SISC
Self-Insured Schools of California
Schools Helping Schools

Self-Insured Schools of California
Proactive Care Plan
(Silver/Bronze/Gold/Platinum/Diamond)

Plan Document and Summary Plan Description
Effective: October 01, 2026

Claims Processed by:

6535 State Hwy 161 S, Suite 100
Irving, TX 75039
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INTRODUCTION AND PURPOSE; GENERAL PLAN INFORMATION

Introduction and Purpose

The Plan Sponsor has established the Plan for the benefit of eligible Employees and their eligible Dependents, in accordance with the terms and conditions described herein. Plan benefits are funded solely from the general assets of the Plan Sponsor which are comprised of contributions from participating entities. Participants in the Plan may be required to contribute toward their benefits. Contributions received from Participants are used to cover Plan costs and are expended immediately.

The Plan Sponsor's purpose in establishing the Plan is to protect eligible Employees and their Dependents against certain health expenses and to help defray the financial effects arising from Injury or Illness. To accomplish this purpose, the Plan Sponsor must be mindful of the need to control and minimize health care costs through innovative and efficient plan design and cost containment provisions, and of abiding by the terms of the Plan Document, to allow the Plan Sponsor to effectively assign the resources available to help Participants in the Plan to the maximum feasible extent.

The Plan Sponsor has adopted this Plan Document as the written description of the Plan to set forth the terms and provisions of the Plan that provide for the payment or reimbursement of all or a portion of certain expenses for eligible benefits. The Plan Document is maintained by **Self-Insured Schools of California** and may be reviewed at any time during normal working hours by any Participant.

General Plan Information

Name of Plan:
Self-Insured Schools of California

Plan Sponsor:
Self-Insured Schools of California
P.O. Box 1847
Bakersfield, CA 93303-1847
Phone: 1-661-636-4410

Plan Administrator:
(Named Fiduciary)
Self-Insured Schools of California
P.O. Box 1847
Bakersfield, CA 93303-1847
Phone: 1-661-636-4410

Plan Sponsor ID No. (EIN):
77-0162263

Source of Funding:
Self-Funded

Plan Status:
Non-Grandfathered

Applicable Law:
Federal

Plan Year:

October 1 through September 30

Plan Type:
Medical
Prescription Drug

Third Party Administrator:
WebTPA
6535 State Hwy 161 S, Suite 100
Irving, TX 75039
Phone: 1-866-259-5540
Website: www.webtpa.com
Email: helpme@webtpa.com

Prescription Drug Plan Administrator:
Navitus RX
Phone: 1-866-333-2757
Website/Email: www.navitus.com

Agent for Service of Process:
Self-Insured Schools of California (SISC)
P.O. Box 1847
Bakersfield, CA 93303-1847
Phone: 1-661-636-4410

Utilization Review Manager:
Communitas
1-866-259-5540

Non-English Language Notice

This Plan Document contains a summary in English of a Participant's plan rights and benefits under the Plan. If a Participant has difficulty understanding any part of this Plan Document, he or she may contact the Plan Administrator at the contact information above.

Legal Entity; Service of Process

The Plan is a legal entity. Legal notice may be filed with, and legal process served upon, the Plan Administrator.

Not a Contract

This Plan Document and any amendments constitute the terms and provisions of coverage under this Plan. The Plan Document is not to be construed as a contract of any type between the Company and any Participant or to be consideration for, or an inducement or condition of, the employment of any Employee. Nothing in this Plan Document shall be deemed to give any Employee the right to be retained in the service of the Company or to interfere with the right of the Company to discharge any Employee at any time; provided, however, that the foregoing shall not be deemed to modify the provisions of any collective bargaining agreements which may be entered into by the Company with the bargaining representatives of any Employees.

Mental Health Parity

Pursuant to the Mental Health Parity Act (MHPA) of 1996 and the Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA), collectively, the mental health parity provisions, this Plan applies its terms uniformly and enforces parity between covered health care benefits and covered mental health and substance disorder benefits relating to financial cost sharing restrictions and treatment duration limitations. For further details, please contact the Plan Administrator.

Non-Discrimination

No eligibility rules or variations in contribution amounts will be imposed based on an eligible Employee's and his or her Dependent's/Dependents' health status, medical condition, claims experience, receipt of health care, medical history, genetic information, evidence of insurability, disability, or any other health status related factor. Coverage under this Plan is provided regardless of an eligible Employee's and his or her Dependent's/Dependents' race, color, national origin, disability, age, sex, gender identity or sexual orientation. Variations in the administration, processes or benefits of this Plan that are based on clinically indicated reasonable medical management practices, or are part of permitted wellness incentives, disincentives and/or other programs do not constitute discrimination.

Applicable Law

This Plan is a governmental (sponsored) plan and as such it is exempt from the requirements of the Employee Retirement Income Security Act of 1974 (also known as ERISA), which is a Federal law regulating Employee welfare and pension plans. The Participants' rights in the Plan are governed by the plan documents and applicable State law and regulations.

Discretionary Authority

To the extent allowed by law, the Plan Administrator shall have sole, full and final discretionary authority to interpret all Plan provisions, including the right to remedy possible ambiguities, inconsistencies and/or omissions in the Plan and related documents; to make determinations in regards to issues relating to eligibility for benefits; to decide disputes that may arise relative to a Participant's rights; and to determine all questions of fact and law arising under the Plan.

DEFINITIONS

The following words and phrases shall have the following meanings when used in the Plan Document. Some of the terms used in this document begin with a capital letter, even though the term normally would not be capitalized. These terms have special meaning under the Plan. Most terms will be listed in this Definitions section, but some terms are defined within the provision the term is used. Becoming familiar with the terms defined in the Definitions section will help to better understand the provisions of this Plan.

The following definitions are not an indication that charges for particular care, supplies or services are eligible for payment under the Plan, however they may be used to identify ineligible expenses; please refer to the appropriate sections of the Plan Document for that information.

"Accident"
"Accident" shall mean an event which takes place without one's foresight or expectation, or a deliberate act that results in unforeseen consequences.

"Accidental Bodily Injury" or "Accidental Injury"
"Accidental Bodily Injury" or "Accidental Injury" shall mean an Injury sustained as the result of an Accident, due to an outside traumatic event, or due to exposure to the elements.

"Actively at Work" or "Active Employment"
An Employee is "Actively at Work" or in "Active Employment" on any day the Employee performs in the customary manner all of the regular duties of employment. An Employee will be deemed Actively at Work on each day of a regular paid vacation or on a regular non-working day, provided the covered Employee was Actively at Work on the last preceding regular work day, or pursuant to the Plan's Leave of Absence provisions (including any State-mandated leave). An Employee will not be considered under any circumstances Actively at Work if he or she has effectively terminated employment.

"ADA"
"ADA" shall mean the American Dental Association.

"Adverse Benefit Determination"
"Adverse Benefit Determination" shall mean any of the following:

1. A denial in benefits.
2. A reduction in benefits.
3. A rescission of coverage, even if the rescission does not impact a current claim for benefits.
4. A termination of benefits.
5. A failure to provide or make payment (in whole or in part) for a benefit, including any such denial, reduction, termination, or failure to provide or make payment that is based on a determination of a Claimant's eligibility to participate in the Plan.
6. A denial, reduction, or termination of, or a failure to provide or make payment (in whole or in part) for, a benefit resulting from the application of any utilization review.
7. A failure to cover an item or service for which benefits are otherwise provided because it is determined to be Experimental or Investigational or not Medically Necessary or appropriate.

Explanation of Benefits (EOB)
"Explanation of Benefits" shall mean a statement a health plan sends to a Participant which shows charges, payments and any balances owed. It may be sent by mail or e-mail. An Explanation of Benefits may serve as an Adverse Benefit Determination.

"Affordable Care Act (ACA)"

The “Affordable Care Act (ACA)” means the health care reform law enacted in March 2010. The law was enacted in two parts: the Patient Protection and Affordable Care Act was signed into law on March 23, 2010 and was amended by the Health Care and Education Reconciliation Act on March 30, 2010. The name “Affordable Care Act” is commonly used to refer to the final, amended version of the law. In this document, the Plan uses the name Affordable Care Act (ACA) to refer to the health care reform law.

“AHA”
“AHA” shall mean the American Hospital Association.

“Alternate Recipient”
“Alternate Recipient” shall mean any Child of a Participant who is recognized under a Medical Child Support Order as having a right to enrollment under this Plan as the Participant’s eligible Dependent. For purposes of the benefits provided under this Plan, an Alternate Recipient shall be treated as an eligible Dependent.

“AMA”
“AMA” shall mean the American Medical Association.

“Ambulatory Surgical Center”
“Ambulatory Surgical Center” shall mean any permanent public or private State licensed and approved (whenever required by law) establishment that operates exclusively for the purpose of providing Surgical Procedures to patients not requiring hospitalization with an organized medical staff of Physicians, with continuous Physician and nursing care by Registered Nurses (R.N.s). The patient is admitted to and discharged from the facility within the same working day as the facility does not provide service or other accommodations for patients to stay overnight.

“Approved Clinical Trial”
“Approved Clinical Trial” means a phase I, II, III or IV trial that is Federally funded by specified Agencies (National Institutes of Health (NIH), Centers for Disease Control and Prevention (CDCP), Agency for Healthcare Research and Quality (AHRQ), Centers for Medicare and Medicaid Services (CMS), Department of Defense (DOD) or Veterans Affairs (VA), or a non-governmental entity identified by NIH guidelines) or is conducted under an Investigational new drug application reviewed by the Food and Drug Administration (FDA) (if such application is required).

The Affordable Care Act requires that if a “qualified individual” is in an “Approved Clinical Trial,” the Plan cannot deny coverage for related services (“routine patient costs”).

A “qualified individual” is someone who is eligible to participate in an “Approved Clinical Trial” and either the individual’s doctor has concluded that participation is appropriate or the Participant provides medical and scientific information establishing that their participation is appropriate.

“Routine patient costs” include all items and services consistent with the coverage provided in the plan that is typically covered for a qualified individual who is not enrolled in a clinical trial. Routine patient costs do not include 1) the Investigational item, device or service itself; 2) items and services that are provided solely to satisfy data collection and analysis needs and that are not used in the direct clinical management of the patient; and 3) a service that is clearly inconsistent with the widely accepted and established standards of care for a particular Diagnosis. Plans are not required to provide benefits for routine patient care services provided outside of the Plan’s Network area unless Out-of-Network benefits are otherwise provided under the Plan.

“Blue Distinction Center/Blue Distinction Center+”

Blue Distinction Center (BDC) Facility: Blue Distinction facilities have met or exceeded national quality standards for care delivery (quality only).

Blue Distinction Center+ (BDC+) Facility: Blue Distinction+ facilities have met or exceeded national quality standards for care delivery AND have demonstrated that they operate more efficiently (quality and cost).

See also Center(s) of Excellence.

"Calendar Year"
"Calendar Year" shall mean the 12 month period from January 1 through December 31 of each year.

"Cardiac Care Unit"
"Cardiac Care Unit" shall mean a separate, clearly designated service area which is maintained within a Hospital and which meets all the following requirements:

1. It is solely for the care and treatment of critically ill patients who require special medical attention because of their critical condition.
2. It provides within such area special nursing care and observation of a continuous and constant nature not available in the regular rooms and wards of the Hospital.
3. It provides a concentration of special lifesaving equipment immediately available at all times for the treatment of patients confined within such area.
4. It contains at least two beds for the accommodation of critically ill patients.
5. It provides at least one professional Registered Nurse, in continuous and constant attendance of the patient confined in such area on a 24 hour a day basis.

"CDC"
"CDC" shall mean Centers for Disease Control and Prevention.

"Center(s) of Excellence"
Medical care facilities that have met stringent criteria for quality care in the specialized procedures of organ transplantation. These centers have the greatest experience in performing transplant procedures and the best survival rates. The Plan Administrator shall determine what network Centers of Excellence are to be used.

Any plan participant in need of an organ transplant may contact the Third Party Administrator to initiate the pre-certification process resulting in a referral to a Center of Excellence. The Third Party Administrator acts as the primary liaison with the Center of Excellence, patient, and attending physician for all transplant admissions taking place at a Center of Excellence.

Additional information about this option, as well as a list of Centers of Excellence, will be given to plan participant(s) and updated as requested.

"Certified IDR Entity"
"Certified IDR Entity" shall mean an entity responsible for conducting determinations under the No Surprises Act and that has been properly certified by the Department of Health and Human Services, the Department of Labor, and the Department of the Treasury.

"Child" and/or "Children"
"Child" and/or "Children" shall mean any of the following:

- the Employee's biological Child
- any stepchild
- legally adopted Child
- any other Child for whom the Employee has been named legal guardian or legal parent

For purposes of this definition, a legally adopted Child shall include a Child placed in an Employee's physical custody in anticipation of adoption. "Child" shall also mean a covered Employee's Child who is an Alternate Recipient under a Qualified Medical Child Support Order, as required by the Federal Omnibus Budget Reconciliation Act of 1993. A "legal guardian" is a person recognized by a court of law as having the duty of taking care of the person and managing the property and rights of a minor child.

"Child" shall also mean a covered Employee's domestic partner's biological child, legally adopted child, or any other Child for whom the covered domestic partner has been named legal guardian or legal parent.

"CHIP"
"CHIP" refers to the Children's Health Insurance Program or any provision or section thereof, which is herein specifically referred to, as such act, provision or section may be amended from time to time.

"CHIPRA"
"CHIPRA" refers to the Children's Health Insurance Program Reauthorization Act of 2009 or any provision or section thereof, which is herein specifically referred to, as such act.

"Chiropractic Care"
"Chiropractic Care" shall mean the detection and correction, by manual or mechanical means, of the interference with nerve transmissions and expressions resulting from distortion, misalignment or dislocation of the spinal (vertebrae) column.

"Claim Determination Period"
"Claim Determination Period" shall mean each Plan Year.

"Claimant"
"Claimant" shall mean a Participant of the Plan, or entity acting on his or her behalf, authorized to submit claims to the Plan for processing, and/or appeal an Adverse Benefit Determination.

"Clean Claim"
A "Clean Claim" is one that can be processed in accordance with the terms of this document without obtaining additional information from the service Provider or a third party. It is a claim which has no defect or impropriety. A defect or impropriety shall include a lack of required sustaining documentation as set forth and in accordance with this document, or a particular circumstance requiring special treatment which prevents timely payment as set forth in this document, and only as permitted by this document, from being made. A Clean Claim does not include claims under investigation for fraud and abuse or claims under review for Medical Necessity or other coverage criteria, or fees under review for application of the Maximum Allowable Charge, or any other matter that may prevent the charge(s) from being Covered Expenses in accordance with the terms of this document.

Filing a Clean Claim. A Provider submits a Clean Claim by providing the required data elements on the standard claims forms, along with any attachments and additional elements or revisions to data elements, attachments and additional elements, of which the Provider has knowledge. The Plan Administrator may require attachments or other information in addition to these standard forms (as noted elsewhere in this document and at other times prior to claim submittal) to ensure charges constitute Covered Expenses as defined by and in accordance with the terms of this document. The paper claim form or electronic file record must include all required data elements and must be complete, legible, and accurate. A claim will not be considered to be a Clean Claim if the Participant has failed to submit required forms or additional information to the Plan as well.

"CMS"
"CMS" shall mean Centers for Medicare and Medicaid Services.

"COBRA"

“COBRA” shall mean the Consolidated Omnibus Budget Reconciliation Act of 1985, as amended.

“Coinsurance”
“Coinsurance” shall mean a cost sharing feature of many plans which requires a Participant to pay out-of-pocket a prescribed portion of the cost of Covered Expenses. The defined Coinsurance that a Participant must pay out-of-pocket is based upon his or her health plan design. Coinsurance is established as a predetermined percentage of the Maximum Allowable Charge for covered services and usually applies after a Deductible is met in a Deductible plan.

“Copayment” or “Copay”
“Copayment” or “Copay” shall mean a dollar amount per visit the Participant pays to the Provider for health care expenses. In most plans, the Participant pays this after he or she meets his or her Deductible limit.

“Cosmetic Surgery”
“Cosmetic Surgery” shall mean any expenses Incurred in connection with the care and treatment of, or operations which are performed for plastic, reconstructive, or cosmetic purposes or any other service or supply which are primarily used to improve, alter, or enhance appearance of a physical characteristic which is within the broad spectrum of normal but which may be considered displeasing or unattractive, except when required by an Injury.

“Covered Expense(s)”
“Covered Expense(s)” shall mean a service or supply provided in accordance with the terms of this document, whose applicable charge amount does not exceed the Maximum Allowable Charge for an eligible Medically Necessary service, treatment or supply, meant to improve a condition or Participant’s health, which is eligible for coverage in accordance with this Plan. When more than one treatment option is available, and one option is no more effective than another, the Covered Expense is the least costly option that is no less effective than any other option.

All treatment is subject to benefit payment maximums shown in the Summary of Benefits and as set forth elsewhere in this document.

“Custodial Care”
“Custodial Care” shall mean care or confinement designated principally for the assistance and maintenance of the Participant, in engaging in the activities of daily living, whether or not totally disabled. This care or confinement could be rendered at home or by persons without professional skills or training. This care may relieve symptoms or pain but is not reasonably expected to improve the underlying medical condition. Custodial Care includes, but is not limited to, assistance in eating, dressing, bathing and using the toilet, preparation of special diets, supervision of medication which can normally be self-administered, assistance in walking or getting in and out of bed, and all domestic activities.

“Deductible”
“Deductible” shall mean an aggregate amount for certain expenses for covered services that is the responsibility of the Participant to pay for him or herself each Calendar Year before the Plan will begin its payments.

“Dentist”
“Dentist” shall mean a properly trained person holding a D.D.S. or D.M.D. degree and practicing within the scope of a license to practice dentistry within their applicable geographic venue.

“Dependent”
“Dependent” shall mean one or more of the following person(s):

1. An Employee's present spouse, thereby possessing a valid marriage license, not annulled or voided in any way. A Dependent spouse shall therefore not be one who is divorced from the Employee.
2. An Employee's opposite-sex and/or same-sex domestic partner as defined by the law of the state in which they reside. If there is no state definition, the domestic partner is not eligible for coverage under the Plan. ***NOTE:*** *To the extent COBRA coverage is applicable, an Employee's domestic partner is not considered a qualified beneficiary and does not have independent rights under COBRA; however, an Employee's domestic partner will be entitled to COBRA continuation coverage as a dependent of a qualified beneficiary. An Employee's domestic partner and the domestic partner's enrolled children will be considered a qualified beneficiary and eligible to continue coverage under the COBRA provisions to the same extent as an Employee's spouse or Child.*
3. An Employee's Child, or a covered Employee's covered domestic partner's Child who is less than 26 years of age. ***NOTE:*** *Coverage of a Dependent Child will continue until the end of the calendar month he or she turns 26 years of age.*
4. An Employee's Child, or a covered Employee's covered domestic partner's Child, regardless of age, who was covered under the Plan upon attaining the limiting age as stated in the numbers above, who is mentally or physically incapable of sustaining his or her own living. Such Child must have been mentally or physically incapable of earning his or her own living prior to attaining the limiting age as stated in the numbers above. Written proof of such incapacity and dependency satisfactory to the Plan must be furnished and approved by the Plan within 31 days after the date the Child attains the limiting age as stated in the numbers above. The deadline for submission of written proof of incapacity and dependency is 31 days following the original eligibility date for a new or re-enrolling Employee. The Plan may require, at reasonable intervals, subsequent proof satisfactory to the Plan during the next two years after such date. After such two year period, the Plan may require such proof, but not more often than once each year.

An Employee's spouse or domestic partner who is a resident of a country other than the United States shall not be deemed to be a "Dependent."

To establish a Dependent relationship, the Plan reserves the right to require documentation satisfactory to the Plan Administrator.

The Plan Administrator has discretionary authority to interpret these terms, and determine spousal status as defined herein, to the extent allowed by law.

NOTE: Tax treatment for certain dependents. *Federal tax law generally does not recognize former spouses, Legally Separated spouses, civil union or domestic partners, or the children of these partners, as dependents under the federal tax code unless the spouse, partner, or child otherwise qualifies as a dependent under the Internal Revenue Code §152. Therefore, the Employer may be required to automatically include the value of the health care coverage provided to any of the aforementioned individuals, who may be covered under this Plan as eligible Dependents, as additional income to the Employee.*

"Diagnosis"
"Diagnosis" shall mean the act or process of identifying or determining the nature and cause of an Illness or Injury through evaluation of patient history, examination, and review of laboratory data. Diagnosis shall also mean the findings resulting from such act or process.

"Diagnostic Service"
"Diagnostic Service" shall mean an examination, test, or procedure performed for specified symptoms to obtain information to aid in the assessment of the nature and severity of a medical condition or the identification of an Illness or Injury. The Diagnostic Service must be ordered by a Physician or other professional Provider.

“Drug”
“Drug” shall mean a Food and Drug Administration (FDA) approved Drug or medicine that is listed with approval in the *United States Pharmacopeia*, *National Formulary* or *AMA Drug Evaluations* published by the American Medical Association (AMA), that is prescribed for human consumption, and that is required by law to bear the legend: “Caution—Federal Law prohibits dispensing without prescription,” or a State restricted drug (any medicinal substance which may be dispensed only by prescription, according to State law), legally obtained and dispensed by a licensed drug dispenser only, according to a written prescription given by a Physician and/or duly licensed Provider. “Drug” shall also mean insulin for purposes of injection.

“Durable Medical Equipment”
“Durable Medical Equipment” shall mean equipment and/or supplies ordered by a health care Provider for everyday or extended use which meets all of the following requirements:

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.
4. Is appropriate for use in the home.

“Emergency”
“Emergency” shall mean a situation or medical condition with symptoms of sufficient severity (including severe pain) that the absence of immediate medical attention and treatment would reasonably be expected to result in: (a) serious jeopardy to the health of the individual (or, with respect to a pregnant woman, the woman's unborn child); (b) serious impairment to bodily functions; or (c) serious dysfunction of any bodily organ or part. An Emergency includes, but is not limited to, severe chest pain, poisoning, unconsciousness, and hemorrhage. Other Emergencies and acute conditions may be considered on receipt of proof, satisfactory to the Plan, per the Plan Administrator’s discretion, that an Emergency did exist. The Plan may, at its own discretion, request satisfactory proof that an Emergency or acute condition did exist.

“Emergency Medical Condition”
“Emergency Medical Condition” shall mean a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) so that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in a condition described in clause (i), (ii), or (iii) of section 1867(e)(1)(A) of the Social Security Act (42 U.S.C. 1395dd(e)(1)(A)). In that provision of the Social Security Act, clause (i) refers to placing the health of the individual (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy; clause (ii) refers to serious impairment to bodily functions; and clause (iii) refers to serious dysfunction of any bodily organ or part.

“Emergency Services”
“Emergency Services” shall mean, with respect to an Emergency Medical Condition, the following:

1. An appropriate medical screening examination (as required under section 1867 of the Social Security Act, 42 U.S.C. 1395dd) 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
2. 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).

When furnished with respect to an Emergency Medical Condition, Emergency Services shall also include an item or service provided by a Non-Network Provider or Non-Participating Health Care Facility (regardless of the department of the Hospital in which items or services are furnished) after the Participant is stabilized and as part of Outpatient observation or an Inpatient or Outpatient stay with respect to the visit in which the Emergency Services are furnished, until such time as the Provider determines that the Participant is able to travel using non-medical transportation or non-emergency medical transportation, and the Participant is in a condition to, and in fact does, give informed consent to the Provider to be treated as a Non-Network Provider.

"Employee"
A person who is active on the regular payroll of the employer, has begun to perform the duties of their job with the employer, and is regularly scheduled to work for the employer on a full or part-time basis in an employee/employer relationship.

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

Any employee who works at least twenty (20) hours per week is eligible to enroll. Any employee who works an average of thirty (30) hours per week as defined by federal law must be offered coverage. Any employee who works at least 90% of a forty (40) hour work week must enroll according to the SISC eligibility policy.

"Employer"
"Employer" is Self-Insured Schools of California (SISC).

"Essential Health Benefits"
"Essential Health Benefits" shall mean, under section 1302(b) of the Affordable Care Act, those health benefits to include at least the following general categories and the items and services covered within the 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 services; preventive and wellness services and chronic disease management; and pediatric services, including oral and vision care.

"Exclusion"
"Exclusion" shall mean conditions or services that this Plan does not cover.

"Experimental" and/or "Investigational"
"Experimental" and/or "Investigational" ("Experimental") shall mean services or treatments that are not widely used or accepted by most practitioners or lack credible evidence to support positive short or long-term outcomes from those services or treatments and that are not the subject of, or in some manner related to, the conduct of an Approved Clinical Trial, as such term is defined herein; these services are not included under or as Medicare reimbursable procedures, and include services, supplies, care, procedures, treatments or courses of treatment which meet either of the following requirements:

1. Do not constitute accepted medical practice under the standards of the case and by the standards of a reasonable segment of the medical community or government oversight agencies at the time rendered.
2. Are rendered on a research basis as determined by the United States Food and Drug Administration and the AMA's Council on Medical Specialty Societies.

A drug, device, or medical treatment or procedure is Experimental if one of the following requirements is met:

1. If the drug or device cannot be lawfully marketed without approval of the U.S. Food and Drug Administration and approval for marketing has not been given at the time the drug or device is furnished;
2. If reliable evidence shows that the drug, device or medical treatment or procedure is the subject of ongoing Phase I, II, or III clinical trials or under study to determine all of the following:

    a. Maximum tolerated dose.
    b. Toxicity.
    c. Safety.
    d. Efficacy.
    e. Efficacy as compared with the standard means of treatment or Diagnosis.

3. If reliable evidence shows that the consensus among experts regarding the drug, device, or medical treatment or procedure is that further studies or clinical trials are necessary to determine all of the following:

    a. Maximum tolerated dose.
    b. Toxicity.
    c. Safety.
    d. Efficacy.
    e. Efficacy as compared with the standard means of treatment or Diagnosis.

Reliable evidence shall mean one or more of the following:

1. Only published reports and articles in the authoritative medical and scientific literature.
2. The written protocol or protocols used by the treating facility or the protocol(s) of another facility studying substantially the same drug, device, or medical treatment or procedure.
3. The written informed consent used by the treating facility or by another facility studying substantially the same drug, device, or medical treatment or procedure.

Notwithstanding the above, a prescription drug for a treatment that has been approved by the Food and Drug Administration (FDA) but is used as a non-approved treatment shall not be considered Experimental/Investigational for purposes of this Plan and shall be afforded coverage to the same extent as any other prescription drug, provided that the drug is recognized by one of the following as being Medically Necessary for the specific treatment for which it has been prescribed:

1. The American Medical Association Drug Evaluations.
2. The American Hospital Formulary Service Drug Information.
3. The United States Pharmacopeia Drug Information.
4. A clinical study or review article in a reviewed professional journal.

Subject to a medical opinion, if no other Food and Drug Administration (FDA) approved treatment is feasible and as a result the Participant faces a life or death medical condition, the Plan Administrator retains discretionary authority to cover the services or treatment.

The Plan Administrator retains maximum legal authority and discretion to determine what is Experimental.

“Family Unit”
“Family Unit” shall mean the Employee and his or her Dependents covered under the Plan.

“FDA”
“FDA” shall mean Food and Drug Administration.

“Final Internal Adverse Benefit Determination”
"Final Internal Adverse Benefit Determination" shall mean an Adverse Benefit Determination that has been upheld by the Plan at the conclusion of the internal claims and appeals process, or an Adverse Benefit Determination with respect to which the internal claims and appeals process has been deemed exhausted.

“Final Post-Service Appeal”
“Final Post-Service Appeal” shall mean a post-service appeal, which constitutes the last internal appeal available to the Claimant, to be filed with the Plan Administrator, Plan Sponsor, and/or Claims Administrator. The term “Final Post-Service Appeal” shall only refer to such appeals if medical services and/or supplies have already been provided. Upon filing, adjudication and conclusion of this appeal, external review becomes available to the Claimant; otherwise in accordance with applicable terms found within the Plan Document and applicable law. The Plan Administrator, reserves the right to allocate certain discretionary authority as it applies to adjudication of Final Post-Service Appeals to the Claims Administrator.

“FMLA”
“FMLA” shall mean the Family and Medical Leave Act of 1993, as amended.

“FMLA Leave”
“FMLA Leave” shall mean an unpaid, job protected Leave of Absence for certain specified family and medical reasons, which the Company is required to extend to an eligible Employee under the provisions of the FMLA.

“GINA”
“GINA” shall mean the Genetic Information Nondiscrimination Act of 2008 (Public Law No. 110-233), which prohibits group health plans, issuers of individual health care policies, and employers from discriminating on the basis of genetic information.

“Habilitation/Habilitative Services”
“Habilitation/Habilitative Services” shall mean health care services that help a person keep, learn, or improve skills and functioning for daily living. Examples include therapy for a child who is not walking or talking at the expected age. These services may include physical and occupational therapy, speech-language pathology and other services for people with disabilities in a variety of Inpatient and/or Outpatient settings.

“HIPAA”
“HIPAA” shall mean the Health Insurance Portability and Accountability Act of 1996, as amended.

“Home Health Care”
“Home Health Care” shall mean the continual care and treatment of an individual if all of the requirements are met:

1. The institutionalization of the individual would otherwise have been required if Home Health Care was not provided.
2. The Home Health Care is the result of an Illness or Injury.

“Home Health Care Agency”
“Home Health Care Agency” shall mean an agency or organization which provides a program of Home Health Care and which meets one of the following requirements:

1. Is a Federally certified Home Health Care Agency and approved as such under Medicare.
2. Meets the established standards and is operated pursuant to applicable laws in the jurisdiction in which it is located and, is licensed and approved by the regulatory authority having the responsibility for licensing, where licensing is required.

3. Meets all of the following requirements.
    a. It is an agency which holds itself forth to the public as having the primary purpose of providing a Home Health Care delivery system bringing supportive services to the home.
    b. It has a full-time administrator.
    c. It maintains written records of services provided to the patient.
    d. Its staff includes at least one Registered Nurse (R.N.) or it has nursing care by a Registered Nurse (R.N.) available.
    e. Its employees are bonded and it provides malpractice insurance.

"Hospital"
"Hospital" shall mean an Institution, accredited by the Joint Commission on Accreditation of Hospitals (sponsored by the AMA and the AHA), under the supervision of a staff of Physicians that maintains diagnostic and therapeutic facilities on premises, for the provision of medical (including Surgical facilities for all Institutions other than those specializing in the care and treatment of mentally ill patients, provided such Institution is accredited as such a facility by the Joint Commission on Accreditation of Hospitals sponsored by the AMA and the AHA), diagnosis, treatment, and care to Injured or sick persons, on an Inpatient basis, with 24 hour a day nursing service by Registered Nurses.

To be deemed a "Hospital," the facility must be duly licensed if it is not a State tax supported Institution, and must not be primarily a place for rest, the aged, and/or a nursing home, custodial, or training institution; or an Institution which is supported in whole or in part by a Federal government fund.

Institutions and/or facilities not deemed to be a "Hospital" in accordance with Medicare, shall not be deemed to be Hospitals for this Plan's purposes.

"Hospital" shall also have the same meaning, where appropriate in context, set forth in the definition of "Ambulatory Surgical Center".

"HRSA"
"HRSA" shall mean Health Resources and Services Administration.

"Illness"
"Illness" shall mean any disorder which does not arise out of, which is not caused or contributed to by, and which is not a consequence of, any employment or occupation for compensation or profit; however, if evidence satisfactory to the Plan is furnished showing that the individual concerned is covered as an Employee under any workers' compensation law, occupational disease law or any other legislation of similar purpose, or under the maritime doctrine of maintenance, wages, and cure, but that the disorder involved is one not covered under the applicable law or doctrine, then such disorder shall, for the purposes of the Plan, be regarded as an Illness.

"Impregnation and Infertility Treatment"
"Impregnation and Infertility Treatment" shall mean any services, supplies or Drugs related to the Diagnosis or treatment of infertility.

"Incurred"
A Covered Expense is "Incurred" on 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, Covered 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.

“Independent Freestanding Emergency Department”
“Independent Freestanding Emergency Department” means a health care facility that is geographically separate and distinct, and licensed separately, from a Hospital under applicable state law, and which provides any Emergency Services.

“Injury”
“Injury” shall mean an Accidental Bodily Injury, which does not arise out of, which is not caused or contributed to by, and which is not a consequence of, any employment or occupation for compensation or profit.

“Inpatient”
“Inpatient” shall mean a Participant who receives care as a registered and assigned bed patient while confined in a Hospital, other than in its outpatient department, where a room and board is charged by the Hospital.

“Institution”
“Institution” shall mean a facility created and/or maintained for the purpose of practicing medicine and providing organized health care and treatment to individuals, operating within the scope of its license, such as a Hospital, Ambulatory Surgical Center, Psychiatric Hospital, community mental health center, Residential Treatment Facility, psychiatric treatment facility, Substance Use Disorder Treatment Center, alternative birthing center, or any other such facility that the Plan approves.

“Intensive Care Unit”
“Intensive Care Unit” shall have the same meaning set forth in the definition of “Cardiac Care Unit”.

“Intensive Outpatient Services”
“Intensive Outpatient Services” shall mean programs that have the capacity for planned, structured, service provision of at least two hours per day and three days per week. The range of services offered could include group, individual, family or multi-family group psychotherapy, psychoeducational services, and medical monitoring. These services would include multiple or extended treatment/rehabilitation/counseling visits or professional supervision and support. Program models include structured “crisis intervention programs,” “psychiatric or psychosocial rehabilitation,” and some “day treatment”.

“Leave of Absence”
“Leave of Absence” shall mean a period of time during which the Employee must be away from his or her primary job with the Employer, while maintaining the status of Employee during said time away from work, generally requested by an Employee and having been approved by his or her Participating Employer, and as provided for in the Participating Employer’s rules, policies, procedures and practices where applicable.

“Legal Separation” or “Legally Separated”
“Legal Separation” and/or “Legally Separated” shall mean an arrangement under the applicable state laws to remain married but maintain separate lives, pursuant to a valid court order.

“Mastectomy”
“Mastectomy” shall mean the Surgery to remove all or part of breast tissue as a way to treat or prevent breast cancer.

“Maximum Allowable Charge”
The “Maximum Allowable Charge” shall mean the amount payable for a specific covered item under this Plan. The Maximum Allowable Charge will be a negotiated rate, if one exists. If no negotiated rate exists, the Maximum Allowable Charge will be an amount that the Plan is required to pay pursuant to applicable law, applicable all-payer model agreement, court of competent jurisdiction, or Certified IDR Entity.

If and only if none of the factors above is applicable, the Plan Administrator will exercise its discretion to determine the Maximum Allowable Charge based on any of the following: Medicare cost data, established health care pricing databases, amounts actually collected by Providers in the area for similar services, or average wholesale price (AWP) or manufacturer's retail pricing (MRP). These ancillary factors will take into account generally-accepted billing standards and practices.

When more than one treatment option is available, and one option is no more effective than another, the least costly option that is no less effective than any other option will be considered within the Maximum Allowable Charge. The Maximum Allowable Charge will be limited to an amount which, in the Plan Administrator's discretion, is charged for services or supplies that are not unreasonably caused by the treating Provider, including errors in medical care that are clearly identifiable, preventable, and serious in their consequence for patients. A finding of Provider negligence or malpractice is not required for services or fees to be considered ineligible pursuant to this provision.

"Medical Child Support Order"
"Medical Child Support Order" shall mean any judgment, decree or order (including approval of a domestic relations settlement agreement) issued by a court of competent jurisdiction that meets one of the following requirements:

1. Provides for child support with respect to a Participant's Child or directs the Participant to provide coverage under a health benefits plan pursuant to a State domestic relations law (including a community property law).
2. Is made pursuant to a law relating to medical child support described in §1908 of the Social Security Act (as added by Omnibus Budget Reconciliation Act of 1993 §13822) with respect to a group health plan.

"Medical Record Review"
"Medical Record Review" is the process by which the Plan, based upon a Medical Record Review and audit, determines that a different treatment or different quantity of a Drug or supply was provided which is not supported in the billing, then the Plan Administrator may determine the Maximum Allowable Charge according to the Medical Record Review and audit results.

"Medically Necessary"
"Medically Necessary", "Medical Necessity" and similar language refers to health care services ordered by a Physician exercising prudent clinical judgment provided to a Participant for the purposes of evaluation, Diagnosis or treatment of that Participant's Illness or Injury. Such services, to be considered Medically Necessary, must be clinically appropriate in terms of type, frequency, extent, site and duration for the Diagnosis or treatment of the Participant's Illness or Injury. The Medically Necessary setting and level of service is that setting and level of service which, considering the Participant's medical symptoms and conditions, cannot be provided in a less intensive medical setting. Such services, to be considered Medically Necessary must be no more costly than alternative interventions, including no intervention and are at least as likely to produce equivalent therapeutic or diagnostic results as to the Diagnosis or treatment of the Participant's Illness or Injury without adversely affecting the Participant's medical condition. The service must meet all of the following requirements:

1. Its purpose must be to restore health.
2. It must not be primarily custodial in nature.
3. It is ordered by a Physician for the Diagnosis or treatment of an Illness or Injury.
4. The Plan reserves the right to incorporate CMS guidelines in effect on the date of treatment as additional criteria for determination of Medical Necessity and/or a Covered Expense.

For Hospital stays, this means that acute care as an Inpatient is necessary due to the kind of services the Participant is receiving or the severity of the Participant's condition and that safe and adequate care cannot be received as an Outpatient or in a less intensified medical setting. The mere fact that the service is

furnished, prescribed or approved by a Physician does not necessarily mean that it is “Medically Necessary.” In addition, the fact that certain services are specifically excluded from coverage under this Plan because they are not “Medically Necessary” does not mean that all other services are “Medically Necessary”.

To be Medically Necessary, all of the above criteria must be met. The Plan Administrator has the discretionary authority to decide whether care or treatment is Medically Necessary based on recommendations of the Plan Administrator’s own medical advisors, the findings of the American Medical Association or similar organization, or any other sources that the Plan Administrator deems appropriate.

Off-label Drug use is considered Medically Necessary when all of the following conditions are met:

1. The Drug is approved by the Food and Drug Administration (FDA).
2. The prescribed Drug use is supported by one of the following standard reference sources:
    a. Micromedex® DRUGDEX®.
    b. The American Hospital Formulary Service Drug Information.
    c. Medicare approved compendia.
    d. Scientific evidence is supported in well-designed clinical trials published in peer-reviewed medical journals, which demonstrate that the Drug is safe and effective for the specific condition.
3. The Drug is otherwise Medically Necessary to treat the specific condition, including life threatening conditions or chronic and seriously debilitating conditions.

“Medicare”
“Medicare” shall mean the Federal program by which health care is provided to individuals who are 65 or older, certain younger individuals with disabilities, and individuals with End-Stage Renal Disease, administered in accordance with parameters set forth by the Centers for Medicare and Medicaid Services (CMS) and Title XVIII of the Social Security Act of 1965, as amended, by whose terms it was established.

“Mental Disorder," "Behavioral Disorder," or "Neurodevelopmental Disorder”
“Mental Disorder,” “Behavioral Disorder,” or “Neurodevelopmental Disorder” shall mean any Illness or condition, regardless of whether the cause is organic, that is classified as a Mental Disorder, Behavioral Disorder, or Neurodevelopmental Disorder in the current edition of International Classification of Diseases, published by the U.S. Department of Health and Human Services, or is listed in the current edition of Diagnostic and Statistical Manual of Mental Disorders, published by the American Psychiatric Association, or other relevant State guideline or applicable sources.

“Mental Health Parity Act of 1996 (MHPA) and Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA), Collectively, the Mental Health Parity Provisions”
“The Mental Health Parity Provisions” shall mean in the case of a group health plan (or health insurance coverage offered in connection with such a plan) that provides both medical and surgical benefits and mental health or Substance Use Disorder benefits, such plan or coverage shall ensure that all of the following requirements are met:

1. The financial requirements applicable to such mental health or Substance Use Disorder benefits are no more restrictive than the predominant financial requirements applied to substantially all medical and surgical benefits covered by the Plan (or coverage).
2. There are no separate cost sharing requirements that are applicable only with respect to mental health or Substance Use Disorder benefits, if these benefits are covered by the group health plan (or health insurance coverage is offered in connection with such a plan).
3. The treatment limitations applicable to such mental health or Substance Use Disorder benefits are no more restrictive than the predominant treatment limitations applied to substantially all medical and surgical benefits covered by the Plan (or coverage).

