4) Not primarily for the convenience of the Covered Person, the Covered Person's Dentist, or another provider; and

(5) The most appropriate supply or level of service which can safely be provided.

**Dentist** means an individual who is duly licensed to practice dentistry or to perform oral surgery in the state where the service is performed and is operating within the scope of such license. A Physician will be considered a Dentist when performing any covered dental services allowed within such license.

**Dependent** is a Covered Person, other than the Employee or Retiree**,** who is covered by the Plan pursuant to the terms and conditions set forth in the "Eligibility for Participation" section of the Plan.

**Durable Medical Equipment** means equipment that:

(1) Can withstand repeated use;

(2) Is primarily and customarily used to serve a medical purpose;

(3) Generally is not useful to a person in the absence of an Illness or Injury; and

(4) Is appropriate for use in the home.

**Emergency Medical Condition** means a medical condition (including a Mental Disorder or Substance Use Disorder) manifesting itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in a condition described in clause (1) (placing the health of the individual, or with respect to a pregnant woman, the health of the woman or her unborn child), (2) (resulting in serious impairment to bodily functions), or (3) (leading to serious dysfunction of any bodily organ or part) of section 1867(e)(1)(A) of the Social Security Act (42 U.S.C. 1395dd(e)(1)(A)).

Notwithstanding the preceding or anything in the Plan to the contrary, to the extent that the above definition is inconsistent with the applicable provisions of the No Surprises Act (and any binding, authoritative guidance issued under the No Surprises Act), the provisions of the No Surprises Act (and such binding, authoritative guidance issued under the No Surprises Act) shall control.

**Emergency Services**, with respect to an Emergency Medical Condition, means (a) an appropriate medical screening examination (as required under Section 1867 of the Social Security Act (42 U.S.C. 1395dd) (or as would be required under such section if such section applied to an independent freestanding emergency department) that is within the capability of the emergency department of a Hospital or of an independent freestanding emergency department, as applicable, including ancillary services routinely available to the emergency department to evaluate such Emergency Medical Condition; and (b) within the capabilities of the staff and facilities available at the Hospital or the independent freestanding emergency department, as applicable, such further medical examination and treatment as are required under section 1867 of the Social Security Act (42 U.S.C. 1395dd) (or as would be required under such section if such section applied to an independent freestanding emergency department) to Stabilize the patient (regardless of the department of the Hospital in which such further examination or treatment is furnished).

Emergency Services also includes certain post-stabilization services furnished by a Non-Participating Provider or a Non-Participating Provider emergency facility (after a Covered Person is Stabilized and as part an outpatient observation or an Inpatient or outpatient stay with respect to the visit in which the initial services described in (a) above were provided to the extent required under the No Surprises Act), unless each of the following conditions is met:

(1) The attending emergency Physician or treating provider has determined that you are able to travel using nonmedical transportation or non-emergency medical transportation to an available Participating Provider (including a participating facility) located within a reasonable travel distance, taking into account your medical condition and any other relevant factor;

(2) If the provider is a Non-Participating Provider: (a) the provider gives you notice (in the manner required under the No Surprises Act) that the services rendered will be performed by a Non-Participating Provider and you consent to waive your rights to the protections under the Surprise Billing requirements of the No Surprises Act; and (b) you or your authorized representative (as determined under state law and the applicable provisions of the No Surprises Act) are in a condition to provide informed, voluntary consent in accordance with applicable state law; and

(3) The provider satisfies any additional applicable state law requirements and any additional requirements provided in binding, authoritative guidance issued pursuant to the No Surprises Act (as applicable to the Plan).

Notwithstanding the preceding or anything in the Plan to the contrary, to the extent that the above definition is inconsistent with the applicable provisions of the No Surprises Act (and any binding, authoritative guidance issued under the No Surprises Act), the provisions of the No Surprises Act (and such binding, authoritative guidance issued under the No Surprises Act) shall control.

**Employee** is defined in the "Eligibility for Participation" section of the Plan.

**Employer** means the Unified School District #428, or any successor thereto.

**Endodontic Treatment** means procedures for the prevention and treatment of diseases of the dental pulp, pulp chamber, root canal and surrounding periapical structures.

**Experimental and/or Investigational** means services, supplies, care, and treatment which do not constitute accepted and appropriate medical practice considering the facts and circumstances of the case and by the generally accepted standards of a reasonably substantial, qualified, responsible, relevant segment of the appropriate medical community or government oversight agencies at the time services were rendered, as determined by the Plan Administrator as set forth below.

The Plan Administrator must make an independent evaluation of the Experimental or 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. In addition to the above, the Plan Administrator will be guided by the following principles to determine whether a proposed treatment is deemed to be Experimental and/or Investigational:

(1) If the drug or device cannot be lawfully marketed without approval of the U.S. Food and Drug Administration (FDA) and approval for marketing has not been given at the time the drug or device is furnished, then it is deemed to be Experimental and/or Investigational; or

(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, then it is deemed to be Experimental and/or Investigational; or

(3) If Reliable Evidence shows that the drug, device, medical treatment or procedure is the subject of on-going Phase I or Phase II clinical trials or is the subject of the research, Experimental, study, Investigational or other arm of on-going 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, then it is deemed to be Experimental and/or Investigational; or

(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, then it is deemed to be Experimental and/or Investigational.

