WENTE FAMILY ESTATES

PPO MEDICAL PLAN

WITH HEALTH REIMBURSEMENT ACCOUNT

PLAN DOCUMENT

AND

SUMMARY PLAN DESCRIPTION

Effective Date: January 1, 2022

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SUMMARY PLAN DESCRIPTION

Name of Plan:

Wente Family Estates PPO Medical Plan with Health Reimbursement Account

Name, Address and Phone Number of Employer:

Wente Family Estates
5565 Tesla Road
Livermore, CA 94550
925-456-2300

Employer Identification Number:

94-1051349

Plan Number:

501

Group Number:

WV

Type of Plan:

Welfare Benefit Plan: Medical and Prescription benefits

Type of Administration:

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

Name, Address and Phone Number of Plan Administrator, Fiduciary, and Agent for Service of Legal Process:

Wente Family Estates
5565 Tesla Road
Livermore, CA 94550
925-456-2300

Legal process may be served upon the ***plan administrator***.

Wente Family Estates shall perform its duties as the Plan Administrator and in its discretion shall determine appropriate courses of action in light of the reason and purpose for which this Plan is established and maintained. In particular, the Plan Administrator shall have full discretionary authority to interpret all Plan Documents and make all interpretive and factual determinations as to whether any individual is entitled to receive any benefit under the terms of this Plan. Any construction of terms of any Plan Documents and any determination of fact adopted by the Plan Administrator shall be final and legally binding on all parties.

Eligibility Requirements:

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

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

Source of Plan Contributions:

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

Funding Method:

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

Ending Date of Plan Year:

December 31st

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

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

Preferred Provider Networks:

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

Procedures for Filing Claims:

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

The designated ***claims processor*** for claims is:

Trustmark Health Benefits, Inc.
P. O. Box 2920
Clinton, IA 52733-2920

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

Caremark
211 Commerce Street, Suite 800
Nashville, TN 37201

Consumer Assistance Information:

Covered persons may seek consumer assistance information by contacting 1-877-877-3496 or www.Myevhc.com.

Statement of ERISA Rights:

Participants in the ***Plan*** are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA). ERISA provides that all participants shall be entitled to:

1. Examine, without charge, at the ***plan administrator's*** office and at other specified locations, such as worksites and union halls, all documents governing the ***Plan***, including insurance contracts and collective bargaining agreements and a copy of the latest annual report (Form 5500 Series) filed by the ***Plan*** with the U.S. Department of Labor, if applicable.

2. Obtain, upon written request to the ***plan administrator***, copies of documents governing the operation of the ***Plan***, including insurance contracts and collective bargaining agreements and copies of the latest annual report (Form 5500 Series) and updated summary plan description, if applicable. The ***plan administrator*** may make a reasonable charge for the copies.

3. Receive a summary of the ***Plan's*** annual financial report. The ***plan administrator*** is required by law to furnish each participant with a copy of this summary annual report, if applicable.

4. Continue health care coverage for the participant, the participant's spouse, domestic partner or ***dependents*** if there is a loss of coverage under the ***Plan*** as the result of a qualifying event. The participant or ***dependent*** may have to pay for such coverage. Review this summary plan description and the documents governing the ***Plan*** on the rules governing COBRA continuation coverage rights.

In addition to creating rights for ***Plan*** participants, ERISA imposes obligations upon the people who are responsible for the operation of the ***Plan***. The people who operate the ***Plan***, called "fiduciaries" of the ***Plan***, have a duty to do so prudently and in the interest of all ***Plan*** participants.

No one, including the ***employer***, a union, or any other person, may fire an ***employee*** or discriminate against an ***employee*** to prevent the ***employee*** from obtaining any benefit under the ***Plan*** or exercising their rights under ERISA.

If claims for benefits under the ***Plan*** are denied, in whole or in part, the participant must receive a written explanation of the reason for the denial. The participant has the right to have the ***Plan*** review and reconsider the claim.

Under ERISA, there are steps participants can take to enforce their rights. For instance, if material is requested from the ***Plan*** and the material is not received within thirty (30) days, the participant may file suit in a federal court. In such case, the court may require the ***plan administrator*** to provide the materials and pay the participant up to $110 a day until the materials are received, unless the materials were not provided for reasons beyond the control of the ***plan administrator***. If a claim for benefits is denied or ignored in whole or in part and after exhaustion of all administrative remedies, the participant may file suit in a state or federal court.

If it should happen that ***Plan*** fiduciaries misuse the ***Plan's*** money, or if participants are discriminated against for asserting their rights, participants may seek assistance from the U.S. Department of Labor, or may file suit in a federal court. The court will decide who will pay the costs and legal fees. If the participant is successful, the court may order the person who is sued to pay these costs and fees. If the participant loses, the court may order the participant to pay the costs and fees; for example, if it finds the participant's claim frivolous.

Participants should contact the ***plan administrator*** for questions about the ***Plan***. For questions about this statement or about rights under ERISA, participants should contact the nearest office of the Employee Benefits Security

Administration, U.S. Department of Labor listed in their telephone directory or the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue, N.W., Washington, D.C. 20210.

COBRA Continuation Coverage General Notice

Introduction

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

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

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

What is COBRA continuation coverage?

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

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

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

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

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

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

- The parent-***employee*** dies;
- The parent-***employee's*** hours of employment are reduced;
- The parent-***employee's*** employment ends for any reason other than his or her gross misconduct;
- The parent-***employee*** becomes entitled to ***Medicare*** benefits (Part A, Part B, or both);
- The parents become divorced or legally separated; or
- The child stops being eligible for coverage under this ***Plan*** as a "***dependent*** child."

When is COBRA continuation coverage available?

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

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

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

How is COBRA continuation coverage provided?

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

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

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

Disability extension of 18-month period of COBRA continuation coverage

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

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

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

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

Are there other coverage options besides COBRA Continuation Coverage?

Yes. Instead of enrolling in COBRA continuation coverage, there may be other coverage options for you and your family through the Health Insurance Marketplace, ***Medicare***, Medicaid, Children's Health Insurance Program (CHIP)

or other group health plan coverage options (such as a spouse's or domestic partner's plan) through what is called a "special enrollment period." Some of these options may cost less than COBRA continuation coverage. You can learn more about many of these options at www.healthcare.gov.

Can I enroll in ***Medicare*** instead of COBRA Continuation Coverage after my group health plan coverage ends?
In general, if you don't enroll in ***Medicare*** Part A or B when you are first eligible because you are still employed, after the ***Medicare*** initial enrollment period, you have an 8-month special enrollment period to sign up for ***Medicare*** Part A or B, beginning on the earlier of

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

If you don't enroll in ***Medicare*** and elect COBRA continuation coverage instead, you may have to pay a Part B late enrollment penalty and you may have a gap in coverage if you decide you want Part B later. If you elect COBRA continuation coverage and later enroll in ***Medicare*** Part A or B before the COBRA continuation coverage ends, this ***plan*** may terminate your continuation coverage. However, if ***Medicare*** Part A or B is effective on or before the date of the COBRA election, COBRA coverage may not be discontinued on account of ***Medicare*** entitlement, even if you enroll in the other part of ***Medicare*** after the date of the election of COBRA coverage.

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

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

If you have questions

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

Keep your Plan informed of address changes

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

Plan contact information

Trustmark Health Benefits, Inc.
P. O. Box 2920
Clinton, IA 52733-2920
1-877-877-3496

MEDICAL SCHEDULE OF BENEFITS

Benefit Period: January 1 – December 31

MEDICAL BENEFITS-PPO PLAN WITH HRA	PREFERRED PROVIDER	NONPREFERRED PROVIDER
Deductible per benefit period		
Individual	$3,000	$3,000
Family (non-embedded)	$6,000	$6,000
Deductible does not share between preferred and nonpreferred		
Generally, each ***covered person*** must pay all of the costs from providers up to the deductible amount before the ***Plan*** begins to pay. **Non-embedded family deductible**: Any number of covered family members may help to satisfy the family deductible before this ***Plan*** begins to pay for ***covered expenses*** that are subject to the deductible.		
Out-of-Pocket Expense Limit per benefit period (includes deductible, ***coinsurance***, ***copays***, and prescription drug cost-share)		
Individual	$4,000	$6,000
Family (embedded)	$8,000	$12,000
Out-of-pocket expense limit does not share between preferred and nonpreferred		
The out-of-pocket expense limit is the most the ***covered person*** could pay in a year for ***covered expenses***. The ***Plan*** will pay the designated percentage of ***covered expenses*** until the out-of-pocket expense limits are reached, at which time the ***Plan*** will pay 100% of the remainder of ***covered expenses*** for the rest of the benefit period unless stated otherwise. **Embedded family out-of-pocket expense limit:** Any number of covered family members may help to satisfy the family out-of-pocket expense limit, but no family member will incur more than the individual embedded out-of-pocket expense limit. The following charges do not apply to the out-of-pocket expense limit and are never paid at 100%: • expenses not covered by the ***Plan*** • expenses in excess of amounts covered by the ***Plan*** • expenses in excess of ***customary and reasonable amount*** • expenses incurred as a result of failure to obtain pre-certification		
Standard *coinsurance* paid by the *Plan*	100%	70%

MEDICAL BENEFITS-PPO PLAN WITH HRA	PREFERRED PROVIDER	NONPREFERRED PROVIDER
Allergy Services		
Allergy testing, injections and serum	100% after deductible	70% after deductible
Ambulance		
Land	100% after deductible	***preferred provider*** benefit applies
Air	100% after deductible	***preferred provider*** benefit applies
Applied Behavior Analysis Therapy (ABA)	100% after deductible	70% after deductible
Birthing Center	100% after deductible	70% after deductible
Blood *(Blood storage and transfusions)*	100% after deductible	70% after deductible
Cardiac Rehabilitation		
Facility	100% after deductible	70% after deductible
Physician	100% after deductible	70% after deductible
Chemotherapy		
Facility	100% after deductible	70% after deductible
Physician	100% after deductible	70% after deductible
Chiropractic Care Office visits, spinal manipulation, adjustments and x-rays	100% after deductible Maximum: Limited to 20 visits per benefit period	70% after deductible
Contraceptives	See Women's Preventive Services	
Diagnostic Services – Major *(such as MRI, CT Scan, PET Scan)*	100% after deductible	70% after deductible
Diagnostic Services – Minor		
Laboratory and X-ray services		
Primary care physician	100% after deductible	70% after deductible
Specialist	100% after deductible	70% after deductible
Independent Lab/Freestanding Facility	100% after deductible	70% after deductible
Other diagnostic services	100% after deductible	70% after deductible
Dialysis Therapy or Treatment		
Facility	100% after deductible	70% after deductible
Physician	100% after deductible	70% after deductible
Durable Medical Equipment	100% after deductible	70% after deductible

MEDICAL BENEFITS-PPO PLAN WITH HRA	PREFERRED PROVIDER	NONPREFERRED PROVIDER
Emergency Medical Condition Care		
Facility (***copay*** waived if admitted)	$100 ***copay*** after deductible	***preferred provider*** benefit applies
Physician	100% after deductible	***preferred provider*** benefit applies
Non-***Emergency Medical Condition*** Care		
Facility	Not Covered	Not Covered
Physician	Not Covered	Not Covered
Extended Care Facility	100% after deductible	70% after deductible
	Maximum: Limited to 100 days per benefit period	
Hearing		
Routine Exam	Not Covered	Not Covered
Hearing Aids	Not Covered	Not Covered
Home Health Care		
Home health care visits	100% after deductible	70% after deductible
Home health care supplies & services	100% after deductible	70% after deductible
IV therapy	100% after deductible	70% after deductible
	Maximum: Limited to 100 visits per benefit period	
Hospice Care		
Inpatient	100% after deductible	70% after deductible
Outpatient	100% after deductible	70% after deductible
Hospital – Inpatient		
Facility	100% after deductible	70% after deductible
Physician/Surgeon	100% after deductible	70% after deductible
Anesthesia, Radiology, Pathology, Lab	100% after deductible	70% after deductible
Hospital – Outpatient & Ambulatory Surgical Facility		
Facility	100% after deductible	70% after deductible
Physician/Surgeon	100% after deductible	70% after deductible
Anesthesia, Radiology, Pathology, Lab	100% after deductible	70% after deductible
Infertility Services		
Diagnostic testing to determine infertility	Based on service provided	Based on service provided
Medications and treatments	Not Covered	Not Covered
Infusion Therapy		
Facility	100% after deductible	70% after deductible
Physician	100% after deductible	70% after deductible

MEDICAL BENEFITS-PPO PLAN WITH HRA	PREFERRED PROVIDER	NONPREFERRED PROVIDER
Injectables *(See Allergy Services for allergy shots)*		
Office		
Primary care physician	100% after deductible	70% after deductible
Specialist	100% after deductible	70% after deductible
Outpatient	100% after deductible	70% after deductible
Office Visit & Other Services (one ***copay*** per provider per date of service)		
Office visit		
Primary care physician (includes outpatient visits for ***mental and nervous disorders*** and ***substance use disorder***)	100% after deductible	70% after deductible
Specialist	100% after deductible	70% after deductible
Surgery		
Primary care physician	100% after deductible	70% after deductible
Specialist	100% after deductible	70% after deductible
X-ray, lab, minor diagnostics		
Primary care physician	100% after deductible	70% after deductible
Specialist	100% after deductible	70% after deductible
Other services		
Primary care physician	100% after deductible	70% after deductible
Specialist	100% after deductible	70% after deductible
Orthotics	100% after deductible	70% after deductible
Podiatry Services	Based on service provided	Based on service provided
Pregnancy		
Initial pre-natal visit and urinalysis	100% deductible waived	70% after deductible
Subsequent pre-natal visits/care and breastfeeding services and supplies (as required by the ***Affordable Care Act***)	100% deductible waived	70% after deductible
Post-natal care and other non-routine/non-preventive pregnancy related care.	Based on service provided	Based on service provided
Delivery	100% after deductible	70% after deductible
Breast Pumps	100% deductible waived	100% deductible waived up to $500 maximum per benefit period.
Prostheses	100% after deductible	70% after deductible