4. There are no separate treatment limitations that are applicable only with respect to mental health or Substance Use Disorder benefits, if these benefits are covered by the group health plan (or health insurance coverage is offered in connection with such a plan).

“National Medical Support Notice” or “NMSN”
“National Medical Support Notice” or “NMSN” shall mean a notice that contains all of the following information:

1. The name of an issuing State child support enforcement agency.
2. The name and mailing address (if any) of the Employee who is a Participant under the Plan or eligible for enrollment.
3. The name and mailing address of each of the Alternate Recipients (i.e., the Child or Children of the Participant) or the name and address of a State or local official may be substituted for the mailing address of the Alternate Recipients(s).
4. Identity of an underlying child support order.

"Network” or "In-Network"
“Network” or "In-Network" shall mean the facilities, providers and suppliers who have by contract via a medical Provider Network agreed to allow the Plan access to discounted fees for service(s) provided to Participants, and by whose terms the Network’s Providers have agreed to accept Assignment of Benefits and the discounted fees thereby paid to them by the Plan as payment in full for Covered Expenses. The applicable Provider Network will be identified on the Participant’s identification card.

“Non-Network” or “Out-of-Network”
“Non-Network” or “Out-of-Network” shall mean the facilities, Providers and suppliers that do not have an agreement with a designated Network to provide care to Participants.

“Nurse”
“Nurse” shall mean an individual who has received specialized nursing training and is authorized to use the designation Registered Nurse (R.N.), Licensed Vocational Nurse (L.V.N.) or Licensed Practical Nurse (L.P.N.), and who is duly licensed by the State or regulatory agency responsible for such license in the State in which the individual performs the nursing services.

“Open Enrollment Period”
“Open Enrollment Period” shall mean the month of August in each Calendar Year.

“Other Plan”
“Other Plan” shall mean any group health plan or health insurance coverage as defined in 42 U.S. Code § 300gg-91 from which a Participant is entitled to benefits.

“Out-of-Area”
“Out-of-Area” shall mean services received by a Participant outside of the normal geographic area supported by the Plan’s Network, as determined by the Plan Administrator, at the time each Participant becomes eligible for coverage under this Plan.

“Outpatient”
“Outpatient” shall mean treatment including services, supplies, and medicines provided and used at a Hospital under the direction of a Physician to a person not admitted as a registered bed patient; or services rendered in a Physician’s office, laboratory, or x-ray facility, an Ambulatory Surgical Center, or the patient’s home.

“Partial Hospitalization”
“Partial Hospitalization” shall mean medically directed intensive, or intermediate short-term mental health and Substance Use Disorder treatment, for a period of less than twenty-four (24) hours but more than four (4) hours in a day in a licensed or certified facility or program.

“Participant”
“Participant” shall mean any Employee, Dependent, individual that is covered under the Plan through COBRA continuation, or retiree who is eligible for benefits (and enrolled) under the Plan.

“Participating Health Care Facility”
“Participating Health Care Facility” shall mean a Hospital or Hospital Outpatient department, critical access Hospital, Ambulatory Surgical Center, or other Provider as required by law, which has a direct or indirect contractual relationship with the Plan with respect to the furnishing of a healthcare item or service. A single direct contract or case agreement between a health care facility and a plan constitutes a contractual relationship for purposes of this definition with respect to the parties to the agreement and particular individual(s) involved.

“Patient Protection and Affordable Care Act (PPACA)”
The “Patient Protection and Affordable Care Act (PPACA)” means the health care reform law enacted in March 2010, Public Law 111-148; PPACA, together with the Health Care and Education Reconciliation Act, is commonly referred to as Affordable Care Act (ACA). (See “Affordable Care Act”).

“Physician”
“Physician” shall mean a Doctor of Medicine (M.D.), Doctor of Osteopathy (D.O.), Doctor of Dental Surgery (D.D.S.), Doctor of Podiatry (D.P.M.), Doctor of Chiropractic (D.C.), Psychologist (Ph.D.), Audiologist, Certified Nurse Anesthetist, Licensed Professional Counselor, Licensed Professional Physical Therapist, Master of Social Work (M.S.W.), Occupational Therapist, Physiotherapist, Speech Language Pathologist, psychiatrist, midwife, and any other practitioner of the healing arts who is licensed and regulated by a State or Federal agency, acting within the scope of that license.

“Plan Year”
“Plan Year” shall mean a period commencing on the Effective Date or any anniversary of the adoption of this Plan and continuing until the next succeeding anniversary.

“Pre-Admission Tests”
“Pre-Admission Tests” shall mean those medical tests and Diagnostic Services completed prior to a scheduled procedure, including Surgery, or scheduled admissions to the Hospital or Inpatient health care facility provided that all of the following requirements are met:

1. The Participant obtains a written order from the Physician.
2. The tests are approved by both the Hospital and the Physician.
3. The tests are performed on an Outpatient basis prior to Hospital admission.
4. The tests are performed at the Hospital into which confinement is scheduled, or at a qualified facility designated by the Physician who will perform the procedure or Surgery.

“Pregnancy”
“Pregnancy” shall mean a physical state whereby a woman presently bears a child or children in the womb, prior to but likely to result in childbirth, miscarriage and/or non-elective abortion. Pregnancy is considered an Illness for the purpose of determining benefits under this Plan.

“Preventive Care”
“Preventive Care” shall mean certain Preventive Care services.

To comply with the ACA, and in accordance with the recommendations and guidelines, plans shall provide In-Network coverage for all of the following:

1. Evidence-based items or services rated A or B in the United States Preventive Services Task Force recommendations.
2. Recommendations of the Advisory Committee on Immunization Practices adopted by the Director of the Centers for Disease Control and Prevention.
3. Comprehensive guidelines for infants, children, and adolescents supported by the Health Resources and Services Administration (HRSA).
4. Comprehensive guidelines for women supported by the Health Resources and Services Administration (HRSA).

Copies of the recommendations and guidelines may be found at the following websites:
https://www.healthcare.gov/coverage/preventive-care-benefits/;
https://www.uspreventiveservicestaskforce.org/uspstf/recommendation-topics/uspstf-a-and-b-recommendations;
https://www.cdc.gov/acip/vaccine-recommendations/index.html
https://www.aap.org/periodicityschedule;
https://www.hrsa.gov/womensguidelines/.

For more information, Participants may contact the Plan Administrator / Employer.

"Primary Care Physician (PCP)"
"Primary Care Physician" shall mean a family practitioners, general practitioners, internists, OBGYNs, pediatricians, and office-based nurse practitioners, physician's assistants, licensed professional counselors, licensed certified professional counselors, certified chemical dependency counselors, or licensed clinical social workers (unless practicing under a Specialty). In any instance where any of the aforementioned clinicians are practicing as a Specialist, they are considered a Specialist.

"Prior Plan"
"Prior Plan" shall mean the coverage provided on a group or group type basis by the group insurance policy, benefit plan or service plan that was terminated on the day before the Effective Date of the Plan and replaced by the Plan.

"Prior to Effective Date" or "After Termination Date"
"Prior to Effective Date" or "After Termination Date" are dates occurring before a Participant gains eligibility from the Plan, or dates occurring after a Participant loses eligibility from the Plan (unless continuation of benefits applies).

"Privacy Standards"
"Privacy Standards" shall mean the applicable standards for the privacy of individually identifiable health information, pursuant to HIPAA.

"Provider"
"Provider" shall mean an entity whose primary responsibility is related to the supply of medical care. Each Provider must be licensed, registered, or certified by the appropriate State agency where the medical care is performed, as required by that State's law where applicable. Where there is no applicable State agency, licensure, or regulation, the Provider must be registered or certified by the appropriate professional body. The Plan Administrator may determine that an entity is not a "Provider" as defined herein if that entity is not deemed to be a "Provider" by the Centers for Medicare and Medicaid Services (CMS) for purposes arising from payment and/or enrollment with Medicare; however, the Plan Administrator is not so bound by CMS' determination of an entity's status as a Provider. All facilities must meet the standards as set forth within the applicable definitions of the Plan as it relates to the relevant provider type.

“Psychiatric Hospital”
“Psychiatric Hospital” shall mean an Institution, appropriately licensed as a Psychiatric Hospital, established for the primary purpose of providing diagnostic and therapeutic psychiatric services for the treatment of mentally ill persons either by, or under the supervision of, a Physician. As such, to be deemed a “Psychiatric Hospital”, the Institution must ensure every patient is under the care of a Physician and their staffing pattern must ensure the availability of a Registered Nurse 24 hours each day. Should the Institution fail to maintain clinical medical records on all patients permitting the determination of the degree and intensity of treatment to be provided, that Institution will not be deemed to be a “Psychiatric Hospital”.

To be deemed a “Psychiatric Hospital,” the Institution must be duly licensed and must not be primarily a place for rest, the aged, and/or a nursing home, custodial, or training institution.

“Qualified Medical Child Support Order” or “QMCSO”
“Qualified Medical Child Support Order” or “QMCSO” shall mean a Medical Child Support Order, in accordance with applicable law, and which creates or recognizes the existence of an Alternate Recipient’s right to, or assigns to an Alternate Recipient the right to, receive benefits for which a Participant or eligible Dependent is entitled under this Plan.

“Qualifying Payment Amount”
“Qualifying Payment Amount” means the median of the contracted rates recognized by the Plan, or recognized by all plans serviced by the Plan’s Third Party Administrator (if calculated by the Third Party Administrator), for the same or a similar item or service provided by a Provider in the same or similar specialty in the same geographic region. If there are insufficient (meaning fewer than three) contracted rates available to determine a Qualifying Payment Amount, said amount will be determined by referencing a state all-payer claims database or, if unavailable, any eligible third-party database in accordance with applicable law.

“Recognized Amount”
“Recognized Amount” shall mean, except for Non-Network air ambulance services, an amount determined under an applicable all-payer model agreement, or if unavailable, an amount determined by applicable state law. If no such amounts are available or applicable and for Non-Network air ambulance services generally, the Recognized Amount shall mean the lesser of a Provider’s billed charge or the Qualifying Payment Amount.

“Rehabilitation”
“Rehabilitation” shall mean treatment(s) designed to facilitate the process of recovery from Injury or Illness to as normal a condition as possible.

“Rehabilitation Hospital”
“Rehabilitation Hospital” shall mean an appropriately licensed Institution, which is established in accordance with all relevant Federal, State and other applicable laws, to provide therapeutic and restorative services to individuals seeking to maintain, reestablish, or improve motor-skills and other functioning deemed Medically Necessary for daily living, that have been lost or impaired due to Illness and/or Injury. To be deemed a “Rehabilitation Hospital”, the Institution must be legally constituted, operated, and accredited for its stated purpose by either the Joint Commission on Accreditation of Hospitals or the Commission on Accreditation for Rehabilitation Facilities, as well as approved for its stated purpose by the Centers for Medicare and Medicaid Services (CMS) for Medicare purposes.

To be deemed a “Rehabilitation Hospital”, the Institution must be duly licensed and must not be primarily a place for rest, the aged, and/or a nursing home, custodial, or training institution.

“Residential Treatment Facility”
“Residential Treatment Facility” shall mean a facility licensed or certified as such by the jurisdiction in which it is located to operate a program for the treatment and care of Participants diagnosed with alcohol, drug or Substance Use Disorders or mental illness.

“Room and Board”
“Room and Board” shall mean a Hospital’s charge for any of the following:

1. Room and complete linen service.
2. Dietary service including all meals, special diets, therapeutic diets, required nourishment’s, dietary supplements and dietary consultation.
3. All general nursing services including but not limited to coordinating the delivery of care, supervising the performance of other staff members who have delegated member care and member education.
4. Other conditions of occupancy which are Medically Necessary.

“Security Standards”
“Security Standards” shall mean the final rule implementing HIPAA’s Security Standards for the Protection of Electronic Protected Health Information (PHI), as amended.

“Service Waiting Period”
“Service Waiting Period” shall mean an interval of time that must pass before an Employee is eligible to enroll under the terms of the Plan. The Employee must be a continuously Active Employee of the Employer during this interval of time, however for purposes of satisfying a Service Waiting Period an Employee shall be considered an Active Employee for the duration of any absence from work due to a health factor as defined by HIPAA.

“Skilled Nursing Facility”
“Skilled Nursing Facility” shall mean a facility that fully 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, Custodial Care, or educational care.
7. It is approved and licensed by Medicare.

“Specialty Drug(s)”
“Specialty Drug(s)” shall mean high-cost prescription medications used to treat complex, chronic conditions including, but not limited to cancer, rheumatoid arthritis and multiple sclerosis. Specialty Drugs often require special handling (like refrigeration during shipping) and administration (such as injection or infusion). Please contact the Prescription Drug Plan Administrator to determine specific drug coverage.

“Substance Use Disorder”
“Substance Use Disorder” shall mean any disease or condition that is classified as a Substance Use Disorder as listed in the current edition of the International Classification of Diseases, published by the U.S. Department of Health and Human Services, as listed in the current edition of Diagnostic and Statistical Manual of Mental Disorders, published by the American Psychiatric Association, or other relevant State guideline or applicable sources.

“Substance Use Disorder Treatment Center”
“Substance Use Disorder Treatment Center” shall mean an Institution whose facility is licensed, certified or approved as a Substance Use Disorder Treatment Center by a Federal, State, or other agency having legal authority to so license. Where applicable, the “Substance Use Disorder Treatment Center” must also be appropriately accredited by the Joint Commission on Accreditation of Hospitals.

“Surgery”
“Surgery” shall in the Plan Administrator’s discretion mean the treatment of Injuries or disorders of the body by incision or manipulation, especially with instruments designed specifically for that purpose, and the performance of generally accepted operative and cutting procedures, performed within the scope of the Provider’s license.

“Surgical Procedure”
“Surgical Procedure” shall have the same meaning set forth in the definition of “Surgery.”

“Third Party Administrator”
“Third Party Administrator” shall mean the claims administrator which provides customer service and claims payment services only and does not assume any financial risk or obligation with respect to those claims. The Third Party Administrator is not an insurer of health benefits under this Plan. The Third Party Administrator is not responsible for Plan financing and does not guarantee the availability of benefits under this Plan.

“Uniformed Services”
“Uniformed Services” shall mean the Armed Forces, the Army National Guard and the Air National Guard, when engaged in active duty for training, inactive duty training, or full-time National Guard duty, the commissioned corps of the Public Health Service, and any other category of persons designated by the President of the United States in time of war or Emergency.

“USERRA”
“USERRA” shall mean the Uniformed Services Employment and Reemployment Rights Act of 1994 (“USERRA”).

“Utilization Review Manager”
“Utilization Review Manager” shall mean a team of medical care professionals selected to conduct pre-certification review, emergency admission review, continued stay review, discharge planning, patient consultation, and case management. For more information, see the Utilization Management section of this document.

All other defined terms in this Plan Document shall have the meanings specified in the Plan Document where they appear.

ELIGIBILITY FOR COVERAGE

Eligibility for Individual Coverage

An employee will be covered under this Plan the first of the month (unless stated otherwise) following their eligibility date provided the employee satisfies all requirements as listed herein to become eligible.

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

1. Is a full-time, active employee of the employer
   An employee is considered to be full-time if they normally work at least 30 hours per week and are on the regular payroll of the employer for that work.
2. Is a part-time, active employee of the employer
   Any employee who works at least 20 hours per week is eligible to enroll. Any employee who works an average of 30 hours per week as defined by federal law must be offered coverage. Any employee who works at least 90% of a 40 hour work week must enroll according to the SISC eligibility policy.
3. A classified non-temporary employee who works the minimum number of hours required by SISC and the participating employer.
4. A certified employee under contract and who works a minimum of 50% of a certificated job.
5. A retired employee who retired from active employment and was covered under a Plan sponsored by SISC immediately prior to retirement.
6. Is in a class eligible for coverage as shown above.

Reinstatement of Coverage

A covered Employee who is terminated and rehired will be treated as a New Employee upon rehire. Upon return, coverage will be reinstated on the first of the month following the date of rehire, so long as all other eligibility criteria are satisfied.

An Employee who is terminated and rehired will be treated as a continuing Employee upon rehire only if the Employee break in service did not create a break in coverage from the SISC plan and the Employee was a covered Employee immediately prior to termination.

Eligibility for Retiree Coverage

A person is eligible for retiree coverage from the first day that he or she meets one of the following requirements:

1. Is a retired Employee of the Employer.
2. Is an Active Employee who is eligible for retirement under the Plan having a minimum of two consecutive years of employment and is between the ages of 62 and 65. Spouses and Dependents of a retiree are also eligible provided they meet the requirements stated in the provision entitled “Eligibility for Dependent Coverage”.

Retiree coverage will be paid for by the retiree. Rates will be one-half of the prevailing COBRA rates for each class of Employees.

Eligibility Dates for Dependent Coverage

Each Employee will become eligible for coverage under this Plan for his or her Dependents on the latest of the following dates:

1. His or her date of eligibility for coverage for himself or herself under the Plan.
2. The date coverage for his or her Dependents first becomes available under any amendment to the Plan, if such coverage was not provided under the Plan on the Effective Date of the Plan.
3. The first date upon which he or she acquires a Dependent.

4. If applicable, for a Dependent Child, the date the Dependent Child becomes eligible due to a qualifying status change event.

In no event will any Dependent Child be covered as a Dependent of more than one Employee who is covered under the Plan.

In order for an Employee's Dependent to be covered under the Plan the Employee must be enrolled for coverage under the Plan.

Effective Dates of Coverage; Conditions

The coverage for which an individual is eligible under this Plan will become effective on the date specified below, subject to the conditions of this section.

1. Enrollment Application (paper or electronic as applicable). Employee(s) may seek to obtain coverage for themselves and/or Dependents via a form (either paper or electronic as applicable) furnished by the Plan Administrator, in a manner that is satisfactory to the Plan Administrator, and within 31 days following the applicable date of eligibility. If coverage is available and appropriate, coverage will become effective after review of the form, and upon the date such Employee or Dependents become eligible.
2. Birth of Dependent Child. A newborn Child of a covered Employee will be considered eligible and will be covered from the moment of birth for a period of 31 days only for coverage to continue beyond this period, the Employee must submit a written application to the Plan to enroll the Child within the limited 31 day period (i.e. period from the moment of birth). The application must also be accompanied by proof of eligibility, and any required contribution, ongoing, as the case may be. A newborn Child of a Dependent Child is not eligible for this Plan unless the newborn Child meets the definition of an eligible Dependent.
3. Newly Acquired Dependents. If while an Employee is enrolled for coverage, that Employee acquires a Dependent, coverage for the newly acquired Dependent shall be effective on the first of the month following the date of birth or marriage or domestic partnership. Guardianships or adoptions shall be effective on the date the Dependent becomes eligible. A written application must be made to the Plan within 31 days of the date of the newly acquired Dependent's initial eligibility, and any required contributions must be made if enrollment is otherwise approved by the Plan Administrator.
4. Requirement for Employee Coverage. Coverage for Dependents shall only be available to Dependents of Employees eligible for coverage for themselves.
5. Dependents of Multiple Employees. If a Dependent may be deemed to be a Dependent of more than one Covered Employee, such Dependent shall be deemed to be a Dependent of one such Employee only.
6. Medicaid Coverage. An individual's eligibility for any State Medicaid benefits will not be taken into account by the Plan in determining that individual's eligibility under the Plan.
7. FMLA Leave. Regardless of any requirements set forth in the Plan, the Plan shall at all times comply with FMLA.

NOTE: *It is the responsibility of the enrolled Employee to notify his or her Employer of any changes in the Dependent's status.*

Special and Open Enrollment

Federal law requires and the Plan provides so-called "special enrollment periods," during which Employees may enroll in the Plan, even if they declined to enroll during an initial or subsequent eligibility period.

Loss of Other Coverage

This Plan will permit an eligible Employee or Dependent (including his or her spouse or domestic partner) who is eligible, but not enrolled, to enroll for coverage under the terms of the Plan if each of the following conditions is met:

1. The eligible Employee or Dependent was covered under another group health plan or had other health insurance coverage at the time coverage under this Plan was offered.
2. The eligible Employee stated in writing at the time this Plan was offered, that the reason for declining enrollment was due to the eligible Employee having coverage under another group health plan or due to the Employee having other health insurance coverage.
3. The eligible Employee or Dependent lost other coverage pursuant to one of the following events:
    a. The eligible Employee or Dependent was under COBRA and the COBRA coverage was exhausted.
    b. The eligible Employee or Dependent was not under COBRA and the other coverage was terminated as a result of loss of eligibility (including as a result of divorce, loss of Dependent status, death, termination of employment, or reduction in the number of hours worked).
    c. The eligible Employee or Dependent moved out of a Health Maintenance Organization (HMO) service area with no other option available.
    d. The Plan is no longer offering benefits to a class of similarly situated individuals.
    e. The benefit package option is no longer being offered and no substitute is available.
    f. The employer contributions under the other coverage were terminated.

If an Employee is currently enrolled in a benefit package, the Employee may elect to enroll in another benefit package under the Plan if the following requirements are met:

1. Multiple benefit packages are available.
2. A Dependent of the enrolled Employee has a special enrollment right in the Plan because the Dependent has lost eligibility for other coverage.

Special enrollment rights will not be available to an Employee or Dependent if either of the following requirements is met:

1. The other coverage is/was available via COBRA Continuation Coverage and the Employee or Dependent failed to exhaust the maximum time available to him or her for such COBRA coverage; or
2. The Employee or Dependent lost the other coverage as a result of the individual's failure to pay premiums or required contributions or for cause (such as making a fraudulent claim or an intentional misrepresentation of a material fact in connection with the Other Plan).

For an eligible Employee or Dependent(s) who has met the conditions specified above, this Plan will be effective at 12:01 A.M. on the first day of the first calendar month beginning after the date the written or electronic request for enrollment (including the Participant's enrollment application, either paper or electronic as applicable, in the case of enrollment) is received by the Plan and the request is made within 31 days from loss of coverage. For example, if the Employee loses his or her other health coverage on April 22, he or she must notify the Plan Administrator and apply for coverage by close of business on May 23.

New Dependent
An Employee or Dependent who is eligible, but not enrolled in this Plan, may be eligible to enroll during a special enrollment period if an Employee acquires a new Dependent as a result of marriage, domestic partnership, legal guardianship, birth, adoption, or placement for adoption. To be eligible for this special enrollment, the Employee must apply in writing or electronically, as applicable, no later than 31 days after he or she acquires the new Dependent. For example, if the Employee or Employee's spouse gives birth to a baby on June 22, he or she must notify the Plan Administrator and apply for coverage by close of business on July 23. The following conditions apply to any eligible Employee and Dependents:

An Employee or Dependent who is eligible, but not enrolled in this Plan, may enroll during a special enrollment period if both of the following conditions are met:

1. The eligible Employee is a covered Employee under the terms of this Plan but elected not to enroll during a previous enrollment period.
2. An individual has become a Dependent of the eligible Employee through marriage, domestic partnership, legal guardianship, birth, adoption, or placement for adoption.

If the conditions for special enrollment are satisfied, the coverage of the Dependent and/or Employee enrolled during the special enrollment period will be effective at 12:01 A.M. for the following events:

1. In the case of marriage, on the date of the marriage.
2. For a domestic partnership, on the date of the domestic partnership agreement.
3. For a legal guardianship, on the date on which such Child is placed in the covered Employee's home pursuant to a court order appointing the covered Employee as legal guardian for the Child.
4. In the case of a Dependent's birth, as of the date of birth.
5. In the case of a Dependent's adoption or placement for adoption, the date of the adoption or placement for adoption.

Additional Special Enrollment Rights
Employees and Dependents who are eligible but not enrolled are entitled to enroll under one of the following circumstances:

1. The Employee's or Dependent's Medicaid or State Child Health Insurance Plan (i.e. CHIP) coverage has terminated as a result of loss of eligibility and the Employee requests coverage under the Plan within 60 days after the termination.
2. The Employee or Dependent become eligible for a contribution / premium assistance subsidy under Medicaid or a State Child Health Insurance Plan (i.e. CHIP), and the Employee requests coverage under the Plan within 60 days after eligibility is determined.

If the conditions for special enrollment are satisfied, coverage for the Employee and/or his or her Dependent(s) will be effective at 12:01 A.M. on the first day following the above-described additional special enrollment events.

Open Enrollment
Prior to the start of a Plan Year, this Plan has an Open Enrollment Period. Eligible Participants who are not covered under this Plan may enroll for coverage during Open Enrollment Periods. If the Plan has an active open enrollment period, a plan participant who fails to make an election will automatically retain their present coverages. Coverage for Participants enrolling during an Open Enrollment Period will become effective on October 01, as long as all other eligibility requirements have been met. If the other eligibility requirements have not been met, coverage for Participants enrolling during an Open Enrollment Period will become effective as stated in the provision, "Eligibility for Individual Coverage".

The terms of the Open Enrollment Period, including duration of the election period, shall be determined by the Plan Administrator and communicated prior to the start of an Open Enrollment Period.

"Open Enrollment Period" shall mean the month of August in each Calendar Year.

Qualified Medical Child Support Orders
This Plan will provide for immediate enrollment and benefits to the Child or Children of a Participant, not including an ex-stepchild or ex-stepchildren, who are the subject of a Qualified Medical Child Support Order (QMCSO), regardless of whether the Child or Children reside with the Participant, provided the Child or Children are not already enrolled as an eligible Dependent as described in this Plan. If a QMCSO is issued, then the Child or Children shall become Alternate Recipient(s) of the benefits under this Plan, subject to the same limitations, restrictions, provisions and procedures as any other Participant. The Plan Administrator will determine if the order properly meets the standards described herein. A properly

completed National Medical Support Notice (NMSN) will be treated as a QMCSO and will have the same force and effect.

To be considered a Qualified Medical Child Support Order, the Medical Child Support Order must contain the following information:

1. The name and last known mailing address (if any) of the Participant and the name and mailing address of each such Alternate Recipient covered by the order.
2. A reasonable description of the type of coverage to be provided by this Plan to each Alternate Recipient, or the manner in which such type of coverage is to be determined.
3. The period of coverage to which the order applies.
4. The name of this Plan.

A National Medical Support Notice shall be deemed a QMCSO if all of the following requirements are met:

1. It contains the information set forth in the Definitions section in the definition of "National Medical Support Notice."
2. It identifies either the specific type of coverage or all available group health coverage. If the Employer receives a NMSN that does not designate either specific type(s) of coverage or all available coverage, the Employer and the Plan Administrator will assume that all are designated.
3. It informs the Plan Administrator that, if a group health plan has multiple options and the Participant is not enrolled, the issuing agency will make a selection after the NMSN is qualified, and, if the agency does not respond within 20 days, the Child will be enrolled under the Plan's default option (if any).
4. It specifies that the period of coverage may end for the Alternate Recipient(s) only when similarly situated dependents are no longer eligible for coverage under the terms of the Plan, or upon the occurrence of certain specified events.

A NMSN need not be recognized as a QMCSO if it requires the Plan to provide any type or form of benefit, or any option, not otherwise provided to the Participants and eligible Participants without regard to the provisions herein, except to the extent necessary to meet the requirements of a State law relating to Medical Child Support Orders, as described in Social Security Act §1908 (as added by Omnibus Budget Reconciliation Act of 1993 §13822).

In the instance of any Medical Child Support Order received by this Plan, the Plan Administrator shall, as soon as administratively possible, perform the following:

1. In writing, notify the Participant and each Alternate Recipient covered by such Order (at the address included in the Order) of the receipt of such Order and the Plan's procedures for determining whether the Order qualifies as a QMCSO.
2. Make an administrative determination if the order is a QMCSO and notify the Participant and each affected Alternate Recipient of such determination.

In the instance of any National Medical Support Notice received by this Plan, the Plan Administrator shall perform the following:

1. Notify the State agency issuing the notice with respect to the Child whether coverage of the Child is available under the terms of the Plan and, if so:
    a. Whether the Child is covered under the Plan.
    b. Either the effective date of the coverage or, if necessary, any steps to be taken by the custodial parent or by the official of a State or political subdivision to effectuate the coverage.
2. Provide to the custodial parent (or any State official serving in a substitute capacity) a description of the coverage available and any forms or documents necessary to effectuate such coverage.

As required by Federal law, the Plan Administrator shall perform the following:

1. Establish reasonable procedures to determine whether Medical Child Support Order or National Medical Support Notice are Qualified Medical Child Support Orders.
2. Administer the provision of benefits under such qualified orders. Such procedures shall:
    a. Be in writing.
    b. Provide for the notification of each person specified in a Medical Child Support Order as eligible to receive benefits under the plan (at the address included in the Medical Child Support Order) of such procedures promptly upon receipt by the plan of the Medical Child Support Order.
    c. Permit an Alternate Recipient to designate a representative for receipt of copies of notices that are sent to the Alternate Recipient with respect to a Medical Child Support Order.

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

Acquired Companies

Eligible Employees of an acquired company who are Actively at Work and were covered under the Prior Plan of the acquired company will be eligible for the benefits under this Plan on the date of acquisition. Any waiting period previously satisfied under the prior health plan will be applied toward satisfaction of the Service Waiting Period of this Plan. In the event that an acquired company did not have a health plan, all eligible Employees will be eligible on the date of the acquisition.

Genetic Information Nondiscrimination Act ("GINA")

"GINA" prohibits group health plans, issuers of individual health care policies, and employers from discriminating on the basis of genetic information.

The term "genetic information" means, with respect to any individual, information about any of the following:

1. Such individual's genetic tests.
2. The genetic tests of family members of such individual.
3. The manifestation of a disease or disorder in family members of such individual.

The term "genetic information" includes participating in clinical research involving genetic services. Genetic tests would include analysis of human DNA, RNA, chromosomes, proteins, or metabolites that detect genotypes, mutations, or chromosomal changes. Genetic information is a form of Protected Health Information (PHI) as defined by and in accordance with the Health Insurance Portability and Accountability Act of 1996 (HIPAA), and is subject to applicable Privacy and Security Standards.

Family members as it relates to GINA include dependents, plus all relatives to the fourth degree, without regard to whether they are related by blood, marriage, or adoption. Underwriting as it relates to GINA includes any rules for determining eligibility, computing premiums or contributions, and applying pre-existing condition limitations. Offering reduced premiums or other rewards for providing genetic information would be impermissible underwriting.

GINA will not prohibit a health care Provider who is treating an individual from requesting that the patient undergo genetic testing. The rules permit the Plan to obtain genetic test results and use them to make claims payment determinations when it is necessary to do so to determine whether the treatment provided to the patient was medically advisable and/or necessary.

The Plan may request, but not require, genetic testing in certain very limited circumstances involving research, so long as the results are not used for underwriting, and then only with written notice to the individual that participation is voluntary and will not affect eligibility for benefits, premiums or contributions.

In addition, the Plan will notify and describe its activity to the Health and Human Services secretary of its activities falling within this exception.

While the Plan may collect genetic information after initial enrollment, it may not do so in connection with any annual renewal process where the collection of information affects subsequent enrollment. The Plan will not adjust premiums or increase group contributions based upon genetic information, request or require genetic testing or collect genetic information either prior to or in connection with enrollment or for underwriting purposes.

TERMINATION OF COVERAGE

Termination Dates of Individual Coverage

The coverage of any Employee for himself or herself under this Plan will terminate on the earliest to occur of the following dates:

1. The date upon which the Plan is terminated.
2. The date upon which, he or she requests that such coverage be terminated, on the condition that such request is made on or before such date, unless prohibited by law.
3. The date of the expiration of the last period for which the Employee has made a contribution, in the event of his or her failure to make, when due, any contribution for coverage for himself or herself to which he or she has agreed in writing.
4. The date upon which the Employee is no longer eligible for such coverage under the Plan.
5. The date and time at which the termination of employment occurs.
6. Immediately upon submission of a fraudulent claim or any fraudulent information to the Plan (including enrollment information), by and/or on behalf of an Employee or his or her Dependent, or upon the Employee or his or her Dependent gaining knowledge of the submission, as determined by the Plan Administrator in its discretion, consistent with applicable laws and/or rules regarding such rescission.

Termination Dates of Retiree Coverage

The coverage of any retiree who is covered under the Plan will terminate on the earliest to occur of the following dates:

1. The date of termination of the Plan.
2. The date of death of the covered retiree.
3. The date of the expiration of the last period for which the retiree has made a contribution, in the event of his or her failure to make, when due, any contribution for coverage for himself or herself to which he or she has agreed in writing.
4. The date the covered retiree becomes eligible for Medicare coverage or becomes eligible for coverage under another Employer's health plan.

Termination Dates of Dependent Coverage

The coverage for any Dependents of any Employee who are covered under the Plan will terminate on the earliest to occur of the following dates:

1. The date upon which the Plan is terminated.
2. Upon the discontinuance of coverage for Dependents under the Plan.
3. The date of termination of the Employee's coverage for himself or herself under the Plan.
4. The date of the expiration of the last period for which the Employee has made a contribution, in the event of his or her failure to make, when due, any contribution for coverage for Dependents to which he or she has agreed in writing.
5. In the case of a Child age 26 or older for whom coverage is being continued due to mental or physical inability to earn his or her own living, the earliest to occur of:

    a. Cessation of such disability or inability.
    b. Failure to provide any required proof of continuous disability or inability or to submit to any required examination.
    c. Upon the Child's no longer being dependent on the Employee for his or her support.

6. The day immediately preceding the date such person is no longer a Dependent, except for Dependent Children, as defined herein, except as may be provided for in other areas of this section.

7. The last day of the month in which such person ceases to be a Dependent Child, as defined herein, except as may be provided for in other areas of this section or within this document.
8. A covered Employee's domestic partner's Child's (who is not the Employee's Dependent Child) coverage will end on the last day of the month in which the domestic partnership agreement has ended, or on the last day of the month in which the Child reaches the age limitation of the Plan (as outlined in the Plan's definition of "Dependent"), whichever occurs first.
9. For a Dependent Child whose coverage is required pursuant to a QMCSO, the last day of the calendar month as of which coverage is no longer required under the terms of the order or this Plan.
10. Immediately upon submission of a fraudulent claim or any fraudulent information to the Plan (including enrollment information), by and/or on behalf of an Employee or his or her Dependent, or upon the Employee or his or her Dependent gaining knowledge of the submission, as determined by the Plan Administrator in its discretion, consistent with applicable laws and/or rules regarding such rescission.

CONTINUATION OF COVERAGE

NOTE: *Continuation coverage for domestic partners and their Dependents is offered voluntarily by the Employer and is not required by or subject to COBRA. A domestic partner will be treated as a "qualified beneficiary" to the same extent as if the domestic partner were the Employee's spouse. In addition, the Dependent Children of a covered domestic partner will be treated as "qualified beneficiaries" for these purposes to the same extent that Dependents of a spouse would be so treated.*

Continuation During Family and Medical Leave Act (FMLA) Leave

Regardless of the established leave policies mentioned above, the Plan shall at all times comply with FMLA. It is the intention of the Plan Administrator to provide these benefits only to the extent required by applicable law and not to grant greater rights than those so required. During a FMLA Leave, coverage will be maintained in accordance with the same Plan conditions as coverage would otherwise be provided if the covered Employee had been a continuously active employee during the entire leave period. If Plan coverage lapses during the FMLA Leave, coverage will be reinstated for the person(s) who had coverage under the Plan when the FMLA Leave began, upon the Employee's return to work at the conclusion of the FMLA Leave.

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 During USERRA

Participants who are absent from employment because they are in the Uniformed Services, and who are on active military duty, must be offered the right to continue health care benefits. If the military leave orders are for a period of 30 days or less, Participants cannot be required to pay more than the normal Participant contribution amount. After this period, Participants may elect to continue their coverage under this Plan for up to 24 months and Participants cannot be required to pay more than 102 percent of the full contribution amount during that time.

To continue coverage, Participants must comply with the terms of the Plan, and pay their contributions, if any. In addition, USERRA also requires that, regardless of whether a Participant elected to continue his or her coverage under the Plan, his or her coverage and his or her Dependents' coverage be reinstated immediately upon his or her return to employment, so long as he or she meets certain requirements contained in USERRA. Participants should contact their participating Employer for information concerning their eligibility for USERRA and any requirements of the Plan.

Continuation During COBRA – Introduction

The right to this form of continued coverage was created by a Federal law, under the Consolidated Omnibus Budget Reconciliation Act of 1985, as amended ("COBRA"). COBRA Continuation Coverage can become available to Participants when they otherwise would lose their group health coverage. It also can become available to other members of the Participant's family who are covered under the Plan when they otherwise would lose their group health coverage. Under the Plan, certain Participants and their eligible family members (called Qualified Beneficiaries) that elect COBRA Continuation Coverage must pay the entire cost of the coverage, including a reasonable administration fee. There are several ways coverage will terminate, including the failure of the Participant or their covered Dependents to make timely payment of contributions or premiums. For additional information, Participants should contact the Participating Employer to determine if COBRA applies to him or her and/or his or her covered Dependents.

To the extent the Plan does not fully or accurately reflect applicable COBRA regulations, the Plan will at all times comply with such regulations, including but not limited to continuation coverage in connection with a business reorganization or employer withdrawal from a multiemployer plan.

Participants may have other options available when group health coverage is lost. For example, a Participant may be eligible to buy an individual plan through the Health Insurance Marketplace. By enrolling in coverage through the Marketplace, the Participant may qualify for lower costs on his or her monthly premiums and lower out-of-pocket costs. Participants can learn more about many of these options at www.healthcare.gov. Additionally, the Participant may qualify for a 30-day special enrollment period for another group health plan for which the Participant is eligible (such as a spouse's plan), even if that plan generally doesn't accept late enrollees.

COBRA Continuation Coverage

"COBRA Continuation Coverage" is a continuation of Plan coverage when coverage would otherwise end because of a life event known as a "Qualifying Event." COBRA (and the description of COBRA Continuation Coverage contained in this Plan) does not apply to the following benefits (if available as part of the Employer's plan): life insurance, accidental death and dismemberment benefits and weekly income or long term disability benefits. The aforementioned benefits are not considered for continuation under COBRA. The Plan provides no greater COBRA rights than what COBRA requires – nothing in this Plan is intended to expand the Participant's rights beyond COBRA's requirements.

Qualifying Events

A qualifying event is any of those listed below if the Plan provided that the Participant would lose coverage (i.e., cease to be covered under the same terms and conditions as in effect immediately before the qualifying event) in the absence of COBRA continuation coverage. After a Qualifying Event, COBRA Continuation Coverage must be offered to each person who is a "Qualified Beneficiary." A Qualified Beneficiary is someone who is or was covered by the Plan, and has lost or will lose coverage under the Plan due to the occurrence of a Qualifying Event. The Employee and/or Employee's Dependents could therefore become Qualified Beneficiaries if applicable coverage under the Plan is lost because of the Qualifying Event.

An Employee, who is properly enrolled in this Plan and is a covered Employee, will become a Qualified Beneficiary if he or she loses his or her coverage under the Plan because either one of the following Qualifying Events happens:

1. The hours of employment are reduced.
2. The employment ends for any reason other than gross misconduct.

The spouse of a covered Employee will become a Qualified Beneficiary if he or she loses his or her coverage under the Plan because any of the following Qualifying Events happens:

1. The Employee dies.
2. The Employee's hours of employment are reduced.
3. The Employee's employment ends for any reason other than his or her gross misconduct.
4. The Employee becomes entitled to Medicare benefits (under Part A, Part B, or both).
5. The Employee becomes divorced from his or her spouse.

Dependent Children will become Qualified Beneficiaries if they lose coverage under the Plan because any of the following Qualifying Events happens:

1. The parent-covered Employee dies.
2. The parent-covered Employee's hours of employment are reduced.
3. The parent-covered Employee's employment ends for any reason other than his or her gross misconduct.
4. The parent-covered Employee becomes entitled to Medicare benefits (Part A, Part B, or both).
5. The parents become divorced.
6. The Child stops being eligible for coverage under the Plan as a Dependent Child.

Filing a proceeding in bankruptcy under title 11 of the United States Code may be a Qualifying Event. If a proceeding in bankruptcy is filed with respect to Employer, and that bankruptcy results in the loss of coverage for any retired Employee covered under the Plan, the retired Employee will become a Qualified Beneficiary, with the bankruptcy being deemed to be the Qualifying Event. The retired Employee's Dependent(s) (if applicable) will also become Qualified Beneficiaries if the bankruptcy (Qualifying Event) results in a loss of their coverage under the Plan.