Reliable Evidence shall mean only published reports and articles in the authoritative medical and scientific literature; the written protocol or protocols used by the treating facility or the protocol(s) of another facility studying substantially the same drug, 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 FDA for general use.

Expenses for drugs, devices, services, medical treatments, or procedures related to an Experimental and/or Investigational treatment (related services) and complications from an Experimental and/or Investigational treatment and their related services are excluded from coverage, even if such complications and related services would be covered in the absence of the Experimental and/or Investigational treatment.

Final determination of Experimental and/or Investigational, Medical Necessity and/or whether a proposed drug, device, medical treatment, or procedure is covered under the Plan will be made by and in the sole discretion of the Plan Administrator.

**FMLA** means the Family and Medical Leave Act of 1993, as may be amended from time to time.

**Full-Time Employee** is defined in the "Eligibility for Participation" section of the Plan.

**Genetic Information** means information about genes, gene products and inherited characteristics that may derive from the individual or a family member. This includes information regarding carrier status and information derived from laboratory tests that identify mutations in specific genes or chromosomes, physical medical examinations, family histories and direct analysis of genes or chromosomes. Genetic Information will not be taken into account for purposes of (1) determining eligibility for benefits under the Plan (including initial enrollment and continued eligibility) and (2) establishing contribution or premium accounts for coverage under the Plan.

**Harmful Habit** means the acquired habit of thumb sucking, tongue thrusting or bruxism, which causes damage to the teeth and/or periodontal support.

**Health Care Facility** means a: (1) a Hospital; (2) a Hospital outpatient department; (3) a critical access Hospital; and (4) an Ambulatory Surgical Center.

**HIPAA** means the Health Insurance Portability and Accountability Act of 1996 (HIPAA), as may be amended from time to time.

**Home Health Care Agency** means a public or private agency or organization that specializes in providing medical care and treatment in the home. Such a provider must meet all of the following conditions, it: (1) is duly licensed, if such licensing is required, by the appropriate licensing authority to provide skilled nursing services and other therapeutic services; (2) qualifies as a Home Health Care Agency under Medicare; (3) meets the standards of the area-wide healthcare planning agency; (4) provides skilled nursing services and other services on a visiting basis in the patient's home; (5) is responsible for administering a home health care program; and (6) supervises the delivery of a home health care program where the services are prescribed and approved in writing by the patient's attending Physician.

**Hospice** means an agency that provides counseling and incidental medical services and may provide room and board to terminally ill individuals and which meets all of the following requirements: (1) has obtained any required state or governmental Certificate of Need approval; (2) provides 24-hour-a-day, 7 days-a-week service; (3) is under the direct supervision of a duly qualified Physician; (4) has a nurse coordinator who is a registered nurse (R.N.) with 4 years of full-time clinical experience, at least 2 of which involved caring for terminally ill patients; (5) has a social-service coordinator who is licensed in the jurisdiction in which it is located; (6) is an agency that has as its primary purpose the provision of hospice services; (7) has a full-time administrator; (8) maintains written records of services provided to the patient; (9) the employees are bonded and it provides malpractice and malplacement insurance; (10) is established and operated in accordance with the applicable laws in the jurisdiction in which it is located and, where licensing is required, has been licensed and approved by the regulatory authority having responsibility for licensing under the law; (11) provides nursing care by a registered nurse (R.N.), a licensed practical nurse (L.P.N.), a licensed physical therapist, certified occupational therapist, American Speech Language and Hearing Association certified speech therapist or a certified respiratory therapist; and (12) provides a home health aide acting under the direct supervision of one of the above persons while performing services specifically ordered by a Physician.

**Hospital** means a facility which: (1) is licensed as a Hospital where licensing is required; (2) is open at all times; (3) is operated mainly to diagnose and treat Illnesses or Injuries on an Inpatient basis; (4) has a staff of one or more Physicians on call at all times; (5) has 24-hour-a-day nursing services by registered nurses (R.N.'s); and (6) has organized facilities for major Surgery.

However, an institution specializing in the care and treatment of Mental Disorders or Substance Use Disorders which would qualify as a Hospital, except that it lacks organized facilities on its premises for major Surgery, shall be deemed a Hospital.

In no event shall "Hospital" include an institution which is primarily a rest home, a nursing home, a clinic, a Skilled Nursing Facility, a convalescent home, or a similar institution.

**Hour(s) of Service** mean each hour for which an Employee is paid, or entitled to payment, for the performance of duties for the Employer (or a related Employer) and each hour for which an Employee is paid, or entitled to payment by the Employer (or a related Employer) for a period of time during which no duties are performed due to vacation, holiday, Illness, incapacity (including disability), layoff, jury duty, military duty, or leave of absence, but excluding Hours of Service to the extent that the compensation for those services constitutes income from sources outside the United States or performed as (1) a bona fide volunteer (as defined in Treas. Reg. Section 54.4980H-1(a)(7)) or (2) part of a federal or state work study program. For purposes of this definition, a related Employer is any entity that must be treated as part of the same “applicable large employer” as the Employer for purposes of Code Section 4980H, as determined at the time that the applicable Hour of Service is performed or credited.