MEDICAL BENEFITS-PPO PLAN WITH HRA	PREFERRED PROVIDER	NONPREFERRED PROVIDER
Radiation Therapy		
Facility	100% after deductible	70% after deductible
Physician	100% after deductible	70% after deductible
Respiratory Therapy		
Facility	100% after deductible	70% after deductible
Physician	100% after deductible	70% after deductible
Retail Clinic Visits	100% after deductible	70% after deductible
Routine Preventive Care/Wellness Benefits Includes all evidence-based supplies or services that have in effect a rating of A or B in the current recommendations of the United States Preventive Services Task Force (USPSTF). For additional information visit: http://www.uspreventiveservicestaskforce.org	100% deductible waived	70% after deductible
Routine Prostate Examinations	100% deductible waived	70% after deductible
Second Surgical Opinion	100% after deductible	70% after deductible
Temporomandibular Joint Syndrome (TMJ) Treatment	Not Covered	Not Covered
Therapy Services *(physical, speech and occupational)*		
Facility	100% after deductible	70% after deductible
Physician	100% after deductible	70% after deductible
	Maximum prior to pre-certification requirement: 40 visits for physical therapy and occupational therapy; 20 visits for speech and hearing therapy per benefit period	
Transplants (Organ or Tissue)		
Facility	100% after deductible	Not Covered
Physician	100% after deductible	Not Covered
Transportation expenses	100% after deductible	Not Covered
	Maximum: Transportation expenses limited to $10,000 per transplant	
Urgent Care Center		
Visit	100% after deductible	70% after deductible
All other services	100% after deductible	70% after deductible

MEDICAL BENEFITS-PPO PLAN WITH HRA	PREFERRED PROVIDER	NONPREFERRED PROVIDER
Vision – Routine Services *(Routine vision services required by the **Affordable Care Act** shall be covered under the Routine Preventive Care benefit)*	Not Covered	Not Covered
Weight Loss Services		
Surgical treatment	Not Covered	Not Covered
Non-surgical treatment and programs	Not Covered	Not Covered
Wigs	Not Covered	Not Covered
Women's Preventive Services As required by the ***Affordable Care Act***	100% deductible waived	70% after deductible
All Other C*overed Expenses*	100% after deductible	70% after deductible

PRE-CERTIFICATION REQUIREMENTS – $750 penalty for failure to follow pre-certification requirements in accordance with *Utilization Review Program*

Pre-certification is required for the following services. Refer to *Claim Filing Procedure, Pre-Service Claim Procedure, Filing a Pre-Service Claim* for more information:

- ***Inpatient*** Hospitalization
- ***Extended Care Facilities***
- Rehabilitation Facilities
- Psychiatric Treatment Facilities
- Chemical Dependency Treatment Facilities
- Organ and Tissue Transplants in all settings
- Durable medical equipment, based on type of equipment
- Genetic Testing
- Outpatient advanced radiology such as MRI, NRA, PET, CT-Scan and nuclear medicine
- Outpatient surgery
- Renal dialysis
- Certain medical pharmaceuticals
- Partial Hospitalizations
- Home Health Care/Home Infusion Therapy
- Additional visits for Therapy Services in excess of the stated maximum visits in the Medical Schedule of Benefits

Telemedicine Services *(From Teladoc):*

	Member Responsibility
Telemedicine Services – General Medical	Included in Coverage

PRESCRIPTION DRUG PROGRAM
SCHEDULE OF BENEFITS

Benefit Period: January 1 – December 31

Retail Pharmacy (31-day supply)		
Routine preventive drugs required by the ***Affordable Care Act***	100% Deductible Waived	Not Applicable
Generic	$10 ***Copay*** after Deductible	Not Covered
Formulary Brand Name	$30 ***Copay*** after Deductible	Not Covered
Non-Formulary Brand Name	$50 ***Copay*** after Deductible	Not Covered
Mail Order Pharmacy (90-day supply)		
Routine preventive drugs required by the ***Affordable Care Act***	100% Deductible Waived	Not Applicable
Generic	$30 ***Copay*** after Deductible	Not Covered
Formulary Brand Name	$90 ***Copay*** after Deductible	Not Covered
Non-Formulary Brand Name	$150 ***Copay*** after Deductible	Not Covered
Specialty Drugs (31-day supply)	Same as retail	Not Covered

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

Specialty Drugs- Limited to a 31-day supply for Retail or Mail Order

Specialty Drugs - The ***covered person*** must be enrolled in the Caremark Specialty Pharmacy Program to receive continued coverage for their specialty drugs.

Maintenance drugs (drugs which are prescribed for long-term usage) may be dispensed in a ninety (90) day supply at any retail pharmacy. The ***copay*** will be the same as the mail order option listed below.

Deductible does apply to prescription drugs.

PREFERRED PROVIDER OR NONPREFERRED PROVIDER

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

PREFERRED PROVIDER

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

NONPREFERRED PROVIDER

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

1. If a ***nonpreferred provider*** has not satisfied the Notice and Consent Criteria described under number 6. below, for certain items and services, ***covered expenses*** for such services rendered at a ***preferred provider facility*** will be:

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

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

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

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

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

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

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

    d. Ancillary services, including:

        i. Items and services related to emergency medicine, anesthesiology, pathology, radiology, neonatology (whether provided by a ***physician*** or non-***physician*** practitioner);

ii. Items and services provided by assistant surgeons, hospitalists, and intensivists;

iii. Diagnostic services including radiology and laboratory services; and

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

4. Open Negotiation Period

a. A ***nonpreferred provider*** may initiate an open negotiation period with this ***Plan*** regarding ***covered expenses*** described in sections 1., 2., or 3. above. This open negotiation period must be initiated during the thirty (30) business day period beginning on the day the ***nonpreferred provider*** receives

an initial payment or a notice of denial of payment for ***covered expenses*** described in sections 1., 2., or 3. above. To initiate the open negotiation period, the ***nonpreferred provider*** must send notice, consistent with applicable regulations, to this ***Plan*** on a standard form developed by Federal regulators.

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

5. Independent Dispute Resolution

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

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

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

i. Will not be subject to additional ***cost sharing***;

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

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

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

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

6. Notice and Consent Criteria

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

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

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

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

iv. Information about whether pre-certification or other care management limitations may be required in advance of receiving the items or services.

b. The above information must be provided to a ***covered person***:

i. No later than seventy-two (72) hours prior to the date on which the ***covered person*** is furnished the items or services, when the appointment is scheduled at least seventy-two (72) hours prior; or

ii. On the date the appointment is scheduled, in the case where the appointment is scheduled within seventy-two (72) hours prior to the appointment. When the ***covered person*** is provided with the notice and consent on the same date that the items or services are to be furnished, the notice must be provided no later than three (3) hours prior to furnishing the items or services to which the notice and consent requirements apply.

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

7. Continuity of Care

In certain situations, if a ***participating provider*** becomes a ***nonparticipating provider***, and the ***covered person*** is a ***continuing care patient***, this ***Plan*** will provide the ***covered person*** with notice and an opportunity to elect continuing care from such provider. This election will allow the ***covered person*** to continue to receive benefits under this ***Plan*** in accordance with the ***preferred provider cost sharing***, beginning on the date of the notice and continuing for a period ending of the earlier of:

a. Ninety (90) days from the date of the notice; or

b. The date on which the ***covered person*** is no longer a ***continuing care patient*** with respect to such provider.

REFERRALS

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

EXCEPTIONS

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

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

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

3. ***Covered persons*** who do not have access to ***preferred providers*** within fifty (50) miles of their place of residence.

4. Treatment rendered at a ***facility*** of the uniformed services.

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

6. Lactation counseling providers.

MEDICAL EXPENSE BENEFIT

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

COPAY

The ***copay*** is the amount payable by the ***covered person*** for certain services, supplies or treatment. The service and applicable ***copay*** are shown on the *Schedule of Benefits*. The ***covered person*** selects a ***provider*** and pays the applicable ***copay***. The ***Plan*** pays the remaining ***covered expenses*** at the ***negotiated rate*** for ***preferred providers*** or the ***customary and reasonable amount*** for ***nonpreferred providers***. The ***copay*** must be paid each time a treatment or service is rendered.

The ***copay*** will not be applied toward the following:

- The benefit period deductible.

DEDUCTIBLES

Individual Deductible

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

COINSURANCE

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

OUT-OF-POCKET EXPENSE LIMIT

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

Out-of-Pocket Expense Limit Exclusions

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

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

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

MAXIMUM BENEFIT

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

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

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

HOSPITAL/AMBULATORY SURGICAL FACILITY

Covered expenses shall include:

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

2. Miscellaneous ***hospital*** services, supplies, and treatments including, but not limited to:

    a. Admission fees, and other fees assessed by the ***hospital*** for rendering services, supplies and treatments;

    b. Use of operating, treatment or delivery rooms;

    c. Anesthesia, anesthesia supplies and its administration by an employee of the ***hospital***;

    d. Medical and surgical dressings and supplies, casts and splints;

    e. Blood transfusions, including the cost of whole blood, the administration of blood, blood processing and blood derivatives (to the extent blood or blood derivatives are not donated or otherwise replaced);

    f. Drugs and medicines (except drugs not used or consumed in the ***hospital***);

    g. X-ray and diagnostic laboratory procedures and services;

    h. Oxygen and other gas therapy and the administration thereof;

    i. Therapy services.

3. Services, supplies and treatments described above furnished by an ***ambulatory surgical facility***, including follow-up care provided within seventy-two (72) hours of a procedure.

4. Charges for pre-admission testing (x-rays and lab tests) performed within seven (7) days prior to a ***hospital*** admission which are related to the condition which is necessitating the ***confinement***. Such tests shall be payable even if they result in additional medical treatment prior to ***confinement*** or if they show that ***hospital confinement*** is not ***medically necessary***. Such tests shall not be payable if the same tests are performed again after the ***covered person*** has been admitted.

AMBULANCE SERVICES

Covered expenses shall include:

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

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

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

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

EMERGENCY SERVICES/EMERGENCY ROOM SERVICES

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

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

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

URGENT CARE CENTER

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

TELEMEDICINE SERVICES

Covered expenses shall include ***telemedicine services*** for ***medically necessary*** treatment of non-***emergency medical conditions***.

PHYSICIAN SERVICES AND PROFESSIONAL PROVIDER SERVICES

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

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

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

   For related operations or procedures performed through the same incision or in the same operative field, ***covered expenses*** shall include the surgical allowance for the highest paying procedure, plus fifty percent (50%) of the surgical allowance for each additional procedure.

   When two (2) or more unrelated operations or procedures are performed at the same operative session, ***covered expenses*** shall include the surgical allowance for each procedure.

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

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

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

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

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

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

DIAGNOSTIC SERVICES AND SUPPLIES

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

TRANSPLANT

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

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

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

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

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

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

If a ***covered person's*** transplant procedure is not performed as scheduled due to the intended recipient's medical condition or death, benefits will be paid for organ or tissue procurement as described above.

Centers of Medical Excellence (CME) and Blue Distinction Centers for Transplants (BDCT)

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

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

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

PREGNANCY

Covered expenses shall include services, supplies and treatment related to ***pregnancy*** or ***complications of pregnancy*** for a ***covered person***.

The ***Plan*** shall cover services, supplies and treatments for abortions.

Complications from an abortion shall be a ***covered expense*** whether or not the abortion is a ***covered expense***.

BIRTHING CENTER

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

STERILIZATION

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

INFERTILITY SERVICES

Covered expenses shall include expenses for infertility testing for ***employees*** and their ***covered spouse*** or domestic partner.

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

CONTRACEPTIVES

Covered expenses shall include charges for medical procedures or supplies related to contraception, contraceptive devices, contraceptive injections and the surgical implantation and removal of contraceptive devices. FDA approved contraceptive methods shall be considered under the subsection, *Women's Preventive Services*.

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

WELL NEWBORN CARE

The ***Plan*** shall cover well newborn care. ***Covered expenses*** for services, supplies or treatment of the newborn child shall be considered charges of the child and as such, subject to a separate deductible and ***coinsurance*** from the mother.

Such care shall include, but is not limited to:

1. ***Physician*** services

2. ***Hospital*** services

3. Circumcision

ROUTINE PREVENTIVE CARE/WELLNESS BENEFITS

Routine Preventive Care/Wellness Benefits shall include:

1. Evidence-based supplies or services that have in effect a rating of A or B in the current recommendations of the United States Preventive Services Task Force (USPSTF).

2. Annual routine mammograms for women.

3. Colonoscopies, including pre-procedure consultation, bowel preparation kits and pathology exam.

4. Routine immunizations, as recommended by the Advisory Committee on Immunization Practices of the Centers of Disease Control and Prevention for infants and children through age six (6); children and adolescents age seven (7) through eighteen (18) years and adults age nineteen (19) years and older.

5. Evidence-informed Routine Preventive Care and screenings as provided by the Health Resources Services Administration for infants, children, adolescents and adult women, unless included in the USPSTF recommendations.

6. Screening for tobacco use and two (2) tobacco cessation attempts per year and tobacco cessation medications for a ninety (90) day treatment regimen when prescribed by a ***physician.***

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

The ***Plan*** will not provide coverage for the above referenced routine preventive care/wellness services, immunizations, screenings or supplies until the ***Plan*** year that begins on or after one year after the date such recommendation or guideline referenced above is issued.

WOMEN'S PREVENTIVE SERVICES

Covered expenses shall include the following preventive services recommended in guidelines issued by the U.S. Department of Health and Human Services' Health Resources and Services Administration:

1. Annual well-woman office visits to obtain preventive care;

2. Screening for gestational diabetes in a pregnant woman;

3. Human papillomavirus (HPV) DNA testing no more frequently than every three (3) years for a woman age thirty (30) and above;

4. Annual counseling for sexually transmitted infections for a sexually active woman;

5. Annual counseling and screening for human immune deficiency virus for a sexually active woman;

6. FDA approved contraceptive methods, sterilization procedures and patient education and counseling for a woman with reproductive capacity;

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

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

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

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

The ***Plan*** will not provide coverage for the above referenced women's preventive services until the ***Plan*** year that begins on or after one year after the date such recommendation or guideline referenced above is issued.

ROUTINE PROSTATE EXAMINATIONS

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

THERAPY SERVICES

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

Covered expenses shall include:

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

2. Radiation therapy and chemotherapy.

3. Dialysis therapy or treatment.

4. Infusion therapy.

Outpatient therapy services are subject to the ***Essential Health Benefits maximum benefit*** specified on the *Schedule of Benefits*.

While there is no limit on the number of covered visits for Medically Necessary services, additional visits in excess of the stated number of visits require Precertification

HABILITATIVE SERVICES

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

EXTENDED CARE FACILITY

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

If the ***covered person*** is discharged from the ***extended care facility*** and again becomes an ***inpatient*** in such ***facility*** within fourteen (14) days of the original discharge, it is considered one (1) period of ***confinement***.

Covered expenses shall include:

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

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

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

HOME HEALTH CARE

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

1. Part-time or intermittent nursing care by a ***nurse***;

2. Physical, respiratory, occupational or speech therapy;

3. Part-time or intermittent ***home health aide services*** for a ***covered person*** who is receiving covered nursing or therapy services;

4. Medical social service consultations;

5. Nutritional guidance by a registered dietitian and nutritional supplements such as diet substitutes administered intravenously or through hyperalimentation as determined to be ***medically necessary***.