Employer Notice of Qualifying Events
When the Qualifying Event is the end of employment (for reasons other than gross misconduct), reduction of hours of employment, death of the covered Employee, or the covered Employee's becoming entitled to Medicare benefits (under Part A, Part B, or both), the Employer must notify the COBRA Administrator of the Qualifying Event.

Employee Notice of Qualifying Events
In certain circumstances, the covered Employee or Qualified Beneficiary, in order to protect his or her rights under COBRA, is required to provide notification to their HR or benefits office in writing, either by U.S. First Class Mail or hand delivery. These circumstances are any of the following:

1. **Notice of Divorce or Separation**: Notice of the occurrence of a Qualifying Event that is a divorce of a covered Employee (or former Employee) from his or her spouse.
2. **Notice of Child's Loss of Dependent Status**: Notice of the occurrence of a Qualifying Event that is an individual's ceasing to be eligible as a Dependent Child under the terms of the Plan.
3. **Notice of a Second Qualifying Event**: Notice of the occurrence of a second Qualifying Event after a Qualified Beneficiary has become entitled to COBRA Continuation Coverage with a maximum duration of 18 (or 29) months.
4. **Notice Regarding Disability**: Notice that a Qualified Beneficiary entitled to receive COBRA Continuation Coverage with a maximum duration of 18 months has been determined by the Social Security Administration ("SSA") to be disabled at any time during the first 60 days of COBRA Continuation Coverage.
5. **Notice Regarding End of Disability**: Notice that a Qualified Beneficiary, with respect to whom a notice described above in #4 has been provided, has subsequently been determined by the SSA to no longer be disabled.

As indicated above, Notification of a Qualifying Event must be made in writing. Notice must be made by submitting the "Notice of Qualifying Event" form and mailing it by U.S. First Class Mail or hand delivery to their HR or benefits office. This form is available, without charge, from their HR or benefits office.

Notification must include an adequate description of the Qualifying Event or disability determination. Please see the remainder of this section for additional information.

Contents of Employee Notice of Qualifying Events
When applicable, the Employee or Qualified Beneficiary must provide to their HR or benefits office the following substantiating documentation relative to a Qualifying Event:

1. In the case of a Qualifying Event that is divorce, name(s) and address(es) of spouse and Dependent Child or Children covered under the Plan, date of divorce, and a copy of the decree of divorce.
2. In the case of a Qualifying Event that is Medicare entitlement of the covered Employee or former Employee, date of entitlement, and name(s) and address(es) of spouse and Dependent Child or Children covered under the Plan.
3. In the case of a Qualifying Event that is a Dependent Child's cessation of Dependent status under the Plan, name and address of the Child, reason the Child ceased to be an eligible Dependent (for example, attained limiting age).

4. In the case of a Qualifying Event that is the death of the covered Employee or former Employee, the date of death, and name(s) and address(es) of spouse and Dependent Child or Children covered under the Plan.
5. In the case of a Qualifying Event that is disability of a Qualified Beneficiary, name and address of the disabled Qualified Beneficiary, name(s) and address(es) of other family members covered under the Plan, the date the disability began, the date of the SSA's determination, and a copy of the SSA's determination.
6. In the case of a Qualifying Event that is loss of disability status, name and address of the Qualified Beneficiary who is no longer disabled, name(s) and address(es) of other family members covered under the Plan, the date the disability ended and the date of the SSA's determination.

If a copy of the decree of divorce or the SSA's determination cannot be provided by the deadline for providing the notice, complete and provide the notice, as instructed, by the deadline 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 done so. However, no COBRA Continuation Coverage, or extension of such Coverage, will be available until the copy of the decree of divorce or the SSA's determination is provided.

If the notice does not contain all of the required information, their HR or benefits office may request additional information. If the individual fails to provide such information within the time period specified by their HR or benefits in the request, the COBRA Administrator may reject the notice if it does not contain enough information for their HR or benefits office to identify the plan, the covered Employee (or former Employee), the Qualified Beneficiaries, the Qualifying Event or disability, and the date on which the Qualifying Event, if any, occurred.

Notification must be provided to their HR or benefits office.

A form of notice is available, free of charge, from their HR or benefits office and must be used when providing the notice.

Deadline for Providing the Notice
For Qualifying Events described above, notice must be furnished within 60 days of the latest occurring event set forth below:

1. The date upon which the Qualifying Event occurs.
2. The date upon which the Qualified Beneficiary loses (or would lose) Plan coverage due to a Qualifying Event.
3. The date upon which the Qualified Beneficiary is notified via the Plan's SPD or general notice, and/or becomes aware of their status as a Qualified Beneficiary and/or the occurrence of a Qualifying Event; as well as their subsequent responsibility to comply with the Plan's procedure(s) for providing notice to the COBRA Administrator regarding said status.

As described above, if an Employee or Qualified Beneficiary is determined to be disabled under the Social Security Act, the notice must be delivered no more than 60 days after the latest of:

1. The date of the disability determination by the SSA.
2. The date on which a Qualifying Event occurs.
3. The date on which the Qualified Beneficiary loses (or would lose) coverage under the Plan as a result of the Qualifying Event.
4. The date on which the Qualified Beneficiary is informed, through the furnishing of the Plan's SPD or the general notice, of both the responsibility to provide the notice and the Plan's procedures for providing such notice to the COBRA Administrator.

In any event, this notice must be provided within the first 18 months of COBRA Continuation Coverage.

For a change in disability status described above, the notice must be furnished by the date that is 30 days after the later of:

1. The date of the final determination by the SSA that the Qualified Beneficiary is no longer disabled.
2. The date on which the Qualified Beneficiary is informed, through the furnishing of the Plan's SPD or the general notice, of both the responsibility to provide the notice and the Plan's procedures for providing such notice to their HR or benefits office.

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 the person is electing COBRA Continuation Coverage, his or her coverage under the Plan will terminate on the last date for which he or she is eligible under the terms of the Plan, or if the person is extending COBRA Continuation Coverage, such Coverage will end on the last day of the initial 18-month COBRA coverage period.

Who Can Provide the Notice
Any individual who is the covered Employee (or former Employee) with respect to a Qualifying Event, or any representative acting on behalf of the covered Employee (or former Employee) or Qualified Beneficiary, may provide the notice. Notice by one individual shall satisfy any responsibility to provide notice on behalf of all related Qualified Beneficiaries with respect to the Qualifying Event.

Required Contents of the Notice
After receiving a notice of a Qualifying Event, their HR or benefits office must provide the Qualified Beneficiary with an election notice, which describes their rights to COBRA Continuation Coverage and how to make such an election. The notice must contain the following information:

1. Name and address of the covered Employee or former Employee.
2. Name of the Plan and the name, address, and telephone number of the Plan's COBRA administrator.
3. Identification of the Qualifying Event and its date (the initial Qualifying Event and its date if the Qualifying Participant is already receiving COBRA Continuation Coverage and wishes to extend the maximum coverage period).
4. A description of the Qualifying Event (for example, divorce, cessation of Dependent status, entitlement to Medicare by the covered Employee or former Employee, death of the covered Employee or former Employee, disability of a Qualified Beneficiary or loss of disability status).
5. Identification of the Qualified Beneficiaries (by name or by status).
6. An explanation of the Qualified Beneficiaries' right to elect continuation coverage.
7. The date coverage will terminate (or has terminated) if continuation coverage is not elected.
8. How to elect continuation coverage.
9. What will happen if continuation coverage isn't elected or is waived.
10. What continuation coverage is available, for how long, and (if it is for less than 36 months), how it can be extended for disability or second qualifying events.
11. How continuation coverage might terminate early.
12. Premium payment requirements, including due dates and grace periods.
13. A statement of the importance of keeping their HR or benefits office informed of the addresses of Qualified Beneficiaries.
14. A statement that the election notice does not fully describe COBRA or the plan and that more information is available from their HR or benefits office and in the SPD.
15. A certification that the information is true and correct, a signature and date.

Electing COBRA Continuation Coverage
Complete instructions on how to elect COBRA Continuation Coverage will be provided by their HR or benefits office within 14 days of receiving the notice of the Qualifying Event. The individual then has 60 days in which to elect COBRA Continuation Coverage. The 60 day period is measured from the later of the

date coverage terminates or the date of the notice containing the instructions. If COBRA Continuation Coverage is not elected in that 60 day period, then the right to elect it ceases.

Each Qualified Beneficiary will have an independent right to elect COBRA Continuation Coverage. Covered Employees may elect COBRA Continuation Coverage on behalf of all other Qualified Beneficiaries, including their spouses, and parents or a legal guardian may elect COBRA Continuation Coverage on behalf of their Children.

In the event that their HR or benefits office determines that the individual is not entitled to COBRA Continuation Coverage, the COBRA Administrator will provide to the individual an explanation as to why he or she is not entitled to COBRA Continuation Coverage.

Waiver Before the End of the Election Period
If, during the election period, a Qualified Beneficiary waives COBRA continuation coverage, the waiver can be revoked at any time before the end of the election period. Revocation of the waiver is an election of COBRA continuation coverage. However, if a waiver is later revoked, coverage need not be provided retroactively (that is, from the date of the loss of coverage until the waiver is revoked). Waivers and revocations of waivers are considered made on the date they are sent to the Plan Administrator or its designee, as applicable.

Duration of COBRA Continuation Coverage
The maximum time period shown below shall dictate for how long COBRA Continuation Coverage will be available. The maximum time period for coverage is based on the type of the Qualifying Event and the status of the Qualified Beneficiary. Multiple Qualifying Events that may be combined under COBRA will not ordinarily continue coverage for more than 36 months beyond the date of the original Qualifying Event. For all other Qualifying Events, the continuation period is measured from the date of the Qualifying Event, not the date of loss of coverage.

In the case of a bankruptcy Qualifying Event, the maximum coverage period for a Qualified Beneficiary who is the covered retiree ends on the date of the retiree's death. The maximum coverage period for a Qualified Beneficiary who is the covered Dependent of the retiree ends on the earlier of the Qualified Beneficiary's death or 36 months after the death of the retiree.

When the Qualifying Event is the death of the covered Employee (or former Employee), the covered Employee's (or former Employee's) becoming entitled to Medicare benefits (under Part A, Part B, or both), a divorce, or a Dependent Child's losing eligibility as a Dependent Child, COBRA Continuation Coverage lasts for up to a total of 36 months.

When the Qualifying Event is the end of employment or reduction of the covered Employee's hours of employment, and the covered Employee became entitled to Medicare benefits less than 18 months before the Qualifying Event, COBRA Continuation Coverage for Qualified Beneficiaries other than the covered Employee lasts until 36 months after the date of Medicare entitlement. For example, if a covered Employee becomes entitled to Medicare eight months before the date on which his or her employment terminates, COBRA Continuation Coverage for his or her spouse and Children can last up to thirty-six months after the date of Medicare entitlement, which is equal to twenty-eight months after the date of the Qualifying Event (thirty-six months minus eight months).

Otherwise, when the Qualifying Event is the end of employment (for reasons other than gross misconduct) or reduction of the covered Employee's hours of employment, COBRA Continuation Coverage generally lasts for only up to a total of 18 months. There are two ways in which this 18 month period of COBRA Continuation Coverage can be extended.

Disability Extension of COBRA Continuation Coverage
Disability can extend the 18 month period of continuation coverage for a Qualifying Event that is a termination of employment or reduction of hours, if an Employee or anyone in an Employee's family covered under the Plan is determined by the Social Security Administration ("SSA") to be disabled, and the Employee notifies their HR or benefits office. The Employee and his or her Dependents may thereby be entitled to an additional 11 months of COBRA Continuation Coverage, for a total of 29 months, if the disability started at some time before the 60th day of COBRA Continuation Coverage and lasts at least until the end of the 18 month period of COBRA Continuation Coverage. The Plan can charge 150% of the premium cost for the extended period of coverage.

Second Qualifying Event Extension of COBRA Continuation Coverage
If an Employee's family experiences another Qualifying Event while receiving 18 months of COBRA Continuation Coverage, Dependents may receive up to 18 additional months of COBRA Continuation Coverage, for a maximum of 36 months, if notice of the second Qualifying Event is provided to their HR or benefits office in accordance with the procedures set forth herein. This extension may be applicable to the Employee's death, Medicare Parts A and/or B eligibility, divorce, or a loss of Dependent status under the terms of the Plan if the event would have also caused the spouse or Dependent Child to lose coverage under the Plan regardless of whether the first Qualifying Event had occurred.

Shorter Duration of COBRA Continuation Coverage
COBRA establishes required periods of coverage for continuation health benefits. A plan, however, may provide longer periods of coverage beyond those required by COBRA. COBRA Qualified Beneficiaries generally are eligible for group coverage during a maximum of 18 months after Qualifying Events arising due to employment termination or reduction of hours of work. Certain Qualifying Events, or a second Qualifying Events during the initial period of coverage, may permit a Qualified Beneficiary to receive a maximum of 36 months of coverage.

It is not necessary that COBRA Continuation Coverage be in effect for the maximum period of time, as set forth herein. COBRA Continuation Coverage will terminate immediately, unless otherwise noted, upon the occurrence of any of the following events:

- Contributions are not paid in full on a timely basis,
- The Plan Sponsor ceases to maintain any group health plan,
- The Qualified Beneficiary begins coverage under another group health plan after electing continuation coverage,
- The Qualified Beneficiary enrolls in Medicare Part A or B after electing continuation coverage,
- The Qualified Beneficiary engages in fraud or other conduct that would justify termination of coverage of a similarly situated participant or beneficiary not receiving continuation coverage, or
- If covered under an 11-month disability extension, there is a final determination that the Qualified Beneficiary is no longer disabled for Social Security Purposes (coverage shall terminate on the first day of the month at least 30 days after the determination is made that the Qualified Beneficiary is no longer disabled).

If COBRA Continuation Coverage is terminated early, their HR or benefits office will provide the Qualified Beneficiary with an early termination notice.

Employee Notice of Other Enrollment
If the Qualified Beneficiary becomes enrolled in Medicare or under another group health plan after electing COBRA Continuation Coverage, the Qualified Beneficiary must notify their HR or benefits office in writing immediately.

Contribution and/or Premium Requirements

The cost of the elected COBRA Continuation Coverage must be paid within 45 days of its election. Payments will then be subsequently due on the first day of each month. COBRA Continuation Coverage will be canceled and will not be reinstated if any payment is made late; however, their HR or benefits office must allow for a 30 day grace period during which a late payment may still be made without the loss of COBRA Continuation Coverage.

Additional Information
Please contact their HR or benefits office with any questions about the Plan and COBRA Continuation Coverage.

Questions concerning the Plan or COBRA continuation coverage rights should be addressed to their HR or benefits office. For more information about a Participant's rights under COBRA, HIPAA, the Affordable Care Act, and other laws affecting group health plans, contact the nearest Regional or District Office of the U.S. Department of Labor's Employee Benefits Security Administration (EBSA) or visit https://www.dol.gov/agencies/ebsa. (Addresses and phone numbers of Regional and District EBSA Offices are available through EBSA's website.) For more information about the Marketplace, visit www.HealthCare.gov.

Current Addresses
Important information may be distributed by mail. In order to protect the rights of the Employee's family, the Employee should keep their HR or benefits office (who has been previously identified in this Continuation of Coverage section) informed of any changes in the addresses of family members.

GENERAL LIMITATIONS AND EXCLUSIONS

Some health care services are not covered by the Plan. Coverage is not available from the Plan for charges arising from care, supplies, treatment, and/or services:

Administrative Costs. That are solely for and/or applicable to administrative costs of completing claim forms or reports or for providing records wherever allowed by applicable law and/or regulation.

After the Termination Date. That are Incurred by the Participant on or after the date coverage terminates, even if payments have been predetermined for a course of treatment submitted before the termination date, unless otherwise deemed to be covered in accordance with the terms of the Plan or applicable law and/or regulation.

Broken Appointments. That are charged solely due to the Participant's having failed to honor an appointment.

Complications of Non-Covered Services. That are required as a result of complications from a service not covered under the Plan, unless expressly stated otherwise.

Confined Persons. That are for services, supplies, and/or treatment arising from confinement in a prison, jail or other penal institution.

Cosmetic Surgery. That are incurred in connection with the care and/or treatment of Surgical Procedures which are performed for plastic, reconstructive or cosmetic purposes or any other service or supply which are primarily used to improve, alter or enhance appearance, whether or not for psychological or emotional reasons, except to the extent where it is needed for: (a) repair or alleviation of damage resulting from an Accident; (b) because of infection or Illness; (c) because of congenital disease, developmental condition or anomaly of a covered Dependent Child which has resulted in a functional defect. A treatment will be considered cosmetic for either of the following reasons: (a) its primary purpose is to beautify or (b) there is no documentation of a clinically significant impairment, meaning decrease in function or change in physiology due to Injury, Illness or congenital abnormality. The term "cosmetic services" includes those services which are described in IRS Code Section 213(d)(9).

Custodial Care. That do not restore health or are provided mainly as a rest cure or for maintenance care, unless specifically mentioned otherwise.

Excess. That exceed Plan limits, set forth herein and including (but not limited to) the Maximum Allowable Charge in the Plan Administrator's discretion and as determined by the Plan Administrator, in accordance with the Plan terms as set forth by and within this document.

Experimental. That are Experimental or Investigational.

Family Member. That are performed by a person who is related to the Participant as a spouse, parent, Child, brother or sister, whether the relationship exists by virtue of "blood" or "in law."

Foreign Travel. Expenses for planned and/or routine services received or supplies purchased outside the United States, including those rendered on a cruise ship, are excluded under this Plan. Services in the case of a medical emergency or provided through the Blue Cross Blue Shield Global Core® Program are a covered charge.

Government. That the Participant obtains, but which is paid, may be paid, is provided or could be provided at no cost to the Participant through any program or agency, in accordance with the laws or regulations of any government, or where care is provided at government expense, unless there is a legal obligation for

the Participant to pay for such treatment or service in the absence of coverage. This Exclusion does not apply when otherwise prohibited by law, including laws applicable to Medicaid and Medicare.

Incurred by Other Persons. That are expenses actually Incurred by other persons.

Long Term Care. That are related to long term care.

Medical Necessity. That are not Medically Necessary and/or arise from services and/or supplies that are not Medically Necessary.

Military Service. That are related to conditions determined by the Veteran's Administration to be connected to active service in the military of the United States, except to the extent prohibited or modified by law.

Negligence. That are for Injuries resulting from negligence, misfeasance, malfeasance, nonfeasance or malpractice on the part of any caregiver, Institution, or Provider, as determined by the Plan Administrator, in its discretion, in light of applicable laws and evidence available to the Plan Administrator.

No Coverage. That are Incurred at a time when no coverage is in force for the applicable Participant and/or Dependent.

No Legal Obligation. That are for services provided to a Participant for which the Provider of a service does not and/or would not customarily render a direct charge, or charges Incurred for which the Participant or Plan has no legal obligation to pay, or for which no charges would be made in the absence of this coverage, including but not limited to charges for services not actually rendered, fees, care, supplies, or services for which a person, company or any other entity except the Participant or the Plan, may be liable for necessitating the fees, care, supplies, or services.

Non-Prescription Drugs. For drugs for use outside of a Hospital or other Inpatient facility that can be purchased over-the-counter and without a Physician's written prescription. Drugs for which there is a non-prescription equivalent available. This does not apply to the extent the non-prescription drug must be covered under Preventive Care, subject to the Affordable Care Act, as amended.

Not Acceptable. That are not accepted as standard practice by the American Medical Association (AMA), American Dental Association (ADA), or the Food and Drug Administration (FDA).

Not Covered Provider. That are performed by Providers that do not satisfy all the requirements per the Provider definition as defined within this Plan.

Occupational. That are for any condition, Illness, Injury or complication thereof arising out of or in the course of employment, including self-employment, or an activity for wage or profit where workers' compensation or another form of occupational Injury medical coverage is available.

Other than Attending Physician. That are other than those certified by a Physician who is attending the Participant as being required for the treatment of Injury or Illness and performed by an appropriate Provider.

Personal Injury Insurance. That are in connection with an automobile accident for which benefits payable hereunder are, or would be otherwise covered by, mandatory no-fault automobile insurance or any other similar type of personal injury insurance required by state or federal law, without regard to whether the Participant actually had such mandatory coverage. Benefits will be excluded to the amount of first party medical coverage required under the applicable state law, regardless of a Participant's election of lesser coverage. This Exclusion does not apply if the Injured person is a passenger in a non-family owned vehicle or a pedestrian.

Postage, Shipping, Handling Charges, Etc. That are for any postage, shipping or handling charges which may occur in the transmittal of information to the Third Party Administrator; including interest or financing charges.

Prior to Coverage. That are rendered or received prior to or after any period of coverage hereunder, except as specifically provided herein.

Professional (and Semi-Professional) Athletics (Injury/Illness). That are in connection with any Injury or Illness arising out of or in the course of any employment for wage or profit; or related to professional or semi-professional athletics, including practice.

Prohibited by Law. That are themselves prohibited by applicable law, in general or within the context of the course of treatment, or to the extent that payment under this Plan is prohibited by applicable law.

Provider Error. That are required as a result of unreasonable Provider error.

Subrogation, Reimbursement, and/or Third Party Responsibility. That are for an Illness or Injury not payable by virtue of the Plan's subrogation, reimbursement, and/or third party responsibility provisions.

Unreasonable. That are required to treat Illness or Injuries arising from and due to error(s) caused at any point in the course of treatment by any Provider, including, but not limited to, a Physician or Hospital, wherein such Illness, Injury, infection or complication is not reasonably expected to occur. This Exclusion will apply to expenses directly or indirectly resulting from circumstances that, in the opinion of the Plan Administrator in its sole discretion, gave rise to the expense, whether or not they were directly or indirectly caused by the treating Provider, and are not generally foreseeable or expected amongst professionals practicing the same or similar type(s) of medicine as the treating Provider whose error caused the loss(es).

War/Riot. That are Incurred as a result of war or any act of war, whether declared or undeclared, or any act of aggression by any country, including rebellion or riot, when the Participant is a member of the armed forces of any country, or during service by a Participant in the armed forces of any country, or voluntary participation in a riot. This Exclusion does not apply to any Participant who is not a member of the armed forces, and does not apply to victims of any act of war or aggression.

With respect to any Illness or Injury which is otherwise covered by the Plan, the Plan will not deny benefits otherwise provided for treatment of the Illness or Injury if the Illness or Injury results from being the victim of an act of domestic violence or a documented medical condition, even if the condition is not diagnosed before the Illness or Injury. To the extent consistent with applicable law, this exception will not require this Plan to provide particular benefits other than those provided under the terms of the Plan.

PLAN ADMINISTRATION

The Plan Administrator has been granted the authority to administer the Plan. The Plan Administrator has retained the services of the Third Party Administrator to provide certain claims processing and other technical services. The claims processing and other technical services delegated to the Third Party Administrator notwithstanding, the Plan Administrator reserves the unilateral right and power to administer and to interpret, construe and construct the terms and provisions of the Plan, including without limitation, correcting any error or defect, supplying any omission, reconciling any inconsistency and making factual determinations.

Plan Administrator

The Plan is administered by the Plan Administrator in accordance with these provisions. An individual, committee, or entity may be appointed by the Plan Sponsor to be Plan Administrator and serve at the convenience of the Plan Sponsor. If the appointed Plan Administrator or a committee member resigns, dies, is otherwise unable to perform, is dissolved, or is removed from the position, the Plan Sponsor shall appoint a new Plan Administrator as soon as reasonably possible.

Discretionary Authority

The Plan is administered by the Plan Administrator (which may be the Plan Sponsor or another entity appointed by the Plan Sponsor for this purpose). The Plan Administrator (or the Claims Administrator insofar as it relates to Final Post-Service Appeals) shall have sole, full and final discretionary authority to interpret all Plan provisions, including the right to remedy possible ambiguities, inconsistencies and/or omissions in the Plan and related documents; to make determinations in regards to issues relating to eligibility for benefits; to decide disputes that may arise relative to a Participant's rights; and to determine all questions of fact and law arising under the Plan.

The Plan Administrator, Plan Sponsor, and/or any other fiduciary appointed by the Plan Sponsor for this purpose, reserves the right to allocate certain discretionary authority as it applies to assessment and final determinative authority on and regarding Final Post-Service Appeal[s], to the Claims Administrator.

The Claims Administrator shall at all times strictly abide by and make determination(s) in accordance with the terms of the Plan and applicable law. In instances where the Plan Administrator, Plan Sponsor, and/or any other fiduciary appointed by the Plan Sponsor for this purpose, delegates fiduciary authority to the Claims Administrator to make a determination regarding a Final Post-Service Appeal, the Claims Administrator shall have discretion to interpret the terms of this Plan, and the Claims Administrator possesses all duties and rights otherwise ascribed to the Plan Administrator, Plan Sponsor, and/or any other fiduciary appointed by the Plan Sponsor for this purpose, in this limited scope only. In such instances, the Claims Administrator's determinations will be final and binding on all interested parties, and failure to comply with said determination by the Plan Administrator, Plan Sponsor and/or any other fiduciary appointed to act on behalf of the Plan, shall absolve the Claims Administrator of any and all fiduciary (and other) liability, responsibility, obligations, and/or duties.

The Plan shall be administered by the Plan Administrator, in accordance with its terms. Policies, interpretations, practices, and procedures are established and maintained by the Plan Administrator. It is the express intent of this Plan that the Plan Administrator shall have maximum legal discretionary authority to construe and interpret the terms and provisions of the Plan, to make all interpretive and factual determinations as to whether any individual is eligible and entitled to receive any benefit under the terms of this Plan, to decide disputes which may arise with respect to a Participant's rights, and to decide questions of Plan interpretation and those of fact relating to the Plan. The decisions of the Plan Administrator will be final and binding on all interested parties. Benefits will be paid under this Plan only if the Plan Administrator, in its discretion, determines that the Participant is entitled to them.

If due to errors in drafting, any Plan provision does not accurately reflect its intended meaning, as demonstrated by prior interpretations or other evidence of intent, or as determined by the Plan Administrator in its sole and exclusive judgment, the provision shall be considered ambiguous and shall be interpreted by the Plan Administrator in a fashion consistent with its intent, as determined by the Plan Administrator. The Plan may be amended retroactively to cure any such ambiguity, notwithstanding anything in the Plan to the contrary.

The foregoing provisions of this Plan may not be invoked by any person to require the Plan to be interpreted in a manner which is inconsistent with its interpretations by the Plan Administrator. All actions taken and all determinations by the Plan Administrator shall be final and binding upon all persons claiming any interest under the Plan subject only to the claims appeal procedures of the Plan.

Duties of the Plan Administrator

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 Participant's rights and/or availability of benefits.
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.
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 establish and communicate procedures to determine whether a Medical Child Support Order is a QMCSO.
10. To delegate to any person or entity such powers, duties and responsibilities as it deems appropriate.
11. To perform each and every function necessary for or related to the Plan's administration.

Amending and Terminating the Plan

This Plan was established for the exclusive benefit of the Employees with the intention it will continue indefinitely; however, as the settlor of the Plan, the Plan Sponsor, through its directors and officers, may, in its sole discretion, at any time, amend, suspend or terminate the Plan in whole or in part. This includes amending the benefits under the Plan or the trust agreement (if any). All amendments to this Plan shall become effective as of a date established by the Plan Sponsor.

Any amendment to the Plan that is not made effective at the beginning of a normal Plan Year by integration into a full Plan Document restatement, including suspension and/or termination, shall follow the amendment procedure outlined in this section. The amendment procedure is accomplished by a separate, written amendment decided upon and/or enacted by resolution of the Plan Sponsor's directors or officers (in compliance with its articles of incorporation or bylaws and if these provisions are deemed applicable), or by the sole proprietor in his or her own discretion if the Plan Sponsor is a sole proprietorship, but always in accordance with applicable Federal and State law.

If the Plan is terminated, the rights of the Participants are limited to expenses Incurred before termination. In connection with the termination, the Plan Sponsor may establish a deadline by which all claims must be submitted for consideration. Benefits will be paid only for Covered Expenses Incurred prior to the termination date and submitted in accordance with the rules established by the Plan Sponsor. Upon termination, any Plan assets will be used to pay outstanding claims and all expenses of Plan termination. As it relates to distribution of assets upon termination of the Plan, any contributions paid by Participants will be used for the exclusive purpose of providing benefits and defraying reasonable expenses related to Plan administration, and will not inure to the benefit of the Employer.

Summary of Material Modification (SMM)

A Summary of Material Modifications reports changes in the information provided within the Summary Plan Description. Examples include a change to Deductibles, eligibility or the addition or deletion of coverage.

The Plan Administrator shall notify all covered Employees of any plan amendment considered a Material Modifications by the Plan as soon as administratively feasible after its adoption, but no later than within 210 days after the close of the Plan Year in which the changes became effective. If said Material Modification is affected by amendment as described above, distribution of a copy of said written amendment, within all applicable time limits, shall be deemed sufficient notification to satisfy the Plan's Summary of Material Modifications requirements.

NOTE: *The Affordable Care Act (ACA) requires that if a Plan's Material Modifications are not reflected in the Plan's most recent Summary of Benefits and Coverage (SBC) then the Plan must provide written notice to Participants at least 60 days before the effective date of the Material Modification.*

Summary of Material Reduction (SMR)

A Summary of Material Reduction (SMR) is a type of SMM. A Material Reduction generally means any modification that would be considered by the average participant to be an important reduction in covered services or benefits. Examples include reductions in benefits or increases in Deductibles or Copayments.

The Plan Administrator shall notify all eligible Employees of any plan amendment considered a Material Reduction in covered services or benefits provided by the Plan as soon as administratively feasible after its adoption, but no later than 60 days after the date of adoption of the reduction. Eligible Employees and beneficiaries must be furnished a summary of such reductions, and any changes so made shall be binding on each Participant. The 60 day period for furnishing a summary of Material Reduction does not apply to any Employee covered by the Plan who would reasonably expect to receive a summary through other means within the next 90 days.

If said Material Reduction is affected by amendment as described above, distribution of a copy of said written amendment, within all applicable time limits, shall be deemed sufficient notification to satisfy the Plan's Summary of Material Reduction requirements.

Material Reduction disclosure provisions are subject to the requirements of the Health Insurance Portability and Accountability Act of 1996 (HIPAA) and any related amendments.

Misuse of Identification Card

If an Employee or covered Dependent permits any person who is not a covered Participant of the Family Unit to use any identification card issued, the Plan Sponsor may give Employee written notice that his (and his family's) coverage will be terminated in accordance with the Plan's provisions.

CLAIM PROCEDURES; PAYMENT OF CLAIMS

Introduction

In accordance with applicable law, the Plan will allow an authorized representative to act on a Claimant's behalf in pursuing or appealing a benefit claim.

The availability of health benefit payments is dependent upon Claimants complying with the following:

Health Claims

Full and final authority to adjudicate claims and make determinations as to their payability by and under the Plan belongs to and resides solely with the Plan Administrator. The Plan Administrator shall make claims adjudication determinations after full and fair review and in accordance with the terms of this Plan and applicable law. To receive due consideration, claims for benefits and questions regarding said claims should be directed to the Third Party Administrator. The Plan Administrator may delegate to the Third Party Administrator responsibility to process claims in accordance with the terms of the Plan and the Plan Administrator's directive(s). The Third Party Administrator is not a fiduciary of the Plan and does not have discretionary authority to make claims payment decisions or interpret the meaning of the Plan terms.

Written proof that expenses eligible for Plan reimbursement and/or payment were Incurred, as well as proof of their eligibility for payment by the Plan, must be provided to the Plan Administrator via the Third Party Administrator. Although a provider of medical services and/or supplies may submit such claims directly to the Plan by virtue of an assignment of benefits, ultimate responsibility for supplying such written proof remains with the Claimant. The Plan Administrator may determine the time and fashion by which such proof must be submitted. No benefits shall be payable under the Plan if the Plan Administrator determines that the claims are not eligible for Plan payment, or, if inadequate proof is provided by the Claimant or entities submitting claims to the Plan on the Claimant's behalf.

A call from a Provider who wants to know if an individual is covered under the Plan, or if a certain procedure is covered by the Plan, prior to providing treatment is not a "claim," since an actual claim for benefits is not being filed with the Plan. These are simply requests for information, and any response is not a guarantee of benefits, since payment of benefits is subject to all Plan provisions, limitations and Exclusions. Once treatment is rendered, a Clean Claim must be filed with the Plan (which will be a "Post-service Claim"). At that time, a determination will be made as to what benefits are payable under the Plan.

A Claimant has the right to request a review of an Adverse Benefit Determination. If the claim is denied at the end of the appeal process, as described below, the Plan's final decision is known as a Final Internal Adverse Benefit Determination. If the Claimant receives notice of a Final Internal Adverse Benefit Determination, or if the Plan does not follow the claims procedures properly, the Claimant then has the right to request an independent external review. The external review procedures are described below.

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

Benefits will be payable to a Claimant, or to a Provider that has accepted an assignment of benefits as consideration in full for services rendered.

According to Federal regulations which apply to the Plan, there are four types of claims: Pre-service (Urgent and Non-urgent), Concurrent Care and Post-service.

1. Pre-service Claims. A "Pre-service Claim" occurs when issuance of payment by the Plan is dependent upon determination of payability prior to the receipt of the applicable medical care;

however, if the Plan does not require the Claimant to obtain approval of a medical service prior to getting treatment, then there is no "Pre-service Claim".

Urgent care or Emergency medical services or admissions will not require notice to the Plan prior to the receipt of care. Furthermore, if in the opinion of a Physician with knowledge of the Claimant's medical condition, pre-determination of payability by the Plan prior to the receipt of medical care (a Pre-service Claim) would result in a delay adequate to jeopardize the life or health of the Claimant, hinder the Claimant's ability to regain maximum function (compared to treatment without delay), or subject the Claimant to severe pain that cannot be adequately managed without the care or treatment that is the subject of the claim, said claim may be deemed to be a "Pre-service Urgent Care Claim". In such circumstances, the Claimant is urged to obtain the applicable care without delay, and communicate with the Plan regarding their claim(s) as soon as reasonably possible.

If, due to Emergency or urgency as defined above, a Pre-service claim is not possible, the Claimant must comply with the Plan's requirements with respect to notice required after receipt of treatment, and must file the claim as a Post-service Claim, as herein described.

Pre-admission certification of a non-Emergency Hospital admission is a "claim" only to the extent of the determination made – that the type of procedure or condition warrants Inpatient confinement for a certain number of days. The rules regarding Pre-service Claims will apply to that determination only. Once a Claimant has the treatment in question, the claim for benefits relating to that treatment will be treated as a Post-service Claim.

2. Concurrent Claims. If a Claimant requires an on-going course of treatment over a period of time or via a number of treatments, the Plan may approve of a "Concurrent Claim." In such circumstances, the Claimant must notify the Plan of such necessary ongoing or routine medical care, and the Plan will assess the Concurrent Claim as well as determine whether the course of treatment should be reduced or terminated. The Claimant, in turn, may request an extension of the course of treatment beyond that which the Plan has approved. If the Plan does not require the Claimant to obtain approval of a medical service prior to getting treatment, then there is no need to contact the Plan Administrator to request an extension of a course of treatment, and the Claimant must simply comply with the Plan's requirements with respect to notice required after receipt of treatment, as herein described.

3. Post-service Claims. A "Post-service Claim" is a claim for benefits from the Plan after the medical services and/or supplies have already been provided.

When Claims Must Be Filed

Post-service health claims (which must be Clean Claims) must be filed with the Third Party Administrator within 12 months of the date charges for the service(s) and/or supplies were Incurred. Claims filed later than that date shall be denied. Benefits are based upon the Plan's provisions at the time the charges were Incurred.

A Pre-service Claim (including a Concurrent claim that also is a Pre-service claim) is considered to be filed when the request for approval of treatment or services is received by the Third Party Administrator in accordance with the Plan's procedures.

A Post-service Claim is considered to be filed when the following information is received by the Third Party Administrator, together with the industry standard claim form:

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. Any applicable pre-negotiated rate.
6. The name of the Plan.
7. The name of the covered Employee.
8. The name of the patient.

Upon receipt of this information, the claim will be deemed to be initiated with the Plan.

The Third Party Administrator will determine if enough information has been submitted to enable proper consideration of the claim (a Clean Claim). If not, more information may be requested as provided herein. This additional information must be received by the Third Party Administrator within 45 days (48 hours in the case of Pre-service urgent care claims) from receipt by the Claimant of the request for additional information. **Failure to do so may result in claims being declined or reduced.**

Timing of Claim Decisions
The Plan Administrator shall notify the Claimant, in accordance with the provisions set forth below, of any Adverse Benefit Determination (and, in the case of Pre-service claims and Concurrent claims, of decisions that a claim is payable in full) within the following timeframes:

1. Pre-service Urgent Care Claims:

    a. If the Claimant has provided all of the necessary information, as soon as possible, taking into account the medical exigencies, but not later than 72 hours after receipt of the claim.
    b. If the Claimant has not provided all of the information needed to process the claim, then the Claimant will be notified as to what specific information is needed as soon as possible, but not later than 24 hours after receipt of the claim.
    c. The Claimant will be notified of a determination of benefits as soon as possible, but not later than 48 hours, taking into account the medical exigencies, after the earliest of:
        i. The Plan's receipt of the specified information.
        ii. The end of the period afforded the Claimant to provide the information.
    d. If there is an Adverse Benefit Determination, a request for an expedited appeal may be submitted orally or in writing by the Claimant. All necessary information, including the Plan's benefit determination on review, may be transmitted between the Plan and the Claimant by telephone, facsimile, or other similarly expeditious method. Alternatively, the Claimant may request an expedited review under the external review process.

2. Pre-service Non-urgent Care Claims:
    a. If the Claimant has provided all of the information needed to process the claim, in a reasonable period of time appropriate to the medical circumstances, but not later than 15 days after receipt of the claim, unless an extension has been requested, then prior to the end of the 15 day extension period.
    b. If the Claimant has not provided all of the information needed to process the claim, then the Claimant will be notified as to what specific information is needed as soon as possible. The Claimant will be notified of a determination of benefits in a reasonable period of time appropriate to the medical circumstances, either prior to the end of the extension period (if additional information was requested during the initial processing period), or by the date agreed to by the Plan Administrator and the Claimant (if additional information was requested during the extension period).

3. Concurrent Claims:
    a. Plan Notice of Reduction or Termination. If the Plan Administrator is notifying the Claimant of a reduction or termination of a course of treatment (other than by Plan amendment or

termination), notification will occur before the end of such period of time or number of treatments. The Claimant will be notified sufficiently in advance of the reduction or termination to allow the Claimant to appeal and obtain a determination on review of that Adverse Benefit Determination before the benefit is reduced or terminated. This rule does not apply if benefits are reduced or eliminated due to plan amendment or termination. A similar process applies for claims based on a rescission of coverage for fraud or misrepresentation.

b. Request by Claimant Involving Urgent Care. If the Plan Administrator receives a request from a Claimant to extend the course of treatment beyond the period of time or number of treatments involving urgent care, notification will occur as soon as possible, taking into account the medical exigencies, but not later than 24 hours after receipt of the claim, as long as the Claimant makes the request at least 24 hours prior to the expiration of the prescribed period of time or number of treatments. If the Claimant submits the request with less than 24 hours prior to the expiration of the prescribed period of time or number of treatments, the request will be treated as a claim involving urgent care and decided within the urgent care timeframe.

c. Request by Claimant Involving Non-urgent Care. If the Plan Administrator receives a request from the Claimant for a claim not involving urgent care, the request will be treated as a new benefit claim and decided within the timeframe appropriate to the type of claim (either as a Pre-service Non-urgent claim or a Post-service claim).

d. Request by Claimant Involving Rescission. With respect to rescissions, the following timetable applies:

i.	Notification to Claimant	30 days
ii.	Notification of Adverse Benefit Determination on appeal	30 days

4. <u>Post-service Claims:</u>
   a. If the Claimant has provided all of the information needed to process the claim, in a reasonable period of time, but not later than 30 days after receipt of the claim, unless an extension has been requested, then prior to the end of the 15 day extension period.
   b. If such an extension is necessary due to a failure of the Claimant to submit the information necessary to decide the claim, the notice of extension shall specifically describe the required information, and the Claimant shall be afforded at least 45 days from receipt of the notice within which to provide the specified information.
   c. If the Claimant has not provided all of the information needed to process the claim and additional information is requested during the initial processing period, then the Claimant will be notified of a determination of benefits prior to the end of the extension period, unless additional information is requested during the extension period, then the Claimant will be notified of the determination by a date agreed to by the Plan Administrator and the Claimant.