For Employees paid on an hourly basis, an Employer must calculate actual Hours of Service from records of hours worked and hours for which payment is made or due (the “actual method”). For Employees paid on a non-hourly basis, the Employer must calculate Hours of Service based on the actual method or, provided doing so does not substantially understate the Employee’s hours, using an equivalency method where the Employee is credited with either: (1) 8 Hours of Service for each day for which the Employee would be required to be credited with one Hour of Service; or (2) 40 Hours of Service for each week for which the Employee would be required to be credited with at least one Hour of Service.

**Illness** means a non-occupational bodily disorder, disease, physical sickness, pregnancy (including childbirth and miscarriage), Mental Disorder or Substance Use Disorder.

**Incurred** means the date the service is rendered, or the supply is obtained. With respect to a course of treatment or procedure which includes several steps or phases of treatment, 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, Covered 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.

**Injury** means physical damage to the body, caused by an external force and which is due directly and independently of all other causes, to an Accident.

**Inpatient** means any person who, while confined to a Hospital, is assigned to a bed in any department of the Hospital other than its outpatient department and for whom a charge for room and board is made by the Hospital.

**Intensive Care Unit** means 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: (1) facilities for special nursing care not available in regular rooms and wards of the Hospital; (2) special lifesaving equipment which is immediately available at all times; (3) at least 2 beds for the accommodation of the critically ill; and (4) at least one registered nurse (R.N.) in continuous and constant attendance 24 hours a day.

**Late Enrollee** is an eligible Employee or eligible Dependent that does not elect coverage under this Plan during their original 30-day eligibility period. A Special Enrollee is not considered a Late Enrollee.

**Leave of Absence** means a Leave of Absence of an Employee that has been approved by the Employer, as provided for in the Employer’s rules, policies, procedures, and practices.

**Legal Guardian** is defined in the "Eligibility for Participation" section of the Plan.

**Lifetime Maximum** means the maximum benefit payable during an individual's lifetime while covered under this Plan. Benefits are available only when an individual is eligible for coverage under this Plan. The Plan may provide for a Lifetime Maximum benefit for specific types of medical treatment. Any Lifetime Maximum will be shown in the applicable Schedule of Benefits.

**Long-Term Acute Care Facility/Hospital** (LTACH) means a facility that provides specialized acute care for medically complex patients who are critically ill; have multi-system complications and/or failures and require hospitalization in a facility offering specialized treatment programs and aggressive clinical and therapeutic intervention on a 24-hour-a-day, 7 days a week basis. The severity of the LTACH patient’s condition requires a Hospital stay that provides: (1) interactive Physician direction with daily on-site assessment; (2) significant ancillary services as dictated by complex, acute medical needs - such as full service and laboratory, radiology, respiratory care services, etc.; (3) a patient-centered outcome-focused, interdisciplinary approach requiring a Physician-directed professional team that includes intensive case management to move the patient efficiently through the continuum of care; (4) clinically competent care providers with advanced assessment and intervention skills; and (5) education for the patient and family to manage their present and future healthcare needs.

**Maintenance Therapy** means medical and non-medical health-related services that do not seek to cure or that are provided during periods when the medical condition of the patient is not changing or does not require continued administration by medical personnel.

**Medically Necessary**/**Medical Necessity** means treatment is generally accepted by medical professionals in the United States as proven, effective, and appropriate for the condition based on recognized standards of the health care specialty involved.

(1) "Proven" means the care is not considered Experimental and/or Investigational, meets a particular standard of care accepted by the medical community and is approved by the Food and Drug Administration (FDA) for general use.

(2) “Effective" means the treatments beneficial effects can be expected to outweigh any harmful effects. Effective care is treatment proven to have a positive effect on your health, while addressing particular problems caused by disease, Injury, Illness, or a clinical condition.

(3) "Appropriate" means the treatment's timing and setting are proper and cost effective.

Medical treatments which are not proven, effective and appropriate are not covered by the Plan.

All criteria must be satisfied. When a Physician recommends or approves certain care it does not mean that care is Medically Necessary.

**Medicare** means the program of health care for the aged established by Title XVIII of the Social Security Act of 1965, as amended.

**Mental Disorder** means any disease or condition, regardless of whether the cause is organic, that is classified as a Mental Disorder in the current edition of the International Classification of Diseases published by the U.S. Department of Health and Human Services.

**Morbid Obesity** is defined as (1) a body mass index (BMI) of 40 or greater or (2) a BMI of 35 or greater in conjunction with a severe co-morbidity, such as obesity hypoventilation, sleep apnea, diabetes, hypertension, cardiomyopathy, or musculoskeletal dysfunction.

**Non-Participating Provider** means a health care practitioner or health care facility that has not contracted directly with the Plan or an entity contracting on behalf of the Plan to provide health care services to Plan enrollees.

**Orthodontic Treatment** means the corrective movement of teeth to treat a handicapping malocclusion of the mouth.

**Out-of-Pocket Maximum** has the same meaning as set forth in the section of this Plan entitled “General Overview of the Plan”.

**Participating Provider** means a health care practitioner or health care facility that has contracted directly with the Plan or an entity contracting on behalf of the Plan to provide health care services to Plan enrollees.