6. Private Duty Nursing services

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

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

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

HOSPICE CARE

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

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

1. The ***covered person*** is terminally ill, and

2. The ***covered person*** has a life expectancy of six (6) months or less.

Covered expenses shall include:

1. ***Confinement*** in a ***hospice*** to include ancillary charges and ***room and board***.

2. Services, supplies and treatment provided by a ***hospice*** to a ***covered person*** in a home setting.

3. ***Physician*** services and/or nursing care by a ***nurse***.

4. Physical therapy, occupational therapy, speech therapy or respiratory therapy.

5. Nutrition services to include nutritional advice by a registered dietitian, and nutritional supplements such as diet substitutes administered intravenously or through hyperalimentation as determined to be ***medically necessary***.

6. Counseling services provided through the ***hospice***.

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

DURABLE MEDICAL EQUIPMENT

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

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

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

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

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

PROSTHESES

The initial purchase of a prosthesis (other than dental) provided for functional reasons when replacing all or part of a missing body part (including contiguous tissue) or to replace all or part of the function of a permanently inoperative or

malfunctioning body organ shall be a ***covered expense***. A charge for the purchase of a prosthesis is considered ***incurred*** on the date the prosthesis is received/delivered. A prosthesis that is received/delivered after the termination date of a ***covered person's*** coverage under the ***Plan*** is not covered. Repair or replacement of a prosthesis which is ***medically necessary*** due to normal use or a physiological change in the patient's condition will be considered a ***covered expense***.

ORTHOTICS

Orthotic devices and appliances (a rigid or semi-rigid supportive device, including custom/molded foot orthotics, which restricts or eliminates motion for a weak or diseased body part), including initial purchase, fitting and repair shall be a ***covered expense***. Orthopedic shoes or corrective shoes, unless they are an integral part of a leg brace, and other supportive devices for the feet shall not be covered.

DENTAL SERVICES

Covered expenses shall include repair of sound natural teeth or surrounding tissue provided it is the result of an ***injury*** provided a continuous course of dental treatment is started within twelve (12) months of the ***injury***. Damage to the teeth as a result of chewing or biting shall not be considered an ***injury*** under this benefit.

Surgical removal of bone or soft tissue impacted wisdom teeth or osseous surgery shall also be considered a ***covered expense***.

Covered expenses shall include charges for oral surgery such as the excision of partially or completely unerupted impacted teeth, excision of the entire tooth, closed or open reduction of fractures or dislocations of the jaw, and other incision or excision procedures performed on the gums and tissues of the mouth when not performed in conjunction with the extraction of teeth.

Facility charges for oral surgery or dental treatment that ordinarily could be performed in the provider's office will be covered only if the ***covered person*** has a concurrent hazardous medical condition that prohibits performing the treatment safely in an office setting.

ORTHOGNATHIC DISORDERS

The ***plan*** covers orthognathic surgery to repair or correct a severe facial deformity or disfigurement that orthodontics alone cannot correct, provided:

- the deformity or disfigurement is accompanied by a documented clinically significant functional impairment, and there is a reasonable expectation that the procedure will result in meaningful functional improvement; or
- the orthognathic surgery is ***medically necessary*** as a result of tumor, trauma, disease; or
- the orthognathic surgery is performed prior to age 19 and is required as a result of severe congenital facial deformity or congenital condition.

Repeat or subsequent orthognathic surgeries for the same condition are covered only when the previous orthognathic surgery met the above requirements, and there is a high probability of significant additional improvement as determined by medical management review.

SPECIAL EQUIPMENT AND SUPPLIES

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

- casts;
- splints;
- braces;

- trusses;
- surgical and orthopedic appliances;
- colostomy and ileostomy bags and supplies required for their use;
- catheters;
- and blood sugar measurement devices;
- allergy serums;
- crutches;
- electronic pacemakers;
- oxygen and the administration thereof;
- respiratory spacers
- peak flow meters
- nebulizers
- the initial pair of eyeglasses or contact lenses due to cataract surgery;
- soft lenses or sclera shells intended for use in the treatment of ***illness*** or ***injury*** of the eye;
- support or compression stockings, when prescribed by a ***physician***;
- surgical dressings and other medical supplies ordered by a ***professional provider*** in connection with medical treatment, but not common first aid supplies.

COSMETIC/RECONSTRUCTIVE SURGERY

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

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

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

GENDER DYSPHORIA

Covered expenses shall include treatment provided by a ***professional provider*** for gender dysphoria, a disorder characterized by the specific diagnostic criteria classified in the current edition of the Diagnostic and Statistical Manual of Mental Disorders published by the American Psychiatric Association. Treatment includes ***medically necessary*** psychotherapy, hormone therapy, prescription drugs and surgery. Cosmetic services, including the following, are not covered:

1. Abdominoplasty;
2. Blepharoplasty;
3. Breast enlargement, including augmentation mammoplasty and breast implants;
4. Body contouring such as lipoplasty or liposuction;
5. Brow lift;
6. Calf implants;
7. Cheek, chin, nose implants;
8. Electrolysis;
9. Injection of fillers or neurotoxins;

10. Face lift, forehead lift or neck tightening;
11. Facial bone remodeling;
12. Hair removal;
13. Hair transplantation;
14. Jaw reduction or jaw contouring;
15. Laryngoplasty;
16. Lip augmentation;
17. Lip reduction;
18. Mastopexy;
19. Pectoral implants for chest masculinization;
20. Removal of redundant skin;
21. Rhinoplasty;
22. Skin resurfacing;
23. Thyroid cartilage reduction;
24. Voice modification surgery;
25. Voice lessons and voice therapy.

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

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

Covered expenses will include eligible charges related to ***medically necessary*** mastectomy.

For a ***covered person*** who elects breast reconstruction in connection with such mastectomy, ***covered expenses*** will include:

1. reconstruction of a surgically removed breast, including nipple and areola reconstruction and repigmentation; and

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

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

MENTAL & NERVOUS DISORDERS

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

Covered expenses shall include:

1. ***Inpatient hospital confinement***;

2. Individual psychotherapy;

3. Group psychotherapy;

4. Psychological testing;

5. Electro-Convulsive therapy (electroshock treatment) or convulsive drug therapy, including anesthesia when administered concurrently with the treatment by the same ***professional provider***.

SUBSTANCE USE DISORDER

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

AUTISM SPECTRUM DISORDERS

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

ROUTINE PATIENT COSTS FOR APPROVED CLINICAL TRIALS

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

1. An investigational item, device or service;

2. An item or service provided solely to satisfy data collection and analysis needs, which are not used in the direct clinical management of the patient; or,

3. A service that is clearly inconsistent with widely accepted and established standards of care for a particular diagnosis.

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

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

1. The referring health care professional is a participating health care ***provider*** and has concluded that the ***covered person's*** participation in such trial would be appropriate; or,

2. The ***covered person*** provides medical and scientific information establishing that the ***covered person's*** participation in such trial would be appropriate.

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

PODIATRY SERVICES

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

CHIROPRACTIC CARE

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

PATIENT EDUCATION

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

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

OUTPATIENT CARDIAC/PULMONARY REHABILITATION PROGRAMS

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

SLEEP DISORDERS

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

MEDICAL EXCLUSIONS

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

1. Charges for the reversal of surgical sterilization procedures.

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

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

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

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

6. Charges for biofeedback therapy.

7. Except as specified herein, charges for services, supplies or treatments which are primarily educational in nature, charges for services for educational or vocational testing or training and work hardening programs regardless of diagnosis or symptoms; charges for self-help training or other forms of non-medical self-care.

8. Charges for marriage, career or legal counseling.

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

10. Charges for routine vision examinations and eye refractions; vision therapy (orthoptics); eyeglasses or contact lenses, except as specified herein; dispensing optician's services.

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

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

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

14. Charges for nonprescription drugs, such as vitamins, cosmetic dietary aids, and nutritional supplements except as provided in, *Routine Preventive Care/Wellness Benefits* in accordance with United States Preventive Services Task Force (USPSTF) recommendations and except as provided in *Medical Expense Benefit, Prescription Drugs*.

15. Any prescription refilled in excess of the number specified by the ***physician*** or any refill dispensed after one (1) year from the ***physician's*** original order. Dispensing limitation: the amount normally prescribed by a ***physician***.

16. Charges for ***outpatient*** prescription drugs, except as specifically indicated in *Medical Expense Benefit, Prescription Drugs*.

17. Charges for treatment, services, supplies, or prescription drugs designed or used to diagnose, treat, alter, impact, or differentiate a ***covered person's*** genetic make-up or genetic predisposition, including but not limited to "genetic therapy".

    "Genetic Therapy" means Genomic medical treatment and/or genetic therapies that are both commercially available as well of those in development, including, but not limited to Kymriah, Yescarta, Luxturna, gene transfer, delivery of nucleic acid into a patient's cells, treatment of genetic disorders, any other autologous and allogenic T-cell immunotherapies, any form of cell therapies, gene therapies, gene regulation, or genomic editing.

18. Charges for prescription drugs that are covered under the *Prescription Drug Program* or for the Prescription Drug.

19. Charges for orthopedic shoes (except when they are an integral part of a leg brace and the cost is included in the orthotist's charge) or shoe inserts.

20. Charges in connection with any illness or injury sustained while taking part or attempting to take part in an illegal act, including but not limited to misdemeanors and felonies; or for any Injury or Illness that arises from or is caused during the commission of any illegal act. It is not necessary that an arrest occur, criminal charges be filed, or, if filed, that a conviction result for the Plan Administrator to determine that an act constitutes an Illegal Act. Plan Administrator has the full discretion to determine whether a particular act constitutes and Illegal Act. Proof beyond a reasonable doubt is not required to be deemed an Illegal Act. This exclusion does not apply if the Injury (a) resulted from being the victim of an act of domestic violence, or (b) resulted from a documented medical condition (including both Physician and mental health conditions).

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

22. Charges ***incurred*** as a result of, or in connection with, any procedure or treatment excluded by the ***Plan*** which has resulted in medical complications.

23. Charges for services, supplies or treatment primarily for weight reduction or treatment of obesity, including, but not limited to: exercise programs or use of exercise equipment; special diets or diet supplements; appetite suppressants; Nutri/System, Weight Watchers or similar programs; and ***hospital confinements*** for weight reduction programs, except as specifically provided herein or as required by the United States Preventive Services Task Force (USPSTF) A & B recommendations.

24. Charges for surgical weight reduction procedures and all related charges, even if resulting from morbid obesity.

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

26. Charges for examination to determine hearing loss or the fitting, purchase, repair or replacement of a hearing aid; or for a cochlear implant, bone-anchored hearing aid, auditory brainstem implant, or any other surgically implantable device to correct hearing loss, or surgery to implant such a device.

27. Charges for routine or periodic physical examinations, such as annual physical, screening examination, employment physical, or any related charges, such as premarital lab work, mammogram, and other care not associated with treatment or diagnosis of an ***illness*** or ***injury***, except as specified herein.

28. Charges related to acupuncture treatment.

29. Charges for treatment of temporomandibular joint dysfunction (TMJ) and related conditions by any method.

30. Charges for ***custodial care***, domiciliary care or rest cures.

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

32. Charges for wigs, artificial hairpieces, artificial hair transplants, or any drug - prescription or otherwise -used to eliminate baldness or stimulate hair growth.

33. Charges for expenses related to hypnosis.

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

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

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

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

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

39. Charges for massage therapy, sex therapy, diversional therapy or recreational therapy.

40. Charges for procurement and storage of one's own blood, unless ***incurred*** within three (3) months prior to a scheduled surgery.

41. Charges for holistic medicines or providers of naturopathy.

42. Charges for or related to the following types of treatment:

    a. primal therapy;

    b. rolfing;

    c. psychodrama;

    d. megavitamin therapy;

    e. visual perceptual training.

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

44. Charges for exercise programs for treatment of any condition, except as specified herein.

45. Charges for immunizations required for travel.

46. Charges for drugs, devices, supplies, treatments, procedures or services that are considered ***experimental/investigational*** by the ***Plan***. The ***Plan*** will consider a drug, device, supply, treatment, procedure or service to be "***experimental***" or "***investigational***":

a. if, in the case of a drug, device or supply, the drug, device or supply cannot be lawfully marketed without approval of the U.S. Food and Drug Administration and approval for marketing has not been given at the time the drug, device or supply is furnished; or

b. if the drug, device, supply, treatment, procedure or service, or the patient's informed consent document utilized with respect to the drug, device, supply, treatment, procedure or service was reviewed and approved by the treating ***facility's*** institutional review board or other body serving a similar function, or if federal law requires such review or approval; or

c. if the ***plan sponsor*** (or its designee) determines in its sole discretion that the drug, device, supply, treatment, procedure or service is the subject of on-going Phase I or Phase II clinical trials; is the research, ***experimental*** study or ***investigational*** arm of on-going Phase III clinical trials, or is otherwise under study to determine maximum tolerated dose, toxicity, safety or efficacy; or

d. if the ***plan sponsor*** (or its designee) determines in its sole discretion based on documentation in one of the standard reference compendia or in substantially accepted peer-reviewed medical literature that the prevailing opinion among experts regarding the drug, device, supply, treatment, procedure or service is that further studies or clinical trials are necessary to determine its maximum tolerated dose, toxicity, safety or efficacy.

47. Charges for private duty nursing, except as provided in the "Home Health Services.

48. Charges for any services, supplies or treatment not specifically provided herein.

PRESCRIPTION DRUG PROGRAM

PHARMACY OPTION

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

PHARMACY OPTION COPAY

The ***copay*** is applied to each covered pharmacy drug charge and is shown on the *Schedule of Benefits*. Any one prescription is limited to a thirty one (31) day supply. Maintenance drugs (drugs which are prescribed for long-term usage) may be dispensed in a ninety (90) day supply.

If the ***covered person*** purchases a brand drug when the ***physician*** has indicated a ***generic drug*** can be dispensed, the ***covered person*** will be required to pay the difference between the ***generic drug*** and brand name requested, plus the brand ***copay***. The ***covered person*** may appeal the ***adverse benefit determination***. Refer to the subsection, *Appealing an Adverse Benefit Determination on a Post-Service Prescription Drug Claim,* for detailed information on how to initiate the appeal process. This difference between the cost of the brand name drug and the ***generic drug*** shall not accumulate toward the out-of-pocket limit. When the out-of-pocket expense limit is reached, prescription drugs will be paid at 100%.

MAIL ORDER OPTION

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

MAIL ORDER OPTION COPAY

The ***copay*** is applied to each covered mail order prescription charge and is shown on the *Schedule of Benefits*. Any one prescription is limited to a ninety (90) day supply.