5. <u>Extensions:</u>
   a. Pre-service Urgent Care Claims. No extensions are available in connection with Pre-service urgent care claims.
   b. Pre-service Non-urgent Care Claims. This period may be extended by the Plan for up to 15 days, provided that the Plan Administrator both determines that such an extension is necessary due to matters beyond the control of the Plan and notifies the Claimant, prior to the expiration of the initial 15 day processing period, of the circumstances requiring the extension of time and the date by which the Plan expects to render a decision.
   c. Post service Claims. This period may be extended by the Plan for up to 15 days, provided that the Plan Administrator both determines that such an extension is necessary due to matters beyond the control of the Plan and notifies the Claimant, prior to the expiration of the initial 30 day processing period, of the circumstances requiring the extension of time and the date by which the Plan expects to render a decision.

6. Calculating Time Periods. The period of time within which a benefit determination is required to be made shall begin at the time a claim is deemed to be filed in accordance with the procedures of the Plan.

Notification of an Adverse Benefit Determination
The Plan Administrator shall provide a Claimant with a notice, either in writing or electronically (or, in the case of Pre-service urgent care claims, by telephone, facsimile or similar method, with written or electronic notice following within three days), containing the following information:

1. Information sufficient to allow the Claimant to identify the claim involved (including date of service, the health care Provider, the claim amount, if applicable, and a statement describing the availability, upon request, of the Diagnosis code and its corresponding meaning, and the treatment code and its corresponding meaning).
2. A reference to the specific portion(s) of the Plan Document upon which a denial is based.
3. Specific reason(s) for a denial, including the denial code and its corresponding meaning, and a description of the Plan's standard, if any, that was used in denying the claim.
4. A description of any additional information necessary for the Claimant to perfect the claim and an explanation of why such information is necessary.
5. A description of the Plan's review procedures and the time limits applicable to the procedures.
6. A statement that the Claimant is entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records and other information relevant to the Claimant's claim for benefits.
7. Upon request, the identity of any medical or vocational experts consulted in connection with a claim, even if the Plan did not rely upon their advice (or a statement that the identity of the expert will be provided, upon request).
8. Any rule, guideline, protocol or similar criterion that was relied upon in making the determination (or a statement that it was relied upon and that a copy will be provided to the Claimant, free of charge, upon request).
9. In the case of denials based upon a medical judgment (such as whether the treatment is Medically Necessary or Experimental), either an explanation of the scientific or clinical judgment for the determination, applying the terms of the Plan to the Claimant's medical circumstances, or a statement that such explanation will be provided to the Claimant, free of charge, upon request.
10. In a claim involving urgent care, a description of the Plan's expedited review process.

Appeal of Adverse Benefit Determinations

Full and Fair Review of All Claims
In cases where a claim for benefits is denied, in whole or in part, and the Claimant believes the claim has been denied wrongly, the Claimant may appeal the denial and review pertinent documents. The claims procedures of this Plan provide a Claimant with a reasonable opportunity for a full and fair review of a claim and Adverse Benefit Determination. More specifically, the Plan provides:

1. A 180 day timeframe following receipt of a notification of an initial Adverse Benefit Determination within which to appeal the determination. The Plan will not accept appeals filed after a 180 day timeframe.
2. The opportunity to submit written comments, documents, records, and other information relating to the claim for benefits.
3. The opportunity to review the Claim file and to present evidence and testimony as part of the internal claims and appeals process.
4. A review that does not afford deference to the previous Adverse Benefit Determination and that is conducted by an appropriate named fiduciary of the Plan, who shall be neither the individual who made the Adverse Benefit Determination that is the subject of the appeal, nor the subordinate of such individual.

5. A review that takes into account all comments, documents, records, and other information submitted by the Claimant relating to the claim, without regard to whether such information was submitted or considered in the prior benefit determination.
6. That, in deciding an appeal of any Adverse Benefit Determination that is based in whole or in part upon a medical judgment, the Plan fiduciary shall consult with a health care professional who has appropriate training and experience in the field of medicine involved in the medical judgment, who is neither an individual who was consulted in connection with the Adverse Benefit Determination that is the subject of the appeal, nor the subordinate of any such individual.
7. Upon request, the identity of medical or vocational experts whose advice was obtained on behalf of the Plan in connection with a claim, even if the Plan did not rely upon their advice.
8. If applicable, a discussion of the basis for disagreeing with the disability determination made by either (a) the Social Security Administration; or (b) an independent medical expert that has conducted a full medical review of the Claimant if presented by the Claimant in support of the claim.
9. That a Claimant will be provided, free of charge: (a) reasonable access to, and copies of, all documents, records, and other information relevant to the Claimant's claim in possession of the Plan Administrator or Third Party Administrator; (b) information regarding any voluntary appeals procedures offered by the Plan; (c) information regarding the Claimant's right to an external review process; (d) any internal rule, guideline, protocol or other similar criterion relied upon, considered or generated in making the adverse determination; and (e) an explanation of the scientific or clinical judgment for the determination, applying the terms of the Plan to the Claimant's medical circumstances.
10. That a Claimant will be provided, free of charge, and sufficiently in advance of the date that the notice of Final Internal Adverse Benefit Determination is required, with new or additional evidence considered, relied upon, or generated by the Plan in connection with the Claim, as well as any new or additional rationale for a denial at the internal appeals stage, and a reasonable opportunity for the Claimant to respond to such new evidence or rationale.

Requirements for First Level Appeal

The Claimant must file an appeal regarding a Post-service claim and applicable Adverse Benefit Determination, in writing within 180 days following receipt of the notice of an Adverse Benefit Determination.

For Pre-service Claims. Oral appeals should be submitted in writing as soon as possible after it has been initiated. To file any appeal in writing, follow the instructions on the Notice of Adverse Benefit Determination or contact the following:

WebTPA
Phone: 1-866-259-5540
Email: helpme@webtpa.com

For Post-service Claims. To file any appeal in writing, the Claimant's appeal must be addressed as follows:

WebTPA
P.O. Box 99906
Grapevine, TX 76099-9706
Phone: 1-866-259-5540
Email: helpme@webtpa.com

It shall be the responsibility of the Claimant or authorized representative to submit an appeal under the provisions of the Plan. Any appeal must include:

1. The name of the Employee/Claimant.
2. The Employee/Claimant's member identification number.

3. The group name or identification number.
4. All facts and theories supporting the claim for benefits.
5. A statement in clear and concise terms of the reason or reasons for disagreement with the handling of the claim.
6. Any material or information that the Claimant has which indicates that the Claimant is entitled to benefits under the Plan.

Timing of Notification of Benefit Determination on Review
The Plan Administrator shall notify the Claimant of the Plan's benefit determination on review within the following timeframes:

1. Pre-service Urgent Care Claims: As soon as possible, taking into account the medical exigencies, but not later than 72 hours after receipt of the appeal.
2. Pre-service Non-urgent Care Claims: Within a reasonable period of time appropriate to the medical circumstances, but not later than 30 days after receipt of the appeal.
3. Concurrent Claims: The response will be made in the appropriate time period based upon the type of claim: Pre-service Urgent, Pre-service Non-urgent or Post-service.
4. Post-service Claims: Within a reasonable period of time, but not later than 30 days per internal appeal.

Calculating Time Periods. The period of time within which the Plan's determination is required to be made shall begin at the time an appeal is filed in accordance with the procedures of this Plan, without regard to whether all information necessary to make the determination accompanies the filing.

Manner and Content of Notification of Adverse Benefit Determination on Review
The Plan Administrator shall provide a Claimant with notification, with respect to Pre-service urgent care claims, by telephone, facsimile or similar method, and with respect to all other types of claims, in writing or electronically, of a Plan's Adverse Benefit Determination on review, setting forth:

1. Information sufficient to allow the Claimant to identify the claim involved (including date of service, the health care Provider, the claim amount, if applicable, and a statement describing the availability, upon request, of the Diagnosis code and its corresponding meaning, and the treatment code and its corresponding meaning).
2. Specific reason(s) for a denial, including the denial code and its corresponding meaning, and a description of the Plan's standard, if any, that was used in denying the claim, and a discussion of the decision.
3. A reference to the specific portion(s) of the summary plan description on which the denial is based.
4. The identity of any medical or vocational experts consulted in connection with a claim, even if the Plan did not rely upon their advice (or a statement that the identity of the expert will be provided, upon request).
5. A statement that the Claimant is entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the Claimant's claim for benefits.
6. Any rule, guideline, protocol or similar criterion that was relied upon, considered, or generated in making the determination will be provided free of charge. If this is not practical, a statement will be included that such a rule, guideline, protocol or similar criterion was relied upon in making the determination and a copy will be provided to the Claimant, free of charge, upon request.
7. A description of any additional information necessary for the Claimant to perfect the claim and an explanation of why such information is necessary.
8. A description of available internal appeals and external review processes, including information regarding how to initiate an appeal.
9. A description of the Plan's review procedures and the time limits applicable to the procedures.
10. In the case of denials based upon a medical judgment (such as whether the treatment is Medically Necessary or Experimental), either an explanation of the scientific or clinical judgment for the

determination, applying the terms of the Plan to the Claimant's medical circumstances, will be provided. If this is not practical, a statement will be included that such explanation will be provided to the Claimant, free of charge, upon request.

11. Information about the availability of, and contact information for, an applicable office of health insurance consumer assistance or ombudsman established under applicable federal law to assist Participants with the internal claims and appeals and external review processes.
12. The following statement: "You and your Plan may have other voluntary alternative dispute resolution options, such as mediation. One way to find out what may be available is to contact your local U.S. Department of Labor Office and your State insurance regulatory agency".

Furnishing Documents in the Event of an Adverse Determination
In the case of an Adverse Benefit Determination on review, the Plan Administrator shall provide such access to, and copies of, documents, records, and other information described in the provision relating to "Manner and Content of Notification of Adverse Benefit Determination on Review" as appropriate.

Decision on Review
The decision by the Plan Administrator or other appropriate named fiduciary of the Plan on review will be final, binding and conclusive and will be afforded the maximum deference permitted by law. All claim review procedures provided for in the Plan must be exhausted before any legal action is brought.

Requirements for Second Level Appeal
The Claimant must file an appeal regarding a Post-service claim and applicable Adverse Benefit Determination, in writing within 60 days following receipt of the notice of the first level Adverse Benefit Determination.

Two Levels of Appeal
This Plan requires two levels of appeal by a Claimant before the Plan's internal appeals are exhausted. For each level of appeal, the Claimant and the Plan are subject to the same procedures, rights, and responsibilities as stated within this Plan. Each level of appeal is subject to the above-outlined submission and response guidelines.

Once a Claimant receives an Adverse Benefit Determination in response to an initial claim for benefits, the Claimant may appeal that Adverse Benefit Determination, which will constitute the initial appeal. If the Claimant receives an Adverse Benefit Determination in response to that initial appeal, the Claimant may appeal that Adverse Benefit Determination as well, which will constitute the final internal appeal. If the Claimant receives an Adverse Benefit Determination in response to the Claimant's second appeal, such Adverse Benefit Determination will constitute the Final Internal Adverse Benefit Determination, and the Plan's internal appeals procedures will have been exhausted.

Deemed Exhaustion of Internal Claims Procedures and De Minimis

<u>Final Internal Adverse Benefit Determination</u>

Upon receipt, review, adjudication and conclusion of a Final Post-Service Appeal, if it is determined by the Plan fiduciary – either the Plan Administrator, Plan Sponsor, and/or other named fiduciary assigned authority and the duty to otherwise handle appeals– that benefits and/or coverage is not available from the Plan as it relates to claims for benefits submitted to the Plan; when such a final Adverse Benefit Determination is made, by either the Plan Administrator, Plan Sponsor, and/or other named fiduciary assigned authority and the duty to otherwise handle appeals the determination will be final and binding on all interested parties.

<u>Exception to the Deemed Exhaustion Rule</u>

A Claimant will not be required to exhaust the internal claims and appeals procedures described above if the Plan fails to adhere to the claims procedures requirements. In such an instance, a Claimant may proceed immediately to the external review program or make a claim in court. However, the internal claim and appeals procedures will not be deemed exhausted (meaning the Claimant must adhere to them before participating in the external review program or bringing a claim in court) in the event of a de minimis violation that does not cause, and is not likely to cause, prejudice or harm to the Claimant as long as the Plan Administrator demonstrates that the violation was for good cause or due to matters beyond the control of the Plan, the violation occurred in the context of an ongoing, good faith exchange of information between the Plan and the Claimant, and the violation is not reflective of a pattern or practice of non-compliance.

If a Claimant believes the Plan Administrator has engaged in a violation of the claims procedures and would like to pursue an immediate review, the Claimant may request that the Plan provide a written explanation of the violation, including a description of the Plan's basis for asserting that the violation should not result in a "deemed exhaustion" of the claims procedures. The Plan will respond to this request within ten days. If the external reviewer or a court rejects a request for immediate review because the Plan has met the requirements for the "de minimis" exception described above, the Plan will provide the Claimant with notice of an opportunity to resubmit and pursue an internal appeal of the claim.

External Review Process

The Federal external review process does not apply to a denial, reduction, termination, or a failure to provide payment for a benefit based on a determination that a Claimant or beneficiary fails to meet the requirements for eligibility under the terms of a group health plan.

The Federal external review process, in accordance with the current Affordable Care Act regulations and other applicable law, applies only to:

1. Any eligible Adverse Benefit Determination (including a Final Internal Adverse Benefit Determination) by a plan or issuer that involves medical judgment (including, but not limited to, those based on the plan's or issuer's requirements for Medical Necessity, appropriateness, health care setting, level of care, or effectiveness of a covered benefit; its determination that a treatment is Experimental or Investigational; its determination whether a Claimant or beneficiary is entitled to a reasonable alternative standard for a reward under a wellness program; its determination whether a plan or issuer is complying with the nonquantitative treatment limitation provisions of Code section 9812 and § 54.9812-1, which generally require, among other things, parity in the application of medical management techniques), as determined by the external reviewer.
2. An Adverse Benefit Determination that involves consideration of whether the Plan is complying with the surprise billing and cost-sharing protections set forth in the No Surprises Act.
3. A rescission of coverage (whether or not the rescission has any effect on any particular benefit at that time).

<u>Standard external review</u>

Standard external review is an external review that is not considered expedited (as described in the "expedited external review" paragraph in this section).

1. <u>Request for external review</u>. The Plan will allow a Claimant to file a request for an external review with the Plan if the request is filed within four months after the date of receipt of a notice of a Final Internal Adverse Benefit Determination. If there is no corresponding date four months after the date of receipt of such a notice, then the request must be filed by the first day of the fifth month following the receipt of the notice. For example, if the date of receipt of the notice is October 30, because there is no February 30, the request must be filed by March 1. If the last filing date would fall on a Saturday, Sunday, or Federal holiday, the last filing date is extended to the next day that is not a Saturday, Sunday, or Federal holiday.

2. Preliminary review. Within five business days following the date of receipt of the external review request, the Plan will complete a preliminary review of the request to determine whether:

    a. The Claimant is or was covered under the Plan at the time the health care item or service was requested or, in the case of a retrospective review, was covered under the Plan at the time the health care item or service was provided.
    b. The Adverse Benefit Determination or the Final Internal Adverse Benefit Determination does not relate to the Claimant's failure to meet the requirements for eligibility under the terms of the Plan (e.g., worker classification or similar determination).
    c. The Claimant has exhausted the Plan's internal appeal process (unless the Claimant is not required to exhaust the internal appeals process under the final regulations) and rendered the appeal available for standard external review.
    d. The Claimant has provided all the information and forms required to process an external review. Within one business day after completion of the preliminary review, the Plan will issue a notification in writing to the Claimant. If the request is complete but not eligible for external review, such notification will include the reasons for its ineligibility and contact information for the Employee Benefits Security Administration (toll-free number 866-444-EBSA (3272)). If the request is not complete, such notification will describe the information or materials needed to make the request complete and the Plan will allow a Claimant to perfect the request for external review within the four-month filing period or within the 48 hour period following the receipt of the notification, whichever is later.

3. Referral to Independent Review Organization. The Plan will assign an independent review organization (IRO) that is accredited by URAC or by a similar nationally-recognized accrediting organization to conduct the external review. Moreover, the Plan will take action against bias and to ensure independence. Accordingly, the Plan will contract with (or direct the Third Party Administrator to contract with, on its behalf) at least three IROs for assignments under the Plan and rotate claims assignments among them (or incorporate other independent unbiased methods for selection of IROs, such as random selection). In addition, the IRO may not be eligible for any financial incentives based on the likelihood that the IRO will support the denial of benefits. In reaching a decision, the assigned IRO will review the claim de novo and is not bound by any decisions or conclusions reached during the Plan's internal claims and appeals process.

4. Reversal of Plan's decision. Upon receipt of a notice of a final external review decision reversing the Adverse Benefit Determination or Final Internal Adverse Benefit Determination, the Plan will provide coverage or payment for the claim without delay, regardless of whether the plan intends to seek judicial review of the external review decision and unless or until there is a judicial decision otherwise.

Expedited external review

1. Request for expedited external review. The Plan will allow a Claimant to make a request for an expedited external review with the Plan at the time the Claimant receives:

    a. An Adverse Benefit Determination if the Adverse Benefit Determination involves a medical condition of the Claimant for which the timeframe for completion of a standard internal appeal under the final regulations would seriously jeopardize the life or health of the Claimant or would jeopardize the Claimant's ability to regain maximum function and the Claimant has filed a request for an expedited internal appeal.
    b. A Final Internal Adverse Benefit Determination, if the Claimant has a medical condition where the timeframe for completion of a standard external review would seriously jeopardize the life or health of the Claimant or would jeopardize the Claimant's ability to regain maximum function, or if the Final Internal Adverse Benefit Determination concerns

an admission, availability of care, continued stay, or health care item or service for which the Claimant received Emergency Services, but has not been discharged from a facility.

2. Preliminary review. Immediately upon receipt of the request for expedited external review, the Plan will determine whether the request meets the reviewability requirements set forth above for standard external review. The Plan will immediately send a notice that meets the requirements set forth above for standard external review to the Claimant of its eligibility determination.

3. Referral to Independent Review Organization. Upon a determination that a request is eligible for external review following the preliminary review, the Plan will assign an IRO pursuant to the requirements set forth above for standard review. The Plan will provide or transmit all necessary documents and information considered in making the Adverse Benefit Determination or Final Internal Adverse Benefit Determination to the assigned IRO electronically or by telephone or facsimile or any other available expeditious method. The assigned IRO, to the extent the information or documents are available and the IRO considers them appropriate, will consider the information or documents described above under the procedures for standard review.

4. Notice of final external review decision. The Plan's (or Third Party Administrator's) contract with the assigned IRO will require the IRO to provide notice of the final external review decision, in accordance with the requirements set forth above, as expeditiously as the Claimant's medical condition or circumstances require, but in no event more than 72 hours after the IRO receives the request for an expedited external review. If the notice is not in writing, within 48 hours after the date of providing that notice, the assigned IRO will provide written confirmation of the decision to the Claimant and the Plan.

Appointment of Authorized Representative

A Claimant may designate another individual to be an authorized representative and act on his or her behalf and communicate with the Plan with respect to a specific benefit claim or appeal of a denial.

Should a Claimant designate an authorized representative, all future communications from the Plan will be conducted with the authorized representative instead of the Claimant, unless the Plan Administrator is otherwise notified in writing by the Claimant. A Claimant can revoke the authorized representative at any time. A Claimant may authorize only one person as an authorized representative at a time.

Recognition as an authorized representative is completely separate from a Provider accepting an assignment of benefits, requiring a release of information, or requesting completion a similar form. An assignment of benefits by a Claimant shall not be recognized as a designation of the Provider as an authorized representative. Assignment and its limitations under this Plan are described below.

Autopsy

Upon receipt of a claim for a deceased Claimant for any condition Illness or Injury that is the basis of such claim, the Plan maintains the right to request an autopsy be performed upon said Claimant. The request for an autopsy may be exercised only where not prohibited by any applicable law.

Payment of Benefits

Where benefit payments are allowable in accordance with the terms of this Plan, payment shall be made in U.S. Dollars (unless otherwise agreed upon by the Plan Administrator). Payment shall be made, in the Plan Administrator's discretion, to an assignee of an assignment of benefits, but in any instance may alternatively be made to the Claimant, on whose behalf payment is made and who is the recipient of the services for which payment is being made. Should the Claimant be deceased, payment shall be made to the Claimant's heir, assign, agent or estate (in accordance with written instructions), or, if there is no such arrangement and in the Plan Administrator's discretion, the institute and/or Provider who provided the care and/or supplies for which payment is to be made – regardless of whether an assignment of benefits occurred.

Assignments
For this purpose, the term “Assignment of Benefits” (or “AOB”) is defined as an arrangement whereby a Participant of the Plan, at the discretion of the Plan Administrator, assigns its right to seek and receive payment of eligible Plan benefits, less Deductible, Copayments and Coinsurance amounts, to a medical Provider. If a Provider accepts said arrangement, the Provider’s rights to receive Plan benefits are equal to those of the Participant, and are limited by the terms of this Plan Document. A Provider that accepts this arrangement indicates acceptance of an AOB and Deductibles, Copayments, and Coinsurance amounts, as consideration in full for treatment rendered.

The Plan Administrator may revoke an AOB at its discretion and treat the Participant of the Plan as the sole beneficiary. Benefits for medical expenses covered under this Plan may be assigned by a Participant to the Provider as consideration in full for services rendered; however, if those benefits are paid directly to the Participant, the Plan will be deemed to have fulfilled its obligations with respect to such benefits. The Plan will not be responsible for determining whether any such assignment is valid. Payment of benefits which have been assigned may be made directly to the assignee unless a written request not to honor the assignment, signed by the Participant, has been received before the proof of loss is submitted, or the Plan Administrator – at its discretion – revokes the assignment.

No Participant shall at any time, either during the time in which he or she is a Participant in the Plan, or following his or her termination as a Participant, in any manner, have any right to assign his or her right to sue to recover benefits under the Plan, to enforce rights due under the Plan or to any other causes of action which he or she may have against the Plan or its fiduciaries. A medical Provider which accepts an AOB does as consideration in full for services rendered and is bound by the rules and provisions set forth within the terms of this document.

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

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

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

Providers and any other person or entity accepting payment from the Plan or to whom a right to benefits has been assigned, in consideration of services rendered, payments and/or rights, agrees to be bound by the terms of this Plan and agree to submit claims for reimbursement in strict accordance with their State's health care practice acts, ICD 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 Claimant, Provider or other person or entity to enforce the provisions of this section, then that Claimant, Provider or other person or entity agrees to pay the Plan's attorneys' fees and costs, regardless of the action's outcome.

Further, Claimant and/or their Dependents, beneficiaries, estate, heirs, guardian, personal representative, or assigns (Claimants) 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 Claimant(s) are entitled, for or in relation to facility-acquired condition(s), Provider error(s), or damages arising from another party's act or omission for which the Plan has not already been refunded.

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

1. In error.
2. Pursuant to a misstatement contained in a proof of loss or a fraudulent act.
3. Pursuant to a misstatement made to obtain coverage under this Plan within two years after the date such coverage commences.
4. With respect to an ineligible person.
5. In anticipation of obtaining a recovery if a Claimant fails to comply with the Plan's Third Party Recovery, Subrogation and Reimbursement provisions.
6. Pursuant to a claim for which benefits are recoverable under any policy or act of law providing for coverage for occupational injury or disease to the extent that such benefits are recovered. This provision (6) shall not be deemed to require the Plan to pay benefits under this Plan in any such instance.

The deduction may be made against any claim for benefits under this Plan by a Claimant or by any of his covered Dependents if such payment is made with respect to the Claimant or any person covered or asserting coverage as a Dependent of the Claimant.

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 Claimant for any outstanding amount(s).

Medicaid Coverage
A Claimant'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 such Claimant. Any such benefit payments will be subject to the State's right to reimbursement for benefits it has paid on behalf of the Claimant, 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.

Limitation of Action
A Claimant cannot bring any legal action against the Plan for a claim of benefits until 90 days after all appeal processes have been exhausted. After 90 days, if the Claimant wants to bring a legal action against the Plan, he or she must do so within one year of the date he or she is notified of the final decision on the final appeal or he or she will lose any rights to bring such an action against the Plan.

COORDINATION OF BENEFITS

Coordination of the Benefit Plans

Coordination of benefits sets out rules for the order of payment of Covered Expenses when two or more plans, including Medicare, are paying. When a Participant is covered by this Plan and another plan, the plans will coordinate benefits when a claim is received.

Standard Coordination of Benefits

The plan that pays first according to the rules will pay as if there were no Other Plan involved. The secondary and subsequent plans will pay the balance due up to 100% of the total allowable charges.

Benefits Subject to This Provision

The following shall apply to the entirety of the Plan and all benefits described therein.

Excess Insurance

Except as outlined in the "Effect on Benefits" provision in regard to any Other Plan, if at the time of Injury, Illness or disability there is available, or potentially available any coverage (including but not limited to coverage resulting from a judgment at law or settlements), the benefits under this Plan shall apply only as an excess over such other sources of coverage.

The Plan's benefits shall be excess to any of the following:

1. The responsible party, its insurer, or any other guarantor 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, including any similar coverage under a different name in a particular state.
3. Any policy of insurance from any insurance company or guarantor of a responsible third party, including but not limited to an employer's policy.
4. Workers' compensation or other liability insurance company.
5. Any of the following:
    - Crime victim restitution funds
    - Civil restitution funds
    - No-fault restitution funds such as vaccine injury compensation funds
    - Any medical, applicable disability or other benefit payments
    - School insurance coverage

Vehicle Limitation

When medical payments are available under any vehicle insurance, the Plan shall pay excess benefits only. This Plan shall always be considered secondary to such plans and/or policies and will exclude benefits subject to the Exclusions in this Plan up to the maximum amount available to the Participant under applicable state law, regardless of a Participant's election of lesser coverage amount. This applies to all forms of medical payments under vehicle plans and/or policies regardless of their names, titles or classifications.

Effect on Benefits

Application to Benefit Determinations

The plan that pays first according to the rules in the provision entitled "Order of Benefit Determination" will pay as if there were no Other Plan involved. The secondary and subsequent plans will pay the balance due up to 100% of the total Covered Expenses. When there is a conflict in the rules, this Plan will never pay more than 50% of Covered Expenses when paying secondary. Benefits will be coordinated on the basis of a Claim Determination Period.

When medical payments are available under automobile insurance, this Plan will pay excess benefits only. This Plan will always be considered secondary regardless of the individual's election under personal injury protection (PIP) coverage with the automobile insurance carrier regarding priority of payment.

When some "Other Plan" provides benefits in the form of services (rather than cash payments), the Plan Administrator shall assess the value of said benefit(s) and determine the reasonable cash value of the service or services rendered, by determining the amount that would be payable in accordance with the terms of the Plan.

In certain instances, the benefits of the Other Plan will be ignored for the purposes of determining the benefits under this Plan. This is the case when all of the following occur:

1. The Other Plan would, according to its rules, determine its benefits after the benefits of this Plan have been determined.
2. The rules in the provision entitled "Order of Benefit Determination" would require this Plan to determine its benefits before the Other Plan.

Order of Benefit Determination
For the purposes of the provision entitled "Application to Benefit Determinations", the rules establishing the order of benefit determination between the Plan and an Other Plan are:

1. A plan without a coordinating provision will always be the primary plan.
2. The benefits of a plan which covers the person on whose expenses a claim is based other than as a dependent shall be determined before the benefits of a plan which covers such person as a Dependent.
3. If the person for whom claim is made is a dependent child covered under both parents' plans, the plan covering the parent whose birthday (month and day of birth, not year) falls earlier in the year will be primary, except:
    a. When the parents were never married, are separated, or are divorced, the benefits of a plan which covers the child as a dependent of the parent with custody will be determined before the benefits of a plan which covers the child as a dependent of the parent without custody.
    b. When the parents are divorced and the parent with custody of the child has remarried, the benefits of a plan which covers the child as a dependent of the parent with custody shall be determined before the benefits of a plan which covers that child as a dependent of the stepparent, and the benefits of a plan which covers that child as a dependent of the stepparent will be determined before the benefits of a plan which covers that child as a dependent of the parent without custody.

    Notwithstanding the above, if there is a court decree which would otherwise establish financial responsibility for the child's health care expenses, the benefits of the plan which covers the child as a dependent of the parent with such financial responsibility shall be determined before the benefits of any Other Plan which covers the child as a dependent child.

4. 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 a claim is based for the longer period of time shall be determined before the benefits of a plan which has covered such person for the shorter period of time.
5. To the extent required by Federal and State regulations, this Plan will pay before any Medicare, Tricare, Medicaid, State child health benefits or other applicable State health benefits program.

Right to Receive and Release Necessary Information

The Plan Administrator may, without notice to or consent of any person, release to or obtain from any insurance company or other organization or individual any information regarding coverage, expenses, and benefits which the Plan Administrator, in its sole discretion, considers necessary to determine, implement and apply the terms of this provision or any provision of similar purpose of any Other Plan. Any Participant claiming benefits under this Plan shall furnish to the Plan Administrator such information as requested and as may be necessary to implement this provision.

Facility of Payment

A payment made under any Other Plan may include an amount that should have been paid under this Plan. 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. Any such amount paid under this provision shall be deemed to be benefits paid under this Plan. The Plan Administrator will not have to pay such amount again and this Plan shall be fully discharged from liability.

Right of Recovery

In accordance with the Recovery of Payments provision, whenever payments have been made by this Plan with respect to Covered 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 Coordination of Benefits section, the Plan shall have the right to recover such payments, to the extent of such excess, from any one or more of the following as this Plan shall determine: any person to or with respect to whom such payments were made, or such person's legal representative, any insurance companies, or any other individuals or organizations which the Plan determines are responsible for payment of such Covered Expenses, and any future benefits payable to the Participant or his or her Dependents. Please see the Recovery of Payments provision above for more details.

MEDICARE

Applicable to Active Employees and Their Spouses Ages 65 and Over

An Active Employee and his or her spouse (ages 65 and over) may, at the option of such Employee, elect or reject coverage under this Plan. If such Employee elects coverage under this Plan, the benefits of this Plan shall be determined before any benefits provided by Medicare. If coverage under this Plan is rejected by such Employee, benefits listed herein will not be payable even as secondary coverage to Medicare.

Applicable to All Other Participants Eligible for Medicare Benefits

To the extent required by Federal regulations, this Plan will pay before any Medicare benefits. There are some circumstances under which Medicare would be required to pay its benefits first. In these cases, benefits under this Plan would be calculated as secondary payor (as described under the section entitled "Coordination of Benefits"). If the Provider accepts assignment with Medicare, Covered Expenses will not exceed the Medicare approved expenses.

Applicable to Medicare Services Furnished to End Stage Renal Disease ("ESRD") Participants Who Are Covered Under This Plan

If any Participant is enrolled in Medicare coverage because of ESRD, the benefits of the Plan will be determined before Medicare benefits for the first 30 months of the Participant's Medicare entitlement, regardless of the date of enrollment, unless applicable Federal law provides to the contrary, in which event the benefits of the Plan will be determined in accordance with such law.

THIRD PARTY RECOVERY, SUBROGATION AND REIMBURSEMENT

Payment Condition

The Plan, in its sole discretion, may elect to conditionally advance payment of benefits in those situations where an Injury, Illness or disability is caused in whole or in part by, or results from the acts or omissions of Participants, and/or their Dependents, beneficiaries, estate, heirs, guardian, personal representative, or assigns (collectively referred to hereinafter in this section as "Participant(s)") or a third party, where any party besides the Plan may be responsible for expenses arising from an incident, and/or other funds are available, including but not limited to crime victim restitution funds, civil restitution funds, no-fault restitution funds (including vaccine injury compensation funds), uninsured motorist, underinsured motorist, medical payment provisions, third party assets, third party insurance, and/or guarantor(s) of a third party, any medical, applicable disability, or other benefit payments, and school insurance coverage (collectively "Coverage").

Participant(s), 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. The Plan shall have an equitable lien on any funds received by the Participant(s) 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 Participant(s) agrees to include the Plan's name as a co-payee on any and all settlement drafts. Further, by accepting benefits the Participant(s) 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 Participant shall be a trustee over those Plan assets.

In the event a Participant(s) settles, recovers, or is reimbursed by any Coverage, the Participant(s) agrees to reimburse the Plan for all benefits paid or that will be paid by the Plan on behalf of the Participant(s). When such a recovery does not include payment for future treatment, the Plan's right to reimbursement extends to all benefits paid or that will be paid by the Plan on behalf of the Participant(s) for charges Incurred up to the date such Coverage or third party is fully released from liability, including any such charges not yet submitted to the Plan. If the Participant(s) fails to reimburse the Plan out of any judgment or settlement received, the Participant(s) will be responsible for any and all expenses (fees and costs) associated with the Plan's attempt to recover such money. Nothing herein shall be construed as prohibiting the Plan from claiming reimbursement for charges Incurred after the date of settlement if such recovery provides for consideration of future medical expenses.

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 Participant(s) 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

As a condition to participating in and receiving benefits under this Plan, the Participant(s) 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 and/or entity and to any Coverage to which the Participant(s) is entitled, regardless of how classified or characterized, at the Plan's discretion, if the Participant(s) fails to so pursue said rights and/or action.

If a Participant(s) receives or becomes entitled to receive benefits, an automatic equitable lien attaches in favor of the Plan to any claim, which any Participant(s) 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 Participant 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 Participant 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.

The Plan may, at its discretion, in its own name or in the name of the Participant(s) 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.

If the Participant(s) fails to file a claim or pursue damages against:

1. The responsible party, its insurer, or any other guarantor 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 responsible third party, including but not limited to an employer's policy.
4. Workers' compensation or other liability insurance company.
5. Any of the following:
    - Crime victim restitution funds
    - Civil restitution funds
    - No-fault restitution funds such as vaccine injury compensation funds
    - Any medical, applicable disability or other benefit payments
    - School insurance coverage

the Participant(s) authorizes the Plan to pursue, sue, compromise and/or settle any such claims in the Participant's/Participants' and/or the Plan's name and agrees to fully cooperate with the Plan in the prosecution of any such claims. The Participant(s) 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

The Plan shall be entitled to recover 100% of the benefits paid or payable benefits Incurred, that have been paid and/or will be paid by the Plan, or were otherwise Incurred by the Participant(s) prior to and until the release from liability of the liable entity, as applicable, without deduction for attorneys' fees and costs or application of the common fund doctrine, made whole doctrine, or any other similar legal or equitable theory, and without regard to whether the Participant(s) 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 and extends until the date upon which the liable party is released from liability. If the Participant's/Participants' 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 Participant are deemed held in constructive trust and should not be dissipated or disbursed until such time as the Participant's obligation to reimburse the Plan has been satisfied in accordance with these provisions. The Participant 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.

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. Additionally, the Participant shall indemnify the Plan against any of the Participant's attorney's fees, costs, or other expenses

related to the Participant's recovery for which the Plan becomes responsible by any means other than the Plan's explicit written consent.

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 Participant(s), 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.

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 Participant(s).

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 or disability.

Participant is a Trustee Over Plan Assets

Any Participant 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 Participant understands that he or she is required to:

1. 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.
2. Instruct his or her attorney to ensure that the Plan and/or its authorized representative is included as a payee on all settlement drafts.
3. In circumstances where the Participant is not represented by an attorney, instruct the insurance company or any third party from whom the Participant obtains a settlement, judgment or other source of Coverage to include the Plan or its authorized representative as a payee on the settlement draft.
4. 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.

To the extent the Participant disputes this obligation to the Plan under this section, the Participant 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 or she exercises control, in an account segregated from their general accounts or general assets until such time as the dispute is resolved.

No Participant, 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.

Release of Liability

The Plan's right to reimbursement extends to any incident related care that is received by the Participant(s) ("Incurred") prior to the liable party being released from liability. The Participant's/Participants' obligation to reimburse the Plan is therefore tethered to the date upon which the claims were Incurred, not the date upon which the payment is made by the Plan. In the case of a settlement, the Participant has an obligation to review the "lien" provided by the Plan and reflecting claims paid by the Plan for which it seeks reimbursement, prior to settlement and/or executing a release of any liable or potentially liable third party, and is also obligated to advise the Plan of any incident related care incurred prior to the proposed date of

settlement and/or release, which is not listed but has been or will be incurred, and for which the Plan will be asked to pay.

Excess Insurance

Except as outlined in the "Effect on Benefits" provision in regard to any Other Plan, if at the time of Injury, Illness 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 guarantor 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 responsible third party, including but not limited to an employer's policy.
4. Workers' compensation or other liability insurance company.
5. Any of the following:
    - Crime victim restitution funds
    - Civil restitution funds
    - No-fault restitution funds such as vaccine injury compensation funds
    - Any medical, applicable disability or other benefit payments
    - School insurance coverage

Separation of Funds

Benefits paid by the Plan, funds recovered by the Participant(s), and funds held in trust over which the Plan has an equitable lien exist separately from the property and estate of the Participant(s), such that the death of the Participant(s), or filing of bankruptcy by the Participant(s), 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 Participant(s) 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 Participant(s) and all others that benefit from such payment.

Obligations

It is the Participant's/Participants' obligation at all times, both prior to and after payment of medical benefits by the Plan:

1. To cooperate with the Plan, or any representatives of the Plan, in protecting its rights, including discovery, attending depositions, and/or cooperating in trial to preserve the Plan's rights.
2. To provide the Plan with pertinent information regarding the Illness, disability, or Injury, including accident reports, settlement information and any other requested additional information.
3. To take such action and execute such documents as the Plan may require to facilitate enforcement of its subrogation and reimbursement rights.
4. To do nothing to prejudice the Plan's rights of subrogation and reimbursement.
5. To promptly reimburse the Plan when a recovery through settlement, judgment, award or other payment is received.
6. To notify the Plan or its authorized representative of any incident related claims or care which may be not identified within the lien (but has been Incurred) and/or reimbursement request submitted by or on behalf of the Plan.

7. To notify the Plan or its authorized representative of any settlement prior to finalization of the settlement.
8. To not settle or release, without the prior consent of the Plan, any claim to the extent that the Participant may have against any responsible party or Coverage.
9. To instruct his/her attorney to ensure that the Plan and/or its authorized representative is included as a payee on any settlement draft.
10. In circumstances where the Participant is not represented by an attorney, instruct the insurance company or any third party from whom the Participant obtains a settlement to include the Plan or its authorized representative as a payee on the settlement draft.
11. To make good faith efforts to prevent disbursement of settlement funds until such time as any dispute between the Plan and Participant over settlement funds is resolved.

If the Participant(s) and/or his or her attorney fails to reimburse the Plan for all benefits paid, or to be paid, Incurred, or that will be Incurred, prior to the date of the release of liability from the relevant entity, as a result of said Injury or condition, out of any proceeds, judgment or settlement received, the Participant(s) will be responsible for any and all expenses (whether fees or costs) associated with the Plan's attempt to recover such money from the Participant(s).

The Plan's rights to reimbursement and/or subrogation are in no way dependent upon the Participant's/Participants' cooperation or adherence to these terms.

Offset

If timely repayment is not made, or the Participant 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 Participant'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 Participant(s) in an amount equivalent to any outstanding amounts owed by the Participant to the Plan. This provision applies even if the Participant has disbursed settlement funds.

Minor Status

In the event the Participant(s) 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.

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 Administrator 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 with respect to this provision. The Plan Administrator may amend the Plan at any time without notice.

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.

MISCELLANEOUS PROVISIONS

Clerical Error/Delay

Any clerical error by the Plan Administrator or an agent of the Plan Administrator in keeping pertinent records or a delay in making any changes to such records will not invalidate coverage otherwise validly in force or continue coverage validly terminated. Contributions made in error by Participants due to such clerical error will be returned to the Participant; coverage will not be inappropriately extended. Contributions that were due but not made, in error and due to such clerical error will be owed immediately upon identification of said clerical error. Failure to so remedy amounts owed may result in termination of coverage. Effective Dates, waiting periods, deadlines, rules, and other matters will be established based upon the terms of the Plan, as if no clerical error had occurred. An equitable adjustment of contributions will be made when the error or delay is discovered.