**Physician** means a legally licensed Physician who is acting within the scope of their license and any other licensed practitioner required to be recognized for benefit payment purposes under the laws of the state in which they practice and who is acting within the scope of their license. The definition of Physician includes but is not limited to: Doctor of Medicine (M.D.), Doctor of Osteopathy (D.O.), Chiropractor, Licensed Consulting Psychologist, Licensed Psychologist, Licensed Clinical Social Worker, Occupational Therapist, Optometrist, Ophthalmologist, Physical Therapist, Podiatrist, Registered Nurse (R.N.), Licensed Practical Nurse (L.P.N.), Nurse Practitioner, Physician’s Assistant, Speech or Hearing Therapist, Speech Pathologist and Licensed Midwife (if covered by the Plan). An employee of a Physician who provides services under the direction and supervision of such Physician will also be deemed to be an eligible provider under the Plan.

**Plan** means the Unified School District #428 Employee Benefits Plan.

**Plan Administrator** means the administrator of the Plan.

**Plan Sponsor** means Unified School District #428 or any successor thereto.

**Plan Year** means the period from October 1 - September 30 each year.

**Prescription Drug** is defined in the "Prescription Drug Card Program" section of the Plan.

**Primary Care Physician (PCP)** means a licensed Physician practicing in one of the following fields: (1) family practice; (2) general practice; (3) internal medicine; (4) obstetrics and gynecology; or (5) pediatrics.

**Qualified Clinical Trial:** Please refer to the CancerCARE for Life Program section of the Plan for information related to Qualified Clinical Trial Expenses for cancer. For all others, Qualified Clinical Trial means 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 condition and is described in (1), (2) or (3) below:

(1) The study or investigation is approved or funded (which may include funding though in-kind contributions) by one 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 & Medicaid Services;

(e) A cooperative group or center of one of the entities described in (a) through (d) above;

(f) A qualified non-governmental research entity identified in guidelines issued by the National Institutes of Health for center support grants; or

(g) The Department of Veteran Affairs; the Department of Defense or the Department of Energy, if (i) 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 of studies and investigations used by the National Institutes of Health; and (ii) assures unbiased review of the highest scientific standards by qualified individuals who have no interest in the outcome of the review.

(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.

**Recognized Amount** means either (1) the amount established through an all-payer rate setting model (if any) that applies to the Plan and/or provider under section 1115A of the Social Security Act; (2) the amount required under any state law (if any) that applies to your situation and service (i.e., state surprise medical billing law) where (1) does not apply; or (3) the lesser of billed charges or the “qualifying payment amount” (if (1) and (2) do not apply). The “qualifying payment amount” is the amount determined by the Plan in accordance with the applicable requirements of the No Surprises Act. In the case of any air ambulance services, item (3) above will apply unless otherwise provided under the No Surprises Act (and/or other binding, authoritative guidance under the No Surprises Act).

**Reconstructive Surgery** means Surgery that is incidental to an Injury, Illness or Congenital Anomaly when the primary purpose is to improve physiological functioning of the involved part of the body. The fact that physical appearance may change or improve as a result of Reconstructive Surgery does not classify such Surgery as Cosmetic when a physical impairment exists, and the Surgery restores or improves function. Additionally, the fact that a Covered Person may suffer psychological consequences or socially avoidant behavior as a result of an Injury, Illness or Congenital Anomaly does not classify Surgery to relieve such consequences or behavior as Reconstructive Surgery.

**Rehabilitation Facility** means a facility must meet all of the following requirements: (1) must be for the treatment of acute Injury or Illness; (2) is licensed as an acute Rehabilitation Facility; (3) the care is under the direct supervision of a Physician; (4) services are Medically Necessary; (5) services are specific to an active written treatment plan; (6) the patient's condition requires skilled nursing care and interventions which cannot be achieved or managed at a lower level of care; (7) nursing services are available 24 hours a day; and (8) the confinement is not for Custodial Care or maintenance care.

**Residential Treatment Facility** means a facility that provides 24-hour treatment for Mental Disorders or Substance Use Disorders on an Inpatient basis. It must provide at least the following: room and board; medical services; nursing and dietary services; patient diagnosis, assessment, and treatment; individual, family and group counseling; and educational and support services. A Residential Treatment Facility is recognized if it carries out its stated purpose in compliance with all relevant state and local laws.

**Retiree** is defined in the "Eligibility for Participation" section of the Plan.

**Seasonal Employee** means an Employee who is hired into a position that recurs annually at about the same time each year for which the customary annual employment is 6 months or less.

**Security Standards** mean the final rule implementing HIPAA's Security Standards for the Protection of Electronic PHI, as amended.

**Semi-Private Room** means a Hospital room shared by 2 or more patients.

**Skilled Nursing Facility** is a facility that meets all of the following requirements:

(1) It is licensed to provide professional nursing services on an Inpatient basis to persons convalescing from 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 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, drug addicts, alcoholics, developmentally disabled, Custodial, or educational care or care of Mental Disorders.

(7) It is approved and licensed by Medicare.

This term also applies to charges Incurred in a facility referring to itself as an extended care facility, convalescent nursing home, rehabilitation hospital, long-term acute care facility or any other similar nomenclature.

**Special Enrollee** is an eligible Employee or eligible Dependent that does not elect coverage under this Plan during their original 30-day eligibility period and who later enrolls in the Plan due to a Special Enrollment Event.

**Specialist** means a licensed Physician that provides services to a Covered Person within the range of their specialty (e.g., cardiologist, neurologist, etc.).