If the ***covered person*** purchases a brand drug when the ***physician*** has indicated a ***generic drug*** can be dispensed, the ***covered person*** will be required to pay the difference between the ***generic drug*** and brand name requested, plus the brand ***copay***. The ***covered person*** may appeal the ***adverse benefit determination***. Refer to the subsection, *Appealing an Adverse Benefit Determination on a Post-Service Prescription Drug Claim,* for detailed information on how to initiate the appeal process. This difference between the cost of the brand name drug and the ***generic drug*** shall not accumulate toward the out-of-pocket limit. When the out-of-pocket expense limit is reached, prescription drugs will be paid at 100%.

SPECIALTY PHARMACY PROGRAM

Employees and their covered ***dependents*** who take specialty biotech injectables and oral medications must enroll in the Specialty Pharmacy Program through Caremark to receive continued coverage for their specialty drugs. Specialty drugs include select injectable and oral medications for the following conditions:

1. Allergic Asthma
2. Crohn's disease
3. Enzyme replacement for Lysosomal Storage Disorder
4. Gaucher disease
5. Hematopoietics
6. Hemophilia, Von Willebrand disease and related bleeding disorders
7. Hepatitis C
8. Hormonal therapies
9. Immune deficiencies
10. Multiple Sclerosis
11. Oncology
12. Osteoarthritis
13. Psoriasis
14. Pulmonary Arterial Hypertension
15. Pulmonary disease
16. Renal disease
17. Respiratory Syncytial Virus
18. Rheumatoid Arthritis
19. Other Disorders

To take advantage of this program, the ***covered person*** will need to transfer the related prescription to Caremark. To transfer a prescription, call 1-800-237-2767. A representative of Caremark will call the ***covered person's physician*** and take care of the appropriate paperwork.

The medication will be shipped to a location of the ***covered person's*** choice from Caremark's mail service pharmacy within twenty-four (24) to seventy-two (72) hours.

Specialty drugs may be subject to prior authorization. For detailed information on the prior authorization process, refer to the subsection, *Prior Authorization Program* below.

For details regarding the applicable ***copay*** and supply limitations, please refer to the *Schedule of Benefits, Prescription Drug Program, Specialty Pharmacy Program*.

PRIOR AUTHORIZATION PROGRAM

CVS/Caremark has been retained by the ***plan administrator*** to provide prior authorization services for a particular set of drugs, which may include specialty drugs or compound drugs. The ***Plan*** has approved a predetermined set of criteria to be applied to this prior authorization process. The correct telephone number to call, based on the adjudication platform being used to adjudicate the ***covered person's*** drug claim, will be provided in the drug claim response messaging sent to the pharmacy when the drug claim is denied for prior authorization required. If the pharmacy does not contact the ***covered person's physician*** directly, the ***covered person*** should obtain this telephone number from the pharmacy and provide it to their ***physician*** and instruct the ***physician*** to call the CVS/Caremark Prior Authorization Department. CVS/Caremark will determine whether or not the drug will be a ***covered expense***, based upon the predetermined set of criteria and the information supplied by the ***physician***. CVS/Caremark will notify the ***physician*** who submitted the request for prior authorization that the drug is or is not covered by the ***Plan*** within two (2) days of its receipt of the request (or twenty-four (24) hours if an ***urgent care*** claim). The request for prior authorization is considered to be a pre-service claim as described in the U.S. Department of Labor Regulations 2560.503-1 (issued November 21, 2000).

If the ***covered person's physician*** fails to follow the proper procedure for obtaining prior authorization, CVS/Caremark will notify the ***physician*** (orally, or in writing upon request) of the failure and the proper procedures as soon as possible, but in no event later than five (5) days (or 24 hours if an ***urgent care*** claim**)** after receiving a communication that fails to follow the proper procedure. Notwithstanding the foregoing, such notification by CVS/Caremark will occur only if CVS/Caremark has received a communication from the ***physician*** that at least specifies (i) the ***covered person*** (ii) the ***covered person's*** specific medical condition or symptom, and (iii) a specific drug for which approval is requested.

COVERED PRESCRIPTION DRUGS

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

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

3. Insulin, insulin needles and syringes and diabetic supplies.

4. Oral contraceptives, regardless of the reason prescribed.

5. Contraceptive devices.

6. Routine preventive drugs as required by the ***Affordable Care Act***.

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

LIMITS TO THIS BENEFIT

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

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

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

EXPENSES NOT COVERED

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

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

3. A drug or medicine labeled: "Caution - limited by federal law to ***investigational*** use."

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

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

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

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

8. A charge for prescription drugs which may be properly received without charge under local, state or federal programs.

9. A charge for hypodermic syringes and/or needles.

10. A charge for prescription drugs for smoking cessation purposes, including smoking deterrent patches , except as required by the United States Preventive Services Task Force (USPSTF) A & B recommendations.

11. A charge for infertility medication.

12. A charge for minerals.

13. A charge for fluoride supplements, except as required by the United States Preventive Services Task Force (USPSTF) A & B recommendations.

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

15. A charge for weight loss drugs.

16. A charge for Hematinics.

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

Any prescription drug covered under the *Prescription Drug Program* will not be covered under the *Medical Expense Benefit*, except as specified in *Medical Expense Benefit, Prescription Drugs*.

NOTICE OF AUTHORIZED REPRESENTATIVE

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

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

The "***named fiduciary***" for purposes of an appeal of an ***adverse benefit determination*** on a Post-Service Prescription Drug Claim, as described in U. S. Department of Labor Regulations 2560.503-1 (issued November 21, 2000), is the ***pharmacy benefit manager***.

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

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

1. The ***covered person*** has the right to submit documents, information and comments and to present evidence and testimony.
2. The ***covered person*** has the right to access, free of charge, ***relevant information*** to the claim for benefits.
3. Before a final ***adverse benefit determination*** on appeal is rendered, the ***covered person*** will be provided, free of charge, with any new or additional rationale or evidence considered, relied upon, or generated by the ***Plan*** in connection with the claim. Such information will be provided as soon as possible and sufficiently in advance of the notice of ***final internal adverse benefit determination***. However, there could be circumstances where the new or additional evidence or rationale could be received so late that it would be impossible to provide to provide the ***covered person*** in time to have a reasonable opportunity to respond. In these circtumstances, the period for providing notice of final determination on appeal will be tolled until the earliest of the following dates:
   a. The date the ***covered person*** responds to the new or additional rationale or evidence; or
   b. Three (3) weeks from the date the new or additional rationale or evidence was mailed to the ***covered person***.

4. The review takes into account all information submitted by the ***covered person***, even if it was not considered in the initial benefit determination.
5. The review by the ***named fiduciary*** will not afford deference to the original ***adverse benefit determination***.
6. The ***named fiduciary*** will not be:
   a. The individual who originally denied the claim, nor
   b. Subordinate to the individual who originally denied the claim.
7. If the original ***adverse benefit determination*** was, in whole or in part, based on medical judgment:
   a. The ***named fiduciary*** will consult with a ***professional provider*** who has appropriate training and experience in the field involving the medical judgment; and
   b. The ***professional provider*** utilized by the ***named fiduciary*** will be neither:
      (i.) An individual who was consulted in connection with the original ***adverse benefit determination***, nor
      (ii.) A subordinate of any other ***professional provider*** who was consulted in connection with the original ***adverse benefit determination***.
8. If requested, the ***named fiduciary*** will identify the medical or vocational expert(s) who gave advice in connection with the original ***adverse benefit determination***, whether or not the advice was relied upon.

NOTICE OF BENEFIT DETERMINATION ON A POST-SERVICE PRESCRIPTION DRUG CLAIM APPEAL

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

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

1. The specific reasons for the ***adverse benefit determination***.
2. Reference to specific ***Plan*** provisions on which the ***adverse benefit determination*** is based.
3. A statement that the ***covered person*** has the right to access, free of charge, ***relevant information*** to the claim for benefits.
4. A statement of the ***covered person's*** right to request an external review and a description of the process for requesting such a review.
5. A statement that if the ***covered person's*** appeal is denied, the ***covered person*** has the right to bring a civil action under section 502 (a) of the Employee Retirement Income Security Act of 1974.
6. If an internal rule, guideline, protocol or other similar criterion was relied upon, the Notice of Appeal Decision will contain either:
   a. A copy of that criterion, or
   b. A statement that such criterion was relied upon and will be supplied free of charge, upon request.
7. If the ***adverse benefit determination*** was based on ***medical necessity***, ***experimental/investigational*** treatment or similar exclusion or limit, the ***plan administrator*** (or its designee) will supply either:
   a. An explanation of the scientific or clinical judgment, applying the terms of the ***Plan*** to the claimant's medical circumstances, or
   b. A statement that such explanation will be supplied free of charge, upon request.

EXTERNAL APPEAL

The "***named fiduciary***" for purposes of an external appeal of an ***adverse benefit determination*** on a Pre-Service or Post-Service claim, as described in U. S. Department of Labor Regulations 2560.503-1, is the ***claims processor***.

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

1. ***Medical necessity***;

2. Appropriateness;

3. ***Experimental*** or ***investigational*** treatment;

4. Health care setting;

5. Level of care; and

6. Effectiveness of a ***covered expense***.

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

RIGHT TO EXTERNAL APPEAL

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

1. Medical judgment; or

2. Rescission of coverage under this ***Plan***.

NOTICE OF RIGHT TO EXTERNAL APPEAL

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

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

1. The reason for ineligibility and the availability of the Employee Benefits Security Administration at 1-866-444-3272, if the request is complete but not eligible for external review.

2. If the request is incomplete, the information or materials necessary to make the request complete and the opportunity for the ***covered person*** to perfect the external review request by the later of the following:

    a. The four (4) month filing period; or

    b. Within the forty-eight (48) hour time period following the ***covered person's*** receipt of notification.

INDEPENDENT REVIEW ORGANIZATION

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

NOTICE OF EXTERNAL REVIEW DETERMINATION

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

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

EXPEDITED EXTERNAL REVIEW

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

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

A ***final internal adverse benefit determination*** involving a medical condition for which the timeframe for completion of a standard external review would seriously jeopardize the health or life of the ***covered person*** or the ***covered person's*** ability to regain maximum function or if the ***final internal adverse benefit determination*** involves any of the following:

a. An admission,

b. Availability of care,

c. Continued stay, or

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

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

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

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

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

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

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

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

PLAN EXCLUSIONS

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

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

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

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

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

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

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

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

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

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

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

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

12. Charges for services, supplies or treatment rendered by any individual who is a ***close relative*** of the ***covered person*** or who resides in the same household as the ***covered person***.

13. Charges for services, supplies or treatment rendered by ***physicians*** or ***professional providers*** beyond the scope of their license; for any treatment, ***confinement*** or service which is not recommended by or performed by an appropriate ***professional provider***.

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

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

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

17. If the primary plan has a restricted list of healthcare providers and the ***covered person*** chooses not to use a provider from the primary plan's restricted list, this ***Plan*** will not pay for any charges disallowed by the primary plan due to the use of such provider, if shown on the primary carrier's explanation of benefits.

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

ELIGIBILITY, ENROLLMENT AND EFFECTIVE DATE

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

EMPLOYEE ELIGIBILITY

All ***full-time employees*** regularly scheduled to work at least thirty (30) hours per work week shall be eligible to enroll for coverage under the ***Plan***. This does not include ***employees*** working less than an average of thirty (30) hours per work week over the ***employer's measurement period***.

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

EMPLOYEE ENROLLMENT

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

EMPLOYEE(S) EFFECTIVE DATE

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

DEPENDENT(S) ELIGIBILITY

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

1. The term "spouse" means the spouse of the ***employee*** under a legally valid existing marriage, provided that there exists no applicable law or laws, as determined by the ***plan administrator*** that would prohibit or otherwise adversely affect the administration of the ***Plan*** in accordance with such definition.

2. The term "domestic partner" means that the ***dependent***:

    a. Is the opposite or same sex as the ***employee***; and

    b. Is at least eighteen (18) years of age and competent to enter into a contract; and

    c. Is not legally married or the domestic partner of another individual; and

    d. Is not related to the ***employee*** by blood closer that which would bar marriage in the State of CA; and

    e. Has allowed at least six (6) months to pass since the termination of any previous same-sex domestic partnership; and

f. Has lived together as a couple with the ***employee*** in a shared residence for at least six (6) consecutive months; and

g. Partnership must be registered by your City, County Clerk or State.

3. The ***employee's*** natural child, stepchild, legally adopted child, child ***placed for adoption***, ***foster child***, and a child for whom the ***employee*** or covered spouse or domestic partner has been appointed legal guardian, through the end of the month in which the child reaches twenty-six (26) years of age.

4. An eligible child shall also include any other child of an ***employee*** or their spouse or domestic partner who is recognized in a Qualified Medical Child Support Order (QMCSO) or National Medical Support Notice (NMSN) which has been issued by any court judgment, decree, or order as being entitled to enrollment for coverage under the ***Plan***. Such child shall be referred to as an ***alternate recipient***. ***Alternate recipients*** are eligible for coverage only if the ***employee*** is also covered under the ***Plan***. An application for enrollment must be submitted to the ***employer*** for coverage under the ***Plan***. The ***employer/plan administrator*** shall establish written procedures for determining whether a medical child support order is a QMCSO or NMSN and for administering the provision of benefits under the ***Plan*** pursuant to a valid QMCSO or NMSN. Within a reasonable period after receipt of a medical child support order, the ***employer/plan administrator*** shall determine whether such order is a QMCSO, as defined in Section 609 of ERISA, or a NMSN, as defined in 42 U.S.C.A §666 of the Child Support Performance and Incentive Act of 1998.

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

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

   Proof of incapacitation must be provided within thirty-one (31) days of the child's loss of eligibility and thereafter as requested by the ***employer*** or ***claims processor***, but not more than once every two (2) years. Eligibility may not be continued beyond the earliest of the following:

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

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

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

DEPENDENT ENROLLMENT

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

DEPENDENT(S) EFFECTIVE DATE

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

1. The date the ***employee's*** coverage becomes effective.

2. The date the ***dependent*** is acquired, provided the ***employee*** has applied for ***dependent*** coverage within thirty (30) days of the date acquired.

3. Newborn children shall be covered from birth, provided the ***employee*** has applied for ***dependent*** coverage within thirty (30) days of birth.

4. Coverage for a newly adopted or to be adopted child shall be effective on the date the child is ***placed for adoption***, provided the ***employee*** has applied for ***dependent*** coverage within thirty (30) days of the date the child is ***placed for adoption***.

SPECIAL ENROLLMENT PERIOD (OTHER COVERAGE)

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

1. Termination of the other coverage (including exhaustion of COBRA benefits).

2. Cessation of employer contributions toward the other coverage.

3. Legal separation or divorce.

4. Termination of other employment or reduction in number of hours of other employment.

5. Death of ***dependent,*** spouse or domestic partner.

6. Cessation of other coverage because ***employee*** or ***dependent*** no longer resides or works in the service area and no other benefit package is available to the individual.