If, an overpayment occurs in a Plan reimbursement amount, the Plan retains a contractual right to the overpayment. The person or institution receiving the overpayment will be required to return the incorrect amount of money. In the case of a Participant, the amount of overpayment may be deducted from future benefits payable.

Conformity With Applicable Laws

Any provision of this Plan that is contrary to any applicable law, equitable principle, regulation or court order (if such a court is of competent jurisdiction) will be interpreted to comply with said law, or, if it cannot be so interpreted, shall be automatically amended to satisfy the law's minimum requirement, including, but not limited to, stated maximums, Exclusions, or statutes of limitations. It is intended that the Plan will conform to the requirements of applicable law.

Fraud

Under this Plan, coverage may be retroactively canceled or terminated (rescinded) if a Participant acts fraudulently or intentionally makes material misrepresentations of fact. It is a Participant's responsibility to provide accurate information and to make accurate and truthful statements, including information and statements regarding family status, age, relationships, etc. It is also a Participant's responsibility to update previously provided information and statements. Failure to do so may result in coverage of Participants being canceled, and such cancellation may be retroactive.

If a Participant, or any other entity, submits or attempts to submit a claim for or on behalf of a person who is not a Participant of the Plan; submits a claim for services or supplies not rendered; provides false or misleading information in connection with enrollment in the Plan; or provides any false or misleading information to the Plan as it relates to any element of its administration; that shall be deemed to be fraud. If a Participant is aware of any instance of fraud, and fails to bring that fraud to the Plan Administrator's attention, that shall also be deemed to be fraud. Fraud will result in immediate termination of all coverage under this Plan for the Participant and their entire Family Unit of which the Participant is a member.

A determination by the Plan that a rescission is warranted will be considered an Adverse Benefit Determination for purposes of review and appeal. A Participant whose coverage is being rescinded will be provided a 30 day notice period as described under the Affordable Care Act (ACA) and regulatory guidance. Claims Incurred after the retroactive date of termination shall not be further processed and/or paid under the Plan. Claims Incurred after the retroactive date of termination that were paid under the Plan will be treated as erroneously paid claims under this Plan.

Headings

The headings used in this Plan Document are used for convenience of reference only. Participants are advised not to rely on any provision because of the heading.

Pronouns
Unless the context otherwise demands, words importing any gender shall be interpreted to mean any or all genders.

Word Usage
Wherever any words are used herein in the singular or plural, they shall be construed as though they were in the plural or singular, as the case may be, in all cases where they would so apply.

No Waiver or Estoppel
All parts, portions, provisions, and conditions in the Plan, and/or other items addressed in this Plan shall be deemed to be in full force and effect, and not waived, absent an explicit written instrument expressing otherwise; executed by the Plan Administrator. Absent such explicit waiver, there shall be no waiver of or estoppel against the enforcement of any provision of this Plan. Failure by any applicable entity to enforce any part of the Plan shall not constitute a waiver, either as it specifically applies to a particular circumstance, or as it applies to the Plan's general administration. If an explicit written waiver is executed, that waiver shall only apply to the matter addressed therein, and shall be interpreted in the most narrow fashion possible.

Plan Contributions
The Plan Administrator shall, from time to time, evaluate the funding method of the Plan and determine the amount to be contributed by the Participating Employer and the amount to be contributed (if any) by each Participant.

The Plan Sponsor shall fund the Plan in a manner consistent with the provisions of the Internal Revenue Code and such other laws and regulations as shall be applicable to the end that the Plan shall be funded on a lawful and sound basis. The manner and means by which the Plan is funded shall be solely determined by the Plan Sponsor, to the extent allowed by applicable law.

Notwithstanding any other provision of the Plan, the Plan Administrator's obligation to pay claims otherwise allowable under the terms of the Plan shall be limited to its obligation to make contributions to the Plan as set forth in the preceding paragraph. Payment of said claims in accordance with these procedures shall discharge completely the Company's obligation with respect to such payments.

In the event that the Company terminates the Plan, then as of the effective date of termination, the Employer and eligible Employees shall have no further obligation to make additional contributions to the Plan and the Plan shall have no obligation to pay claims Incurred after the termination date of the Plan.

Right to Receive and Release Information
The Plan Administrator may, without notice to or consent of any person, release to or obtain from any insurance company or other organization or person any information regarding coverage, expenses, and benefits which the Plan Administrator, in its sole discretion, considers necessary to determine and apply the provisions and benefits of this Plan. In so acting, the Plan Administrator shall be free from any liability that may arise with regard to such action. Any Participant claiming benefits under this Plan shall furnish to the Plan Administrator such information as requested and as may be necessary to implement this provision.

Written Notice
Any written notice required under this Plan which, as of the Effective Date, is in conflict with the law of any governmental body or agency which has jurisdiction over this Plan shall be interpreted to conform to the minimum requirements of such law.

Right of Recovery

In accordance with the Recovery of Payments provision, whenever payments have been made by this Plan in a total amount, at any time, in excess of the maximum amount of benefits payable under this Plan, the Plan shall have the right to recover such payments, to the extent of such excess, from any one or more of the following as this Plan shall determine: any person to or with respect to whom such payments were made, or such person's legal representative, any insurance companies, or any other individuals or organizations which the Plan determines are responsible for payment of such amount, and any future benefits payable to the Participant or his or her Dependents. See the Recovery of Payments provision for full details.

Statements

All statements made by the Company or by a Participant will, in the absence of fraud, be considered representations and not warranties, and no statements made for the purpose of obtaining benefits under this document will be used in any contest to avoid or reduce the benefits provided by the document unless contained in a written application for benefits and a copy of the instrument containing such representation is or has been furnished to the Participant.

Any Participant who knowingly and with intent to defraud the Plan, files a statement of claim containing any materially false information, or conceals for the purpose of misleading, information concerning any material fact, commits a fraudulent act. The Participant may be subject to prosecution by the United States Department of Labor. Fraudulently claiming benefits may be punishable by a substantial fine, imprisonment, or both.

Protection Against Creditors

To the extent this provision does not conflict with any applicable law, no benefit payment under this Plan shall be subject in any way to alienation, sale, transfer, pledge, attachment, garnishment, execution or encumbrance of any kind, and any attempt to accomplish the same shall be void. If the Plan Administrator shall find that such an attempt has been made with respect to any payment due or to become due to any Participant, the Plan Administrator in its sole discretion may terminate the interest of such Participant or former Participant in such payment. And in such case the Plan Administrator shall apply the amount of such payment to or for the benefit of such Participant or former Participant, his or her spouse, parent, adult Child, guardian of a minor Child, brother or sister, or other relative of a Dependent of such Participant or former Participant, as the Plan Administrator may determine, and any such application shall be a complete discharge of all liability with respect to such benefit payment. However, at the discretion of the Plan Administrator, benefit payments may be assigned to health care Providers.

SUMMARY OF BENEFITS

General Limits

Payment for any of the expenses listed below is subject to all Plan Exclusions, limitations and provisions. All coverage figures, if applicable, are after the out of pocket Deductible has been satisfied.

See the Utilization Management section for more information regarding Pre-Certification and/or Notification requirements.

Network and Non-Network Provider Arrangement

The Plan contracts with medical Provider Networks to access discounted fees for service for Participants. Hospitals, Physicians and other Providers who have contracted with the medical Provider Networks are called "Network Providers." Those who have not contracted with the Networks are referred to in this Plan as "Non-Network Providers." This arrangement results in the following benefits to Participants:

1. The Plan provides different levels of benefits based on whether the Participants use a Network or Non-Network Provider. Unless one of the exceptions shown below applies, if a Participant elects to receive medical care from the Non-Network Provider, the benefits payable are generally lower than those payable when a Network Provider is used. The following exceptions apply:

    a. In the event a Network Provider refers a Participant to a Non-Network Provider for diagnostic testing, x-rays, laboratory services or anesthesia, then charges of the Non-Network Provider will be paid as though the services were provided by a Network Provider.
    b. The Network Provider level of benefits is payable for any Participant who cannot access Network Providers because they reside outside the Network service area. The Network service area is defined as 50 miles.
    c. The Network Provider level of benefits is payable when a Participant receives Emergency care either Out-of-Area or at a Non-Network Hospital for an Accidental Bodily Injury or Emergency.

2. Except as outlined in "No Surprises Act – Emergency Services and Surprise Bills" below, if the charge billed by a Non-Network Provider for any covered service is higher than the Maximum Allowable Charge determined by the Plan, Participants are responsible for the excess unless the Provider accepts assignment of benefits as consideration in full for services rendered. Since Network Providers have agreed to accept a negotiated discounted fee as full payment for their services, Participants are not responsible for any billed amount that exceeds that fee. The Plan Administrator reserves the right to revoke any previously-given assignment of benefits or to proactively prohibit assignment of benefits to anyone, including any Provider, at its discretion.

3. To receive benefit consideration, Participants may need to submit claims for services provided by Non-Network Providers to the Third Party Administrator. Network Providers have agreed to bill the Plan directly, so that Participants do not have to submit claims themselves.

4. Benefits available to Network Providers are limited such that if a Network Provider advances or submits charges which exceed amounts that are eligible for payment in accordance with the terms of the Plan, or are for services or supplies for which Plan coverage is not available, or are otherwise limited or excluded by the Plan, benefits will be paid in accordance with the terms of the Plan.

Please note affirmation that a treatment, service, or supply is of a type compensable by the Plan is not a guarantee that the particular treatment, service, or supply in question, upon receipt of a Clean Claim and review by the Plan Administrator, will be eligible for payment.

If a Participant receives information with respect to an item or service from the Plan, its representative, or a database maintained by the Plan or its representative indicating that a particular Provider is an In-Network Provider and the Participant receives such item or service in reliance on that information, the Participant's Coinsurance, Copayment, Deductible, and out-of-pocket maximum will be calculated as if the Provider had been In-Network despite that information proving inaccurate.

Balance Billing

In the event that a claim submitted by a Network or Non-Network Provider is subject to a medical bill review or medical chart audit and some or all of the charges in connection with such claim are repriced because of billing errors and/or overcharges, it is the Plan's position that the Participant should not be responsible for payment of any charges denied as a result of the medical bill review or medical chart audit, and should not be balance billed for the difference between the billed charges and the amount determined to be payable by the Plan Administrator, although the Plan has no control over any Provider's actions, including balance billing.

In addition, with respect to services rendered by a Network Provider being paid in accordance with a discounted rate, it is the Plan's position that the Participant should not be responsible for the difference between the amount charged by the Network Provider and the amount determined to be payable by the Plan Administrator, and should not be balance billed for such difference. Again, the Plan has no control over any Network Provider that engages in balance billing practices, except to the extent that such practices are contrary to the contract governing the relationship between the Plan and the Network Provider.

The Participant is responsible for any applicable payment of Coinsurances, Deductibles, and out-of-pocket maximums and may be billed for any or all of these.

Choice of Providers

The Plan is not intended to disturb the Physician-patient relationship. Each Participant has a free choice of any Physician or surgeon, and the Physician-patient relationship shall be maintained. Physicians and other health care Providers are not agents or delegates of the Plan Sponsor, Company, Plan Administrator, Employer or Third Party Administrator. The delivery of medical and other health care services on behalf of any Participant remains the sole prerogative and responsibility of the attending Physician or other health care Provider. The Participant, together with his or her Physician, is 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.

Network Provider Information

The Network Providers are merely independent contractors; neither the Plan nor the Plan Administrator make any warranty as to the quality of care that may be rendered by any Network Provider.

The Network Provider list changes frequently; therefore, it is recommended that a Participant verify with the Provider that the Provider is still a Network Provider before receiving services.

Out-of-Area Services

Overview

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

When you receive care outside of the Anthem Service Area, you will receive it from one of two kinds of Providers. Most Providers ("participating providers") contract with the local Blue Cross and/or Blue Shield Plan in that geographic area ("Host Blue"). Some Providers ("nonparticipating providers") don't contract with the Host Blue. We explain below how we pay both kinds of Providers

Inter-Plan Arrangements Eligibility – Claim Types
Most claim types are eligible to be processed through Inter-Plan Arrangements, as described above. Examples of claims that are not included are prescription drugs that you obtain from a pharmacy and most dental or vision benefits.

Non-Network Providers Outside Anthem Service Area

Allowed Amounts and Member Liability Calculation
When Covered Services are provided outside of Anthem's Service Area by non-network providers, the Plan may determine benefits and make payment based on pricing from either the Host Blue or the pricing arrangements required by applicable state or federal law. In these situations, the amount you pay for such services as deductible, copayment or coinsurance will be based on that allowed amount Also, you may be responsible for the difference between the amount that the non-participating provider bills and the payment the Plan will make for the Covered Services as set forth in this paragraph. Federal or state law, as applicable, will govern payments for out-of-network emergency services.

Exceptions
In certain situations, the Plan may use other pricing methods, such as billed charges the pricing it would use if the healthcare services had been obtained within the Anthem Service Area, or a special negotiated price to determine the amount the Plan will pay for services provided by nonparticipating providers. In these situations, you may be liable for the difference between the amount that the nonparticipating provider bills and the payment the Plan makes for the Covered Services as set forth in this paragraph.

BlueCard® Program

Under the BlueCard® Program, when you receive covered services within the geographic area served by a Host Blue, Anthem will still fulfill our contractual obligations. But, the Host Blue is responsible for: (a) contracting with its Providers; and (b) handling its interactions with those Providers.

When you receive Covered Services outside the Service Area and the claim is processed through the BlueCard Program, the amount you pay is calculated based on the lower of:

- The billed charges for covered services; or
- The negotiated price that the Host Blue makes available to Us.

Often, this "negotiated price" will be a simple discount that reflects an actual price that the Host Blue pays to the Provider. Sometimes, it is an estimated price that takes into account special arrangements with that Provider. Sometimes, such an arrangement may be an average price, based on a discount that results in expected average savings for services provided by similar types of Providers. Estimated and average pricing arrangements may also involve types of settlements, incentive payments and/or other credits or charges.

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

Negotiated (non–BlueCard Program) Arrangements
With respect to one or more Host Blues, instead of using the BlueCard Program, Anthem may process your claims for covered services through negotiated arrangements for national accounts.

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

Blue Cross Blue Shield Global Core® Program

If you plan to travel outside the United States, call customer service to find out your Blue Cross Blue Shield Global Core benefits. Benefits for services received outside of the United States may be different from services received in the United States. The plan only covers Emergency, including ambulance, and Urgent Care outside of the United States. Remember to take an up to date health ID card with you.

When you are traveling abroad and need medical care, you can call the Blue Cross Blue Shield Global Core Service Center any time. They are available 24 hours a day, seven days a week. The toll free number is 800-810-2583. Or you can call them collect at 804-673-1177.

If you need inpatient hospital care, you or someone on your behalf, should contact us for preauthorization. Keep in mind, if you need emergency medical care, go to the nearest hospital. There is no need to call before you receive care.

How claims are paid with Blue Cross Blue Shield Global Core
In most cases, when you arrange inpatient hospital care with Blue Cross Blue Shield Global Core, claims will be filed for you. The only amounts that you may need to pay up front are any copayment, coinsurance or deductible amounts that may apply.

You will typically need to pay for the following services up front:

- Doctors services;
- Inpatient hospital care not arranged through Blue Cross Blue Shield Global Core; and
- Outpatient services.

You will need to file a claim form for any payments made up front.

When you need Blue Cross Blue Shield Global Core claim forms you can get international claims forms in the following ways:

- Call the Blue Cross Blue Shield Global Core Service Center at the numbers above; or
- Online at www.bcbsglobalcore.com.

You will find the address for mailing the claim on the form.

Claims Audit

In addition to the Plan's Medical Record Review process, the Plan Administrator may use its discretionary authority to utilize an independent bill review and/or claim audit program or service for a complete claim. While every claim may not be subject to a bill review or audit, the Plan Administrator has the sole discretionary authority for selection of claims subject to review or audit.

The analysis will be employed to identify charges billed in error and/or charges that exceed the Maximum Allowable Charge or services that are not Medically Necessary and may include a patient medical billing records review and/or audit of the patient's medical charts and records.

Upon completion of an analysis, a report will be submitted to the Plan Administrator or its agent to identify the charges deemed in excess of the Maximum Allowable Charge or other applicable provisions, as outlined in this Plan Document.

Despite the existence of any agreement to the contrary, the Plan Administrator has the discretionary authority to reduce any charge to the Maximum Allowable Charge, in accord with the terms of this Plan Document.

No Surprises Act – Emergency Services and Surprise Bills

For Non-Network claims subject to the No Surprises Act ("NSA"), Participant cost-sharing will be the same amount as would be applied if the claim was provided by a Network Provider and will be calculated as if the Plan's Covered Expense was the Recognized Amount, regardless of the Plan's actual Maximum Allowable Charge. The NSA prohibits Providers from pursuing Participants for the difference between the Maximum Allowable Charge and the Provider's billed charge for applicable services, with the exception of valid Plan-appointed cost-sharing as outlined above. Any such cost-sharing amounts will accrue toward In-Network Deductibles and out of pocket maximums.

Benefits for claims subject to the NSA will be denied or paid within 30 days of receipt of an initial claim, and if approved will be paid directly to the Provider.

Claims subject to the NSA are those which are submitted for:

- Emergency Services;
- Non-emergency services rendered by a Non-Network Provider at a Participating Health Care Facility, provided the Participant has not validly waived the applicability of the NSA; and
- Covered Non-Network air ambulance services.

Continuity of Care

In the event a Participant is a continuing care patient receiving a course of treatment from a Provider which is In-Network or otherwise has a contractual relationship with the Plan governing such care and that contractual relationship is terminated, not renewed, or otherwise ends for any reason other than the Provider's failure to meet applicable quality standards or for fraud, the Participant shall have the following rights to continuation of care.

The Plan shall notify the Participant in a timely manner that the Provider's contractual relationship with the Plan has terminated, and that the Participant has rights to elect continued transitional care from the Provider. If the Participant elects in writing to receive continued transitional care, Plan benefits will apply under the same terms and conditions as would be applicable had the termination not occurred, beginning on the date the Plan's notice of termination is provided and ending 90 days later or when the Participant ceases to be a continuing care patient, whichever is sooner.

For purposes of this provision, "continuing care patient" means an individual who:

1. is undergoing a course of treatment for a serious and complex condition from a specific Provider,
2. is undergoing a course of institutional or Inpatient care from a specific Provider,
3. is scheduled to undergo non-elective Surgery from a specific Provider, including receipt of postoperative care with respect to the Surgery,
4. is pregnant and undergoing a course of treatment for the Pregnancy from a specific Provider, or
5. is or was determined to be terminally ill and is receiving treatment for such Illness from a specific Provider.

Note that during continuation, although Plan benefits will be processed as if the termination had not occurred and the law requires the Provider to continue to accept the previously-contracted amount, the

contract itself will have terminated, and thus the Plan may be unable to protect the Participant if the Provider pursues a balance bill.

Transition of Care

If a Participant is under the care of a Non-Network Provider at the time of joining the Plan, there are a limited number of medical conditions that may qualify for transition of care. If transitional care is appropriate, specific treatment by a Non-Network Provider may be covered at the Network level of benefits for a limited period of time. The Third Party Administrator will review and approve or deny such requests.

Summary of Benefits - Medical

The following benefits are per Participant per Calendar Year. All benefits are subject to the Maximum Allowable Charge.

Silver Plan	Anthem Network	Out-of-Network
Deductible Individual Family Unit ***Note: Covered Expenses incurred in and applied toward the Deductible in October, November and December will be applied toward the Deductible the next Calendar Year.***	 $2,000 $4,000	 $2,000 $4,000
• Covered Expenses applied toward the "individual" Deductible amount will be applied toward the "family" Deductible amount. • Covered Expenses applied toward satisfying the Anthem Network Deductible will apply toward the Out-of-Network Deductible. • Covered Expenses applied toward satisfying the Out-of-Network Deductible will apply toward satisfying the Anthem Network Deductible. • The Deductible is embedded, meaning an "individual" will only have to meet the "individual" Deductible amount.		
Maximum Out-of-Pocket Individual Family Unit ***Note: Covered Expenses incurred in and applied toward the Anthem Network out-of-pocket maximum in October, November and December will be applied toward the Anthem Network out-of-pocket maximum in the next Calendar Year.***	 $4,000 $8,000	 Unlimited Unlimited

- Covered Expenses applied toward the "individual" out-of-pocket maximum amount will be applied toward the "family" out-of-pocket maximum amount.
- Covered Expenses applied toward satisfying the Anthem Network out-of-pocket maximums will not apply toward the Out-of-Network out-of-pocket maximum.
- Covered Expenses applied toward satisfying the Out-of-Network out-of-pocket maximum will not apply toward satisfying the Anthem Network out-of-pocket maximum.
- The individual out-of-pocket maximum is embedded, meaning an individual will only have to meet the individual out-of-pocket maximum before benefits will be paid at 100% for that individual.

The following table identifies what does and does not apply toward the Anthem Network and Out-of-Network Out-of-Pocket Maximums:

Plan Features	Applies to the Anthem Network Out-of-Pocket Maximum?	Applies to the Out-of-Network Out-of-Pocket Maximum?
Payments toward the annual Deductible	Yes	Yes
Coinsurance payments	Yes	Yes
Copayments	Yes	Yes
Charges for non-covered services	No	No
The amounts of any Pre-Certification penalties	No	No
Charges that exceed Covered Expenses	No	No

Silver Plan Covered Medical Expenses	Anthem Network	Out-of-Network	Limits
Coverage for all services is based on Medical Necessity. **Participants using Out-of-Network services are responsible for all copays, coinsurance and amounts above the Maximum Allowable Charge except for services that are subject to the No Surprises Act.**			
Abortion Office Hospital/Ambulatory Surgical Center (ASC)	100%-PCP $300 copay per day after deductible-Specialist $1,800 copay after deductible-Hospital $600 copay after deductible-ASC	100%-PCP $300 copay per day after deductible-Specialist $1,800 copay after deductible-Hospital $600 copay after deductible-ASC	Elective or non-elective abortions covered.
Acupuncture	100%	50%	Limited to 12 visits per Calendar Year.
Advanced Imaging (CT, MRI, PET scan, Nuclear Studies) Freestanding Radiology Center Outpatient Hospital Physician Office	 $300 copay per day after deductible $750 copay per day after deductible $300 copay per day after deductible	 $300 copay per day after deductible $750 copay per day after deductible $300 copay per day after deductible	Out-of-Network benefit maximum: $800 per test.
Allergy Services Office Visit	100%-PCP $100 copay-Specialist	100%-PCP $100 copay-Specialist	

Silver Plan Covered Medical Expenses	Anthem Network	Out-of-Network	Limits
Coverage for all services is based on Medical Necessity. **Participants using Out-of-Network services are responsible for all copays, coinsurance and amounts above the Maximum Allowable Charge except for services that are subject to the No Surprises Act.**			
Office Visit with Injection Injection Only Serum Testing	100%-PCP $100 copay-Specialist 100% 100%-PCP $100 copay-Specialist 100%-PCP $100 copay per day-Specialist	100%-PCP $100 copay-Specialist 100% 100%-PCP $100 copay-Specialist Not Covered	
Ambulance Ground Air	$700 copay after deductible $700 copay after deductible	$700 copay after deductible $700 copay after deductible	Out-of-Network applies to in-network benefits. Out-of-Network Air Ambulance: $50,000 per trip maximum for non-emergent services.
Ambulatory Surgical Center	$600 copay after deductible	$600 copay after deductible	
Anesthesia	100%	100%	
Autism Office Visit, Testing	100%	100%	See Habilitative Services and Therapies for therapy coverage.
Chemotherapy/Radiation Therapy	100%	100%	
Chiropractic Care	100%	Not Covered	
Dialysis	100%	100%	Out-of-Network benefit maximum: $350 per visit.
Durable Medical Equipment	100%	Not Covered	
Eye Exam	100%	100%	Examination including refraction covered only when performed in conjunction with a medical diagnosis.
Gender-Affirming Care	*Reimbursed based on the services rendered	Not Covered	*Benefits will be applied based on the services billed: inpatient, outpatient, therapy.

Silver Plan Covered Medical Expenses	Anthem Network	Out-of-Network	Limits
Coverage for all services is based on Medical Necessity. **Participants using Out-of-Network services are responsible for all copays, coinsurance and amounts above the Maximum Allowable Charge except for services that are subject to the No Surprises Act.**			
			See Medical Benefits for additional information on travel expenses.
Genetic Counseling or Testing Office Outpatient Hospital Freestanding Lab	 100% $150 copay per day 100%	 Not Covered Not Covered Not Covered	
Gene Therapy	Reimbursed based on the services rendered	Reimbursed based on the services rendered	Benefits will be applied based on the services billed: inpatient, outpatient, office.
Glaucoma, Cataract Surgery and Lenses (one set)	$600 copay after deductible-Ambulatory Surgery Center $1,800 copay after deductible-Outpatient Hospital	$600 copay after deductible-Ambulatory Surgery Center $1,800 copay after deductible-Outpatient Hospital	One set of lenses or glasses covered after ocular surgery when the lens of the eyes has been removed such as with a cataract extraction.
Habilitative Services and Therapies Applied Behavior Analysis (ABA) Therapy Billed with Autism Diagnosis-Occupation Therapy, Physical Therapy, Speech-Language Pathology Occupational Therapy, Physical Therapy, Speech-Language Pathology	 100% 100% 100%	 100% 100% Not Covered	Aquatic and Physical Therapy: Maximum 30 visits combined per Calendar year. Occupational and Speech Therapy: Maximum of 30 visits per therapy per Calendar Year.
Hearing Aids	100%	100%	Covered up to a benefit maximum of $700 per plan participant, every 24 month period for both ears. Maximum includes: monaural or binaural hearing aids, ear

Silver Plan Covered Medical Expenses	Anthem Network	Out-of-Network	Limits
Coverage for all services is based on Medical Necessity. **Participants using Out-of-Network services are responsible for all copays, coinsurance and amounts above the Maximum Allowable Charge except for services that are subject to the No Surprises Act.**			
			mold(s), batteries, cords, other ancillary equipment.
Home Health Care	100%	100%	Maximum of 100 visits per Calendar Year. Out-of-Network benefit maximum: $150 per day.
Hospice Care Inpatient, Outpatient Bereavement Counseling	100% 100%	100% 100%	
Hospital Inpatient Hospital Including-Rehabilitation 23 hour Observation Lab X-ray Outpatient Surgery Pre-admission Testing-Lab X-ray	$600 copay per day after deductible $150 copay per day-Outpatient Hospital 100%-Freestanding Facility $225 copay per day after deductible-Outpatient Hospital $75 copay after deductible-Freestanding Facility $1,800 copay after deductible $150 copay per day $225 copay per day after deductible	$600 copay per day after deductible Not Covered Not Covered $1,800 copay after deductible Not Covered Not Covered	Out-of-network non-emergency admit: Maximum payment up to $600 per day.
Independent Lab	100%	Not Covered	
Implantable Hearing Devices	$600 copay after deductible-Ambulatory Surgery Center $1,800 copay after deductible - Outpatient Hospital	$600 copay after deductible - Ambulatory Surgery Center $1,800 copay after deductible -Outpatient Hospital	Includes cochlear implants and bone anchored devices.
Mental Health and Substance Use Disorder Expenses Inpatient Facility, Residential Treatment Facility	$600 copay per day after deductible	$600 copay per day after deductible	Out-of-network non-emergency admit: Maximum payment up to $600 per day.

Silver Plan Covered Medical Expenses	Anthem Network	Out-of-Network	Limits
Coverage for all services is based on Medical Necessity. **Participants using Out-of-Network services are responsible for all copays, coinsurance and amounts above the Maximum Allowable Charge except for services that are subject to the No Surprises Act.**			
Partial Hospitalization, Intensive Outpatient Services, Outpatient Facility/Office Visit Services	100%	100%	
Morbid Obesity/Obesity Office Visit Lab	100%-PCP $100 copay-Specialist 100%	100%-PCP $100 copay-Specialist Not Covered	See "Bariatric Surgery" for more information on surgery benefits.
Newborn Care Well Baby Sick Baby	100% $600 copay per day after deductible	100% $600 copay per day after deductible	Well baby processed under mother unless mother is not a dependent on the plan, then the charges will be processed under the baby with the inpatient copay applying. Out-of-network non-emergency admit: Maximum payment up to $600 per day.
Nutritional Counseling	100%	100%	Covered for the management of diabetes, treatment of eating disorders such as anorexia nervosa and nervosa and as required under preventive benefits. Limited to 36 visits per Calendar Year.
Outpatient Emergency Services – Emergency Room	$700 copay after deductible	$700 copay after deductible	ER copay waived if admitted. Inpatient benefits would apply.
Outpatient Emergency Services-Other Providers	100%	100%	
Physician Services **Primary Care:** Office Visit, Telehealth Visit, Office Visit with Injection	100%	100%	

Silver Plan Covered Medical Expenses	Anthem Network	Out-of-Network	Limits
Coverage for all services is based on Medical Necessity. **Participants using Out-of-Network services are responsible for all copays, coinsurance and amounts above the Maximum Allowable Charge except for services that are subject to the No Surprises Act.**			
Specialist: Office Visit, Telehealth Visit, Office Visit with Injection	$100 copay	$100 copay	
Lab/X-ray-Primary Care, Lab-Specialist	100%	Not Covered	
X-ray-Specialist	$75 copay per day after deductible	Not Covered	
Diagnostics in Office (other than lab/x-ray)	100%	Not Covered	
Injection Only	100%	100%	
Surgery	100%-PCP $300 copay per day after deductible-Specialist	100%-PCP $300 copay per day after deductible-Specialist	
Physician Charges-Inpatient/Outpatient	100%	100%	
Retail Health Clinic	100%	100%	
Telehealth Visits with LiveHealth, Midi Health Integrative Women's Care	100%	Not Applicable	Contact: www.livehealthonline.com
Pregnancy/Sterilization Expenses Initial Office Visit	100%	100%	
Routine Pre-Natal Services-as required per ACA	100%	Not covered	
Non-Routine Pre-Natal Diagnostic Lab	100%-Office 100%-Freestanding Facility $150 copay per day-Outpatient Hospital	Not Covered	
Non-Routine Pre-Natal Diagnostic X-ray including Sonograms	100%-PCP/OB-GYN $75 copay per day after deductible-Specialist $75 copay per day after deductible-Freestanding Facility	Not Covered	Sonograms: Allowed 3, any additional require medical necessity review.

Silver Plan Covered Medical Expenses	Anthem Network	Out-of-Network	Limits
Coverage for all services is based on Medical Necessity. **Participants using Out-of-Network services are responsible for all copays, coinsurance and amounts above the Maximum Allowable Charge except for services that are subject to the No Surprises Act.**			
Delivery/Post Natal, Birthing Center	$225 copay per day after deductible-Outpatient Hospital $600 copay per day after deductible	$600 copay per day after deductible	Out-of-network non-emergency admit: Maximum payment up to $600 per day.
Physician Global Fee, Midwife, Doula	100%	100%	
Amniocentesis	100%-PCP Office $300 copay after deductible-Specialist Office $600 copay after deductible-Ambulatory Surgery Center $1,800 copay after deductible-Outpatient Hospital	100%-PCP Office $300 copay after deductible - Specialist Office $600 copay after deductible - Ambulatory Surgery Center $1,800 copay after deductible -Outpatient Hospital	
Male Sterilization	100%-PCP $100 copay-Specialist $600 copay after deductible - Ambulatory Surgical Center $1,800 copay after deductible - Outpatient Hospital	100%-PCP $100 copay-Specialist $600 copay after deductible - Ambulatory Surgical Center $1,800 copay after deductible -Outpatient Hospital	Female sterilization falls under preventive benefits.
Breast Pump (Manual or Electric)	100%	Not Covered	One breast pump per pregnancy. Over the counter breast pump purchases are not covered.
Preventive Care **Well Adult Care** Physical Exam Mammogram Pap Smear Colonoscopy Immunizations	100%	Not Covered	
Well Child Care Physical Exam Immunizations	100%	Not Covered	
Prosthetics, Orthotics and Supplies Prosthetics, Orthotics	100%	Not Covered	Custom Molded Foot Orthotics: 2 pairs covered per year. Additional 2 pairs would be considered post-surgery if medically necessary.
Custom Molded Foot Orthotics	100%	Not Covered	
Supplies	100%	Not Covered	

Silver Plan Covered Medical Expenses	Anthem Network	Out-of-Network	Limits
Coverage for all services is based on Medical Necessity. **Participants using Out-of-Network services are responsible for all copays, coinsurance and amounts above the Maximum Allowable Charge except for services that are subject to the No Surprises Act.**			
Rehabilitative Services and Therapies Aquatic Therapy, Autism Spectrum Disorder Treatment, Cardiac Therapy, Occupational Therapy, Physical Therapy, Respiration Therapy, Speech Therapy	100%	Not Covered	Cardiac Therapy: Limited to phase 1 and 2 for 36 visits per Calendar Year. Aquatic and Physical Therapy: Maximum 30 visits combined per Calendar year. Occupational and Speech Therapy: Maximum of 30 visits per therapy per Calendar Year.
Second Surgical Opinion	100%-PCP $100 copay-Specialist	100%-PCP $100 copay-Specialist	
Skilled Nursing Facility	$1,200 copay after deductible per admission	$1,200 copay after deductible per admission	Maximum 150 days per Calendar Year.
Sleep Disorders/Sleep Study Office or Facility Setting Home Setting	 $600 copay after deductible $600 copay after deductible	 Not Covered Not Covered	
Temporomandibular Joint Disorder (TMJ) Office Visit Diagnostic X-ray Testing Surgery Oral Devices	 100%-PCP $100 copay-Specialist 100%-PCP $75 copay per day after deductible-Specialist $75 copay per day after deductible-Freestanding Facility $225 copay per day after deductible-Outpatient Hospital 100% 100%	 100%-PCP $100 copay-Specialist Not Covered 100% Not Covered	
Urgent Care	100%	100%	

Covered Services using Center of Excellence/Blue Distinction Center	Network Center of Excellence/Blue Distinction Center	Anthem Network	Out-of-Network	Limits
Bariatric Surgery	Reimbursed based on the services rendered-See Summary of Benefits	Not Covered	Not Covered	**See the Blue Distinction Center/Blue Distinction Center + Program section for additional information on benefits, exclusions and travel expenses.**
Cornea Transplants	Reimbursed based on the services rendered-See Summary of Benefits	Reimbursed based on the services rendered-See Summary of Benefits	Reimbursed based on the services rendered-See Summary of Benefits	
All Other Organ Transplants	Reimbursed based on the services rendered-See Summary of Benefits	Not Covered	Not Covered	
Inpatient Hip/Knee Replacement, Spine Surgeries	Reimbursed based on the services rendered-See Summary of Benefits	Not Covered	Not Covered	

Bronze Plan	Anthem Network	Out-of-Network
Deductible Individual Family Unit ***Note: Covered Expenses incurred in and applied toward the deductible in October, November and December will be applied toward the deductible the next Calendar Year.***	 $3,000 $6,000	 $3,000 $6,000
• Covered Expenses applied toward the "individual" Deductible amount will be applied toward the "family" Deductible amount. • Covered Expenses applied toward satisfying the Anthem Network Deductible will apply toward the Out-of-Network Deductible. • Covered Expenses applied toward satisfying the Out-of-Network Deductible will apply toward satisfying the Anthem Network Deductible. • The Deductible is embedded, meaning an "individual" will only have to meet the "individual" Deductible amount.		
Maximum Out-of-Pocket Individual Family Unit ***Note: Covered Expenses incurred in and applied toward the Anthem Network out-of-pocket maximum in October, November and December will be applied toward the Anthem Network out-of-pocket maximum in the next Calendar Year.***	 $5,000 $10,000	 Unlimited Unlimited

- Covered Expenses applied toward the "individual" out-of-pocket maximum amount will be applied toward the "family" out-of-pocket maximum amount.
- Covered Expenses applied toward satisfying the Anthem Network out-of-pocket maximums will not apply toward the Out-of-Network out-of-pocket maximum.
- Covered Expenses applied toward satisfying the Out-of-Network out-of-pocket maximum will not apply toward satisfying the Anthem Network out-of-pocket maximum.
- The individual out-of-pocket maximum is embedded, meaning an individual will only have to meet the individual out-of-pocket maximum before benefits will be paid at 100% for that individual.

The following table identifies what does and does not apply toward the Anthem Network and Out-of-Network Out-of-Pocket Maximums:

Plan Features	Applies to the Anthem Network Out-of-Pocket Maximum?	Applies to the Out-of-Network Out-of-Pocket Maximum?
Payments toward the annual Deductible	Yes	Yes
Coinsurance payments	Yes	Yes
Copayments	Yes	Yes
Charges for non-covered services	No	No
The amounts of any Pre-Certification penalties	No	No
Charges that exceed Covered Expenses	No	No

Bronze Plan Covered Medical Expenses	**Anthem Network**	**Out-of-Network**	**Limits**
Coverage for all services is based on Medical Necessity. **Participants using Out-of-Network services are responsible for all copays, coinsurance and amounts above the Maximum Allowable Charge except for services that are subject to the No Surprises Act.**			
Abortion Office Hospital/Ambulatory Surgical Center (ASC)	100%-PCP $100 copay per day-Specialist $1,800 copay after deductible-Hospital $600 copay after deductible-ASC	100%-PCP $100 copay per day-Specialist $1,800 copay after deductible-Hospital $600 copay after deductible-ASC	Elective or non-elective abortions covered.
Acupuncture	100%	50%	Limited to 12 visits per Calendar Year.
Advanced Imaging (CT, MRI, PET scan, Nuclear Studies) Freestanding Radiology Center Outpatient Hospital Physician Office	 $300 copay per day after deductible $750 copay per day after deductible $300 copay per day after deductible	 $300 copay per day after deductible $750 copay per day after deductible $300 copay per day after deductible	Out-of-Network benefit maximum: $800 per test.
Allergy Services Office Visit	100%-PCP $100 copay-Specialist	100%-PCP $100 copay-Specialist	

Bronze Plan Covered Medical Expenses	Anthem Network	Out-of-Network	Limits
Coverage for all services is based on Medical Necessity. **Participants using Out-of-Network services are responsible for all copays, coinsurance and amounts above the Maximum Allowable Charge except for services that are subject to the No Surprises Act.**			
Office Visit with Injection Injection Only Serum Testing	100%-PCP $100 copay-Specialist 100% 100%-PCP $100 copay-Specialist 100%-PCP $100 copay per day-Specialist	100%-PCP $100 copay-Specialist 100% 100%-PCP $100 copay-Specialist Not Covered	
Ambulance Ground Air	$700 copay after deductible $700 copay after deductible	$700 copay after deductible $700 copay after deductible	Out-of-Network applies to in-network benefits. Out-of-Network Air Ambulance: $50,000 per trip maximum for non-emergent services.
Ambulatory Surgical Center	$600 copay after deductible	$600 copay after deductible	
Anesthesia	100%	100%	
Autism Office Visit, Testing	100%	100%	See Habilitative Services and Therapies for therapy coverage.
Chemotherapy/Radiation Therapy	100%	100%	
Chiropractic Care	100%	Not Covered	
Dialysis	100%	100%	Out-of-Network benefit maximum: $350 per visit.
Durable Medical Equipment	100%	Not Covered	
Eye Exam	100%	100%	Examination including refraction covered only when performed in conjunction with a medical diagnosis.
Gender-Affirming Care	*Reimbursed based on the services rendered	Not Covered	*Benefits will be applied based on the services billed: inpatient, outpatient, therapy.