**Specialty Drug** is defined in the "Prescription Drug Card Program" section of the Plan.

**Spouse** is defined in the "Eligibility for Participation" section of the Plan.

**Stabilize** means, with respect to an Emergency Medical Condition, to provide such medical treatment for the condition as may be necessary to assure, within reasonable medical probability, that no material deterioration of the condition is likely to result from or occur during the transfer of the individual from a facility; or with respect to an Emergency Medical Condition of a pregnant woman who is having contractions (1) there is adequate time to effect a safe transfer to another Hospital before delivery; and (2) transfer will not pose a threat to the health or safety of the woman or her unborn child to deliver (including the placenta).

**Substance Use Disorder** means any disease or condition that is classified as a Substance Use Disorder in the current edition of the International Classification of Diseases published by the U.S. Department of Health and Human Services.

**Surgery** or **Surgical Procedure** means 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 dilation and curettage; or

(7) Biopsy.

**Surprise Bill/Surprise Billing** happens when people unknowingly get care from providers that are outside of their health Plan's Network and can happen for both emergency and non-emergency care.

**Third Party Administrator** means Meritain Health, Inc., P.O. Box 853921, Richardson, TX 75085-3921.

**Urgent Care Clinic** means a facility that treats an urgent condition that requires prompt medical attention but is not a life-threatening Emergency Medical Condition. A board-certified Physician, a registered nurse and a registered x-ray technician must be in attendance at all times that the facility is open. The facility must include x-ray and laboratory equipment and a life support system. For the purpose of this Plan, a facility meeting these requirements will be considered to be an Urgent Care Clinic, by whatever actual name it may be called; however, an after-hours clinic shall be excluded from the terms of this definition. Additionally, this will not include an emergency room of a Hospital or a free-standing emergency room facility.

**USERRA** means the Uniformed Services Employment and Reemployment Rights Act of 1994 (USERRA), as may be amended from time to time.

**Usual and Customary Charge (U&C)** means, with respect to Non-Participating Providers, charges made for medical or dental services or supplies essential to the care of the individual that will be subject to a Usual and Customary determination. Subject to the rest of this definition, the Usual and Customary Charge means the lesser of the charge by other providers in the same geographic area or billed charges for the same or comparable service or supply. From time to time, the Plan may enter into an agreement with a Non-Participating Provider (directly or indirectly through a third party) which sets the rate the Plan will pay for a service or supply. In these cases the Usual and Customary Charge will be the rate established in such agreement with the Non-Participating Provider.

The Plan may reduce the Usual and Customary Charge by applying reimbursement policies administered by the Plan’s Third Party Administrator. These reimbursement policies address the appropriate billing of services, taking into account factors that are relevant to the cost of the service such as:

(1) The duration and complexity of a service;

(2) Whether multiple procedures are billed at the same time, but no additional overhead is required;

(3) Whether an Assistant Surgeon is involved and necessary for the service;

(4) If follow up care is included;

(5) Whether there are any other characteristics that may modify or make a particular service unique; and

(6) When a charge includes more than one claim line, whether any services described by a claim line are part of or incidental to the primary service provided.

The reimbursement policies utilized are based on review of the policies developed for Medicare; the generally accepted standards of medical and dental practice, which are based on credible scientific evidence published in peer-reviewed literature generally recognized by the relevant medical or dental community or which are otherwise consistent with Physician or dental specialty society recommendations; and the views of Physicians and Dentists practicing in the relevant clinical areas.

The Usual and Customary Charge for covered services will be based on the median contract rate when a Covered Person had no control over the services performed by a Non-Participating Provider who is under agreement with a Network facility or when the Covered Person seeks Emergency Services for an Emergency Medical Condition from a Non-Participating Provider.

# PLAN ADMINISTRATION

**Delegation of Responsibility**
The Plan Sponsor is a named fiduciary of the Plan with full discretionary authority for the control and management of the operation and administration of the Plan. The Plan Sponsor may delegate fiduciary and other responsibilities to any individual or entity. Any person to whom any responsibility is delegated may serve in more than one fiduciary capacity with respect to the Plan and may be a participant in the Plan.

**Authority to Make Decisions**
The Plan is administered by the Plan Administrator. The Plan Administrator has retained the services of the Third Party Administrator to provide certain claims processing and other ministerial services. 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 will appoint a new Plan Administrator as soon as reasonably possible.

The Plan Administrator will 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 will 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 and/or Investigational), to decide disputes which may arise relative to you and/or your Dependent's rights and to decide questions of Plan interpretation and those of fact and law 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 you and/or your Dependent (as applicable) are entitled to them.

The duties of the Plan Administrator include the following:

(1) To administer the Plan in accordance with its terms;

(2) To determine all questions of eligibility, status, and coverage under the Plan;

(3) To interpret the Plan, including the authority to construe possible ambiguities, inconsistencies, omissions, and disputed terms;

(4) To make factual findings;

(5) To decide disputes which may arise relative to a Covered Person's rights;

(6) To prescribe procedures for filing a claim for benefits, to review claim denials and appeals relating to them and to uphold or reverse such denials; or, alternatively, to appoint a qualified administrator to carry out these functions on the Plan Administrator's behalf;

(7) To keep and maintain the Plan documents and all other records pertaining to the Plan;

(8) To appoint and supervise a Third Party Administrator to pay claims;

(9) To perform all necessary reporting as required by federal or state law;

(10) To establish and communicate procedures to determine whether a child support order or decree is a QMCSO;

(11) To delegate to any person or entity such powers, duties, and responsibilities as it deems appropriate; and

(12) To perform each and every function necessary for or related to the Plan's administration.