7. Cessation of ***dependent*** status under other coverage and ***dependent*** is otherwise eligible under ***employee's Plan***.

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

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

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

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

The ***effective date*** of coverage as the result of a special enrollment shall be the first day of the first calendar month following the special enrollment event.

SPECIAL ENROLLMENT PERIOD (DEPENDENT ACQUISITION)

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

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

- Marriage or domestic partnership
- birth of a ***dependent*** child
- adoption or ***placement for adoption*** of a ***dependent*** child
- legal guardianship of a ***dependent*** child
- a ***foster child*** being placed with the ***employee***

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

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

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

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

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

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

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

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

OPEN ENROLLMENT

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

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

The ***effective date*** of coverage as the result of an open enrollment period will be the following January 1st.

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

1. Change in family status. A change in family status shall include only:
    a. Change in ***employee's*** legal marital or domestic partnership status ;
    b. Change in number of ***dependents***;
    c. Termination or commencement of employment by the ***employee***, spouse, domestic partner or ***dependent***;
    d. ***Dependent*** satisfies (or ceases to satisfy) ***dependent*** eligibility requirements;
    e. Change in residence or worksite of ***employee***, spouse, domestic partner or ***dependent***.
2. Significant change in the cost of coverage under the ***employer's*** group medical plan.
3. Cessation of required contributions.
4. Taking or returning from a ***leave of absence*** under the Family and Medical Leave Act of 1993.
5. Significant change in the health coverage of the ***employee***, spouse or domestic partner attributable to the spouse's or domestic partner‘s employment.
6. A Special Enrollment Period as mandated by the Health Insurance Portability and Accountability Act of 1996.
7. A court order, judgment or decree.
8. Entitlement to ***Medicare*** or Medicaid, or enrollment in a state child health insurance program (CHIP).
9. A COBRA qualifying event.

TERMINATION OF COVERAGE

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

TERMINATION OF EMPLOYEE COVERAGE

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

TERMINATION OF DEPENDENT(S) COVERAGE

1. The date the ***employer*** terminates the ***Plan*** and offers no other group health plan.
2. The date the ***employee's*** coverage terminates.
3. The last day of the month such person ceases to meet the eligibility requirements of the ***Plan***.
4. The date the ***employee*** ceases to make any required contributions on the ***dependent's*** behalf.
5. The date the ***employee's dependent*** spouse or domestic partner becomes a full-time, active duty member of the armed forces of any country.
6. The date the ***Plan*** discontinues ***dependent*** coverage for any and all ***dependents***.
7. The date the ***employee's dependent*** spouse or domestic partner becomes eligible as an ***employee***.

LEAVE OF ABSENCE

Eligible Leave

Coverage may be continued for a limited time, contingent upon payment of any required contributions for Employees and/or Dependents, when the Employee is on an authorized Leave of Absence from the Employer. For additional information on Wente Family Estate's leave policy contact the Human Resources Department.

FAMILY AND MEDICAL LEAVE ACT (FMLA)

Eligible Leave

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

Contributions

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

Reinstatement

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

Repayment Requirement

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

EMPLOYEE REINSTATEMENT

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

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

2. Rehire or return to active service must occur within six (6) months of the last day worked.

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

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

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

An ***employee*** who returns to work more than six (6) months following an approved ***leave of absence***, ***layoff***, or termination of employment will be considered a new ***employee*** for purposes of eligibility and will be subject to all eligibility requirements, including all requirements relating to the ***effective date*** of coverage.

CONTINUATION OF COVERAGE

In order to comply with federal regulations, the ***Plan*** includes a continuation of coverage option for certain individuals whose coverage would otherwise terminate. The following is intended to comply with the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA), as amended. This continuation of coverage may be commonly referred to as "COBRA coverage" or "continuation coverage."

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

QUALIFYING EVENTS

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

1. Death of the ***employee***.

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

3. Divorce or legal separation from the ***employee***.

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

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

NOTIFICATION REQUIREMENTS

1. When eligibility for continuation of coverage results from a spouse or domestic partner being divorced or legally separated from a covered ***employee***, or a child's loss of ***dependent*** status, the ***employee*** or ***dependent*** must submit a completed Qualifying Event Notification form to the ***plan administrator*** (or its designee) within sixty (60) days of the latest of:

    a. The date of the event;

    b. The date on which coverage under the ***Plan*** is or would be lost as a result of that event; or

    c. The date on which the ***employee*** or ***dependent*** is furnished with a copy of this Plan Document and Summary Plan Description.

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

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

2. When eligibility for continuation of coverage results from any qualifying event under the ***Plan*** other than the ones described in Paragraph 1 above, the ***employer*** must notify the ***plan administrator*** (or its designee) not later than thirty (30) days after the date on which the ***employee*** or ***dependent*** loses coverage under the ***Plan*** due to the qualifying event. Within fourteen (14) days of the receipt of the notice of the qualifying event, the ***plan administrator*** (or its designee) will furnish the Election Notice to the ***employee*** or ***dependent***.

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

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

   a. The date coverage under the ***Plan*** would otherwise end; or

   b. The date the person receives the Election Notice from the ***plan administrator*** (or its designee).

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

COST OF COVERAGE

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

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

WHEN CONTINUATION COVERAGE BEGINS

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

FAMILY MEMBERS ACQUIRED DURING CONTINUATION

A spouse, domestic partner or ***dependent*** child newly acquired during continuation coverage is eligible to be enrolled as a ***dependent***. The standard enrollment provision of the ***Plan*** applies to enrollees during continuation coverage. A ***dependent*** acquired and enrolled after the original qualifying event, other than a child born to or ***placed for adoption***

with a covered ***employee*** during a period of COBRA continuation coverage, is not eligible for a separate continuation if a subsequent event results in the person's loss of coverage.

EXTENSION OF CONTINUATION COVERAGE

1. In the event any of the following events occur during the period of continuation coverage resulting from an 18-Month Qualifying Event, it is possible for a ***dependent's*** continuation coverage to be extended:

   a. Death of the ***employee***.

   b. Divorce or legal separation from the ***employee***.

   c. The child's loss of ***dependent*** status.

   Written notice of such event must be provided by submitting a completed Additional Extension Event Notification form to the ***plan administrator*** (or its designee) within sixty (60) days of the latest of:

   (i.) The date of that event;

   (ii.) The date on which coverage under the ***Plan*** would be lost as a result of that event if the first qualifying event had not occurred; or

   (iii.) The date on which the ***employee*** or ***dependent*** is furnished with a copy of the Plan Document and Summary Plan Description.

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

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

2. A person who loses coverage on account of an 18-Month Qualifying Event may extend the maximum period of continuation coverage from eighteen (18) months to up to twenty-nine (29) months in the event both of the following occur:

   a. That person (or another person who is entitled to continuation coverage on account of the same 18-Month Qualifying Event) is determined by the Social Security Administration, under Title II or Title XVI of the Social Security Act, to have been disabled before the sixtieth (60^{th}) day of continuation coverage; and

   b. The disability status, as determined by the Social Security Administration, lasts at least until the end of the initial eighteen (18) month period of continuation coverage.

   The disabled person (or his representative) must submit written proof of the Social Security Administration's disability determination to the ***plan administrator*** (or its designee) within the initial eighteen (18) month period of continuation coverage and no later than sixty (60) days after the latest of:

   (i.) The date of the disability determination by the Social Security Administration;

   (ii.) The date of the 18-Month Qualifying Event;

(iii.) The date on which the person loses (or would lose) coverage under the ***Plan*** as a result of the 18-Month Qualifying Event; or

(iv.) The date on which the person is furnished with a copy of the Plan Document and Summary Plan Description.

Should the disabled person fail to notify the ***plan administrator*** (or its designee) in writing within the time frame described above, the disabled person (and others entitled to disability extension on account of that person) will then be entitled to whatever period of continuation he or they would otherwise be entitled to, if any. The ***Plan*** may require that the individual pay one hundred and fifty percent (150%) of the cost of continuation coverage during the additional eleven (11) months of continuation coverage. In the event the Social Security Administration makes a final determination that the individual is no longer disabled, the individual must provide notice of that final determination no later than thirty (30) days after the later of:

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

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

END OF CONTINUATION

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

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

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

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

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

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

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

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

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

SPECIAL RULES REGARDING NOTICES

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

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

3. As to an Election Notice, Non-Eligibility Notice or Early Termination Notice:

    a. A single notice addressed to both the ***employee*** and the spouse or domestic partner will be sufficient as to both individuals if, on the basis of the most recent information available to the ***Plan***, the spouse or domestic partner resides at the same location as the ***employee***; and

    b. A single notice addressed to the ***employee,*** spouse, or the domestic partner will be sufficient as to each ***dependent*** child of the ***employee*** if, on the basis of the most recent information available to the ***Plan***, the ***dependent*** child resides at the same location as the individual to whom such notice is provided.

MILITARY MOBILIZATION

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

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

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

1. Twenty-four (24) months beginning on the day that the leave commences, or

2. A period beginning on the day that the leave began and ending on the day after the ***employee*** fails to return to employment within the time allowed.

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

PLAN CONTACT INFORMATION

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

ADDRESS CHANGES

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

CLAIM FILING PROCEDURE

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

POST-SERVICE CLAIM PROCEDURE

FILING A CLAIM

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

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

2. All claims submitted for benefits must contain all of the following:

   a. Name of patient.
   b. Patient's date of birth.
   c. Name of ***employee***.
   d. Address of ***employee***.
   e. Name of ***employer*** and group number.
   f. Name, address and tax identification number of provider.
   g. ***Employee*** Trustmark Health Benefits, Inc. Member Identification Number.
   h. Date of service.
   i. Diagnosis and diagnosis code. (applies to medical claims ONLY)
   j. Description of service and procedure number.
   k. Charge for service.
   l. The nature of the ***accident***, ***injury*** or ***illness*** being treated.

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

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

NOTICE OF AUTHORIZED REPRESENTATIVE

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

NOTICE OF CLAIM

A claim for benefits should be submitted to the ***claims processor*** within ninety (90) calendar days after the occurrence or commencement of any services by the ***Plan***, or as soon thereafter as reasonably possible.

Failure to file a claim within the time provided shall not invalidate or reduce a claim for benefits if: (1) it was not reasonably possible to file a claim within that time; and (2) that such claim was furnished as soon as possible, but no later than twelve (12) months after the loss occurs or commences unless the claimant is legally incapacitated.

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

TIME FRAME FOR BENEFIT DETERMINATION

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

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

NOTICE OF ADVERSE BENEFIT DETERMINATION

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

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

1. Information sufficient to identify the claim involved.
2. The specific reasons for the ***adverse benefit determination***, to include:
    a. The denial code and its specific meaning, and
    b. A description of the ***Plan's*** standards, if any, used when denying the claim.
3. Reference to the ***Plan*** provisions on which the ***adverse benefit determination*** is based.
4. A description of any additional material or information needed and an explanation of why such material or information is necessary.
5. A description of the ***Plan's*** claim appeal procedure and applicable time limits.
6. A statement that if the ***covered person's*** appeal (Refer to *Appealing an Adverse Benefit Determination on a Post-Service Claim* below) is denied, the ***covered person*** has the right to bring a civil action under section 502 (a) of the Employee Retirement Income Security Act of 1974.
7. If an internal rule, guideline, protocol or other similar criterion was relied upon, the Notice of Adverse Benefit Determination will contain either:
    a. A copy of that criterion, or
    b. A statement that such criterion was relied upon and will be supplied free of charge, upon request.
8. If the ***adverse benefit determination*** was based on ***medical necessity***, ***experimental/investigational*** treatment or similar exclusion or limit, the ***plan administrator*** (or its designee) will supply either:
    a. An explanation of the scientific or clinical judgment, applying the terms of the ***Plan*** to the ***covered person's*** medical circumstances, or
    b. A statement that such explanation will be supplied free of charge, upon request.

APPEALING AN ADVERSE BENEFIT DETERMINATION ON A POST-SERVICE CLAIM

The "***named fiduciary***" for purposes of an appeal of an ***adverse benefit determination*** on a Post-Service claim, as described in U. S. Department of Labor Regulations 2560.503-1 (issued November 21, 2000), is the ***claims processor***

A ***covered person***, or the ***covered person's*** authorized representative, may request a review of an ***adverse benefit determination*** on a Post-Service claim by making written request to the ***named fiduciary*** within one hundred eighty

(180) calendar days from receipt of notification of the ***adverse benefit determination*** and stating the reasons the ***covered person*** feels the claim should not have been denied.

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

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

NOTICE OF BENEFIT DETERMINATION ON APPEAL

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

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

1. The specific reasons for the ***adverse benefit determination***.
2. Reference to specific ***Plan*** provisions on which the ***adverse benefit determination*** is based.
3. A statement that the ***covered person*** has the right to access, free of charge, ***relevant information*** to the claim for benefits.
4. A statement of the ***covered person's*** right to request an external review and a description of the process for requesting such a review.
5. A statement that if the ***covered person's*** appeal is denied, the ***covered person*** has the right to bring a civil action under section 502 (a) of the Employee Retirement Income Security Act of 1974.
6. If an internal rule, guideline, protocol or other similar criterion was relied upon, the Notice of Appeal Decision will contain either:
    a. A copy of that criterion, or
    b. A statement that such criterion was relied upon and will be supplied free of charge, upon request.
7. If the ***adverse benefit determination*** was based on ***medical necessity***, ***experimental/investigational*** treatment or similar exclusion or limit, the ***plan administrator*** (or its designee) will supply either:

a. An explanation of the scientific or clinical judgment, applying the terms of the ***Plan*** to the claimant's medical circumstances, or
b. A statement that such explanation will be supplied free of charge, upon request.

FOREIGN CLAIMS

In the event a ***covered person*** incurs a ***covered expense*** in a foreign country, the ***covered person*** shall be responsible for providing the following information to the ***claims processor*** before payment of any benefits due are payable:

1. The claim form, provider invoice and any documentation required to process the claim must be submitted in the English language.

2. The charges for services must be converted into U.S. dollars.

3. A current published conversion chart, validating the conversion from the foreign country's currency into U.S. dollars, must be submitted with the claim.

PRE-SERVICE CLAIM PROCEDURE

HEALTH CARE MANAGEMENT

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

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

UTILIZATION REVIEW PROGRAM

Benefits are provided only for ***medically necessary*** and appropriate services as determined by the ***Health Care Management Organization***. Utilization Review is designed to work together with the ***covered person*** and their provider to help members receive ***medically necessary*** and appropriate medical care and avoid unexpected out-of-pocket expense.