Bronze Plan Covered Medical Expenses	Anthem Network	Out-of-Network	Limits
Coverage for all services is based on Medical Necessity. **Participants using Out-of-Network services are responsible for all copays, coinsurance and amounts above the Maximum Allowable Charge except for services that are subject to the No Surprises Act.**			
			See Medical Benefits for additional information on travel expenses.
Genetic Counseling or Testing Office Outpatient Hospital Freestanding Lab	 100% $150 copay per day 100%	 Not Covered Not Covered Not Covered	
Gene Therapy	Reimbursed based on the services rendered	Reimbursed based on the services rendered	Benefits will be applied based on the services billed: inpatient, outpatient, office.
Glaucoma, Cataract Surgery and Lenses (one set)	$600 copay after deductible-Ambulatory Surgery Center $1,800 copay after deductible-Outpatient Hospital	$600 copay after deductible-Ambulatory Surgery Center $1,800 copay after deductible-Outpatient Hospital	One set of lenses or glasses covered after ocular surgery when the lens of the eyes has been removed such as with a cataract extraction.
Habilitative Services and Therapies Applied Behavior Analysis (ABA) Therapy Billed with Autism Diagnosis-Occupation Therapy, Physical Therapy, Speech-Language Pathology Occupational Therapy, Physical Therapy, Speech-Language Pathology	 100% 100% 100%	 100% 100% Not Covered	Aquatic and Physical Therapy: Maximum 30 visits combined per Calendar year. Occupational and Speech Therapy: Maximum of 30 visits per therapy per Calendar Year.
Hearing Aids	100%	100%	Covered up to a benefit maximum of $700 per plan participant, every 24 month period for both ears. Maximum includes: monaural or binaural hearing aids, ear mold(s), batteries,

Bronze Plan Covered Medical Expenses	Anthem Network	Out-of-Network	Limits
Coverage for all services is based on Medical Necessity. **Participants using Out-of-Network services are responsible for all copays, coinsurance and amounts above the Maximum Allowable Charge except for services that are subject to the No Surprises Act.**			
			cords, other ancillary equipment.
Home Health Care	100%	100%	Maximum of 100 visits per Calendar Year. Out-of-Network benefit maximum: $150 per day.
Hospice Care Inpatient, Outpatient Bereavement Counseling	100% 100%	100% 100%	
Hospital Inpatient Hospital Including-Rehabilitation 23 hour Observation Lab X-ray Outpatient Surgery Pre-admission Testing-Lab X-ray	$600 copay per day after deductible $150 copay per day-Outpatient Hospital 100%-Freestanding Facility $225 copay per day after deductible-Outpatient Hospital $75 copay per day after deductible-Freestanding Facility $1,800 copay after deductible $150 copay per day $225 copay per day after deductible	$600 copay per day after deductible Not Covered Not Covered $1,800 copay after deductible Not Covered Not Covered	Out-of-network non-emergency admit: Maximum payment up to $600 per day.
Independent Lab	100%	Not Covered	
Implantable Hearing Devices	$600 copay after deductible-Ambulatory Surgery Center $1,800 copay after deductible-Outpatient Hospital	$600 copay after deductible-Ambulatory Surgery Center $1,800 copay after deductible-Outpatient Hospital	Includes cochlear implants and bone anchored devices.

Bronze Plan Covered Medical Expenses	Anthem Network	Out-of-Network	Limits
Coverage for all services is based on Medical Necessity. **Participants using Out-of-Network services are responsible for all copays, coinsurance and amounts above the Maximum Allowable Charge except for services that are subject to the No Surprises Act.**			
Mental Health and Substance Use Disorder Expenses Inpatient Facility, Residential Treatment Facility Partial Hospitalization, Intensive Outpatient Services, Outpatient Facility/Office Visit Services	$600 copay per day after deductible 100%	$600 copay per day after deductible 100%	Out-of-network non-emergency admit: Maximum payment up to $600 per day.
Morbid Obesity/Obesity Office Visit Lab	100%-PCP $100 copay-Specialist 100%	100%-PCP $100 copay-Specialist Not Covered	See "Bariatric Surgery" for more information on surgery benefits.
Newborn Care Well Baby Sick Baby	100% $600 copay per day after deductible	100% $600 copay per day after deductible	Well baby processed under mother unless mother is not a dependent on the plan, then the charges will be processed under the baby with the inpatient copay applying. Out-of-network non-emergency admit: Maximum payment up to $600 per day.
Nutritional Counseling	100%	100%	Covered for the management of diabetes, treatment of eating disorders such as anorexia nervosa and nervosa and as required under preventive benefits. Limited to 36 visits per Calendar Year.
Outpatient Emergency Services – Emergency Room	$700 copay after deductible	$700 copay after deductible	ER copay waived if admitted. Inpatient benefits would apply.
Outpatient Emergency Services-Other Providers	100%	100%	

Bronze Plan Covered Medical Expenses	Anthem Network	Out-of-Network	Limits
Coverage for all services is based on Medical Necessity. **Participants using Out-of-Network services are responsible for all copays, coinsurance and amounts above the Maximum Allowable Charge except for services that are subject to the No Surprises Act.**			
Physician Services **Primary Care:** Office Visit, Telehealth Visit, Office Visit with Injection	100%	100%	
Specialist: Office Visit, Telehealth Visit, Office Visit with Injection	$100 copay	$100 copay	
Lab/X-ray-Primary Care, Lab-Specialist	100%	Not Covered	
X-ray-Specialist	$75 copay per day after deductible	Not Covered	
Diagnostics in Office (other than lab/x-ray)	100%	Not Covered	
Injection Only	100%	100%	
Surgery	100%-PCP $300 copay per day after deductible-Specialist	100% $300 copay per day after deductible-Specialist	
Physician Charges-Inpatient/Outpatient	100%	100%	
Retail Health Clinic	100%	100%	
Telehealth Visits with LiveHealth, Midi Health Integrative Women's Care	100%	Not Applicable	Contact: www.livehealthonline.com
Pregnancy/Sterilization Expenses Initial Office Visit	100%	100%	
Routine Pre-Natal Services-as required per ACA	100%	Not covered	
Non-Routine Pre-Natal Diagnostic Lab	100%-Office 100%-Freestanding Facility $150 copay per day-Outpatient Hospital	Not Covered	

Bronze Plan Covered Medical Expenses	Anthem Network	Out-of-Network	Limits
Coverage for all services is based on Medical Necessity. **Participants using Out-of-Network services are responsible for all copays, coinsurance and amounts above the Maximum Allowable Charge except for services that are subject to the No Surprises Act.**			
Non-Routine Pre-Natal Diagnostic X-ray including Sonograms	100%-PCP/OB-GYN $75 copay per day after deductible-Specialist $75 copay per day after deductible-Freestanding Facility $225 copay per day after deductible-Outpatient Hospital	Not Covered	Sonograms: Allowed 3, any additional require medical necessity review.
Delivery/Post Natal, Birthing Center	$600 copay per day after deductible	$600 copay per day after deductible	Out-of-network non-emergency admit: Maximum payment up to $600 per day.
Physician Global Fee, Midwife, Doula	100%	100%	
Amniocentesis	100%-PCP Office $300 copay after deductible-Specialist Office $600 copay after deductible-Ambulatory Surgery Center $1,800 copay after deductible-Outpatient Hospital	100%-PCP Office $300 copay after deductible-Specialist Office $600 copay after deductible-Ambulatory Surgery Center $1,800 copay after deductible-Outpatient Hospital	
Male Sterilization	100%-PCP $300 copay after deductible-Specialist $600 copay after deductible-Ambulatory Surgical Center $1,800 copay after deductible - Outpatient Hospital	100%-PCP $300 copay after deductible-Specialist $600 copay after deductible - Ambulatory Surgical Center $1,800 copay after deductible -Outpatient Hospital	Female sterilization falls under preventive benefits.
Breast Pump (Manual or Electric)	100%	Not Covered	One breast pump per pregnancy. Over the counter breast pump purchases are not covered.
Preventive Care **Well Adult Care** Physical Exam Mammogram Pap Smear Colonoscopy Immunizations	100%	Not Covered	
Well Child Care Physical Exam Immunizations	100%	Not Covered	

Bronze Plan Covered Medical Expenses	Anthem Network	Out-of-Network	Limits
Coverage for all services is based on Medical Necessity. **Participants using Out-of-Network services are responsible for all copays, coinsurance and amounts above the Maximum Allowable Charge except for services that are subject to the No Surprises Act.**			
Prosthetics, Orthotics and Supplies Prosthetics, Orthotics Custom Molded Foot Orthotics Supplies	 100% 100% 100%	 Not Covered Not Covered Not Covered	Custom Molded Foot Orthotics: 2 pairs covered per year. Additional 2 pairs would be considered post-surgery if medically necessary.
Rehabilitative Services and Therapies Aquatic Therapy, Autism Spectrum Disorder Treatment, Cardiac Therapy, Occupational Therapy, Physical Therapy, Respiration Therapy, Speech Therapy	100%	Not Covered	Cardiac Therapy: Limited to phase 1 and 2 for 36 visits per Calendar Year. Aquatic and Physical Therapy: Maximum 30 visits combined per Calendar year. Occupational and Speech Therapy: Maximum of 30 visits per therapy per Calendar Year.
Second Surgical Opinion	100%-PCP $100 copay-Specialist	100%-PCP $100 copay-Specialist	
Skilled Nursing Facility	$1,200 copay after deductible per admission	$1,200 copay after deductible per admission	Maximum 150 days per Calendar Year.
Sleep Disorders/Sleep Study Office or Facility Setting Home Setting	 $600 copay after deductible $600 copay after deductible	 Not Covered Not Covered	
Temporomandibular Joint Disorder (TMJ) Office Visit Diagnostic X-ray Testing Surgery Oral Devices	 100%-PCP $100 copay-Specialist 100%-PCP $75 copay per day after deductible-Specialist $75 copay per day after deductible-Freestanding Facility $225 copay per day after deductible-Outpatient Hospital 100% 100%	 100%-PCP $100 copay-Specialist Not Covered 100% Not Covered	

Bronze Plan Covered Medical Expenses	Anthem Network	Out-of-Network	Limits
Coverage for all services is based on Medical Necessity. **Participants using Out-of-Network services are responsible for all copays, coinsurance and amounts above the Maximum Allowable Charge except for services that are subject to the No Surprises Act.**			
Urgent Care	100%	100%	

Covered Services using Center of Excellence/Blue Distinction Center	Network Center of Excellence/Blue Distinction Center	Anthem Network	Out-of-Network	Limits
Bariatric Surgery	Reimbursed based on the services rendered-See Summary of Benefits	Not Covered	Not Covered	**See the Blue Distinction Center/Blue Distinction Center + Program section for additional information on benefits, exclusions and travel expenses.**
Cornea Transplants	Reimbursed based on the services rendered-See Summary of Benefits	Reimbursed based on the services rendered-See Summary of Benefits	Reimbursed based on the services rendered-See Summary of Benefits	
All Other Organ Transplants	Reimbursed based on the services rendered-See Summary of Benefits	Not Covered	Not Covered	
Inpatient Hip/Knee Replacement, Spine Surgeries	Reimbursed based on the services rendered-See Summary of Benefits	Not Covered	Not Covered	

Gold Plan	Anthem Network	Out-of-Network
Deductible Individual Family Unit	 Not Applicable Not Applicable	 Not Applicable Not Applicable
Maximum Out-of-Pocket Individual Family Unit ***Note: Covered Expenses incurred in and applied toward the Anthem Network out-of-pocket maximum in October, November and December will be applied toward the Anthem Network out-of-pocket maximum in the next Calendar Year.***	 $3,000 $6,000	 Unlimited Unlimited

- Covered Expenses applied toward the “individual” out-of-pocket maximum amount will be applied toward the “family” out-of-pocket maximum amount.
- Covered Expenses applied toward satisfying the Anthem Network out-of-pocket maximums will not apply toward the Out-of-Network out-of-pocket maximum.
- Covered Expenses applied toward satisfying the Out-of-Network out-of-pocket maximum will not apply toward satisfying the Anthem Network out-of-pocket maximum.
- The individual out-of-pocket maximum is embedded, meaning an individual will only have to meet the individual out-of-pocket maximum before benefits will be paid at 100% for that individual.

The following table identifies what does and does not apply toward the Anthem Network and Out-of-Network Out-of-Pocket Maximums:

Plan Features	Applies to the Anthem Network Out-of-Pocket Maximum?	Applies to the Out-of-Network Out-of-Pocket Maximum?
Payments toward the annual Deductible	Not Applicable	Not Applicable
Coinsurance payments	Yes	Yes
Copayments	Yes	Yes
Charges for non-covered services	No	No
The amounts of any Pre-Certification penalties	No	No
Charges that exceed Covered Expenses	No	No

Gold Plan Covered Medical Expenses	Anthem Network	Out-of-Network	Limits
Coverage for all services is based on Medical Necessity. **Participants using Out-of-Network services are responsible for all copays, coinsurance and amounts above the Maximum Allowable Charge except for services that are subject to the No Surprises Act.**			
Abortion Office Hospital/Ambulatory Surgical Center (ASC)	100%-PCP $300 copay per day-Specialist $1,800 copay-Hospital $600 copay-ASC	100%-PCP $300 copay per day-Specialist $1,800 copay-Hospital $600 copay-ASC	Elective or non-elective abortions covered.
Acupuncture	100%	50%	Limited to 12 visits per Calendar Year.
Advanced Imaging (CT, MRI, PET scan, Nuclear Studies) Freestanding Radiology Center Outpatient Hospital Physician Office	 $300 copay per day $750 copay per day $300 copay per day	 $300 copay per day $750 copay per day $300 copay per day	Out-of-Network benefit maximum: $800 per test.
Allergy Services Office Visit Office Visit with Injection	100%-PCP $100 copay-Specialist 100%-PCP $100 copay-Specialist	100%-PCP $100 copay-Specialist 100%-PCP $100 copay-Specialist	

Gold Plan Covered Medical Expenses	Anthem Network	Out-of-Network	Limits
Coverage for all services is based on Medical Necessity. **Participants using Out-of-Network services are responsible for all copays, coinsurance and amounts above the Maximum Allowable Charge except for services that are subject to the No Surprises Act.**			
Injection Only Serum Testing	100% 100%-PCP $100 copay-Specialist 100%-PCP $100 copay per day-Specialist	100% 100%-PCP $100 copay-Specialist Not Covered	
Ambulance Ground Air	$700 copay $700 copay	$700 copay $700 copay	Out-of-Network applies to in-network benefits. Out-of-Network Air Ambulance: $50,000 per trip maximum for non-emergent services.
Ambulatory Surgical Center	$600 copay	$600 copay	
Anesthesia	100%	100%	
Autism Office Visit, Testing	100%	100%	See Habilitative Services and Therapies for therapy coverage.
Chemotherapy/Radiation Therapy	100%	100%	
Chiropractic Care	100%	Not Covered	
Dialysis	100%	100%	Out-of-Network benefit maximum: $350 per visit.
Durable Medical Equipment	100%	Not Covered	
Eye Exam	100%	100%	Examination including refraction covered only when performed in conjunction with a medical diagnosis.
Gender-Affirming Care	*Reimbursed based on the services rendered	Not Covered	*Benefits will be applied based on the services billed: inpatient, outpatient, therapy. See Medical Benefits for additional

Gold Plan Covered Medical Expenses	Anthem Network	Out-of-Network	Limits
Coverage for all services is based on Medical Necessity. **Participants using Out-of-Network services are responsible for all copays, coinsurance and amounts above the Maximum Allowable Charge except for services that are subject to the No Surprises Act.**			
			information on travel expenses.
Genetic Counseling or Testing Office Outpatient Hospital Freestanding Lab	 100% $150 copay per day 100%	 Not Covered Not Covered Not Covered	
Gene Therapy	100%	100%	
Glaucoma, Cataract Surgery and Lenses (one set)	$600 copay-Ambulatory Surgery Center $1,800 copay-Outpatient Hospital	$600 copay-Ambulatory Surgery Center $1,800 copay-Outpatient Hospital	One set of lenses or glasses covered after ocular surgery when the lens of the eyes has been removed such as with a cataract extraction.
Habilitative Services and Therapies Applied Behavior Analysis (ABA) Therapy Billed with Autism Diagnosis-Occupation Therapy, Physical Therapy, Speech-Language Pathology Occupational Therapy, Physical Therapy, Speech-Language Pathology	 100% 100% 100%	 100% 100% Not Covered	Aquatic and Physical Therapy: Maximum 30 visits combined per Calendar year. Occupational and Speech Therapy: Maximum of 30 visits per therapy per Calendar Year.
Hearing Aids	100%	100%	Covered up to a benefit maximum of $700 per plan participant, every 24 month period for both ears. Maximum includes: monaural or binaural hearing aids, ear mold(s), batteries, cords, other ancillary equipment.
Home Health Care	100%	100%	Maximum of 100 visits per Calendar Year.

Gold Plan Covered Medical Expenses	Anthem Network	Out-of-Network	Limits
Coverage for all services is based on Medical Necessity. **Participants using Out-of-Network services are responsible for all copays, coinsurance and amounts above the Maximum Allowable Charge except for services that are subject to the No Surprises Act.**			
			Out-of-Network benefit maximum: $150 per day.
Hospice Care Inpatient, Outpatient Bereavement Counseling	100% 100%	100% 100%	
Hospital Inpatient Hospital Including-Rehabilitation 23 hour Observation Lab X-ray Outpatient Surgery Pre-admission Testing-Lab X-ray	$600 copay per day $150 copay per day-Outpatient Hospital 100%-Freestanding Facility $225 copay per day-Outpatient Hospital $75 copay-Freestanding Facility $1,800 copay $150 copay per day $225 copay per day	$600 copay per day Not Covered Not Covered $1,800 copay Not Covered Not Covered	Out-of-network non-emergency admit: Maximum payment up to $600 per day.
Independent Lab	100%	Not Covered	
Implantable Hearing Devices	$600 copay-Ambulatory Surgery Center $1,800 copay-Outpatient Hospital	$600 copay-Ambulatory Surgery Center $1,800 copay-Outpatient Hospital	Includes cochlear implants and bone anchored devices.
Mental Health and Substance Use Disorder Expenses Inpatient Facility, Residential Treatment Facility Partial Hospitalization, Intensive Outpatient Services, Outpatient Facility/Office Visit Services	$600 copay per day 100%	$600 copay per day 100%	Out-of-network non-emergency admit: Maximum payment up to $600 per day.

Gold Plan Covered Medical Expenses	Anthem Network	Out-of-Network	Limits
Coverage for all services is based on Medical Necessity. **Participants using Out-of-Network services are responsible for all copays, coinsurance and amounts above the Maximum Allowable Charge except for services that are subject to the No Surprises Act.**			
Morbid Obesity/Obesity Office Visit Lab	100%-PCP $100 copay-Specialist 100%	100%-PCP $100 copay-Specialist Not Covered	See "Bariatric Surgery" for more information on surgery benefits.
Newborn Care Well Baby Sick Baby	100% $600 copay per day	100% $600 copay per day	Well baby processed under mother unless mother is not a dependent on the plan, then the charges will be processed under the baby with the inpatient copay applying. Out-of-network non-emergency admit: Maximum payment up to $600 per day.
Nutritional Counseling	100%	100%	Covered for the management of diabetes, treatment of eating disorders such as anorexia nervosa and nervosa and as required under preventive benefits. Limited to 36 visits per Calendar Year.
Outpatient Emergency Services-Emergency Room	$700 copay	$700 copay	ER copay waived if admitted. Inpatient benefits would apply.
Outpatient Emergency Services-Other Providers	100%	100%	
Physician Services **Primary Care:** Office Visit, Telehealth Visit, Office Visit with Injection **Specialist:** Office Visit, Telehealth Visit, Office Visit with Injection	100% $100 copay	100% $100 copay	

Gold Plan Covered Medical Expenses	Anthem Network	Out-of-Network	Limits
Coverage for all services is based on Medical Necessity. **Participants using Out-of-Network services are responsible for all copays, coinsurance and amounts above the Maximum Allowable Charge except for services that are subject to the No Surprises Act.**			
Lab/X-ray-Primary Care, Lab-Specialist	100%	Not Covered	
X-ray-Specialist	$75 copay per day	Not Covered	
Diagnostics in Office (other than lab/x-ray)	100%	Not Covered	
Injection Only	100%	100%	
Surgery	100%-PCP $300 copay per day-Specialist	100% $300 copay per day-Specialist	
Physician Charges-Inpatient/Outpatient	100%	100%	
Retail Health Clinic	100%	100%	
Telehealth Visits with LiveHealth, Midi Health Integrative Women's Care	100%	Not Applicable	Contact: www.livehealthonline.com
Pregnancy/Sterilization Expenses			
Initial Office Visit	100%	100%	
Routine Pre-Natal Services-as required per ACA	100%	Not covered	
Non-Routine Pre-Natal Diagnostic Lab	100%-Office 100%-Freestanding Facility $150 copay per day-Outpatient Hospital	Not Covered	
Non-Routine Pre-Natal Diagnostic X-ray including Sonograms	100%-PCP/OB-GYN $75 copay per day-Specialist $75 copay per day-Freestanding Facility $225 copay per day-Outpatient Hospital	Not Covered	Sonograms: Allowed 3, any additional require medical necessity review.
Delivery/Post Natal, Birthing Center	$600 copay per day	$600 copay per day	Out-of-network non-emergency admit: Maximum payment up to $600 per day.
Physician Global Fee, Midwife, Doula	100%	100%	

Gold Plan Covered Medical Expenses	Anthem Network	Out-of-Network	Limits
Coverage for all services is based on Medical Necessity. **Participants using Out-of-Network services are responsible for all copays, coinsurance and amounts above the Maximum Allowable Charge except for services that are subject to the No Surprises Act.**			
Amniocentesis	100%-PCP Office $300 copay-Specialist Office $600 copay-Ambulatory Surgery Center $1,800 copay-Outpatient Hospital	100%-PCP Office $300 copay-Specialist Office $600 copay-Ambulatory Surgery Center $1,800 copay-Outpatient Hospital	
Male Sterilization	100%-PCP $00 copay-Specialist $600 copay-Ambulatory Surgical Center $1,800 copay-Outpatient Hospital	100%-PCP $00 copay-Specialist $600 copay-Ambulatory Surgical Center $1,800 copay-Outpatient Hospital	Female sterilization falls under preventive benefits.
Breast Pump (Manual or Electric)	100%	Not Covered	One breast pump per pregnancy. Over the counter breast pump purchases are not covered.
Preventive Care **Well Adult Care** Physical Exam Mammogram Pap Smear Colonoscopy Immunizations	100%	Not Covered	
Well Child Care Physical Exam Immunizations	100%	Not Covered	
Prosthetics, Orthotics and Supplies Prosthetics, Orthotics	100%	Not Covered	Custom Molded Foot Orthotics: 2 pairs covered per year. Additional 2 pairs would be considered post-surgery if medically necessary.
Custom Molded Foot Orthotics	100%	Not Covered	
Supplies	100%	Not Covered	
Rehabilitative Services and Therapies Aquatic Therapy, Autism Spectrum Disorder Treatment, Cardiac Therapy, Occupational Therapy, Physical Therapy, Respiration Therapy, Speech Therapy	100%	Not Covered	Cardiac Therapy: Limited to phase 1 and 2 for 36 visits per Calendar Year. Aquatic and Physical Therapy: Maximum 30 visits combined per Calendar year.

Gold Plan Covered Medical Expenses	Anthem Network	Out-of-Network	Limits
Coverage for all services is based on Medical Necessity. **Participants using Out-of-Network services are responsible for all copays, coinsurance and amounts above the Maximum Allowable Charge except for services that are subject to the No Surprises Act.**			
			Occupational and Speech Therapy: Maximum of 30 visits per therapy per Calendar Year.
Second Surgical Opinion	100%-PCP $100 copay-Specialist	100%-PCP $100 copay-Specialist	
Skilled Nursing Facility	$1,200 copay per admission	$1,200 copay per admission	Maximum 150 days per Calendar Year.
Sleep Disorders/Sleep Study Office or Facility Setting Home Setting	 $600 copay $600 copay	 Not Covered Not Covered	
Temporomandibular Joint Disorder (TMJ) Office Visit Diagnostic X-ray Testing Surgery Oral Devices	 100%-PCP $100 copay-Specialist 100%-PCP $75 copay per day-Specialist $75 copay per day-Freestanding Facility $225 copay per day-Outpatient Hospital 100% 100%	 100%-PCP $100 copay-Specialist Not Covered 100% Not Covered	
Urgent Care	100%	100%	

Covered Services using Center of Excellence/Blue Distinction Center	Network Center of Excellence/Blue Distinction Center	Anthem Network	Out-of-Network	Limits
Bariatric Surgery	Reimbursed based on the services rendered-See Summary of Benefits	Not Covered	Not Covered	**See the Blue Distinction Center/Blue Distinction Center + Program section for additional information on benefits, exclusions**
Cornea Transplants	Reimbursed based on the services rendered-See Summary of Benefits	Reimbursed based on the services rendered-See Summary of Benefits	Reimbursed based on the services rendered-See Summary of Benefits	
All Other Organ Transplants	Reimbursed based on the services rendered-See Summary of Benefits	Not Covered	Not Covered	

Inpatient Hip/Knee Replacement, Spine Surgeries	Reimbursed based on the services rendered- See Summary of Benefits	Not Covered	Not Covered	**and travel expenses.**

Platinum Plan	Anthem Network	Out-of-Network
Deductible Individual Family Unit	 Not Applicable Not Applicable	 Not Applicable Not Applicable
Maximum Out-of-Pocket Individual Family Unit ***Note: Covered Expenses incurred in and applied toward the Anthem Network out-of-pocket maximum in October, November and December will be applied toward the Anthem Network out-of-pocket maximum in the next Calendar Year.***	 $2,000 $4,000	 Unlimited Unlimited

- Covered Expenses applied toward the "individual" out-of-pocket maximum amount will be applied toward the "family" out-of-pocket maximum amount.
- Covered Expenses applied toward satisfying the Anthem Network out-of-pocket maximums will not apply toward the Out-of-Network out-of-pocket maximum.
- Covered Expenses applied toward satisfying the Out-of-Network out-of-pocket maximum will not apply toward satisfying the Anthem Network out-of-pocket maximum.
- The individual out-of-pocket maximum is embedded, meaning an individual will only have to meet the individual Out-of-Pocket maximum before benefits will be paid at 100% for that individual.

The following table identifies what does and does not apply toward the Anthem Network and Out-of-Network Out-of-Pocket Maximums:

Plan Features	Applies to the Anthem Network Out-of-Pocket Maximum?	Applies to the Out-of-Network Out-of-Pocket Maximum?
Payments toward the annual Deductible	Not Applicable	Not Applicable
Coinsurance payments	Yes	Yes
Copayments	Yes	Yes
Charges for non-covered services	No	No
The amounts of any Pre-Certification penalties	No	No
Charges that exceed Covered Expenses	No	No

Platinum Plan Covered Medical Expenses	Anthem Network	Out-of-Network	Limits
Coverage for all services is based on Medical Necessity. **Participants using Out-of-Network services are responsible for all copays, coinsurance and amounts above the Maximum Allowable Charge except for services that are subject to the No Surprises Act.**			
Abortion Office Hospital/Ambulatory Surgical Center (ASC)	100%-PCP $200 copay-Specialist $1,200 copay-Hospital $400 copay-ASC	100%-PCP $200 copay-Specialist $1,200 copay-Hospital $400 copay-ASC	Elective or non-elective abortions covered.
Acupuncture	100%	50%	Limited to 12 visits per Calendar Year.
Advanced Imaging (CT, MRI, PET scan, Nuclear Studies) Freestanding Radiology Center Outpatient Hospital Physician Office	 $200 copay per day $500 copay per day $200 copay per day	 $200 copay per day $500 copay per day $200 copay per day	Out-of-Network benefit maximum: $800 per test.
Allergy Services Office Visit Office Visit with Injection Injection Only Serum Testing	 100%-PCP $70 copay-Specialist 100%-PCP $70 copay-Specialist 100% 100%-PCP $70 copay-Specialist 100%-PCP $70 copay per day-Specialist	 100%-PCP $70 copay-Specialist 100%-PCP $100 copay-Specialist 100% 100%-PCP $70 copay-Specialist Not Covered	
Ambulance Ground Air	 $600 copay $600 copay	 $600 copay $600 copay	Out-of-Network applies to in-network benefits. Out-of-Network Air Ambulance: $50,000 per trip maximum for non-emergent services.
Ambulatory Surgical Center	$400 copay	$400 copay	
Anesthesia	100%	100%	
Autism Office Visit, Testing	100%	100%	See Habilitative Services and Therapies for therapy coverage.

Platinum Plan Covered Medical Expenses	Anthem Network	Out-of-Network	Limits
Coverage for all services is based on Medical Necessity. **Participants using Out-of-Network services are responsible for all copays, coinsurance and amounts above the Maximum Allowable Charge except for services that are subject to the No Surprises Act.**			
Chemotherapy/Radiation Therapy	100%	100%	
Chiropractic Care	100%	Not Covered	
Dialysis	100%	100%	Out-of-Network benefit maximum: $350 per visit.
Durable Medical Equipment	100%	Not Covered	
Eye Exam	$70 copay	$70 copay	Examination including refraction covered only when performed in conjunction with a medical diagnosis.
Gender-Affirming Care	*Reimbursed based on the services rendered	Not Covered	*Benefits will be applied based on the services billed: inpatient, outpatient, therapy. See Medical Benefits for additional information on travel expenses.
Genetic Counseling or Testing Office Outpatient Hospital Freestanding Lab	 100% $100 copay per day 100%	 Not Covered Not Covered Not Covered	
Gene Therapy	100%	100%	
Glaucoma, Cataract Surgery and Lenses (one set)	$400 copay-Ambulatory Surgery Center $1,200 copay-Outpatient Hospital	$400 copay-Ambulatory Surgery Center $1,200 copay-Outpatient Hospital	One set of lenses or glasses covered after ocular surgery when the lens of the eyes has been removed such as with a cataract extraction.
Habilitative Services and Therapies Applied Behavior Analysis (ABA) Therapy Billed with Autism Diagnosis-	 100% 100%	 100% 100%	Aquatic and Physical Therapy: Maximum 30 visits combined per Calendar year. Occupational and Speech Therapy: Maximum of 30 visits

Platinum Plan Covered Medical Expenses	Anthem Network	Out-of-Network	Limits
Coverage for all services is based on Medical Necessity. **Participants using Out-of-Network services are responsible for all copays, coinsurance and amounts above the Maximum Allowable Charge except for services that are subject to the No Surprises Act.**			
Occupation Therapy, Physical Therapy, Speech-Language Pathology Occupational Therapy, Physical Therapy, Speech-Language Pathology	100%	Not Covered	per therapy per Calendar Year.
Hearing Aids	100%	100%	Covered up to a benefit maximum of $700 per plan participant, every 24 month period for both ears. Maximum includes: monaural or binaural hearing aids, ear mold(s), batteries, cords, other ancillary equipment.
Home Health Care	100%	100%	Maximum of 100 visits per Calendar Year. Out-of-Network benefit maximum: $150 per day.
Hospice Care Inpatient, Outpatient Bereavement Counseling	 100% 100%	 100% 100%	
Hospital Inpatient Hospital Including-Rehabilitation 23 hour Observation Lab X-ray Outpatient Surgery Pre-admission Testing-	 $400 copay per day $100 copay per day-Outpatient Hospital 100%-Freestanding Facility $150 copay per day-Outpatient Hospital $50 copay-Freestanding Facility $1,200 copay	 $400 copay per day Not Covered Not Covered $1,200 copay	Out-of-network non-emergency admit: Maximum payment up to $600 per day.

Platinum Plan Covered Medical Expenses	Anthem Network	Out-of-Network	Limits
Coverage for all services is based on Medical Necessity. **Participants using Out-of-Network services are responsible for all copays, coinsurance and amounts above the Maximum Allowable Charge except for services that are subject to the No Surprises Act.**			
Lab X-ray	$100 copay per day $150 copay per day	Not Covered Not Covered	
Independent Lab	100%	Not Covered	
Implantable Hearing Devices	$400 copay-Ambulatory Surgery Center $1,200 copay-Outpatient Hospital	$400 copay-Ambulatory Surgery Center $1,200 copay-Outpatient Hospital	Includes cochlear implants and bone anchored devices.
Mental Health and Substance Use Disorder Expenses Inpatient Facility, Residential Treatment Facility Partial Hospitalization, Intensive Outpatient Services, Outpatient Facility/Office Visit Services	$400 copay per day 100%	$400 copay per day 100%	Out-of-network non-emergency admit: Maximum payment up to $600 per day.
Morbid Obesity/Obesity Office Visit Lab	$100-PCP $70 copay-Specialist 100%	100%-PCP $70 copay-Specialist Not Covered	See “Bariatric Surgery” for more information on surgery benefits.
Newborn Care Well Baby Sick Baby	100% $400 copay per day	100% $400 copay per day	Well baby processed under mother unless mother is not a dependent on the plan, then the charges will be processed under the baby with the inpatient copay applying. Out-of-network non-emergency admit: Maximum payment up to $600 per day.
Nutritional Counseling	100%	100%	Covered for the management of diabetes, treatment of eating disorders such as anorexia nervosa

Platinum Plan Covered Medical Expenses	Anthem Network	Out-of-Network	Limits
Coverage for all services is based on Medical Necessity. **Participants using Out-of-Network services are responsible for all copays, coinsurance and amounts above the Maximum Allowable Charge except for services that are subject to the No Surprises Act.**			
			and nervosa and as required under preventive benefits. Limited to 36 visits per Calendar Year.
Outpatient Emergency Services - Emergency Room	$600 copay	$600 copay	ER copay waived if admitted. Inpatient benefits would apply.
Outpatient Emergency Services-Other Providers	100%	100%	
Physician Services **Primary Care:** Office Visit, Telehealth Visit, Office Visit with Injection	100%	100%	
Specialist: Office Visit, Telehealth Visit, Office Visit with Injection	$70 copay	$70 copay	
Lab/X-ray-Primary Care, Lab-Specialist	100%	Not Covered	
X-ray-Specialist	$50 copay per day	Not Covered	
Diagnostics in Office (other than lab/x-ray)	100%	Not Covered	
Injection Only	100%	100%	
Office Surgery	100%-PCP $200 copay per day-Specialist	100%-PCP $200 copay per day-Specialist	
Physician Charges-Inpatient/Outpatient	100%	100%	
Retail Health Clinic	100%	100%	
Telehealth Visits with LiveHealth	100%	Not Applicable	Contact: www.livehealthonline.com
Pregnancy/Sterilization Expenses Initial Office Visit	100%	100%	

Platinum Plan Covered Medical Expenses	Anthem Network	Out-of-Network	Limits
Coverage for all services is based on Medical Necessity. **Participants using Out-of-Network services are responsible for all copays, coinsurance and amounts above the Maximum Allowable Charge except for services that are subject to the No Surprises Act.**			
Routine Pre-Natal Services-as required per ACA	100%	Not covered	
Non-Routine Pre-Natal Diagnostic Lab	100%-Office 100%-Freestanding Facility $100 copay per day-Outpatient Hospital	Not Covered	
Non-Routine Pre-Natal Diagnostic X-ray including Sonograms	100%-PCP/OB-GYN $50 copay per day-Specialist $50 copay per day-Freestanding Facility $150 copay per day-Outpatient Hospital	Not Covered	Sonograms: Allowed 3, any additional require medical necessity review.
Delivery/Post Natal, Birthing Center	$400 copay per day	$400 copay per day	Out-of-network non-emergency admit: Maximum payment up to $600 per day.
Physician Global Fee, Midwife, Doula	100%	100%	
Amniocentesis	100%-PCP Office $200 copay-Specialist Office $400 copay-Ambulatory Surgery Center $1,200 copay-Outpatient Hospital	100%-PCP Office $200 copay-Specialist Office $400 copay-Ambulatory Surgery Center $1,200 copay-Outpatient Hospital	
Male Sterilization	100%-PCP $200 copay-Specialist $400 copay-Ambulatory Surgical Center $1,200 copay-Outpatient Hospital	100%-PCP $200 copay-Specialist $400 copay-Ambulatory Surgical Center $1,200 copay-Outpatient Hospital	Female sterilization falls under preventive benefits.
Breast Pump (Manual or Electric)	100%	Not Covered	One breast pump per pregnancy. Over the counter breast pump purchases are not covered.

Platinum Plan Covered Medical Expenses	Anthem Network	Out-of-Network	Limits
Coverage for all services is based on Medical Necessity. **Participants using Out-of-Network services are responsible for all copays, coinsurance and amounts above the Maximum Allowable Charge except for services that are subject to the No Surprises Act.**			
Preventive Care **Well Adult Care** Physical Exam Mammogram Pap Smear Colonoscopy Immunizations **Well Child Care** Physical Exam Immunizations	 100% 100%	 Not Covered Not Covered	
Prosthetics, Orthotics and Supplies Prosthetics, Orthotics Custom Molded Foot Orthotics Supplies	 100% 100% 100%	 Not Covered Not Covered Not Covered	Custom Molded Foot Orthotics: 2 pairs covered per year. Additional 2 pairs would be considered post-surgery if medically necessary.
Rehabilitative Services and Therapies Aquatic Therapy, Autism Spectrum Disorder Treatment, Cardiac Therapy, Occupational Therapy, Physical Therapy, Respiration Therapy, Speech Therapy	 100%	 Not Covered	Cardiac Therapy: Limited to phase 1 and 2 for 36 visits per Calendar Year. Aquatic and Physical Therapy: Maximum 30 visits combined per Calendar year. Occupational and Speech Therapy: Maximum of 30 visits per therapy per Calendar Year.
Second Surgical Opinion	100%-PCP $70 copay-Specialist	100%-PCP $70 copay-Specialist	
Skilled Nursing Facility	$800 copay per admission	$800 copay per admission	Maximum 150 days per Calendar Year.
Sleep Disorders/Sleep Study Office or Facility Setting Home Setting	 $600 copay $600 copay	 Not Covered Not Covered	
Temporomandibular Joint Disorder (TMJ) Office Visit	 100%-PCP $70 copay-Specialist	 100%-PCP $70 copay-Specialist	

Platinum Plan Covered Medical Expenses	Anthem Network	Out-of-Network	Limits
Coverage for all services is based on Medical Necessity. **Participants using Out-of-Network services are responsible for all copays, coinsurance and amounts above the Maximum Allowable Charge except for services that are subject to the No Surprises Act.**			
Diagnostic X-ray Testing	100%-PCP $50 copay per day-Specialist $50 copay per day-Freestanding Facility $150 copay per day-Outpatient Hospital	Not Covered	
Surgery	100%	100%	
Oral Devices	100%	Not Covered	
Urgent Care	100%	100%	

Covered Services using Center of Excellence/Blue Distinction Center	Network Center of Excellence/Blue Distinction Center	Anthem Network	Out-of-Network	Limits
Bariatric Surgery	Reimbursed based on the services rendered-See Summary of Benefits	Not Covered	Not Covered	**See the Blue Distinction Center/Blue Distinction Center + Program section for additional information on benefits, exclusions and travel expenses.**
Cornea Transplants	Reimbursed based on the services rendered-See Summary of Benefits	Reimbursed based on the services rendered-See Summary of Benefits	Reimbursed based on the services rendered-See Summary of Benefits	
All Other Organ Transplants	Reimbursed based on the services rendered-See Summary of Benefits	Not Covered	Not Covered	
Inpatient Hip/Knee Replacement, Spine Surgeries	Reimbursed based on the services rendered-See Summary of Benefits	Not Covered	Not Covered	

Diamond Plan	Anthem Network	Out-of-Network
Deductible Individual Family Unit	 Not Applicable Not Applicable	 Not Applicable Not Applicable
Maximum Out-of-Pocket Individual Family Unit ***Note: Covered Expenses incurred in and applied toward the Anthem Network out-of-pocket maximum in October, November and December will be applied toward the Anthem Network out-of-pocket maximum in the next Calendar Year.***	 $1,000 $3,000	 Unlimited Unlimited

- Covered Expenses applied toward the "individual" out-of-pocket maximum amount will be applied toward the "family" out-of-pocket maximum amount.
- Covered Expenses applied toward satisfying the Anthem Network out-of-pocket maximums will not apply toward the Out-of-Network out-of-pocket maximum.
- Covered Expenses applied toward satisfying the Out-of-Network out-of-pocket maximum will not apply toward satisfying the Anthem Network out-of-pocket maximum.
- The individual out-of-pocket maximum is embedded, meaning an individual will only have to meet the individual out-of-pocket maximum before benefits will be paid at 100% for that individual.