**Amendment or Termination of Plan**
The Plan Sponsor expects to maintain this Plan indefinitely; however, the Plan Sponsor may, in its sole discretion, at any time, amend, suspend, or terminate the Plan in whole or in part.

Any such amendment, suspension or termination shall be taken and enacted in accordance with applicable federal and state law and any applicable governing documents.

If the Plan is terminated, the rights of Covered Person*s* are limited to expenses Incurred before termination. All amendments to this Plan shall become effective as of a date established by the Plan Sponsor.

# MISCELLANEOUS INFORMATION

**Assignment of Benefits**
No benefit under the Plan shall be subject in any manner to anticipation, alienation, sale, transfer, assignment, pledge, encumbrance or charge and any attempt to do so shall be void. No benefit under the Plan shall in any manner be liable for or subject to the debts, contracts, liabilities, engagements, or torts of any person.

Notwithstanding the foregoing, the Plan will honor any Qualified Medical Child Support Order ("QMCSO") which provides for coverage under the Plan for an alternate recipient, in the manner described in the Plan's QMCSO procedures.

**Clerical Error**
Clerical errors made on the records of the Plan and delays in making entries on such records shall not invalidate coverage nor cause coverage to be in force or to continue in force. Rather, the effective dates of coverage shall be determined solely in accordance with the provisions of this Plan regardless of whether any contributions with respect to you and/or your Dependents have been made or have failed to be made because of such errors or delays. Upon discovery of any such error or delay, an equitable adjustment of any such contributions will be made.

**Conformity with Applicable Laws**
This Plan shall be deemed automatically to be amended to conform as required by any applicable law, regulation or the order or judgment of a court of competent jurisdiction governing provisions of this Plan, including, but not limited to, stated maximums, exclusions, or limitations. In the event that any law, regulation or the order or judgment of a court of competent jurisdiction causes the Plan Administrator to pay claims that are otherwise limited or excluded under this Plan, such payments will be considered as being in accordance with the terms of Plan. It is intended that the Plan will conform to the requirements of any applicable federal or state law.

**Cost of the Plan**
The Plan Sponsor is responsible for funding the Plan and will do so as required by law. To the extent permitted by law, the Plan Sponsor is free to determine the manner and means of funding the Plan, including, but not limited to, payment of Plan expenses from the Employer’s general assets. If applicable, a biometric evaluation to determine health risk factors associated with a wellness program will be paid from the general assets of the Employer. The amount of contribution (if any) for your coverage or coverage for your Dependents will be determined from time to time by the Plan Sponsor, in its sole discretion.

**Interpretation of this Document**
The use of masculine pronouns in this Plan shall apply to persons of both sexes unless the context clearly indicates otherwise. The headings used in this Plan are used for convenience of reference only. You and your Dependents are advised not to rely on any provision because of the heading.

The use of the words, “you” and “your” throughout this Plan applies to eligible or covered Employees and, where appropriate in context, their covered Dependents.

**Minimum Essential Coverage**
Refer to the Employer’s Summary of Benefits and Coverage (SBC) for determination as to whether the Plan provides “minimum essential coverage” within the meaning of Code Section 5000A(f) and any accompanying regulations or guidance and whether it provides “minimum value” within the meaning of Code Section 36B(c)(2)(C)(ii) and any accompanying regulations or guidance (e.g., the Plan provides at least 60% actuarial value).

**No Contract of Employment**
This Plan and any amendments constitute the terms and provisions of coverage under this Plan. The Plan shall not be deemed to constitute a contract of any type between the Employer and any person or to be consideration for or an inducement or condition of the employment of any Employee. Nothing in this Plan shall be deemed to give any Employee the right to be retained in the service of the Employer or to interfere with the right of the Employer to discharge any Employee at any time.

**Release of Information**
For the purpose of determining the applicability of and implementing the terms of these benefits, the Plan Administrator may, without the consent of or notice to any person, release, or obtain any information necessary to determine the acceptability of any applicant or person covered for benefits under this Plan. In so acting, the Plan Administrator shall be free from any liability that may arise with regard to such action; however, the Plan Administrator at all times will comply with the applicable privacy standards. Any Covered Person claiming benefits under this Plan shall furnish to the Plan Administrator such information as may be necessary to implement this provision.

**Workers' Compensation**
This Plan excludes coverage for any Injury or Illness that is eligible for coverage under any Workers' Compensation policy or law regardless of the date of onset of such Injury or Illness. However, if benefits are paid by the Plan and it is later determined that you received or are eligible to receive Workers' Compensation coverage for the same Injury or Illness, the Plan is entitled to full recovery for the benefits it has paid. This exclusion applies to past and future expenses for the Injury or Illness regardless of the amount or terms of any settlement you receive from Workers' Compensation. The Plan will exercise its right to recover against you. The Plan reserves its right to exercise its rights under this section and the section entitled "Recovery of Payment" even though:

(1) The Workers' Compensation benefits are in dispute or are made by means of settlement or compromise;

(2) No final determination is made that the Injury or Illness was sustained in the course of or resulted from your employment;

(3) The amount of Workers' Compensation benefits due specifically to health care expense is not agreed upon or defined by you or the Workers' Compensation carrier; or

(4) The health care expense is specifically excluded from the Workers' Compensation settlement or compromise.