No benefits are payable, however, unless the ***covered person's*** coverage is in force at the time services are rendered, and the payment of benefits is subject to all the terms and requirements of this ***Plan***.

Important: The Utilization Review Program requirements described in this section do not apply when coverage under this ***Plan*** is secondary to another plan providing benefits for the ***covered person***.

The Utilization Review Program evaluates the ***medical necessity*** and appropriateness of care and the setting in which care is provided. The ***covered person*** and their ***physician*** are advised if the ***Health Care Management Organization*** has determined that services can be safely provided in an ***outpatient*** setting, or if an ***inpatient*** stay is appropriate. Services that are ***medically necessary*** and appropriate are certified by the ***Health Care Management Organization*** and monitored so that the ***covered person*** knows when it is no longer ***medically necessary*** and appropriate to continue those services.

This ***Plan*** includes the processes of pre-service, care coordination, and retrospective reviews to determine when services should be covered by the ***Plan***. Their purpose is to promote the delivery of cost-effective medical care by reviewing the use of procedures and, where appropriate, the setting or place of service where care is provided. This ***Plan*** requires that ***covered expenses*** and the setting in which such ***covered expenses*** are provided be ***medically necessary*** and appropriate for benefits to be provided.

Certain services require pre-service review of benefits in order for benefits to be provided. ***Preferred providers*** will initiate the review on the ***covered person's*** behalf. A ***nonpreferred provider*** may or may not initiate the review for the ***covered person***. In both cases, it is the ***covered person's*** responsibility to initiate the process and ask their ***physician*** to request pre-service review. The ***covered person*** may also call the ***Health Care Management Organization*** directly. Pre-service review criteria are based on multiple sources including the ***Health Care Management Organization's*** medical policy, clinical guidelines, and pharmacy and therapeutics guidelines. The ***Health Care Management Organization*** may determine that a service that was initially prescribed or requested is not ***medically necessary*** if the ***covered person*** has not previously tried alternative treatments that are more cost effective.

It is the ***covered person's*** responsibility to obtain pre-certification when required, as noted below in the *Utilization Review Requirements and Effect on Benefits* subsection. ***Covered persons*** should read the information that follows and can visit www.anthem.com or call the toll-free number printed on their identification card for pre-service review if they have any questions about which services require pre-service review.

It is also the ***covered person's*** responsibility to see that their ***physician*** starts the utilization review process before scheduling any service subject to the Utilization Review Program. If the ***covered person*** receives any such service,

and does not follow the procedures set forth in this section, benefits will be reduced as shown in subsection, *Utilization Review Requirements and Effect on Benefits*.

UTILIZATION REVIEW REQUIREMENTS AND EFFECT ON BENEFITS

The stages of utilization review are pre-service review, care coordination review, and retrospective review. If the ***covered person*** (or authorized representative) fails to contact the ***Health Care Management Organization*** prior to receiving services that require pre-certification, the amount of benefits payable for ***covered expenses incurred*** shall be reduced by $750.

Pre-service review determines in advance the ***medical necessity*** and appropriateness of certain procedures or admissions and the appropriate length of stay, if applicable. Pre-service review is required for the services listed below. Find the Pre-Certification List at https://www.anthem.com/prior auth list

1. The appropriate utilization reviews must be performed in accordance with this ***Plan***.

    a. Scheduled, non-***emergency medical condition inpatient hospital*** stays, residential ***treatment center*** admissions, and ***partial confinement*** for ***mental and nervous disorder*** or ***substance use disorder***. **Exceptions:** Pre-service review is not required for ***inpatient hospital*** stays for maternity care of forty-eight (48) hours or less following a normal delivery or ninety-six (96) hours or less following a cesarean section.

    b. Non-***emergency medical condition outpatient*** services on the Pre-Certification List; regardless of setting.

2. When pre-service review is performed and the admission, procedure or service is determined to be ***medically necessary*** and appropriate, benefits will be provided for the following:

    a. Transplant services, including transplant travel expense. The following criteria must be met for certain transplants, as follows:
        (i.) For bone, skin or corneal transplants, if the ***physicians*** on the surgical team and the ***facility*** in which the transplant is to take place are approved for the transplant requested.
        (ii.) For transplantation of heart, liver, lung, combination heart-lung, kidney, pancreas, simultaneous pancreas-kidney or bone marrow/stem cell and similar procedures, if the providers of the related preoperative and postoperative services are approved and the transplant will be performed at a *Centers of Medical Excellence (CME)* or a *Blue Distinction Centers for Specialty Care* (*BDCSC*) facility.

    b. Ambulance services in a non-***emergency medical condition*** situation.

    c. Specific ***durable medical equipment,*** see Pre-Certification List.

    d. Infusion therapy or home infusion therapy, if the attending ***physician*** has submitted both a prescription and a plan of treatment before services are rendered.

    e. Home health care. The following criteria must be met:
        (i.) The services can be safely provided in the ***covered person's*** home, as certified by the attending ***physician***;
        (ii.) The attending ***physician*** manages and directs the ***covered person's*** medical care at home; and
        (iii.) The attending ***physician*** has established a definitive treatment plan which must be consistent with the ***covered person's*** medical needs and lists the services to be provided by the ***home health care agency***.

    f. Admissions to an ***extended care facility*** if the ***covered person*** requires daily skilled nursing or rehabilitation, as certified by their attending ***physician***.

If the ***covered person*** proceeds with any services that have been determined to be not ***medically necessary*** and appropriate at any stage of the utilization review process, benefits will not be provided for those services.

Care coordination review determines whether services are ***medically necessary*** and appropriate when the ***Health Care Management Organization*** is notified while service is ongoing, for example, an ***emergency medical condition*** admission to the ***hospital***.

Retrospective review for ***medical necessity*** is performed to review services that have already been provided. This applies in cases when **pre-service review** or **care coordination review** was not completed, or in order to evaluate and audit medical records subsequent to services being provided. Retrospective review may also be performed for services that continued longer than originally certified. Services that are not reviewed prior to or during service delivery will be reviewed retrospectively when the bill is submitted for benefit payment. If that review results in the determination that part or all of the services were not ***medically necessary*** and appropriate, benefits will not be provided for those services.

HOW TO OBTAIN UTILIZATION REVIEW

Note: It is always the *covered person's* responsibility to confirm that the review has been performed. If the review is not performed, benefits will be reduced as shown in the subsection, "Utilization Review Requirements and Effect on Benefits".

Pre-service Reviews. Penalties will result for failure to obtain required pre-service review, before receiving scheduled services, as follows:

1. For all scheduled services that are subject to utilization review, the ***covered person*** or their ***physician*** must initiate the pre-service review at least five (5) working days prior to when the ***covered person*** is scheduled to receive services.

2. The ***covered person*** must tell their ***physician*** that this ***Plan*** requires pre-service review. ***Physicians*** who are ***preferred providers*** will initiate the review on the ***covered person's*** behalf. A ***nonpreferred provider*** may initiate the review for the ***covered person***, or the ***covered person*** may call the ***Health Care Management Organization*** directly. The toll-free number for pre-service review is printed on the ***covered person's*** identification card.

3. If the ***covered person*** does not receive the service within ninety (90) days of the certification, or if the nature of the service changes, a new pre-service review must be obtained.

4. The ***Health Care Management Organization*** will determine if services are ***medically necessary*** and appropriate. For non-***emergency medical condition inpatient hospital*** and residential ***treatment center*** stays, the ***Health Care Management Organization*** will, if appropriate, specify a specific length of stay for services. The ***covered person***, their ***physician*** and the provider of the service will receive a written confirmation showing this information.

Care Coordination Reviews

1. If pre-service review was not performed, the ***covered person***, their ***physician*** or the provider of the service must contact the ***Health Care Management Organization*** for care coordination review. For an ***emergency medical condition*** admission or procedure, the ***Health Care Management Organization*** must be notified within forty-eight (48) hours or the first business day following admission. If the forty-eight (48) hours expires on a day that is not a business day, the timeframe will be extended to include the next business day.

2. When ***preferred providers*** have been informed of the ***covered person's*** need for utilization review, they will initiate the review on the ***covered person's*** behalf. The ***covered person*** may ask a ***nonpreferred provider*** to call the toll free number printed on their identification card or the ***covered person*** may call directly.

3. When the ***Health Care Management Organization*** determines that the service is ***medically necessary*** and appropriate, they will, depending upon the type of treatment or procedure, specify the period of time for which the service is medically appropriate. The ***Health Care Management Organization*** will also determine the medically appropriate setting.

4. If the ***Health Care Management Organization*** determines that the service is not ***medically necessary*** and appropriate, the ***covered person's physician*** will be notified by telephone no later than twenty-four (24) hours following their decision. The ***Health Care Management Organization*** will send written notice to the ***covered person*** and their ***physician*** within two (2) business days following their decision.

Retrospective Reviews

1. If a pre-service review or a care coordination review was not performed, a retrospective review will be done to review services that have already been provided to determine if they were ***medically necessary***.

2. Retrospective review is performed when the ***Health Care Management Organization*** is not notified of the service the ***covered person*** received, and are therefore unable to perform the appropriate review. It is also performed when pre-service or care coordination review has been done, but services continue longer than originally certified.

   It may also be performed for the evaluation and audit of medical documentation after services have been provided, whether or not pre-service or care coordination review was performed.

3. Such services which have been retroactively determined to not be ***medically necessary*** and appropriate will be retrospectively denied certification.

DECISION AND NOTICE REQUIREMENTS

The ***Health Care Management Organization*** will review requests for ***medical necessity*** according to the timeframes listed below. The timeframes and requirements listed are based on federal laws/regulations but subject to any applicable state laws/regulations. The ***covered person*** may call the phone number on the back of their identification card for more details.

Request Category	Timeframe Requirement for Decision
Pre-service non-urgent	15 business days from the receipt of the request
Care coordination review when hospitalized at the time of the request and no previous certification exists	72 hours from the receipt of the request
Care coordination review urgent when request is received at least 24 hours before the end of the previous certification	24 hours from the receipt of the request
Care coordination review urgent when request is received less than 24 hours before the end of the previous certification	72 hours from the receipt of the request
Retrospective	30 calendar days from the receipt of the request

If more information is needed to make a decision, the ***Health Care Management Organization*** will follow federal laws and regulations, tell the requesting ***physician*** and send written notice to the ***covered person*** or their authorized representative of the specific information needed to finish the review. If the ***Plan*** does not get the specific information it needs or if the information is not complete by the timeframe identified in the written notice, the ***Health Care Management Organization*** will make a decision based upon the information received.

The ***Health Care Management Organization*** will give notice of a decision as required by federal laws and regulations. Notice may be given by the following methods:

- **Verbal:** Oral notice given to the requesting ***physician*** by phone or by electronic means if agreed to by the ***physician***.
- **Written:** Mailed letter or electronic means including email and fax given to, at a minimum, the requesting ***physician*** and the ***covered person*** or their authorized representative.

A determination of medical necessity does not guarantee payment or coverage. The determination that services are ***medically necessary*** is based on the clinical information provided. Payment is based on the terms of the ***covered person's*** coverage at the time of service. These terms include certain exclusions, limitations, and other conditions. Payment of benefits could be limited for a number of reasons, including, but not limited to:

1. The information submitted with the claim differs from that given by phone;
2. The service is excluded from coverage;
3. The ***covered person*** must not have exceeded any applicable limits under this ***Plan***; or
4. The ***covered person*** is not eligible for coverage when the service is actually provided.

Revoking or modifying a certification. A certification for services or care may be revoked or modified prior to the services being rendered for reasons, including but not limited to, the following:

1. The ***covered person's*** coverage under this ***Plan*** ends;
2. The ***Plan*** terminates;
3. The ***covered person*** reaches a benefit maximum that applies to the services in question;
4. The ***covered person's*** benefits under the ***Plan*** change so that the services in question are no longer covered or are covered in a different way.

For a copy of the ***medical necessity*** review process, ***covered persons*** should contact customer service at the telephone number on the back of their identification card.

NOTICE OF ADVERSE BENEFIT DETERMINATION ON A PRE-SERVICE CLAIM

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

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

1. Information sufficient to identify the claim involved.
2. The specific reasons for the denial, to include:
   a. The denial code and its specific meaning, and
   b. A description of the ***Plan's*** standards, if any, used when denying the claim.
3. Reference to the ***Plan*** provisions on which the ***adverse benefit determination*** is based.
4. A description of any additional material or information needed and an explanation of why such material or information is necessary.
5. A description of the ***Plan's*** claim appeal procedure and applicable time limits.
6. A statement that if the ***covered person's*** appeal (Refer to *Appealing an Adverse Benefit Determination on a Pre-Service Claim* below) is denied, the ***covered person*** has the right to bring a civil action under section 502 (a) of the Employee Retirement Income Security Act of 1974.
7. If an internal rule, guideline, protocol or other similar criterion was relied upon, the Notice of Adverse Benefit Determination on a Pre-Service Claim will contain either:
   a. A copy of that criterion, or
   b. A statement that such criterion was relied upon and will be supplied free of charge, upon request.
8. If the ***adverse benefit determination*** was based on ***medical necessity***, ***experimental/investigational*** treatment or similar exclusion or limit, the ***plan administrator*** (or its designee) will supply either:
   a. An explanation of the scientific or clinical judgment, applying the terms of the ***Plan*** to the ***covered person's*** medical circumstances, or
   b. A statement that such explanation will be supplied free of charge, upon request.

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

The "***named fiduciary***" for purposes of an appeal of an ***adverse benefit determination*** of a pre-service claim, as described in U. S. Department of Labor Regulations 2560.503-1 (issued November 21, 2000), is the ***Health Care Management Organization*** or the Prescription Benefit Manager for prescription drug claims when prior authorization is required.

A ***covered person*** (or authorized representative) may request a review of an ***adverse benefit determination*** of a pre-service claim by making a verbal or written request to the ***named fiduciary*** within one hundred eighty (180) calendar days from receipt of notification of the ***adverse benefit determination*** and stating the reasons the ***covered person*** feels the claim should not have been denied. If the services in question require pre-certification under the Utilization Review Program, and the ***covered person*** (or authorized representative) wishes to appeal the ***adverse benefit determination*** when the services in question have already been rendered, such an appeal will be considered as a retrospective review by the ***Health Care Management Organization***.

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

1. The ***covered person*** has the right to submit documents, information and comments and to present testimony.
2. The ***covered person*** has the right to access, free of charge, ***relevant information*** to the claim for benefits.
3. Before a final ***adverse benefit determination*** on appeal is rendered, the ***covered person*** will be provided, free of charge, with any new or additional rationale or evidence considered, relied upon, or generated by the

Plan in connection with the claim. Such information will be provided as soon as possible and sufficiently in advance of the notice of ***final internal adverse benefit adverse benefit determination*** to give the ***covered person*** an opportunity to respond. The period for providing notice of ***final internal adverse benefit determination*** on appeal will be tolled until the earliest of the following dates:

a. The date the ***covered person*** responds to the new or additional rationale or evidence; or

b. Three (3) weeks from the date the new or additional rationale or evidence was mailed to the ***covered person***.