The following table identifies what does and does not apply toward the Anthem Network and Out-of-Network Out-of-Pocket Maximums:

Plan Features	Applies to the Anthem Network Out-of-Pocket Maximum?	Applies to the Out-of-Network Out-of-Pocket Maximum?
Payments toward the annual Deductible	Not Applicable	Not Applicable
Coinsurance payments	Yes	Yes
Copayments	Yes	Yes
Charges for non-covered services	No	No
The amounts of any Pre-Certification penalties	No	No
Charges that exceed Covered Expenses	No	No

Diamond Plan Covered Medical Expenses	Anthem Network	Out-of-Network	Limits
Coverage for all services is based on Medical Necessity. **Participants using Out-of-Network services are responsible for all copays, coinsurance and amounts above the Maximum Allowable Charge except for services that are subject to the No Surprises Act.**			
Abortion Office Hospital/Ambulatory Surgical Center (ASC)	 100%-PCP $100 copay per day-Specialist $600 copay-Hospital $200 copay-ASC	 100%-PCP $100 copay per day-Specialist $600 copay-Hospital $200 copay-ASC	Elective or non-elective abortions covered.

Diamond Plan Covered Medical Expenses	Anthem Network	Out-of-Network	Limits
Coverage for all services is based on Medical Necessity. **Participants using Out-of-Network services are responsible for all copays, coinsurance and amounts above the Maximum Allowable Charge except for services that are subject to the No Surprises Act.**			
Acupuncture	100%	50%	Limited to 12 visits per Calendar Year.
Advanced Imaging (CT, MRI, PET scan, Nuclear Studies) Freestanding Radiology Center Outpatient Hospital Physician Office	 $100 copay per day $250 copay per day $100 copay per day	 $100 copay per day $250 copay per day $100 copay per day	Out-of-Network benefit maximum: $800 per test.
Allergy Services Office Visit Office Visit with Injection Injection Only Serum Testing	 100%-PCP $40 copay-Specialist 100%-PCP $40 copay-Specialist 100% 100%-PCP $40 copay-Specialist 100%-PCP $40 copay per day-Specialist	 100%-PCP $40 copay-Specialist 100%-PCP $40 copay-Specialist 100% 100%-PCP $40 copay-Specialist Not Covered	
Ambulance Ground Air	 $300 copay $300 copay	 $300 copay $300 copay	Out-of-Network applies to in-network benefits. Out-of-Network Air Ambulance: $50,000 per trip maximum for non-emergent services.
Ambulatory Surgical Center	$200 copay	$200 copay	
Anesthesia	100%	100%	
Autism Office Visit, Testing	100%	100%	See Habilitative Services and Therapies for therapy coverage.
Chemotherapy/Radiation Therapy	100%	100%	
Chiropractic Care	100%	Not Covered	
Dialysis	100%	100%	Out-of-Network benefit maximum: $350 per visit.

Diamond Plan Covered Medical Expenses	Anthem Network	Out-of-Network	Limits
Coverage for all services is based on Medical Necessity. **Participants using Out-of-Network services are responsible for all copays, coinsurance and amounts above the Maximum Allowable Charge except for services that are subject to the No Surprises Act.**			
Durable Medical Equipment	100%	Not Covered	
Eye Exam	$40 copay	$40 copay	Examination including refraction covered only when performed in conjunction with a medical diagnosis.
Gender-Affirming Care	*Reimbursed based on the services rendered	Not Covered	*Benefits will be applied based on the services billed: inpatient, outpatient, therapy. See Medical Benefits for additional information on travel expenses.
Genetic Counseling or Testing Office Outpatient Hospital Freestanding Lab	 100% $50 copay per day 100%	 Not Covered Not Covered Not Covered	
Gene Therapy	100%	100%	
Glaucoma, Cataract Surgery and Lenses (one set)	$200 copay-Ambulatory Surgery Center $600 copay-Outpatient Hospital	$200 copay-Ambulatory Surgery Center $600 copay-Outpatient Hospital	One set of lenses or glasses covered after ocular surgery when the lens of the eyes has been removed such as with a cataract extraction.
Habilitative Services and Therapies Applied Behavior Analysis (ABA) Therapy Billed with Autism Diagnosis-Occupation Therapy, Physical Therapy, Speech-Language Pathology Occupational Therapy, Physical Therapy, Speech-Language Pathology	 100% 100% 100%	 100% 100% Not Covered	Aquatic and Physical Therapy: Maximum 30 visits combined per Calendar year. Occupational and Speech Therapy: Maximum of 30 visits per therapy per Calendar Year.

Diamond Plan Covered Medical Expenses	Anthem Network	Out-of-Network	Limits
Coverage for all services is based on Medical Necessity. **Participants using Out-of-Network services are responsible for all copays, coinsurance and amounts above the Maximum Allowable Charge except for services that are subject to the No Surprises Act.**			
Hearing Aids	100%	100%	Covered up to a benefit maximum of $700 per plan participant, every 24 month period for both ears. Maximum includes: monaural or binaural hearing aids, ear mold(s), batteries, cords, other ancillary equipment.
Home Health Care	100%	100%	Maximum of 100 visits per Calendar Year. Out-of-Network benefit maximum: $150 per day.
Hospice Care Inpatient, Outpatient Bereavement Counseling	 100% 100%	 100% 100%	
Hospital Inpatient Hospital Including-Rehabilitation 23 hour Observation Lab X-ray Outpatient Surgery Pre-admission Testing-Lab X-ray	 $200 copay per day $50 copay per day-Outpatient Hospital 100%-Freestanding Facility $75 copay per day-Outpatient Hospital $25 copay-Freestanding Facility $600 copay $50 copay per day $75 copay per day	 $200 copay per day Not Covered Not Covered $600 copay Not Covered Not Covered	Out-of-network non-emergency admit: Maximum payment up to $600 per day.
Independent Lab	100%	Not Covered	
Implantable Hearing Devices	$200 copay-Ambulatory Surgery Center	$200 copay-Ambulatory Surgery Center	Includes cochlear implants and bone anchored devices.

Diamond Plan Covered Medical Expenses	Anthem Network	Out-of-Network	Limits
Coverage for all services is based on Medical Necessity. **Participants using Out-of-Network services are responsible for all copays, coinsurance and amounts above the Maximum Allowable Charge except for services that are subject to the No Surprises Act.**			
	$600 copay-Outpatient Hospital	$600 copay-Outpatient Hospital	
Mental Health and Substance Use Disorder Expenses Inpatient Facility, Residential Treatment Facility Partial Hospitalization, Intensive Outpatient Services, Outpatient Facility/Office Visit Services	$200 copay per day 100%	$200 copay per day 100%	Out-of-network non-emergency admit: Maximum payment up to $600 per day.
Morbid Obesity/Obesity Office Visit Lab	100%-PCP $40 copay-Specialist 100%	100%-PCP $40 copay-Specialist Not Covered	See “Bariatric Surgery” for more information on surgery benefits.
Newborn Care Well Baby Sick Baby	100% $200 copay per day	100% $200 copay per day	Well baby processed under mother unless mother is not a dependent on the plan, then the charges will be processed under the baby with the inpatient copay applying. Out-of-network non-emergency admit: Maximum payment up to $600 per day.
Nutritional Counseling	100%	100%	Covered for the management of diabetes, treatment of eating disorders such as anorexia nervosa and nervosa and as required under preventive benefits. Limited to 36 visits per Calendar Year.
Outpatient Emergency Services - Emergency Room	$300 copay	$300 copay	ER copay waived if admitted. Inpatient benefits would apply.

Diamond Plan Covered Medical Expenses	Anthem Network	Out-of-Network	Limits
Coverage for all services is based on Medical Necessity. **Participants using Out-of-Network services are responsible for all copays, coinsurance and amounts above the Maximum Allowable Charge except for services that are subject to the No Surprises Act.**			
Outpatient Emergency Services-Other Providers	100%	100%	
Physician Services **Primary Care:** Office Visit, Telehealth Visit, Office Visit with Injection	100%	100%	
Specialist: Office Visit, Telehealth Visit, Office Visit with Injection	$40 copay	$40 copay	
Lab/X-ray-Primary Care, Lab-Specialist	100%	Not Covered	
X-ray-Specialist	$25 copay per day	Not Covered	
Diagnostics in Office (other than lab/x-ray)	100%	Not Covered	
Injection Only	100%	100%	
Office Surgery	100%-PCP $100 copay per day-Specialist	100%-PCP $100 copay per day-Specialist	
Physician Charges-Inpatient/Outpatient	100%	100%	
Retail Health Clinic	100%	100%	
Telehealth Visits with LiveHealth	100%	Not Applicable	Contact: www.livehealthonline.com
Pregnancy/Sterilization Expenses Initial Office Visit	100%	100%	
Routine Pre-Natal Services-as required per ACA	100%	Not covered	
Non-Routine Pre-Natal Diagnostic Lab	100%-Office 100%-Freestanding Facility $50 copay per day-Outpatient Hospital 100%-PCP/OB-GYN	Not Covered	

Diamond Plan Covered Medical Expenses	Anthem Network	Out-of-Network	Limits
Coverage for all services is based on Medical Necessity. **Participants using Out-of-Network services are responsible for all copays, coinsurance and amounts above the Maximum Allowable Charge except for services that are subject to the No Surprises Act.**			
Non-Routine Pre-Natal Diagnostic X-ray including Sonograms	$25 copay per day-Specialist $25 copay per day-Freestanding Facility $75 copay per day-Outpatient Hospital	Not Covered	Sonograms: Allowed 3, any additional require medical necessity review.
Delivery/Post Natal, Birthing Center	$200 copay per day	$200 copay per day	Out-of-network non-emergency admit: Maximum payment up to $600 per day.
Physician Global Fee, Midwife, Doula	100%	100%	
Amniocentesis	100%-PCP Office $100 copay-Specialist Office $200 copay-Ambulatory Surgery Center $600 copay-Outpatient Hospital	100%-PCP Office $100 copay-Specialist Office $200 copay-Ambulatory Surgery Center $600 copay-Outpatient Hospital	
Male Sterilization	100%-PCP $100 copay-Specialist $200 copay-Ambulatory Surgical Center $600 copay-Outpatient Hospital	100%-PCP $100 copay-Specialist $200 copay-Ambulatory Surgical Center $600 copay-Outpatient Hospital	Female sterilization falls under preventive benefits.
Breast Pump (Manual or Electric)	100%	Not Covered	One breast pump per pregnancy. Over the counter breast pump purchases are not covered.
Preventive Care **Well Adult Care** Physical Exam Mammogram Pap Smear Colonoscopy Immunizations	100%	Not Covered	
Well Child Care Physical Exam Immunizations	100%	Not Covered	
Prosthetics, Orthotics and Supplies Prosthetics, Orthotics	100%	Not Covered	Custom Molded Foot Orthotics: 2 pairs covered per year. Additional 2 pairs would be considered
Custom Molded Foot Orthotics	100%	Not Covered	

Diamond Plan Covered Medical Expenses	Anthem Network	Out-of-Network	Limits
Coverage for all services is based on Medical Necessity. **Participants using Out-of-Network services are responsible for all copays, coinsurance and amounts above the Maximum Allowable Charge except for services that are subject to the No Surprises Act.**			
Supplies	100%	Not Covered	post-surgery if medically necessary.
Rehabilitative Services and Therapies Aquatic Therapy, Autism Spectrum Disorder Treatment, Cardiac Therapy, Occupational Therapy, Physical Therapy, Respiration Therapy, Speech Therapy	100%	Not Covered	Cardiac Therapy: Limited to phase 1 and 2 for 36 visits per Calendar Year. Aquatic and Physical Therapy: Maximum 30 visits combined per Calendar year. Occupational and Speech Therapy: Maximum of 30 visits per therapy per Calendar Year.
Second Surgical Opinion	100%-PCP $40 copay-Specialist	100%-PCP $40 copay-Specialist	
Skilled Nursing Facility	$400 copay per admission	$400 copay per admission	Maximum 150 days per Calendar Year.
Sleep Disorders/Sleep Study Office or Facility Setting Home Setting	 $600 copay $600 copay	 Not Covered Not Covered	
Temporomandibular Joint Disorder (TMJ) Office Visit Diagnostic X-ray Testing Surgery Oral Devices	 100%-PCP $40 copay-Specialist 100%-PCP $25 copay per day-Specialist $25 copay per day-Freestanding Facility $75 copay per day-Outpatient Hospital 100% 100%	 100%-PCP $40 copay-Specialist Not Covered 100% Not Covered	
Urgent Care	100%	100%	

Covered Services using Center of Excellence/Blue Distinction Center	Network Center of Excellence/Blue Distinction Center	Anthem Network	Out-of-Network	Limits
Bariatric Surgery	Reimbursed based on the services rendered-See Summary of Benefits	Not Covered	Not Covered	**See the Blue Distinction Center/Blue Distinction Center + Program section for additional information on benefits, exclusions and travel expenses.**
Cornea Transplants	Reimbursed based on the services rendered-See Summary of Benefits	Reimbursed based on the services rendered-See Summary of Benefits	Reimbursed based on the services rendered-See Summary of Benefits	
All Other Organ Transplants	Reimbursed based on the services rendered-See Summary of Benefits	Not Covered	Not Covered	
Inpatient Hip/Knee Replacement, Spine Surgeries	Reimbursed based on the services rendered-See Summary of Benefits	Not Covered	Not Covered	

MEDICAL BENEFITS

Medical Benefits

These medical benefits will be payable as shown in the Summary of Benefits or as otherwise outlined in this Plan. Subject to the Plan's provisions, limitations and Exclusions, the following are covered major medical benefits:

Abortion. Expenses for or related to an abortion, including FDA-approved drugs for medical abortion, when such items or services are not prohibited by applicable law.

Acupuncture. Relating directly or indirectly to acupuncture, including acupuncture provided in lieu of anesthetic.

Advanced Imaging. Charges for advanced imaging including: Computed Tomographic (CT) studies, Coronary CT angiography, MRI/MRA, nuclear cardiology, nuclear medicine, and PET scans. Covered Expenses include the readings of these medical tests/scans.

Allergy Services. Charges related to the treatment of allergies.

Ambulance (Emergency Only). Covered Expenses for professional ambulance, including approved available air, water and rail transportation, to a local Hospital, or transfer to the nearest facility having the capability to treat the condition, if the transportation is connected with an Inpatient confinement.

Ambulatory Surgical Center. Services of an Ambulatory Surgical Center for Medically Necessary care provided.

Anesthesia. Anesthesia, anesthesia supplies, and administration of anesthesia by facility staff.

Birthing Center. Services of a birthing center for Medically Necessary care provided within the scope of its license.

Blood/Blood Derivatives. Charges for blood and blood plasma (if not replaced by or for the patient), including blood processing and administration services. The Plan shall also cover processing, storage, and administrative services for autologous blood (a patient's own blood) when a Participant is scheduled for Surgery that can be reasonably expected to require blood.

Cataracts. Cataract surgery and one set of lenses (contacts or frame-type) following the surgery.

Chemotherapy. Charges for chemotherapy, including materials and services of technicians.

Chiropractic Care. Spinal adjustment and manipulation, x-rays for manipulation and adjustment, and other modalities performed by a Physician or other licensed practitioner, as limited in the Summary of Benefits.

Cleft Palate. Medically necessary dental or orthodontic services that are an integral part of reconstructive *surgery* for cleft palate procedures. Cleft palate means a condition that may include cleft palate, cleft lip, or other craniofacial anomalies associated with cleft palate.

Contraceptives. The charges for all Food and Drug Administration (FDA) -approved, -granted, or -cleared contraceptives methods, except oral contraceptives, in accordance with Health Resources and Services Administration (HRSA) guidelines. ***NOTE:*** *Oral contraceptives are covered under the Prescription Drug Benefits section*.

COVID-19 Testing. Expenses related to testing for COVID-19.

Custom Molded Foot Orthotics. Expenses for custom molded foot orthotics. Limited to two pair per calendar year. Two additional custom molded foot orthotics will be covered under the Plan if medically necessary following a covered surgery. Non-custom molded foot orthotics are not covered.

Dental Services—Accident Only. Charges made for a continuous course of dental treatment after Injury to sound natural teeth. Sound natural teeth are defined as natural teeth that are free of active clinical decay, have at least 50% bony support and are functional in the arch.

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

Diabetic Education. Services and supplies used in Outpatient diabetes self-management programs are covered under this Plan when they are provided by a Physician.

Diabetic Shoes. Charges for shoes when billed with a diagnosis of diabetes.

Dialysis. Charges for dialysis.

Durable Medical Equipment. Charges for rental, up to the purchase price, of Durable Medical Equipment, including glucose home monitors for insulin dependent diabetics. At its option, and with its advance written approval, the Plan may cover the purchase of such items when it is less costly and more practical than rental. The Plan does not pay for any of the following:

1. Any purchases without its advance written approval.
2. Replacements or repairs. ***NOTE:*** *The Plan covers repair and replacement of Durable Medical Equipment when Medically Necessary due to a physiological change to the patient, due to normal wear and tear of an item, the existing equipment is damaged and cannot be made serviceable or it will cost less to replace the item than to repair the existing item or rent a similar item.*
3. The rental or purchase of items which do not fully meet the definition of “Durable Medical Equipment."

Eye Examination. Charges for an eye examination, including a refraction test/vision test when performed in conjunction with a medical diagnosis.

Fertility Preservation. Coverage includes standard fertility preservation services as a basic healthcare service including, but are not limited to, injections, cryopreservation, and storage for both male and female members when a medically necessary treatment may cause iatrogenic infertility. Members’ cost share for fertility preservation services is based on provider type and service rendered.

Foot Disorders. Surgical treatment of foot disorders, including associated services, performed by a licensed Physician (excluding routine foot care).

Gender-Affirming Care. The Plan covers the following gender-affirming services when ordered by a Provider or Physician:

- Psychotherapy.
- Pre- and post-surgical hormone therapy.
- Gender-affirming surgery/ies. Surgery must be performed by a qualified Provider.

Gender-Affirming Care Travel Expenses

Certain travel expenses incurred in connection with an approved gender-affirming care surgery, when the hospital at which the surgery is performed is seventy-five (75) miles or more from your place of residence, provided the expenses are authorized in advance by the Claims Administrator. The Plan's maximum payment will not exceed $10,000 per gender-affirming care surgery, or series of surgeries (if multiple surgical procedures are performed), for the following travel expenses incurred by you and one (1) companion:

a. ground transportation to and from the hospital when it is seventy-five (75) miles or more from your place of residence
b. coach airfare to and from the hospital when it is three hundred (300) miles or more from your residence
c. lodging, limited to one (1) room, double occupancy
d. other reasonable expenses. Tobacco, alcohol, drug, and meal expenses are excluded.

The calendar year deductible will not apply and no co-payments will be required for gender-affirming care travel expenses authorized in advance by the Claims Administrator. Benefits will be provided for lodging, transportation, and other reasonable expenses up to the current limits set forth in the Internal Revenue Code, not to exceed the maximum amounts specified above. This travel expense benefit is not available for non-surgical gender-affirming care services.

Gene Therapy. Gene therapies and adoptive cellular therapies, as well as associated services and supplies, for Participants if Medically Necessary.

Genetic Counseling or Testing. In addition to coverage specified under Preventive Care, benefits are available for prenatal genetic testing for inherited susceptibility to a medical condition and counseling related to family history or test results to determine the physical characteristics of an unborn child. Refer to the Genetic Information Nondiscrimination Act of 2008 (GINA) subsection for information regarding the prohibition of discriminating on the basis of genetic information.

Glaucoma. Treatment of glaucoma.

Habilitative Services and Therapies. These services include:

1. **Applied Behavior Analysis (ABA) Therapy.** Charges for ABA therapy.
2. **Occupational Therapy.** Treatment or services rendered by a registered occupational therapist, under the direct supervision of a Physician, in a home setting or at a facility or Institution whose primary purpose is to provide medical care for an Illness or Injury, or at a free-standing outpatient facility.
3. **Physical Therapy.** Treatment or services rendered by a physical therapist, under direct supervision of a Physician, in a home setting or a facility or Institution whose primary purpose is to provide medical care for an Illness or Injury, or at a free-standing duly licensed outpatient therapy facility.
4. **Speech-Language Pathology.** Treatment for speech delays and disorders.

See the Summary of Benefits for treatment and/or frequency limitations.

Hearing Aids. Charges for hearing aids, which includes examinations for the prescription, fitting, and/or repair of hearing aids. See the Summary of Benefits for treatment and/or frequency limitations.

Hearing Exams (Non-Routine).

Home Health Care. Charges for Home Health Care services and supplies are covered only for care and treatment of an Illness or Injury when Hospital or Skilled Nursing Facility confinement would otherwise be

required. The Diagnosis, care, and treatment must be certified by the attending Physician and be contained in a home health care plan. Charges by a Home Health Care Agency for any of the following:

1. Registered Nurses or Licensed Practical Nurses.
2. Certified home health aides under the direct supervision of a Registered Nurse.
3. Registered therapist performing physical, occupational or speech therapy.
4. Physician calls in the office, home, clinic or outpatient department.
5. Services, Drugs and medical supplies which are Medically Necessary for the treatment of the Participant that would have been provided in the Hospital, but not including Custodial Care. ***NOTE:*** *Home infusion therapy does not apply to the home health care maximum.*
6. Rental of Durable Medical Equipment or the purchase of this equipment if economically justified, whichever is less.

NOTE: *Transportation services are not covered under this benefit.*

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

Hospice Care. Charges relating to Hospice Care, provided the Participant has a life expectancy of six months or less, subject to the maximums, if any, stated in the Summary of Benefits. Covered Hospice expenses are limited to:

1. Room and Board for confinement in a Hospice.
2. Ancillary charges furnished by the Hospice while the patient is confined therein, including rental of Durable Medical Equipment which is used solely for treating an Injury or Illness.
3. Medical supplies, Drugs and medicines prescribed by the attending Physician, but only to the extent such items are necessary for pain control and management of the terminal condition.
4. Physician services and nursing care by a Registered Nurse, Licensed Practical Nurse or a Licensed Vocational Nurse (L.V.N.).
5. Home health aide services.
6. Home care furnished by a Hospital or Home Health Care Agency, under the direction of a Hospice, including Custodial Care if it is provided during a regular visit by a Registered Nurse, a Licensed Practical Nurse or a home health aide.
7. Medical social services by licensed or trained social workers, Psychologists or counselors.
8. Nutrition services provided by a licensed dietitian.
9. Respite care.
10. Bereavement counseling, which is a supportive service provided by the Hospice team to Participants in the deceased's Family Unit after the death of the terminally ill person, to assist the Participants in adjusting to the death. Benefits will be payable if the following requirements are met:

    a. On the date immediately before his or her death, the terminally ill person was in a Hospice Care Program and a Participant under the Plan.
    b. Charges for such services are Incurred by the Participants within six months of the terminally ill person's death.

The Hospice Care program must be renewed in writing by the attending Physician every 30 days. Hospice Care ceases if the terminal Illness enters remission.

Hospital. Charges made by a Hospital for:

1. Inpatient Treatment
    a. Daily semi private Room and Board charges.
    b. Intensive Care Unit (ICU) and Cardiac Care Unit (CCU) Room and Board charges.
    c. General nursing services.

    d. Medically Necessary services and supplies furnished by the Hospital, other than Room and Board.
2. Outpatient Treatment
    a. Emergency room.
    b. Treatment for chronic conditions.
    c. Physical therapy treatments.
    d. Hemodialysis.
    e. X-ray, laboratory and linear therapy.

Implantable Hearing Devices. For services or supplies in connection with implantable hearing devices, including, but not limited to, cochlear implants and exams for their fitting.

Laboratory and Pathology Services. Charges for x-rays, diagnostic tests, labs, and pathology services.

Mastectomy. The Federal Women's Health and Cancer Rights Act, signed into law on October 21, 1998, contains coverage requirements for breast cancer patients who elect reconstruction in connection with a Mastectomy. The Federal law requires group health plans that provide Mastectomy coverage to also cover breast reconstruction Surgery and prostheses following Mastectomy.

As required by law, the Participant is being provided this notice to inform him or her about these provisions. The law mandates that individuals receiving benefits for a Medically Necessary Mastectomy will also receive coverage for:

1. Reconstruction of the breast on which the Mastectomy has been performed.
2. Surgery and reconstruction of the other breast to produce a symmetrical appearance.
3. Prostheses and physical complications from all stages of Mastectomy, including lymphedemas.

The reconstruction of the breast will be done in a manner determined in consultation with the attending Physician and the patient.

This coverage will be subject to the same annual Deductible and Coinsurance provisions that currently apply to Mastectomy coverage, and will be provided in consultation with the Participant and his or her attending Physician.

Medical Foods. Medical foods are considered a Covered Expense if intravenous therapy (IV) or tube feedings are Medically Necessary. Medical foods taken orally are not covered under the Plan, except for PKU formula when Medically Necessary.

Medical Supplies. Dressings, casts, splints, trusses, braces and other Medically Necessary medical supplies, with the exception of dental braces or corrective shoes,(except for diabetic shoes), but including lancets and chemstrips for diabetics.

Mental Health and Substance Use Disorder Benefits. Benefits are available for Inpatient or Outpatient care for mental health and Substance Use Disorder conditions, including individual and group psychotherapy, psychiatric tests, and expenses related to the Diagnosis when rendered by a covered Provider.

Benefits are available for, but not limited to, Residential Treatment Facility, Partial Hospitalization, and Intensive Outpatient Services.

Methadone Assisted Treatment (MAT).

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

Morbid Obesity. Charges when the treatment meets the Plan's Medical Necessity criteria. To include surgical treatment, non-surgical treatment, and complications from such treatment.

Services must be done at a Blue Distinction Center/Center of Excellence or Blue Distinction Center (BD+). See the "Bariatric Surgery Program" in the Blue Distinction Center/Blue Distinction Center + Program section for additional benefit information.

Severity of obesity judged appropriate for procedure, as indicated by one or more of the following:

1. Adult patient has BMI of forty or greater
2. Adolescent patient [thirteen to seventeen years of age] has BMI of 40 (or 140% of the 95th percentile in age and sex matched growth charge) or greater
3. Adult patient has BMI of thirty-five or greater and a clinically serious condition related to obesity (e.g. type 2 diabetes, obesity hypoventilation, obstructive sleep apnea, nonalcoholic steatohepatitis, pseudotumor, cerebri, severe osteoarthritis, difficult to control hypertension)
4. Adolescent patient [thirteen to seventeen years of age] has BMI of thirty-five (or 120% of the 95th percentile in an age and sex matched growth chart) or greater and a clinically serious condition related to obesity [e.g. type 2 diabetes, obstructive sleep apnea, nonalcoholic steatohepatitis, pseudotumor cerebri, Blount disease (tibia vara), slipped capital femoral epiphysis]
5. Adult patient has BMI of thirty or greater with type 2 diabetes mellitus with inadequately controlled hyperglycemia despite optimal medical treatment (e.g. oral medication, insulin)

Newborn Care. Hospital and Physician nursery care for newborns who are Children of the Employee or spouse and properly enrolled in the Plan, as set forth below. Benefits will be provided under the mother's coverage, and the mother's Deductible and Coinsurance provisions will apply:

1. Hospital routine care for a newborn during the Child's initial Hospital confinement at birth.
2. The following Physician services for well-baby care during the newborn's initial Hospital confinement at birth:
    a. The initial newborn examination and a second examination performed prior to discharge from the Hospital.

NOTE: *The Plan will cover Hospital and Physician nursery care for an ill newborn as any other medical condition, including circumcision (covered from birth to six months and after six months, only medically necessary is covered), provided the newborn is properly enrolled in the Plan. These benefits are provided under the baby's coverage.*

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

Nursing Services. Services of a Registered Nurse or Licensed Practical Nurse.

Nutritional Counseling. Charges for nutritional counseling for the management of diabetes, for the treatment of eating disorders such as anorexia nervosa and nervosa and as required by the Affordable Care Act (ACA) preventive benefits. See the Summary of Benefits for treatment and/or frequency limitations.

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

a. excision of tumors and cysts of the jaw, cheeks, lips, tongue, roof and floor of the mouth
b. excision of benign bony growths of the jaw and hard palate
c. external incision and drainage of cellulitis or soft tissue, not including odontogenic cysts or abscesses
d. treatment of non-dental lesions
e. incision of sensory sinuses, salivary glands, or ducts
f. removal of all teeth at an inpatient or outpatient hospital or dentist's office if removal of the teeth is part of standard medical treatment that is required before the plan participant can undergo radiation therapy for a covered medical condition
g. organ transplant preparation
h. removal of bony impacted teeth

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

Orthognathic Surgery. Orthognathic surgery for a physical abnormality that prevents normal function of the upper or lower jaw and is medically necessary to attain functional capacity of the affected part.

Note: If a plan participant decides to receive dental services that are not covered under this Plan, a participating provider who is a dentist may charge you his or her Maximum Allowable Charge for those services. Prior to providing you with dental services that are not a covered benefit, the dentist should provide a treatment plan that includes each anticipated service to be provided and the estimated cost of each service. If you would like more information about the dental services that are covered under this Plan, please call the number listed on your ID card. To fully understand your coverage under this plan, please carefully review this document.

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

Osteoporosis. Coverage for services related to diagnosis, treatment, and appropriate management of osteoporosis including, but not limited to, all Food and Drug Administration approved technologies, including bone mass measurement technologies as deemed medically necessary.

Outpatient Observation Stays. Services for outpatient observation stays will be considered at the applicable benefit level.

Physician Services. Services of a Physician for Medically Necessary care, including office visits, home visits, Hospital Inpatient care, Hospital Outpatient visits and exams, clinic care and surgical opinion consultations.

Post Aural Therapy. Therapy must follow surgery for a covered implantable hearing device.

Pregnancy Expenses. Expenses attributable to a Pregnancy. Pregnancy expenses of Dependent Children are covered. Benefits for Pregnancy expenses are paid the same as any other Illness. ***NOTE:*** *Preventive care charges for Pregnancy are covered under the Preventive Care benefit in the Medical Benefits section.*

Under the Newborns' and Mothers' Health Protection Act of 1996, group health plans and health insurance issuers generally may not restrict benefits for any Hospital length of stay in connection with childbirth for the mother or newborn Child to less than 48 hours following a vaginal delivery, or less than 96 hours

following a cesarean section. However, Federal law generally does not prohibit the mother's or newborn's attending Provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours as applicable). In any case, plans and issuers may not, under Federal law, require that a Provider obtain authorization from the Plan or the issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours). In no event will an "attending Provider" include a plan, Hospital, managed care organization, or other issuer.

In accordance with the Summary of Benefits and this section, benefits for the care and treatment of Pregnancy that are covered will be subject to all applicable Plan limitations and maximums (if any), and are payable in the same manner as medical or surgical care of an Illness.

Preventive Care. Charges for Preventive Care services. This Plan intends to comply with the Affordable Care Act's (ACA) requirement to offer In-Network coverage for certain preventive services without cost-sharing.

Benefits mandated through the ACA legislation include Preventive Care such as immunizations, screenings, and other services that are listed as recommended by the United States Preventive Services Task Force (USPSTF), the Health Resources and Services Administration (HRSA), and the Federal Centers for Disease Control (CDC).

See the following websites for more details:

https://www.healthcare.gov/coverage/preventive-care-benefits/;
https://www.uspreventiveservicestaskforce.org/uspstf/recommendation-topics/uspstf-a-and-b-recommendations;
https://www.cdc.gov/acip/vaccine-recommendations/index.html
https://www.aap.org/periodicityschedule;
https://www.hrsa.gov/womensguidelines/.

NOTE: *The Preventive Care services identified through the above links are recommended services. It is up to the Provider and/or Physician of care to determine which services to provide; the Plan Administrator has the authority to determine which services will be covered. Preventive Care services will be covered at 100% for Non-Network Providers if there is no Network Provider who can provide a required preventive service. Benefits include gender-specific Preventive Care services, regardless of the sex the Participant was assigned at birth, his or her gender identity, or his or her recorded gender.*

Preventive and Wellness Services for Adults and Children - In compliance with section (2713) of the Affordable Care Act, benefits are available for 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 (USPSTF).

Immunizations that have in effect a recommendation from the Advisory Committee on Immunization Practices (ACIP) of the Centers for Disease Control and Prevention (CDC) with respect to the individual involved. With respect to infants, Children, and adolescents, evidence-informed Preventive Care and screenings as provided for in the comprehensive guidelines supported by the Health Resources and Services Administration (HRSA).

Women's Preventive Services - With respect to women, such additional Preventive Care and screenings as provided for in comprehensive guidelines supported by the Health Resources and Services Administration (HRSA) not otherwise addressed by the recommendations of the United States Preventive Service Task Force (USPSTF), which will be commonly known as HRSA's Women's Preventive Services Required Health Plan Coverage Guidelines. The HRSA has added the following eight categories of women's services to the list of mandatory preventive services:

1. Well-woman visits.
2. Gestational diabetes screening.
3. Human papillomavirus (HPV) Deoxyribonucleic Acid (DNA) testing.
4. Sexually transmitted infection counseling.
5. Human Immunodeficiency Virus (HIV) screening and counseling.
6. Food and Drug Administration (FDA)-approved, -granted, or -cleared contraception methods and contraceptive counseling.
7. Breastfeeding support, supplies and counseling.
8. Domestic violence screening and counseling.

A description of Women's Preventive Services can be found at:
http://www.hrsa.gov/womensguidelines/ or at the websites listed above.

Prosthetics, Supplies and Surgical Dressings. Prosthetic devices (other than dental) to replace all or part of an absent body organ or part, including replacement due to natural growth or pathological change, but not including charges for repair or maintenance.

Radiation Therapy. Charges for radiation therapy and treatment.

Rehabilitative Services and Therapies. Services for individual therapy are covered on an Inpatient or Outpatient basis. They are services or supplies used for the treatment of an Illness or Injury and include:

1. **Autism Spectrum Disorder Treatment.** Charges for treatment of Autism Spectrum Disorder (ASD).
2. **Cardiac Therapy.** Charges for cardiac, not including phase three and phase four.
3. **Occupational Therapy.** Rehabilitation treatment or services rendered by a registered occupational therapist, under the direct supervision of a Physician, in a home setting or at a facility or Institution whose primary purpose is to provide medical care for an Illness or Injury, or at a free-standing outpatient facility.
4. **Physical Therapy.** Rehabilitation treatment or services rendered by a physical therapist, under direct supervision of a Physician, in a home setting or a facility or Institution whose primary purpose is to provide medical care for an Illness or Injury, or at a free-standing duly licensed outpatient therapy facility.
5. **Respiration Therapy.** Respiration therapy services.
6. **Speech Therapy.** Charges for speech therapy.

See the Summary of Benefits for treatment and/or frequency limitations.

Retail Health Clinics. Services and supplies provided by medical professionals who provide basic medical services in a retail health clinic including, but not limited to:

a. exams for minor illnesses and injuries
b. preventive services and vaccinations
c. health condition monitoring and testing

Routine Patient Costs for Participation in an Approved Clinical Trial. Charges for any Medically Necessary services, for which benefits are provided by the Plan, when a Participant is participating in a phase I, II, III or IV clinical trial, conducted in relation to the prevention, detection or treatment of a life-threatening disease or condition, as defined under the ACA, provided:

1. The clinical trial is approved by any of the following:

    a. The Centers for Disease Control and Prevention of the U.S. Department of Health and Human Services.
    b. The National Institute of Health.

c. The U.S. Food and Drug Administration.
d. The U.S. Department of Defense.
e. The U.S. Department of Veterans Affairs.
f. An institutional review board of an institution that has an agreement with the Office for Human Research Protections of the U.S. Department of Health and Human Services.

2. The research Institution conducting the Approved Clinical Trial and each health professional providing routine patient care through the Institution, agree to accept reimbursement at the applicable Covered Expense, as payment in full for routine patient care provided in connection with the Approved Clinical Trial.

Second Surgical Opinions. Charges for second surgical opinions.

Sexual Dysfunction. For any services or supplies for the treatment of male or female sexual dysfunction such as, but not limited to, treatment of erectile dysfunction (including penile implants), anorgasmy, and premature ejaculation.

Skilled Nursing Facility. Charges made by a Skilled Nursing Facility or a convalescent care facility as defined in the Plan, up to the limits set forth in the Summary of Benefits, in connection with convalescence from an Illness or Injury for which the Participant is confined. For information on Inpatient medical benefits for mental health or Substance Use Disorders, please refer to the "Mental Health and Substance Use Disorder Benefits" in the Medical Benefits section above.

Sleep Disorders/Sleep Studies. Care and treatment for sleep disorders when medically necessary. Coverage under the Plan includes sleep studies in the home.

Sterilization for Men. Charges for male sterilization procedures. Benefits for all Food and Drug Administration (FDA) approved charges related to sterilization.

NOTE: Procedures for women are covered under Preventive Care, to the extent required by the Affordable Care Act (ACA). See ***Women's Preventive Services*** for additional information.

Surgery. Surgical operations and procedures, unless otherwise specifically excluded under the Plan, and limited as follows:

1. Multiple procedures adding significant time or complexity will be allowed at:
   a. One hundred percent (100%) of the Maximum Allowable Charge for the first or major procedure.
   b. Fifty percent (50%) of the Maximum Allowable Charge for the secondary and subsequent procedures.
   c. Bilateral procedures which add significant time or complexity, which are provided at the same operative session, will be allowed at one hundred percent (100%) of the Maximum Allowable Charge for the major procedure, and fifty percent (50%) of the Maximum Allowable Charge for the secondary or lesser procedure.
2. The Maximum Allowable Charge for services rendered by an assistant surgeon will be limited to twenty percent (20%) of the Maximum Allowable Charge identified for the surgeon's service.
3. No benefit will be payable for incidental procedures, such as appendectomy during an abdominal Surgery, performed during a single operative session.

Surgical Treatment of Jaw. Surgical treatment of Illnesses, Injuries, fractures and dislocations of the jaw by a Physician or Dentist.

Telehealth. Charges for any Medically Necessary services, for which benefits are otherwise provided by the Plan, when those services are provided via audio or video communications.

Temporomandibular Joint Disorder. Charges for the Diagnosis and treatment of, or in connection with, temporomandibular joint disorders, myofascial pain dysfunction or orthognathic treatment.

Tobacco Use Disorder and/or Nicotine Dependency. Tobacco and nicotine dependence screening, counseling, nicotine withdrawal programs, facilities, Drugs or supplies as required per Affordable Care Act (ACA) preventive benefits.

Transplants. Services and supplies that are incurred for care and treatment due to a bone marrow, organ, or tissue transplant are subject to the exclusions stated in the **Blue Distinction Center/Blue Distinction Center+ Program** section. These exclusions would not apply to plan participants that meet the outlined exception criteria. If the outlined criteria is met, plan participants would receive services at the applicable benefit level.

Medical Exclusions

Some health care services are not covered by the Plan. In addition to the General Exclusions set forth in the General Limitations and Exclusion section, these include, but are not limited to, any charge for care, supplies, or services, which are:

Aids for Non-Verbal Communication. Devices and computers to assist in communication and speech except for speech aid devices and tracheoesophageal voice devices approved by the Claims Administrator.

Alternative Medicine. For holistic or homeopathic treatment, naturopathic services, and thermography, including drugs.

Athletic Training.

Autopsies. Autopsies and post-mortem testing.

Biofeedback. For biofeedback.

Chartered Flights.

Chelation Therapy. Except for lead poisoning.

Cord Blood. Harvesting and storage of umbilical cord blood or except as required as part of a covered transplant procedure.

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

Dental Care. For normal dental care benefits, including any dental, gum treatments, or oral surgery, except as otherwise specifically provided herein.

Education or Training Program. Performed by a Physician or other Provider enrolled in an education or training program when such services are related to the education or training program, except as specifically provided herein.

Educational or Vocational Testing. Services for educational or vocational testing or training. Educational services such as nutrition therapy (except as stated herein), asthma self-management education (except as stated herein), and Lamaze.

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

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

Federal or State Exclusion List. Any service, drug, drug regimen, treatment, or supply furnished, ordered or prescribed by a provider identified as an excluded individual or entity on the U.S. Department of Health and Human Services Office of Inspector General List of Excluded Individuals/Entities (01G List), the General Services Administration System for Award Management (GSA List), State Medicaid exclusion lists, or other exclusion/sanctioned lists as published by federal or state regulatory agencies. This exclusion does not apply to an emergency medical condition.