You are required to notify the Plan Administrator immediately when you file a claim for coverage under Workers' Compensation if a claim for the same Injury or Illness is or has been filed with this Plan. Failure to do so or to reimburse the Plan for any expenses it has paid for which coverage is available through Workers' Compensation, will be considered a fraudulent claim and you will be subject to any and all remedies available to the Plan for recovery and disciplinary action.

# HIPAA PRIVACY PRACTICES

The following is a description of certain rules that apply to the Plan Sponsor regarding uses and disclosures of your health information.

**Disclosure of Summary Health Information to the Plan Sponsor**
In accordance with HIPAA's standards for privacy of individually identifiable health information (the "privacy standards"), the Plan may disclose summary health information to the Plan Sponsor, if the Plan Sponsor requests the summary health information for the purpose of:

(1) Obtaining premium bids from health plans for providing health insurance coverage under this Plan; or

(2) Modifying, amending, or terminating the Plan.

"Summary health information" is information, which may include individually identifiable health information, that summarizes the claims history, claims expenses or the type of claims experienced by individuals in the Plan, but that excludes all identifiers that must be removed for the information to be de-identified, except that it may contain geographic information to the extent that it is aggregated by 5-digit zip code.

**Disclosure of Protected Health Information ("PHI") to the Plan Sponsor for Plan Administration Purposes**
Except as described under "Disclosure of Summary Health Information to the Plan Sponsor" above or under "Disclosure of Certain Enrollment Information to the Plan Sponsor" below or under the terms of an applicable individual authorization, the Plan may disclose PHI to the Plan Sponsor and may permit the disclosure of PHI by a health insurance issuer or HMO with respect to the Plan to the Plan Sponsor only if the Plan Sponsor requires the PHI to administer the Plan. The Plan Sponsor by formally adopting this Plan document certifies that it agrees to:

(1) Not use or further disclose PHI other than as permitted or required by the Plan or as required by law;

(2) Ensure that any agents, to whom the Plan Sponsor provides PHI received from the Plan agree to the same restrictions and conditions that apply to the Plan Sponsor with respect to such PHI;

(3) Not use or disclose PHI for employment-related actions and decisions or in connection with any other benefit or employee benefit plan of the Plan Sponsor;

(4) Report to the Plan any PHI use or disclosure that is inconsistent with the uses or disclosures provided for of which the Plan Sponsor becomes aware;

(5) Make available PHI in accordance with section 164.524 of the privacy standards;

(6) Make available PHI for amendment and incorporate any amendments to PHI in accordance with section 164.526 of the privacy standards;

(7) Make available the information required to provide an accounting of disclosures in accordance with section 164.528 of the privacy standards;

(8) Make its internal practices, books and records relating to the use and disclosure of PHI received from the Plan available to the U.S. Department of Health and Human Services ("HHS"), for purposes of determining compliance by the Plan with part 164, subpart E, of the privacy standards;

(9) If feasible, return or destroy all PHI received from the Plan that the Plan Sponsor still maintains in any form and retain no copies of such PHI when no longer needed for the purpose for which disclosure was made, except that, if such return or destruction is not feasible, limit further uses and disclosures to those purposes that make the return or destruction of the PHI infeasible; and

(10) Ensure that adequate separation between the Plan and the Plan Sponsor, as required in section 164.504(f)(2)(iii) of the privacy standards, is established as follows:

(a) The Plan Sponsor shall only allow certain named employees or classes of employees or other persons under control of the Plan Sponsor who have been designated to carry out plan administration functions, access to PHI. The Plan Sponsor will maintain a list of those persons and that list is incorporated into this document by this reference. The access to and use of PHI by any such individuals shall be restricted to plan administration functions that the Plan Sponsor performs for the Plan.

(b) In the event any of the individuals described in (a) above do not comply with the provisions of the Plan documents relating to use and disclosure of PHI, the Plan Administrator shall impose reasonable sanctions as necessary, in its discretion. Such sanctions shall be imposed progressively (for example, an oral warning, a written warning, time off without pay and termination), if appropriate and shall be imposed so that they are commensurate with the severity of the violation.

"Plan administration" activities are limited to activities that would meet the definition of payment or health care operations, but do not include functions to modify, amend or terminate the Plan or solicit bids from prospective issuers. "Plan administration" functions include quality assurance, claims processing, auditing, monitoring, and management of carve-out plans, such as vision and dental. It does not include any employment-related functions or functions in connection with any other benefit or benefit plans.

The Plan shall disclose PHI to the Plan Sponsor only upon receipt of a certification by the Plan Sponsor that:

(1) The Plan documents have been amended to incorporate the above provisions; and

(2) The Plan Sponsor agrees to comply with such provisions.

**Disclosure of Enrollment Information to the Plan Sponsor**
Pursuant to section 164.504(f)(1)(iii) of the privacy standards, the Plan may disclose to the Plan Sponsor information on whether an individual is participating in the Plan or is enrolled in or has disenrolled from a health insurance issuer or health maintenance organization offered under the Plan.