4. The review takes into account all information submitted by the ***covered person***, even if it was not considered in the initial ***adverse benefit d****etermination*.
5. The review by the ***named fiduciary*** will not afford deference to the original ***adverse benefit determination***.
6. The ***named fiduciary*** will not be:
   a. The individual who originally denied the claim, nor
   b. Subordinate to the individual who originally denied the claim.
7. If the original ***adverse benefit determination*** was, in whole or in part, based on medical judgment:
   a. The ***named fiduciary*** will consult with a ***professional provider*** who has appropriate training and experience in the field involving the medical judgment.
   b. The ***professional provider*** utilized by the ***named fiduciary*** will be neither:
      (i.) An individual who was consulted in connection with the original ***adverse benefit determination***, nor
      (ii.) A subordinate of any other ***professional provider*** who was consulted in connection with the original ***adverse benefit determination***.
8. If requested, the ***named fiduciary*** will identify the medical or vocational expert(s) who gave advice in connection with the original ***adverse benefit determination***, whether or not the advice was relied upon.

NOTICE OF PRE-SERVICE DETERMINATION ON APPEAL

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

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

1. The specific reasons for the ***adverse benefit determination***.
2. Reference to specific ***Plan*** provisions on which the ***adverse benefit determination*** is based.
3. A statement that the ***covered person*** has the right to access, free of charge, ***relevant information*** to the claim for benefits.
4. A statement of the ***covered person's*** right to request an external review and a description of the process for requesting such a review.
5. A statement that if the ***covered person'***s appeal is denied, the ***covered person*** has the right to bring a civil action under section 502 (a) of the Employee Retirement Income Security Act of 1974.
6. If an internal rule, guideline, protocol or other similar criterion was relied upon, the Notice of Appeal Decision will contain either:
   a. A copy of that criterion, or
   b. A statement that such criterion was relied upon and will be supplied free of charge, upon request.
7. If the ***adverse benefit determination*** was based on ***medical necessity***, ***experimental/investigational*** treatment or similar exclusion or limit, the ***plan administrator*** (or its designee) will supply either:
   a. An explanation of the scientific or clinical judgment, applying the terms of the ***Plan*** to the claimant's medical circumstances, or
   b. A statement that such explanation will be supplied free of charge, upon request.

POST-SERVICE AND PRE-SERVICE CLAIM EXTERNAL APPEALS PROCEDURE

EXTERNAL APPEAL

The "***named fiduciary***" for purposes of an external appeal of an ***adverse benefit determination*** on a Pre-Service or Post-Service claim, as described in U. S. Department of Labor Regulations 2560.503-1, is the ***claims processor***.

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

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

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

RIGHT TO EXTERNAL APPEAL

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

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

NOTICE OF RIGHT TO EXTERNAL APPEAL

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

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

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

INDEPENDENT REVIEW ORGANIZATION

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

NOTICE OF EXTERNAL REVIEW DETERMINATION

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

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

EXPEDITED EXTERNAL REVIEW

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

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

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

1. Perform a preliminary review to determine whether the request meets the requirements in the subsection, *Right to External Appeal*.
2. Send notice of the ***Plan's*** decision, as described in the subsection, *Notice of Right to External Appeal*.

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

1. Assign an IRO as described in the subsection, *Independent Review Organization*.
2. Provide all necessary documents or information used to make the ***adverse benefit determination*** or final ***adverse benefit determination*** to the IRO either by telephone, facsimile, electronically or other expeditious method.

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

COORDINATION OF BENEFITS

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

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

DEFINITIONS APPLICABLE TO THIS PROVISION

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

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

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

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

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

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

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

3. A licensed Health Maintenance Organization (HMO);

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

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

6. Group automobile insurance;

7. Individual automobile insurance coverage;

8. Individual automobile insurance coverage based upon the principles of "No-fault" coverage;

9. Any plan or policies funded in whole or in part by an employer, or deductions made by an employer from a person's compensation or retirement benefits;

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

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

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

EFFECT ON BENEFITS

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

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

ORDER OF BENEFIT DETERMINATION

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

1. No Coordination of Benefits Provision

   If the Other Plan contains no provisions for coordination of benefits, then its benefits shall be paid before all Other Plan(s).

2. Member/Dependent

   The plan which covers the claimant directly pays before a plan that covers the claimant as a dependent.

3. Dependent Children of Parents not Separated or Divorced

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

4. Dependent Children of Separated or Divorced Parents

   When parents are separated or divorced, the birthday rule does not apply, instead:

   a. If a court decree has given one parent financial responsibility for the child's health care, the plan of that parent pays first. The plan of the stepparent married to that parent, if any, pays second. The plan of the other natural parent pays third. The plan of the spouse or domestic partner of the other natural parent, if any, pays fourth.

   b. In the absence of such a court decree, the plan of the parent with custody pays first. The plan of the stepparent married to the parent with custody, if any, pays second. The plan of the parent without custody pays third. The plan of the spouse or domestic partner of the parent without custody, if any, pays fourth.

5. Active/Inactive

   The plan covering a person as an active (not laid off or retired) employee or as that person's dependent pays first. The plan covering that person as a laid off or retired employee, or as that person's dependent pays second.

6. Longer/Shorter Length of Coverage

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

COORDINATION WITH MEDICARE

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

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

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

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

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

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

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

LIMITATIONS ON PAYMENTS

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

RIGHT TO RECEIVE AND RELEASE NECESSARY INFORMATION

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

FACILITY OF BENEFIT PAYMENT

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

AUTOMOBILE ACCIDENT BENEFITS

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

1. No-fault automobile insurance laws

2. Financial responsibility laws

3. Other automobile liability insurance laws

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

1. In the event a ***covered person*** incurs medical expenses as a result of ***injuries*** sustained in an automobile accident while "covered by an automobile insurance policy," as an operator of the vehicle, as a passenger, or as a pedestrian, benefits will be further limited to medical expenses, that would in no event be payable under the automobile insurance; provided however that benefits payable due to a required deductible under the automobile insurance policy will be paid by the ***Plan*** up to the amount equal to that deductible.

2. For the purposes of this section the following people are deemed "covered by an automobile insurance policy."

    a. An owner or principal named insured individual under such policy.

    b. A family member of an insured person for whom coverage is provided under the terms and conditions of the automobile insurance policy.

    c. Any other person who, except for the existence of the ***Plan***, would be eligible for medical expense benefits under an automobile insurance policy.

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

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

SUBROGATION/REIMBURSEMENT

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

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

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

2. Equitable Lien and other Equitable Remedies. The ***Plan*** shall have an equitable lien against any rights the ***covered person*** may have to recover the same ***covered expenses*** from any party, including an insurer or another group health program, but limited to the amount of Reimbursable Payments made by the ***Plan***. The equitable lien also attaches to any right to payment from workers' compensation, whether by judgment or settlement, where the ***Plan*** has paid ***covered expenses*** prior to a determination that the ***covered expenses*** arose out of and in the course of employment. Payment by workers' compensation insurers or the employer will be deemed to mean that such a determination has been made.

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

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

3. Assisting in ***Plan's*** Reimbursement Activities. The ***covered person*** has an obligation to assist the ***Plan*** to obtain reimbursement of the Reimbursable Payments that it has made on behalf of the ***covered person***, and to provide the ***Plan*** with any information concerning the ***covered person's*** other insurance coverage (whether through automobile insurance, other group health program, or otherwise) and any other person or entity (including their insurer(s)) that may be obligated to provide payments or benefits to or for the benefit of the ***covered person***. The ***covered person*** is required to (a) cooperate fully in the ***Plan's*** (or any ***Plan*** fiduciary's) enforcement of the terms of the ***Plan***, including the exercise of the ***Plan's*** right to subrogation and reimbursement, whether against the ***covered person*** or any third party, (b) not do anything to prejudice those

enforcement efforts or rights (such as settling a claim against another party without including the ***Plan*** as a co-payee for the amount of the Reimbursable Payments and notifying the ***Plan***), (c) sign any document deemed by the ***plan administrator*** to be relevant to protecting the ***Plan's*** subrogation, reimbursement or other rights, and (d) provide relevant information when requested. The term "information" includes any documents, insurance policies, police reports, or any reasonable request by the ***plan administrator*** or ***claims processor*** to enforce the ***Plan***'s rights.

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

GENERAL PROVISIONS

ADMINISTRATION OF THE PLAN

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

The ***employer*** is the ***named fiduciary*** of the ***Plan*** except as noted herein. Except as otherwise specifically provided in this document, the ***claims processor*** is the ***named fiduciary*** of the ***Plan*** for pre-service and post-service claim appeals As the ***named fiduciary*** for appeals, the ***claims processor*** maintains discretionary authority to review all denied claims under appeal for benefits under the ***Plan***. The ***employer*** maintains discretionary authority to interpret the terms of the ***Plan***, including but not limited to, determination of eligibility for and entitlement to ***Plan*** benefits in accordance with the terms of the ***Plan***; any interpretation or determination made pursuant to such discretionary authority shall be given full force and effect, unless it can be shown that the interpretation or determination was arbitrary and capricious.

APPLICABLE LAW

All provisions of the ***Plan*** shall be construed and administered in a manner consistent with the requirements under the Employee Retirement Income Security Act of 1974 (ERISA), as amended.

ASSIGNMENT

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

Payment of Benefits

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

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

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

BENEFITS NOT TRANSFERABLE

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

CLERICAL ERROR

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

CONFORMITY WITH STATUTE(S)

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

EFFECTIVE DATE OF THE PLAN

The original ***effective date*** of this ***Plan*** was January 1, 2021. The ***effective date*** of the modifications contained herein is January 1, 2022.

FRAUD OR INTENTIONAL MISREPRESENTATION

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

FREE CHOICE OF HOSPITAL AND PHYSICIAN

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

INCAPACITY

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

INCONTESTABILITY

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

LEGAL ACTIONS

The decision by the ***plan administrator/claims processor*** 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 this ***Plan*** Document must be exhausted before any legal or equitable action is brought. Notwithstanding any other state or federal law, any and all legal actions to recover benefits, whether against the ***Plan***, ***plan administrator/claims processor***, any other fiduciary, or their employees, must be filed within one (1) year from the date all claim review procedures provided for in this ***Plan*** Document have been exhausted.

LIMITS ON LIABILITY

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

LOST DISTRIBUTEES

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

MEDICAID ELIGIBILITY AND ASSIGNMENT OF RIGHTS

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

PLAN IS NOT A CONTRACT

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

PLAN MODIFICATION AND AMENDMENT

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

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

PLAN TERMINATION

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

Upon termination of this ***Plan***, all claims ***incurred*** prior to termination, but not submitted to either the ***employer*** or ***claims processor*** within three (3) months of the ***effective date*** of termination of this ***Plan***, will be excluded from any benefit consideration.

PRONOUNS

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

RECOVERY FOR OVERPAYMENT

Whenever payments have been made from the ***Plan*** in excess of the maximum amount of payment necessary, the ***Plan*** will have the right to recover these excess payments. If the ***Plan*** makes any payment that, according to the terms of the ***Plan***, should not have been made, the ***Plan*** may recover that incorrect payment, whether or not it was made due to the ***Plan's*** or the ***Plan*** designee's own error, from the person or entity to whom it was made or from any other appropriate party.

SEVERABILITY

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

STATUS CHANGE

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

TIME EFFECTIVE

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

WORKERS' COMPENSATION NOT AFFECTED

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

HIPAA PRIVACY

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

DISCLOSURE BY PLAN TO PLAN SPONSOR

The ***Plan*** may take the following actions only upon receipt of a ***Plan*** amendment certification:

1. Disclose protected health information to the ***plan sponsor***.

2. Provide for or permit the disclosure of protected health information to the ***plan sponsor*** by a health insurance issuer or HMO with respect to the ***Plan***.

USE AND DISCLOSURE BY PLAN SPONSOR

The ***plan sponsor*** may use or disclose protected health information received from the ***Plan*** to the extent not inconsistent with the provisions of this *HIPAA Privacy* section or the ***privacy rule***.

OBLIGATIONS OF PLAN SPONSOR

The ***plan sponsor*** shall have the following obligations:

1. Ensure that:

    a. Any agents (including a subcontractor) to whom it provides protected health information received from the ***Plan*** agree to the same restrictions and conditions that apply to the ***plan sponsor*** with respect to such information; and

    b. Adequate separation between the ***Plan*** and the ***plan sponsor*** is established in compliance with the requirement in 45 C.F.R. 164.504(f)(2)(iii).

2. Not use or further disclose protected health information received from the ***Plan***, other than as permitted or required by the ***Plan*** documents or as ***required by law***.

3. Not use or disclose protected health information received from the ***Plan***:

    a. For employment-related actions and decisions; or

    b. In connection with any other benefit or employee benefit plan of the ***plan sponsor***.

4. Report to the ***Plan*** any use or disclosure of the protected health information received from the ***Plan*** that is inconsistent with the use or disclosure provided for of which it becomes aware.

5. Make available protected health information received from the ***Plan***, as and to the extent required by the ***privacy rule***:

    a. For access to the individual;

    b. For amendment and incorporate any amendments to protected health information received from the ***Plan***; and

    c. To provide an accounting of disclosures.

6. Make its internal practices, books, and records relating to the use and disclosure of protected health information received from the ***Plan*** available to the Secretary of the U.S. Department of Health and Human Services for purposes of determining compliance by the ***Plan*** with the ***privacy rule***.

7. Return or destroy all protected health information received from the ***Plan*** that the ***plan sponsor*** still maintains in any form and retain no copies when no longer needed for the purpose for which the disclosure by the ***Plan*** was made, but if such return or destruction is not feasible, limit further uses and disclosures to those purposes that make the return or destruction of the information infeasible.

8. Provide protected health information only to those individuals, under the control of the ***plan sponsor*** who perform administrative functions for the ***Plan***; (*i.e.*, eligibility, enrollment, payroll deduction, benefit determination, claim reconciliation assistance), and to make clear to such individuals that they are not to use protected health information for any reason other than for ***Plan*** administrative functions nor to release protected health information to an unauthorized individual.

9. Provide protected health information only to those entities required to receive the information in order to maintain the ***Plan*** (*i.e.*, claim administrator, case management vendor, ***pharmacy benefit manager***, claim subrogation, vendor, claim auditor, network manager, stop-loss insurance carrier, insurance broker/consultant, and any other entity subcontracted to assist in administering the ***Plan***).

10. Provide an effective mechanism for resolving issues of noncompliance with regard to the items mentioned in this provision.