Foot Disorder. Services for routine, palliative, or cosmetic foot care including flat foot conditions, supportive devices for the foot (orthotics), treatment of subluxation of the foot, care of corns, bunions (except capsular or bone *surgery*), callouses, toe nails, fallen arches, weak feet, chronic foot strain, or symptomatic complaints of the feet, unless specifically provided herein.

Growth Hormones. Growth hormones are covered through the prescription drug benefits program.

Hair Pieces. For wigs, artificial hair pieces, human or artificial hair transplants, or any Drug, prescription or otherwise, used to eliminate baldness.

Health Club Memberships.

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

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

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

Hyperhidrosis Treatment. Medical and surgical treatment of excessive sweating (hyperhidrosis).

Hypnosis. Related to the use of hypnosis.

Immunizations. For immunizations and vaccinations for the purpose of travel outside of the United States.

Impregnation and Infertility Treatment. Charges related to Impregnation and Infertility Treatment.

NOTE: *Surrogacy is not covered, however if the surrogate is a Participant, then the Preventive Care and/or Pregnancy expenses will be covered in accordance with the Plan provisions.*

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

Mobile/Wearable Devices. Consumer wearable/personal mobile devices such as a smart phone, smart watch, or other personal tracking devices, including any software or applications.

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

Nutritional Supplements. For nutritional supplements, except as specified under Preventive Care.

Obesity. Related to care and treatment of obesity, weight loss, or dietary control. This exclusion does not apply to obesity screening and counseling that are covered under the Preventive Care benefit.

Organ Transplants. Related to donation of a human organ or tissue, except as specifically provided.

Orthotics. Charges in connection with non-custom molded orthotics.

Orthopedic Shoes. For orthopedic shoes, unless they are an integral part of a leg brace and the cost is included in the orthotist's charge, and other supportive devices for the feet.

Osseous Surgery. For osseous surgery.

Personal Convenience Items. For equipment that does not meet the definition of Durable Medical Equipment, including air conditioners, humidifiers and exercise equipment, whether or not recommended by a Physician.

Prescription Drugs. Prescription drugs charges covered under the prescription drug benefits, other than those covered in a physician's office or inpatient admission.

Private Contracts. Services or supplies provided pursuant to a private contract between the plan participant and a physician, for which reimbursement under the Medicare program is prohibited, as specified in Section 1802 (42 U.S.C. 1395a) of Title XVIII of the Social Security Act.

Private Duty Nursing. Private duty nursing.

Repair of Purchased Equipment. For maintenance and repairs needed due to misuse or abuse of purchased equipment.

Replacement Braces. For replacement of braces of the leg, arm, back, neck, or artificial arms or legs, unless there is sufficient change in the Participant's physical condition to make the original device no longer functional.

Routine Patient Costs for Participation in an Approved Clinical Trial. For costs for participation in an Approved Clinical Trial. The following items are excluded from approved clinical trial coverage under this Plan:

1. The cost of an Investigational new drug or device that is not approved for any indication by the U.S. Food and Drug Administration, including a drug or device that is the subject of the Approved Clinical Trial.
2. The cost of a service that is not a health care service, regardless of whether the service is required in connection with participation in an Approved Clinical Trial.
3. The cost of a service that is clearly inconsistent with widely accepted and established standards of care for a particular Diagnosis.
4. A cost associated with managing an Approved Clinical Trial.
5. The cost of a health care service that is specifically excluded by the Plan.
6. Services that are part of the subject matter of the Approved Clinical Trial and that are customarily paid for by the research institution conducting the Approved Clinical Trial.

If one or more participating Providers do participate in the Approved Clinical Trial, the qualified plan Participant must participate in the Approved Clinical Trial through a participating, Network Provider, if the Provider will accept the Participant into the trial.

The Plan does not cover routine patient care services that are provided outside of this Plan's health care Provider Network unless Non-Network benefits are otherwise provided under this Plan.

Routine Physical Examinations. For routine or periodic physical examinations, related x-ray and laboratory expenses, and nutritional supplements, except as provided in the Summary of Benefits.

Sterilization Reversal. For sterilization procedure reversal.

Tobacco Use Disorder and/or Nicotine Dependency. Tobacco and nicotine dependence screening, counseling, nicotine withdrawal programs, facilities, Drugs or supplies not covered unless as required per Affordable Care Act (ACA) preventive benefits.

Travel. For travel, whether or not recommended by a Physician, except as specifically provided herein. Refer to the Blue Distinction Center/Blue Distinction Center + Program section for additional benefit information.

Varicose Vein Treatment. Treatment of varicose veins or telangiectatic dermal veins (spider veins) by any method (including sclerotherapy or other surgeries) when services are rendered for cosmetic purposes.

Vision Care. Expenses for the following:

1. For eye refractions, eyeglasses, contact lenses, or the vision examination for prescribing or fitting eyeglasses or contact lenses (except for one pair of eyeglass or contact lenses following ocular surgery when the lens of the eye has been removed such as with a cataract extraction).
2. For refractive procedures or other plastic surgeries to correct vision in lieu of eyeglasses.
3. Vision therapy (orthoptics) and supplies.
4. Orthokeratology lenses for reshaping the cornea of the eye to improve vision.

Vitamins. For vitamins, except as specified under Preventive Care.

Weight Loss Programs.

Wigs. Charges associated with the initial purchase of a wig after chemotherapy or radiation therapy.

BLUE DISTINCTION CENTER/BLUE DISTINCTION CENTER + PROGRAM

Transplant Program

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

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

1. Bone marrow
2. Cornea
3. Double lung
4. Heart
5. Combination heart/lung
6. Intestine
7. Kidney
8. Kidney/liver
9. Kidney/pancreas
10. Liver
11. Lung
12. Pancreas
13. Bone marrow/stem cell and similar procedures

When the donor of an organ or tissue is not a plan participant, the donor's hospital, surgical, and medical expenses will be eligible on the basis of a claim made by the plan participant. When both the person donating the organ and the person getting the organ are plan participants under this Plan, each will get benefits under their Plans.

The maximum allowed amount for a donor, including donor testing and donor search, is limited to expense incurred for medically necessary medical services only. The maximum allowed amount for services incidental to obtaining the transplanted material from a living donor or a human organ transplant bank will be covered. Such charges, including complications from the donor procedure for up to six weeks from the date of procurement, are covered. Services for treatment of a condition that is not directly related to or a direct result of the transplant are not covered.

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

Transplant Program Benefits

1. Access to network Center of Excellence/Blue Distinction Center. Travel benefits are only available for access to a network Center of Excellence/Blue Distinction Center as outlined in the applicable Schedule of Benefits.
2. Reimbursement for travel, lodging, and meal expenses incurred during the transplant for plan participant and companion(s) who are traveling on the same day(s) to and/or from the site of treatment, for the purposes of an evaluation, the procedure, and/or necessary post-discharge follow up to a total maximum of **$10,000**. Benefits are paid at a per diem (per day) rate of up to $50 per day for the plan participant or up to $100 per day for the plan participant plus one companion. If the plan participant is enrolled dependent and minor child, the transportation expenses of two companions will be covered and lodging expenses will be reimbursed at a per diem rate up to $100 per day.
3. Services of a transplant case manager, who will coordinate services and savings

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

Covered services are subject to any applicable deductibles and co-payments set forth in the applicable Summary of Benefits.

Transplant Requirements

Transplant benefits under the Plan are only available when a plan participant fully utilizes a network Center of Excellence/Blue Distinction Center, and meets all of the following requirements:

1. Pre-certification must be obtained as outlined in the Utilization Management section.
2. All transplant services must be rendered at a transplant center facility.

Exception: Cornea transplants are not required to be performed in a Blue Distinction Center/Center of Excellence.

Transplant Exclusions

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

1. When the recipient is not an eligible plan participant
2. If a plan participant under this Plan is donating the organ to someone who is not a plan participant, benefits are not available under this Plan
3. When the organ or tissue is sold rather than donated to the recipient
4. Charges that are covered or funded by governmental, foundation, or charitable grans or programs
5. Any of the following or similar items associated with travel:
    a. Entertainment items such as alcohol, cigarettes, toys, books, movies, theater tickets, theme park tickets, flowers, greeting cards, stationary, stamps, postage, gifts, internet service, tips, coupons, vouchers, or travel tickets, frequent flyer miles
    b. Convenience items such as toiletries, paper products, maid service, laundry/dry cleaning, kennel fees, baby-sitter/childcare, valet parking, faxing, cell phones, phone calls, newspapers
    c. Mortgage, rent, security deposit, furniture, utility bills, appliances, utensils, vacation/apartment rentals

d. Vehicle maintenance, automobile mileage, taxi fares, parking, moving trucks/vehicles, mileage within the medical transplant facility city
e. Cash advances/lost wages
f. Rental care, buses, taxis, or shuttle service, except as specifically approved by the Claims Administrator
g. Prepayment or deposits
h. Taxes
i. Travel cost for donor companion/caregiver
j. Return visits for the donor for a treatment of an illness found during the evaluation

Bariatric Surgery Program

Services and supplies in connection with medically necessary bariatric surgery for weight loss are covered under the Plan, only for morbid obesity and only when performed at a designated Blue Distinction Center/Center of Excellence or Blue Distinction Center+ (BD+).

Plan participants must obtain pre-certification for all bariatric surgical procedures. Charges for services provided for or in connection with a bariatric surgical procedure performed at a facility other than a Blue Distinction Center or Blue Distinction Center+ (BD+) will not be covered.

Covered services are subject to any applicable deductibles and co-payments set forth in the applicable Summary of Benefits.

Covered Bariatric Travel Expenses

Certain travel expenses incurred in connection with an approved, specified bariatric surgery, performed at a designated Blue Distinction Center/Center of Excellence or Blue Distinction Center+ (BD+) is fifty (miles or more from the plan participant's place of residence, are covered, provided the expenses are authorized by the Claims Administrator in advance. The fifty mile radius around the Blue Distinction Center/Center of Excellence or Blue Distinction Center+ (BD+) will be determined by the bariatric Blue Distinction Center/Center of Excellence or Blue Distinction Center+ (BD+) coverage
area.

The Plan's maximum payment will not exceed **$3,000** per surgery for the following travel expenses incurred by the member and/or one companion and includes:

1. Transportation for the plan participant and/or one companion to and from the Blue Distinction Center/Center of Excellence or Blue Distinction Center + (BD+) facility (limited to three trip maximum for [one pre-operative trip, one surgery trip and one pos-operative trip is needed].
2. Flight for the plan participant and one companion to and from the Blue Distinction Center/Center of Excellence or Blue Distinction Center+ (BD+) facility will only be economy/coach seating (preferred seats for surgery trip when aisle seat is not available)
3. Check in bag fees will be one bag for the plan participant, one bag for companion for each flight
4. Group transportation (rental) will only be economy/intermediate/standard
5. Group transportation (personal care)-mileage reimbursement is based on current limits set forth in the internal revenue code, not to exceed the maximum amount specific above
6. Other reasonable expenses

Bariatric Travel Exclusions

Any of the following or similar items associated with travel are excluded under the Plan:

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

2. Convenience items such as toiletries, paper products, maid service, laundry/dry cleaning, kennel fees, baby-sitter/childcare, valet parking, faxing, cell phones, phone calls, newspapers
3. Mortgage, rent, security deposit, furniture, utility bills, appliances, utensils, vacation/apartment rentals
4. Vehicle maintenance, automobile mileage, taxi fares, parking, moving trucks/vehicles, mileage within the medical transplant facility city
5. Cash advances/lost wages
6. Rental cars, buses, taxis, or shuttle service, except as specifically approved by the Claims Administrator
7. Prepayment or deposits
8. Taxes

Hip Replacement, Knee Replacement, or Spine Surgery Program

Inpatient services and supplies provided for medically necessary hip, knee replacement or spine surgery when performed by a designated Blue Distinction Center + (BD+). Benefits for the following services are as follows:

1. Total knee replacement
2. Revision knee replacement
3. Total hip replacement
4. Revision hip replacement
5. Discectomy
6. Decompression (without fusion)
7. Primary fusion
8. Revision fusion

Covered services are subject to any applicable deductibles and co-payments set forth in the applicable Summary of Benefits.

Hip replacement, knee replacement, or spine surgery services are subject to pre-certification to determine medical necessity. Benefits are provided for inpatient services for medically necessary hip replacement, knee replacement, or spine surgery.

Covered Travel Expenses

Certain travel expenses incurred in connection with an approved, specified bariatric surgery, performed at a designated Blue Distinction Center/Center of Excellence or Blue Distinction Center+ (BD+) is fifty miles or more from the plan participant's place of residence, are covered, provided the expenses are authorized by the Claims Administrator in advance. The fifty mile radius around the Blue Distinction Center/Center of Excellence or Blue Distinction Center+ (BD+) will be determined by the bariatric Blue Distinction Center/Center of Excellence or Blue Distinction Center+ (BD+) coverage
area.

The Plan's maximum payment will not exceed **$6,000** per surgery for the following travel expenses incurred by the member and/or one companion and includes:

1. Transportation for the plan participant and/or one (1) companion to and from the Blue Distinction Center/Center of Excellence or Blue Distinction Center + (BD+) facility (limited to three trip maximum for [one pre-operative trip, one surgery trip and one pos-operative trip is needed].
2. Flight for the plan participant and one companion to and from the Blue Distinction Center/Center of Excellence or Blue Distinction Center+ (BD+) facility will only be economy/coach seating (preferred seats for surgery trip when aisle seat is not available)
3. Check in bag fees will be one bag for the plan participant, one bag for companion for each flight
4. Group transportation (rental) will only be economy/intermediate/standard

5. Group transportation (personal care)-mileage reimbursement is based on current limits set forth in the internal revenue code, not to exceed the maximum amount specific above
6. Other reasonable expenses

Hip Replacement, Knee Replacement, Or Spine Surgery Travel Exclusions
Any of the following or similar items associated with travel are excluded under the Plan:

1. Entertainment items such as alcohol, cigarettes, toys, books, movies, theater tickets, theme park tickets, flowers, greeting cards, stationary, stamps, postage, gifts, internet service, tips, coupons, vouchers, or travel tickets, frequent flyer miles
2. Convenience items such as toiletries, paper products, maid service, laundry/dry cleaning, kennel fees, baby-sitter/childcare, valet parking, faxing, cell phones, phone calls, newspapers
3. Mortgage, rent, security deposit, furniture, utility bills, appliances, utensils, vacation/apartment rentals
4. Vehicle maintenance, automobile mileage, taxi fares, parking, moving trucks/vehicles, mileage within the medical transplant facility city
5. Cash advances/lost wages
6. Rental cars, buses, taxis, or shuttle service, except as specifically approved by the Claims Administrator
7. Prepayment or deposits
8. Taxes

UTILIZATION MANAGEMENT

"Utilization Management" consists of several components to assist Participants in staying well: providing optimal management of chronic conditions, support, and service coordination during times of acute or new onset of a medical condition. The scope of the program includes Hospital admission pre-certification, continued stay review, length of stay determination, discharge planning, and case management. These programs are designed to ensure that Medically Necessary, high quality patient care is provided and enables maximum benefits under the Plan. In order to maximize Plan reimbursements, please read the following provisions carefully.

Services that Require Pre-Certification
The following services will require Pre-Certification (or reimbursement from the Plan may be reduced):

Inpatient Admissions
- Acute Care Hospital (observation beyond 23 hours is considered inpatient)
  - Maternity only after 48 hours vaginally / 96 hours C-section
- Scheduled Inpatient Surgery (**see Blue Distinction Center section**)
- Acute Physical Rehab
- Skilled Nursing Facility (150 days/yr)
- Behavioral Health/Substance Abuse
- Residential Treatment Center (RTC)

Blue Distinction Centers - Inpatient Surgery Requirements
- Spine Surgery
- Hip Surgery
- Knee Surgery
- Bariatric/Obesity Surgery
- Organ / Bone Marrow / Stem Cell Transplants (excluding cornea)

Outpatient Behavioral Health and Substance Abuse
- Partial Hospitalization Program (PHP)
- Intensive Outpatient (IOP)
- Transcranial Magnetic Stimulation (TMS)
- Applied Behavioral Analysis (ABA) therapy

Medications
- Gene Therapy is included in precert requirement for medical pharmacy/precert

Outpatient Services
Transplants – Unrelated Donor Searches (stem cell and / or solid organ)
Dialysis
Home Health (100 visits/yr benefit limit)
Home Infusion (does not apply towards home health limit)
Sleep Studies (facility-based require precert / home-based do not)

Nutritional Counseling (36 visits / yr)
- Diabetic counseling
- Eating disorder counseling

Cancer / Oncology Treatment
- Chemotherapy (see medication carve-out list for drugs requiring precert)
- Radiation (for oncology diagnoses)
- Cold caps (for appropriate chemotherapy regimens)

Imaging & Diagnostics
— Nuclear scans
— PET scans
— Genetic/Genomic Testing (excluding amniocentesis)

Durable Medical Equipment (DME)
— Custom Orthotics / Prosthetics / Braces
— Bone Growth Stimulators
— Electrical Stimulation Devices (TENS / NMES / EMS / FES)
— Hospital Beds and Accessories
— Negative Pressure Wound Therapy / Vacuum-Assist (VAC)
— Pressure Reducing Surfaces
— Seat Lift Mechanisms
— Oral devices for TMJ
— Vagus Nerve Stimulation Device (VNS)
— Power Wheelchair and Accessories

Therapies
— Physical therapy
— Occupational therapy
— Chiropractic

Air Ambulance (Scheduled Transport Only)

Outpatient / Ambulatory Surgery – (Does not apply to surgery performed in the office setting)

Cardiovascular
— Defibrillator placement/removal (defibrillator checks do not require precert)
— Pacemaker placement/removal (pacemaker checks do not require precert)
— Cardiac ablation
— Angioplasty / Stents (non-urgent)

Maxillofacial
— Temporomandibular Joint (TMJ)

Gender Affirmation
— Genital surgery
— Gonadectomy
— Breast / Chest surgery (Tattooing included)
— Facial surgery
— Body contouring
— Hair removal
— Vocal cord surgery / Voice Therapy

Potentially Cosmetic Procedures
— Blepharoplasty / Ptosis repair
— Bone graft, genioplasty, mentoplasty
— Breast surgery
— Canthopexy / Canthoplasty
— Cervicoplasty
— Chemical Peels
— Dermabrasion
— Dermal fillers
— Excision of excess skin or tissue

— Hair transplant
— Lipectomy/Liposuction
— Lipoma excision
— Otoplasty
— Orthognathic surgeries
— Panniculectomy/Abdominoplasty
— Rhinoplasty or septoplasty
— Rhytidectomy
— Scar revision
— Sclerotherapy
— Skin grafts/skin flaps/tissue grafts
— Skin lesion removal-phototherapy/laser therapy
— Skin substitutes
— Varicose vein treatment (excluding stab phlebectomy)

Any procedures that could be considered experimental or investigational

Remember that although the Plan will automatically pre-certify a maternity length of stay that is 48 hours or less for a vaginal delivery or 96 hours for a cesarean delivery, it is important that the Participant has his or her Physician call to obtain Pre-Certification if there is a need to have a longer stay.

The Pre-Certification process is limited to determining the Medical Necessity of the procedure. This does not verify eligibility for benefits nor guarantee benefit payments under the Plan. It is the Participant's responsibility to verify that the above services have been pre-certified as outlined below.

Pre-Certification Procedures and Contact Information
The Utilization Management Service is simple and easy for Participants to use. Whenever a Participant is advised that services requiring Pre-Certification are needed, it is the Participant's responsibility to call the pre-certification department at its toll free number, which is 1-866-259-5540. The review process will continue, as outlined below, until the completion of the treatment plan and/or the Participant's discharge from the Hospital.

Urgent Care or Emergency Admissions:
If a Participant needs medical care for a condition which could seriously jeopardize his or her life, he or she should obtain such care without delay, and communicate with the Plan as soon as reasonably possible.

If a Participant must be admitted on an Emergency basis, the Participant or an individual acting on behalf of the Participant should follow the Physician's instructions carefully and contact the pre-certification department as follows:

1. For Emergency admissions after business hours on Friday, on a weekend or over a holiday weekend, a call to the pre-certification department must be made within 72 hours after the admission date, but no later than the first business day following the Emergency admission, by or on behalf of the covered patient.
2. For Emergency admissions on a weekday, a call to the pre-certification department must be made within 24 hours after the admission date, by or on behalf of the covered patient.

If a medical service is provided in response to an Emergency situation or urgent care scenario, prior approval from the Plan is not required. The Plan will require notice within 72 hours after the admission date, but no later than the first business day following the Emergency admission, by or on behalf of the covered patient. Such a claim shall then be deemed to be a Post-service Claim.

Non-Emergency Admissions:
For Hospital stays that are scheduled in advance, a call to the pre-certification department should be completed as soon as possible before actual services are rendered. Once the pre-certification call is received, it will be routed to an appropriate review specialist who will create an on-line patient file. The review specialist will contact the Participant's attending Physician to obtain information and to discuss the specifics of the admission request. If appropriate, alternative care will be explored with the Physician.

If, after assessing procedure necessity, the need for an Inpatient confinement is confirmed, the review specialist will determine the intensity of management required and will remain in contact with the Physician or Hospital during the confinement.

If, at any time during the review process, Medical Necessity cannot be validated, the review specialist will refer the episode to a board certified Physician advisor who will immediately contact the attending Physician to negotiate an appropriate treatment plan. At the end of the Hospital confinement, the review specialist is also available to assist with discharge planning and will work closely with the attending Physician and Hospital to ensure that medically appropriate arrangements are made.

Pre-Certification Penalty
The program requires the support and cooperation of each Participant. If a Participant follows the instructions and procedures, he or she will receive the normal Plan benefits for the services. However, if a Participant fails to notify the pre-certification department of any services listed in the provision entitled "Services that Require Pre-Certification," allowed charges will be reduced by 100%. The Participant will be responsible for payment of the part of the charge that is not paid by the Plan.

NOTE: *If a Participant's admission or service is determined to not be Medically Necessary, he or she may pursue an appeal by following the provisions described in the Claims Procedures; Payment of Claims section of this document. The Participant and Provider will be informed of any denial or non-certification in writing.*

Retrospective Review
The Plan allows a review of the Medical Necessity of the health care services provided on an Emergency basis, after they have been provided. Retroactive Pre-Certification is allowed for medical non-Emergency care situations up to 180 days after the date of service without a penalty.

Alternate Course of Treatment
Certain types of conditions, such as spinal cord Injuries, cancer, AIDS or premature births, may require long term, or perhaps lifetime, care. The claims selected will be evaluated as to present course of treatment and alternate care possibilities.

If the Plan Administrator should determine that an alternate, less expensive, course of treatment is appropriate, and if the attending Physician agrees to the alternate course of treatment, all Medically Necessary expenses stated in the treatment plan will be eligible for payment under the Plan, subject to the applicable benefit maximum(s) set forth in this Plan, even if these expenses normally would not be eligible for payment under the Plan. A more expensive course of treatment, selected by the Participant or their attending Physician may not be deemed to be Medically Necessary or within Maximum Allowable Charge limitations, as those terms are defined by the Plan. The Plan may provide coverage in such circumstances by providing benefits equivalent to those available had the Medically Necessary and otherwise covered course of treatment, subject to the Maximum Allowable Charge, been pursued.

Pre-Admission Testing
If a Participant is to be admitted to a Hospital for non-Emergency Surgery or treatment, one set of laboratory tests and x-ray examinations performed on an Outpatient basis within seven days prior to such Hospital admission will be paid, as shown in the Summary of Benefits, provided that the following conditions are met:

1. The tests are related to the performance of the scheduled Surgery or treatment.
2. The tests have been ordered by a Physician after a condition requiring Surgery or treatment has been diagnosed and Hospital admission has been requested by the Physician and confirmed by the Hospital.
3. The Participant is subsequently admitted to the Hospital, or confinement is cancelled or postponed because a Hospital bed is unavailable or if, after the tests are reviewed, the Physician determines that the confinement is unnecessary.
4. The tests are performed in the Hospital where the confinement will take place and accepted in lieu of duplicate tests rendered during confinement.

Second Surgical Opinion
If a Physician recommends Surgery for a Participant, the Participant may request a second opinion as to whether or not the Surgery is Medically Necessary.

In addition, the Plan recommends that a second opinion be obtained prior to the following Surgeries:

1. Adenoidectomy.
2. Bunionectomy.
3. Cataract removal.
4. Coronary Bypass.
5. Cholecystectomy (removal of gallbladder).
6. Dilation and curettage.
7. Hammer Toe repair.
8. Hemorrhoidectomy.
9. Herniorrhaphy.
10. Hysterectomy.
11. Laminectomy (removal of spinal disc).
12. Mastectomy.
13. Meniscectomy (removal of knee cartilage, including arthroscopic approach).
14. Nasal surgery (repair of deviated nasal septum, bone or cartilage).
15. Prostatectomy (removal of all or part of prostate).
16. Release for entrapment of medial nerve (Carpal Tunnel Syndrome).
17. Tonsillectomy.
18. Varicose veins (tying off and stripping).

When a second opinion is requested, the Plan will pay the Maximum Allowable Charge Incurred for that opinion along with laboratory, x-ray and other Medically Necessary services ordered by the second Physician as shown in the Summary of Benefits. Second opinions for Cosmetic Surgery, normal obstetrical delivery and Surgeries that require only local anesthesia are not covered. If the second opinion does not concur with the first, the Plan will pay for a third opinion as outlined above. The second or third opinion must be given within 90 days of the first.

In all cases where a second opinion is requested, the original recommendation for Surgery must have been obtained from a Physician licensed in the medical specialty under which the recommended Surgery falls. The Physician consulted for the second opinion must be licensed in the same medical specialty and may not be a partner of or in association with the original Physician.

Pre-Surgical Approval
The Plan recommends that a pre-determination of benefits be obtained prior to the following Surgical Procedures, since they are usually Cosmetic Surgery or not Medically Necessary. These procedures include, but are not limited to:

1. Abdominoplasty.

2. Blepharoplasty.
3. Breast reduction or enlargement.
4. Dermabrasion.
5. Facial or nasal reconstruction.
6. Gastric bypass.
7. Lipectomy.
8. Penile implant.
9. Scar revision.
10. Sex alteration.
11. Any Experimental or research procedures which are not generally accepted medical practice.

Because of the broad range of Surgical Procedures available and under development, if a Participant is scheduled to undergo any questionable procedure, he or she should contact the Third Party Administrator for further information. Pre-surgical approval is not a guarantee of coverage.

Case Management

Case management is a preemptive coordination of a Participant's care in cases where the medical condition is or is expected to be serious, chronic, or when the cost of treatment is expected to be significant. This program provides for a case manager who monitors Participants and explores, discusses and recommends coordinated and/or alternate types of appropriate Medically Necessary care. Case management is a voluntary service. There are no reductions of benefits or penalties if the patient and family choose not to participate. Each treatment plan is individually tailored to a specific patient and should not be seen as appropriate or recommended for any other patient, even one with the same Diagnosis.

HIPAA PRIVACY

Commitment to Protecting Health Information

The Plan will comply with the Standards for Privacy of Individually Identifiable Health Information (i.e., the "Privacy Rule") set forth by the U.S. Department of Health and Human Services ("HHS") pursuant to the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"). Such standards control the dissemination of "protected health information" ("PHI") of Participants. Privacy Standards will be implemented and enforced in the offices of the Employer and Plan Sponsor and any other entity that may assist in the operation of the Plan.

The Plan is required by law to take reasonable steps to ensure the privacy of the Participant's PHI, and inform him/her about:

1. The Plan's disclosures and uses of PHI.
2. The Participant's privacy rights with respect to his or her PHI.
3. The Plan's duties with respect to his or her PHI.
4. The Participant's right to file a complaint with the Plan and with the Secretary of HHS.
5. The person or office to contact for further information about the Plan's privacy practices.

The Plan provides each Participant with a separate Notice of Privacy Practices. This Notice describes how the Plan uses and discloses a Participant's personal health information. It also describes certain rights the Participant has regarding this information. Additional copies of the Plan's Notice of Privacy Practices are available by calling 1-800-972-1727.

Within this provision capitalized terms may be used, but not otherwise defined. These terms shall have the same meaning as those terms set forth in 45 CFR Sections 160.103 and 164.501. Any HIPAA regulation modifications altering a defined HIPAA term or regulatory citation shall be deemed incorporated into this provision.

Definitions

- **Breach** means an unauthorized acquisition, access, use or disclosure of Protected Health Information ("PHI") or Electronic Protected Health Information ("ePHI") that violates the HIPAA Privacy Rule and that compromises the security or privacy of the information.
- **Protected Health Information ("PHI")** means individually identifiable health information, as defined by HIPAA, that is created or received by the Plan and that relates to the past, present, or future physical or mental health or condition of an individual; the provision of health care to an individual; or the past, present, or future payment for the provision of health care to an individual; and that identifies the individual or for which there is a reasonable basis to believe the information can be used to identify the individual. PHI includes information of persons living or deceased.

How Health Information May Be Used and Disclosed

In general, the Privacy Rules permit the Plan to use and disclose an individual's PHI without individual authorization in the minimum necessary amount only if the use or disclosure is for a Treatment, Payment, or Health Care Operations purpose as defined by HIPAA. For example, the Plan may use or disclose the Participant's PHI in the following ways:

1. To help manage the health care treatment the Participant receives: The Plan can use the Participant's PHI and share it with professionals who are treating the Participant. **Example:** A doctor sends the Plan information about your Diagnosis and treatment plan so the Plan can arrange additional services.

2. For health care operations: The Plan can use and disclose the Participant's PHI to run the Plan and may contact the Participant when necessary. **Example:** The Plan uses PHI about the Participant to develop better services for the Participant.
3. To carry out payment of benefits. **Example:** The Plan discloses PHI to other payers to coordinate benefits.
4. To administer the Plan. **Example:** The Plan discloses PHI to the Plan Sponsor to perform administrative functions and make coverage decisions.
5. If the use or disclosure falls within one of the other limited circumstances described in the rules. **Example:** The Plan makes a disclosure which is required by law or for public health activities.

Reproductive Health Information

Pursuant to federal law (29 FR 32976), unless required by law, the Plan will **not** use or disclose PHI which is requested to investigate or impose liability on any person for the mere act of seeking, obtaining, providing, or facilitating reproductive health care, or to identify any person for either purpose.

If the Plan receives a request for PHI which is potentially related to reproductive health care for one of these impermissible purposes, the Plan will not use or disclose PHI without first obtaining a signed attestation from the requesting party that the request is not for an impermissible purpose.

Primary Uses and Disclosures of PHI

1. Treatment, Payment and Health Care Operations: The Plan has the right to use and disclose a Participant's PHI for all activities as included within the definitions of Treatment, Payment, and Health Care Operations and pursuant to the HIPAA Privacy Rule.
2. Business Associates: The Plan contracts with individuals and entities (Business Associates) to perform various functions on its behalf. In performance of these functions or to provide services, Business Associates will receive, create, maintain, use, or disclose PHI, but only after the Plan and the Business Associate agree in writing to contract terms requiring the Business Associate to appropriately safeguard the Participant's information.
3. Other Covered Entities: The Plan may also disclose or share PHI with other insurance carriers (such as Medicare, etc.) in order to coordinate benefits, if a Participant has coverage through another carrier.

Disclosure of PHI to the Plan Sponsor for Plan Administration Purposes

In order that the Plan Sponsor may receive and use PHI for plan administration purposes, the Plan Sponsor agrees to:

1. Not use or further disclose PHI other than as permitted or required by the plan documents or as required by law (as defined in the Privacy Standards).
2. Ensure that any agents, including a subcontractor, 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. Maintain the confidentiality of all PHI, unless an individual gives specific consent or authorization to disclose such data or unless the data is used for health care payment or Plan operations.
4. Receive PHI, in the absence of an individual's express authorization, only to carry out Plan administration functions.
5. Not use or disclose genetic information for underwriting purposes.
6. 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.
7. Make available PHI in accordance with section 164.524 of the Privacy Standards (45 CFR 164.524).
8. Make available PHI for amendment and incorporate any amendments to PHI in accordance with section 164.526 of the Privacy Standards (45 CFR 164.526).

9. Make its internal practices, books and records relating to the use and disclosure of PHI received from the Plan available to the Secretary of the U.S. Department of Health and Human Services ("HHS"), or any other officer or Employee of HHS to whom the authority involved has been delegated, for purposes of determining compliance by the Plan with part 164, subpart E, of the Privacy Standards (45 CFR 164.500 et seq).
10. 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.

Required Disclosures of PHI

1. Disclosures to Participants: The Plan is required to disclose to a Participant most of the PHI in a Designated Record Set when the Participant requests access to this information. The Plan will disclose a Participant's PHI to an individual who has been assigned as his or her representative and who has qualified for such designation in accordance with the relevant State law. Before disclosure to an individual qualified as a personal representative, the Plan must be given written supporting documentation establishing the basis of the personal representation.
   The Plan may elect not to treat the person as the Participant's personal representative if it has a reasonable belief that the Participant has been, or may be, subjected to domestic violence, abuse, or neglect by such person, it is not in the Participant's best interest to treat the person as his or her personal representative, or treating such person as his or her personal representative could endanger the Participant.

2. Disclosures to the Secretary of the U.S. Department of Health and Human Services: The Plan is required to disclose the Participant's PHI to the Secretary of the U.S. Department of Health and Human Resources when the Secretary is investigating or determining the Plan's compliance with the HIPAA Privacy Rule.

Participant's Rights

The Participant has the following rights regarding PHI about him/her:

1. Request Restrictions: The Participant has the right to request additional restrictions on the use or disclosure of PHI for treatment, payment, or health care operations. The Participant may request that the Plan restrict disclosures to family members, relatives, friends or other persons identified by him/her who are involved in his or her care or payment for his or her care. The Plan is not required to agree to these requested restrictions.
2. Right to Receive Confidential Communication: The Participant has the right to request that he or she receive communications regarding PHI in a certain manner or at a certain location. The request must be made in writing and include how the Participant would like to be contacted. The Plan will accommodate all reasonable requests.
3. Right to Receive Notice of Privacy Practices: The Participant is entitled to receive a paper copy of the plan's Notice of Privacy Practices at any time. To obtain a paper copy, contact the Privacy Officer.
4. Accounting of Disclosures: The Participant has the right to request an accounting of disclosures the Plan has made of his or her PHI. The request must be made in writing and does not apply to disclosures for treatment, payment, health care operations, and certain other purposes. The Participant is entitled to such an accounting for the six years prior to his or her request. Except as provided below, for each disclosure, the accounting will include: (a) the date of the disclosure, (b) the name of the entity or person who received the PHI and, if known, the address of such entity or person; (c) a description of the PHI disclosed, (d) a statement of the purpose of the disclosure that reasonably informs the Participant of the basis of the disclosure, and certain other information. If the Participant wishes to make a request, please contact the Privacy Officer.

5. Access: The Participant has the right to request the opportunity to look at or get copies of PHI maintained by the Plan about him/her in certain records maintained by the Plan. If the Participant requests copies, he or she may be charged a fee to cover the costs of copying, mailing, and other supplies. If a Participant wants to inspect or copy PHI, or to have a copy of his or her PHI transmitted directly to another designated person, he or she should contact the Privacy Officer. A request to transmit PHI directly to another designated person must be in writing, signed by the Participant and the recipient must be clearly identified. The Plan must respond to the Participant's request within 30 days (in some cases, the Plan can request a 30 day extension). In very limited circumstances, the Plan may deny the Participant's request. If the Plan denies the request, the Participant may be entitled to a review of that denial.
6. Amendment: The Participant has the right to request that the Plan change or amend his or her PHI. The Plan reserves the right to require this request be in writing. Submit the request to the Privacy Officer. The Plan may deny the Participant's request in certain cases, including if it is not in writing or if he or she does not provide a reason for the request.
7. Other uses and disclosures not described in this section can only be made with authorization from the Participant. The Participant may revoke this authorization at any time.

Questions or Complaints

If the Participant wants more information about the Plan's privacy practices, has questions or concerns, or believes that the Plan may have violated his or her privacy rights, please contact the Plan using the following information. The Participant may submit a written complaint to the U.S. Department of Health and Human Services or with the Plan. The Plan will provide the Participant with the address to file his or her complaint with the U.S. Department of Health and Human Services upon request.

The Plan will not retaliate against the Participant for filing a complaint with the Plan or the U.S. Department of Health and Human Services.

Contact Information

Privacy Officer Contact Information:
HIPAA Notice of Privacy Practices | SISC - Self-Insured Schools of California

HIPAA SECURITY

Disclosure of Electronic Protected Health Information ("Electronic PHI") to the Plan Sponsor for Plan Administration Functions

STANDARDS FOR SECURITY OF INDIVIDUALLY IDENTIFIABLE HEALTH INFORMATION ("SECURITY RULE")

The Health Insurance Portability and Accountability Act (HIPAA) and other applicable law shall override the following wherever there is a conflict, or a term or terms is/are not hereby defined.

The Security Rule imposes regulations for maintaining the integrity, confidentiality and availability of protected health information that it creates, receives, maintains, or maintains electronically that is kept in electronic format (ePHI) as required under HIPAA.

Definitions

- **Electronic Protected Health Information (ePHI),** as defined in Section 160.103 of the Security Standards (45 C.F.R. 160.103), means individually identifiable health information transmitted or maintained in any electronic media.
- **Security Incidents,** as defined within Section 164.304 of the Security Standards (45 C.F.R. 164.304), means the attempted or successful unauthorized access, use, disclosure, modification, or destruction of information or interference with systems operation in an information system.

Plan Sponsor Obligations

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 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 a 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 administrative, physical, and technical safeguards to protect the confidentiality, integrity, and availability of the Electronic PHI and report to the Plan any security incident of which it becomes aware.
4. Report to the Plan any security incident of which it becomes aware.
5. Establish safeguards for information, including security systems for data processing and storage.
6. 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, except pursuant to an authorization which meets the requirements of the Privacy Standards.
7. Ensure that adequate separation between the Plan and the Plan Sponsor, as required in section 164.504(f)(2)(iii) of the Privacy Standards (45 CFR 164.504(f)(2)(iii)), is established as follows:
    a. The following Employees, or classes of Employees, or other persons under control of the Plan Sponsor, shall be given access to the PHI to be disclosed:
        i. Privacy Officer.
        ii. Director of Employee Benefits.
        iii. Employee Benefits Department employees.
        iv. Information Technology Department.

b. The access to and use of PHI by the individuals identified above shall be restricted to the plan administration functions that the Plan Sponsor performs for the Plan.

Disclosure of Summary Health Information to the Plan Sponsor

The Plan may disclose PHI to the Plan Sponsor of the group health plan for purposes of plan administration or pursuant to an authorization request signed by the Participant. The Plan may use or disclose "summary health information" to the Plan Sponsor for obtaining premium bids or modifying, amending, or terminating the group health plan. "Summary health information" may be individually identifiable health information and it summarizes the claims history, claims expenses or the type of claims experienced by individuals in the plan, but it 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 five-digit zip code.

Disclosure of Certain Enrollment Information to the Plan Sponsor

Pursuant to section 164.504(f)(1)(iii) of the Privacy Standards (45 CFR 164.504(f)(1)(iii)), the Plan may disclose to the Plan Sponsor information on whether an individual is participating in the Plan or is enrolled in or has un-enrolled from a health insurance issuer or health maintenance organization offered by the Plan to the Plan Sponsor.

Disclosure of PHI to Obtain Stop-loss or Excess Loss Coverage

The Plan Sponsor may hereby authorize and direct 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.

Resolution of Noncompliance

In the event that any authorized individual of the Employer's workforce uses or discloses Protected Health Information other than as permitted by the Privacy Standards, the incident shall be reported to the Privacy Officer. The Privacy Officer shall take appropriate action, including:

1. Investigation of the incident to determine whether the breach occurred inadvertently, through negligence, or deliberately; whether there is a pattern of breaches; and the degree of harm caused by the breach.
2. Applying appropriate sanctions against the persons causing the breach, which, depending upon the nature of the breach, may include oral or written reprimand, additional training, or termination of employment.
3. Mitigating any harm caused by the breach, to the extent practicable.
4. Documentation of the incident and all actions taken to resolve the issue and mitigate any damages.
5. Training Employees in privacy protection requirements and appoint a Privacy Officer responsible for such protections.
6. Disclosing the Participant's PHI to the Secretary of the U.S. Department of Health and Health and Human Resources when the Secretary is investigating or determining the Plan's compliance with the HIPAA Privacy Rule.