**Disclosure of PHI to Obtain Stop-loss or Excess Loss Coverage; Disclosures of Genetic Information**
Except as otherwise provided below, the Plan Sponsor hereby authorizes and directs the Plan, through the Plan Administrator or the Third Party Administrator, to disclose PHI to stop-loss carriers, excess loss carriers or managing general underwriters ("MGUs") for underwriting and other purposes in order to obtain and maintain stop-loss or excess loss coverage related to benefit claims under the Plan. Such disclosures shall be made in accordance with the privacy standards.

The Plan will not use or disclose Genetic Information, including information about genetic testing and family medical history, for underwriting purposes. The Plan may use or disclose PHI for underwriting purposes, assuming the use or disclosure is otherwise permitted under the privacy standards and other applicable law, but any PHI that is used or disclosed for underwriting purposes will not include Genetic Information.

"Underwriting purposes" is defined for this purpose under federal law and generally includes any Plan rules relating to (1) eligibility for benefits under the Plan (including changes in deductibles or other cost-sharing requirements in return for activities such as completing a health risk assessment or participating in a wellness program); (2) the computation of premium or contribution amounts under the Plan (including discounts or payments or differences in premiums based on activities such as completing a health risk assessment or participating in a wellness program); and (3) other activities related to the creation, renewal, or replacement of a contract for health insurance or health benefits. However, "underwriting purposes" does not include rules relating to the determination of whether a particular expense or claim is medically appropriate.

# HIPAA SECURITY PRACTICES

**Disclosure of Electronic Protected Health Information ("Electronic PHI") to the Plan Sponsor for Plan Administration Functions**

In accordance with HIPAA's standards for security (the "Security Standards"), to enable the Plan Sponsor to receive and use Electronic PHI for Plan administration functions (as defined in 45 CFR § 164.504(a)), the Plan Sponsor agrees to:

(1) Implement and maintain administrative, physical, and technical safeguards that reasonably and appropriately protect the confidentiality, integrity, and availability of the Electronic PHI that it creates, receives, maintains, or transmits on behalf of the Plan.

(2) Ensure that adequate separation between the Plan and the Plan Sponsor, as required in 45 CFR § 164.504(f)(2)(iii), is supported by reasonable and appropriate security measures.

(3) Ensure that any agent, including any business associate or subcontractor, to whom the Plan Sponsor provides Electronic PHI created, received, maintained, or transmitted on behalf of the Plan, agrees to implement reasonable and appropriate security measures to protect the Electronic PHI.

(4) Report to the Plan any security incident of which it becomes aware.

(5) The Plan Sponsor will promptly report to the Plan any breach of unsecured Protected Health Information of which it becomes aware in a manner that will facilitate the Plan's compliance with the breach reporting requirements of the HITECH Act, based on regulations or other applicable guidance issued by the Department of Health and Human Services.

Any terms not otherwise defined in this section shall have the meanings set forth in the Security Standards.

# GENERAL PLAN INFORMATION

| | |
|---|---|
| **Name of Plan:** | Unified School District #428 Employee Benefits Plan |
| **Plan Sponsor:**<br>**(Named Fiduciary)** | Unified School District #428<br>1809 24th Street<br>Great Bend, KS 67530<br>(620) 793-1500 |
| **Plan Administrator:** | Unified School District #428<br>1809 24th Street<br>Great Bend, KS 67530<br>(620) 793-1500 |
| **Plan Sponsor EIN:** | 48-0721637 |
| **Plan Year:** | October 1 - September 30 |
| **Meritain Health, Inc. Group Number:** | 25971 |
| **Plan Type:** | Welfare benefit plan providing medical, Prescription Drug and dental benefits. |
| **Plan Funding:** | All benefits are paid from the general assets of the Employer.<br>Organ transplant benefits are fully-insured to the extent eligible for coverage under the contract or policy issued by the insurance carrier for organ transplant benefits. To the extent organ transplant benefits are not covered under the contract or policy issued by such insurance carrier, they are paid from the Plan funding of the Employer listed above. |
| **Contributions:** | The cost of coverage under the Plan is funded in part by Employer contributions and in part by Employee contributions. |
| **Third Party Administrator:** | Meritain Health, Inc.<br>P.O. Box 853921<br>Richardson, TX 75085-3921<br>(800) 925-2272 |
| **COBRA Administrator:** | Meritain Health, Inc.<br>ATTN: COBRA Department<br>P.O. Box 860093<br>Minneapolis, MN 55486-0093<br>Fax: (716) 319-5736<br>www.meritain.com |
| **Medical Management Program Administrator:** | Meritain Health Medical Management<br>7400 West Campus Road, F-510<br>New Albany, OH 43054-8725<br>(800) 242-1199 |
| **Teladoc Program Administrator:** | Teladoc, Inc.<br>1945 Lakepointe Drive<br>Lewisville, TX 75057<br>(800) 835-2362<br>www.teladochealth.com |

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|---|---|
| **Prescription Drug Card Program Administrator:** | Scrip World, LLC/CVS Caremark<br>(866) 475-7589<br>www.caremark.com |
| **Agent for Service of Legal Process:** | Unified School District #428<br>1809 24th Street<br>Great Bend, KS 67530<br>(620) 793-1500 |

The Plan is a legal entity. Legal notice may be filed with and legal process served upon, the Plan Administrator.