11. Reasonably and appropriately safeguard electronic protected health information created, received, maintained, or transmitted to or by the ***plan sponsor*** on behalf of the ***Plan***. Specifically, such safeguarding entails an obligation to:

    a. Implement administrative, physical, and technical safeguards that reasonably and appropriately protect the confidentiality, integrity, and availability of the electronic protected health information that the ***plan sponsor*** creates, receives, maintains, or transmits on behalf of the ***Plan***;

    b. Ensure that the adequate separation as required by 45 C.F.R. 164.504(f)(2)(iii) is supported by reasonable and appropriate security measures;

    c. Ensure that any agent, including a subcontractor, to whom it provides this information agrees to implement reasonable and appropriate security measures to protect the information; and

    d. Report to the ***Plan*** any security incident of which it becomes aware.

EXCEPTIONS

Notwithstanding any other provision of this *HIPAA Privacy* section, the ***Plan*** (or a health insurance issuer or HMO with respect to the ***Plan***) may:

1. Disclose summary health information to the ***plan sponsor*** if the ***plan sponsor*** requests it for the purpose of:

    a. Obtaining premium bids from health plans for providing health insurance coverage under the ***Plan***; or

    b. Modifying, amending, or terminating the ***Plan***;

2. Disclose to the ***plan sponsor*** information on whether the individual is participating in the ***Plan***, or is enrolled in or has disenrolled from a health insurance issuer or HMO offered by the ***Plan***;

3. Use or disclose protected health information:

    a. With (and consistent with) a valid authorization obtained in accordance with the ***privacy rule***;

    b. To carry out treatment, payment, or health care operations in accordance with the ***privacy rule***; or

    c. As otherwise permitted or required by the ***privacy rule***.

DEFINITIONS

Certain words and terms used herein shall be defined as follows and are shown in ***bold and italics*** throughout the document:

Accident

An unforeseen event resulting in ***injury***.

Adverse Benefit Determination

Adverse benefit determination shall mean any of the following:

1. A denial in benefits.

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 e ***covered person's*** eligibility to participate in the ***Plan***.

6. A denial, reduction, or termination of, or a failure to provide or make payment (in whole or in part) for, a benefit resulting from the application of any utilization review.

7. A failure to cover an item or service for which benefits are otherwise provided because it is determined to be ***experimental/investigational*** or not ***medically necessary*** or appropriate.

Affordable Care Act

The Patient Protection and Affordable Care Act, as amended by the Health Care and Education Reconciliation Act of 2010 and all applicable regulations and regulatory guidance.

Alternate Recipient

Any child of an ***employee,*** spouse or their domestic partner who is recognized in a Qualified Medical Child Support Order (QMCSO) or National Medical Support Notice (NMSN) which has been issued by any court judgment, decree, or order as being entitled to enrollment for coverage under the ***Plan***.

Ambulatory Surgical Facility

A ***facility*** provider with an organized staff of ***physicians*** which has been approved by the Joint Commission on the Accreditation of Healthcare Organizations, or by the Accreditation Association for Ambulatory Health, Inc., or by ***Medicare***; or that has a contract with the ***Preferred Provider Organization*** as a ***preferred provider***. An ***ambulatory surgical facility*** is a ***facility*** that:

1. Has permanent facilities and equipment for the purpose of performing surgical procedures on an ***outpatient*** basis;

2. Provides treatment by or under the supervision of ***physicians*** and nursing services whenever the ***covered person*** is in the ***ambulatory surgical facility***;

3. Does not provide ***inpatient*** accommodations; and

4. Is not, other than incidentally, a ***facility*** used as an office or clinic for the private practice of a ***physician***.

Anesthesia Conversion Factor

A ***median contracted rate*** expressed in dollars per unit.

Applied Behavioral Analysis (ABA)

A type of intensive behavioral therapy in which individuals trained in objective observation, evidence based assessment, data collection, and functional analyses utilize these data to produce meaningful changes in human behavior.

Approved Clinical Trial

A Phase I, Phase II, Phase III, or Phase IV clinical trial that is conducted in relation to the prevention, detection, or treatment of cancer or other" life-threatening disease or condition" and is further described in accordance with federal law and applicable federal regulations.

Autism Spectrum Disorder

A condition related to brain development that affects how a person perceives and socializes with others, causing problems in social interaction and communication. This disorder also includes limited and repetitive behavior.

Base Unit

For an anesthesia service code, ***base units*** are specified in the most recent edition (as of the date of service) of the American Society of Anesthesiologists Relative Value Guide.

Birthing Center

A ***facility*** that meets professionally recognized standards and complies with all licensing and other legal requirements that apply.

Certified IDR Entity

An entity responsible for conducting payment determinations, through the Federal independent dispute resolution process, that has been certified by the Secretaries of Labor, Health and Human Services and the Treasury.

Chiropractic Care

Services as provided by a licensed Chiropractor, M.D., or D.O. for manipulation or manual modalities in the treatment of the spinal column, neck, extremities or other joints, other than for a fracture or surgery.

Claims Processor

Refer to the *Summary Plan Description* (SPD) section of this document.

Close Relative

The ***employee's*** spouse, domestic partner, children, brothers, sisters, or parents; or the children, brothers, sisters or parents of the ***employee's*** spouse or domestic partner.

Coinsurance

The benefit percentage of ***covered expenses*** payable by the ***Plan*** for benefits that are provided under the ***Plan***. The ***coinsurance*** is applied to ***covered expenses*** after the deductible(s) have been met, if applicable.

Complications of Pregnancy

A disease, disorder or condition which is diagnosed as distinct from ***pregnancy***, but is adversely affected by or caused by ***pregnancy***. Some examples are:

1. Intra-abdominal surgery (but not elective Cesarean Section).
2. Ectopic ***pregnancy***.
3. Toxemia with convulsions (Eclampsia).
4. Pernicious vomiting (hyperemesis gravidarum).
5. Nephrosis.
6. Cardiac Decompensation.
7. Missed Abortion.
8. Miscarriage.

These conditions are not included: false labor; occasional spotting; rest during ***pregnancy*** even if prescribed by a ***physician***; morning sickness; or like conditions that are not medically termed as ***complications of pregnancy***.

Concurrent Care

A request by a ***covered person*** (or their authorized representative) to the ***Health Care Management Organization*** prior to the expiration of a ***covered person's*** current course of treatment to extend such treatment OR a determination by the ***Health Care Management Organization*** to reduce or terminate an ongoing course of treatment.

Confinement

A continuous stay in a ***hospital***, ***treatment center***, ***extended care facility***, ***hospice***, or ***birthing center*** due to an ***illness*** or ***injury*** diagnosed by a ***physician***. Later stays shall be deemed part of the original ***confinement*** unless there was either complete recovery during the interim from the ***illness*** or ***injury*** causing the initial stay, or unless the latter stay results from a cause or causes unrelated to the ***illness*** or ***injury*** causing the initial stay.

Continuing Care Patient

A ***covered person*** who, with respect to a ***participating provider*** is:
1. Undergoing a course of treatment for a ***serious and complex condition*** from the ***participating provider***;
2. Undergoing a course of institutional or ***inpatient*** care from the ***participating provider***;
3. Scheduled to undergo nonelective surgery from the ***participating provider***, including postoperative care;
4. Pregnant and undergoing a course of treatment for the pregnancy from the ***participating provider***; or
5. Determined to be terminally ill with a life expectancy of 6 months or less, and is receiving treatment for such ***illness*** from the ***participating provider***.

Contracted Rate

The total amount (including ***cost sharing***) that plan sponsors of self-funded plans administered by ***claims processor*** are contractually agreed to pay a ***preferred provider*** for ***covered expenses***.

Copay

A cost sharing arrangement whereby a ***covered person*** pays a set amount to a provider for a specific service at the time the service is provided.

Cosmetic Surgery

Surgery for the restoration, repair, or reconstruction of body structures directed toward altering appearance.

Cost Sharing

The amount a ***covered person*** is responsible for paying for ***covered expenses***. ***Cost sharing*** includes applicable ***copays***, ***coinsurance*** and deductible. ***Cost sharing*** does not include balance billing by ***nonpreferred providers***, or the cost of items or services that are not ***covered expenses***.

Covered Expenses

Medically necessary services, supplies or treatments that are recommended or provided by a ***physician***, ***professional provider*** or covered ***facility*** for the treatment of an ***illness*** or ***injury*** and that are not specifically excluded from coverage herein. ***Covered expenses*** shall include specified preventive care services.

Covered Person

A person who is eligible for coverage under the ***Plan***, or becomes eligible at a later date, and for whom the coverage provided by the ***Plan*** is in effect.

Custodial Care

Care provided primarily for maintenance of the ***covered person*** or which is designed essentially to assist the ***covered person*** in meeting his activities of daily living and which is not primarily provided for its therapeutic value in the treatment of an ***illness*** or ***injury***. ***Custodial care*** includes, but is not limited to: help in walking, bathing, dressing, feeding, preparation of special diets and supervision over self-administration of medications. Such services shall be considered ***custodial care*** without regard to the provider by whom or by which they are prescribed, recommended or performed.

Room and board and skilled nursing services are not, however, considered ***custodial care*** (1) if provided during ***confinement*** in an institution for which coverage is available under the ***Plan***, and (2) if combined with other ***medically necessary*** therapeutic services, under accepted medical standards, which can reasonably be expected to substantially improve the ***covered person's*** medical condition.

Customary and Reasonable Amount

Any negotiated fee (where the provider has contracted to accept such fee as payment in full for ***covered expenses*** of the ***Plan***) assessed for services, supplies or treatment by a ***nonpreferred provider***, or a fee assessed by a provider of service for services, supplies or treatment which shall not exceed the general level of charges made by others rendering or furnishing such services, supplies or treatment within the area where the charge is ***incurred*** and is comparable in severity and nature to the ***illness*** or ***injury***. Due consideration shall be given to any medical complications or unusual circumstances which require additional time, skill or experience. Except as to negotiated fees, the ***customary and reasonable amount*** is determined from a statistical review and analysis of the charges for a given procedure in a given area. The term "area" as it would apply to any particular service, supply or treatment means a county or such greater area as is necessary to obtain a representative cross-section of the level of charges. The percentage applicable to this ***Plan*** is 50% and is applied to CPT codes using Fair Health benchmarking tables. The PPO ***negotiated rate*** *is the* ***customary and reasonable amount***.

Covered expenses provided by a ***nonpreferred provider*** subject to the requirements specified in numbers 1., 2., or 3. in the *Nonpreferred Provider subsection*, under the *Preferred Provider or Nonpreferred Provider section*, are not subject to the ***customary and reasonable amount***, but instead are subject to the lesser of the ***qualifying payment amount*** or the ***nonpreferred provider's*** actual charge.

Dentist

A Doctor of Dental Medicine (D.M.D.), a Doctor of Dental Surgery (D.D.S.), a Doctor of Medicine (M.D.), or a Doctor of Osteopathy (D.O.), other than a ***close relative*** of the ***covered person***, who is practicing within the scope of his license.

Dependent

Refer to the *Eligibility, Enrollment and Effective Date, Dependent(s) Eligibility* section for what constitutes a ***dependent***.

Durable Medical Equipment

Medical equipment which:

1. Can withstand repeated use;

2. Is primarily and customarily used to serve a medical purpose;

3. Is generally not used in the absence of an ***illness*** or ***injury***;

4. Is appropriate for use in the home.

All provisions of this definition must be met before an item can be considered ***durable medical equipment***. ***Durable medical equipment*** includes, but is not limited to: crutches, wheel chairs, ***hospital*** beds, etc.

Effective Date

The date of the ***Plan*** or the date on which the ***covered person's*** coverage commences, whichever occurs later.

Emergency Medical Condition

A medical condition, including a ***mental and nervous disorder*** or ***substance use disorder***, manifesting itself by acute symptoms of sufficient severity (including severe pain) so that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in:

1. Placing the ***covered person's*** life (or with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy, or

2. Causing serious impairment to bodily functions, or

3. Causing serious dysfunction of any bodily organ or part.

Emergency Services

1. With respect to an ***emergency medical condition***, a medical screening examination that is within the capability of the emergency department of a ***hospital*** or of an ***independent freestanding emergency department***, including ancillary services routinely available to the emergency department to evaluate such ***emergency medical condition***, and such further medical examination and treatment, to the extent they are within the capabilities of the staff and facilities available at a ***hospital*** or an ***independent freestanding emergency department***, as are required to ***stabilize*** the patient; and

2. Additional items and services,

    a. For which benefits are provided or covered under this ***Plan***; and

    b. That are furnished by a ***nonpreferred provider*** (regardless of the department of the ***hospital*** or ***independent freestanding emergency department*** in which such items or services are furnished) after

the ***covered person*** is ***stabilized*** and as part of ***outpatient*** observation or an ***inpatient*** or ***outpatient*** stay with respect to the visit in which the services provided by the emergency department are furnished; however, such items and services shall not be included as ***emergency services*** if:

i. The attending ***physician*** or treating provider determines that the ***covered person*** is able to travel using nonmedical transportation or nonemergency medical transportation to an available ***preferred provider*** or ***facility*** located within a reasonable travel distance, taking into account the individual's medical condition;

ii. Notice and Consent Criteria is satisfied, as specified in section, *Preferred Provider or Nonpreferred Provider*, under number 6. of subsection *Nonpreferred Provider*; and

iii. The ***covered person*** (or an authorized representative) is in a condition to receive the notice and consent described in the Notice and Consent Criteria as determined by the attending emergency ***physician*** or treating provider using appropriate medical judgement, and to provide informed consent in accordance with applicable law.

Employee

A person directly involved in the regular business of and compensated for services, as reported on the individual's annual W-2 form, by the ***employer***, who is regularly scheduled to work not less than the hours per work week as listed in the section titled *Eligibility, Enrollment and Effective Date, Employee Eligibility* on a ***full-time*** status basis.

Employer

The ***employer*** is Wente Family Estates.

Essential Health Benefits

Those benefits identified by the U.S. Secretary of Health and Human Services, including benefits for ***covered expenses*** incurred for the following services:

1. Ambulatory patient services;
2. ***Emergency services***;
3. Hospitalization;
4. Maternity and newborn care;
5. Mental health and substance use disorder services, including behavioral health treatment ***(mental and nervous disorder*** and ***substance use disorder)***;
6. Prescription drugs;
7. ***Habilitative services***, ***rehabilitative services*** and ***habilitative and rehabilitative devices***;
8. Laboratory services;
9. Preventive and wellness services and chronic disease management;
10. Pediatric services, including oral and vision care.

Experimental/Investigational

Services, supplies, drugs and treatment which do not constitute accepted medical practice properly within the range of appropriate medical practice under the standards of the case and by the standards of a reasonably substantial, qualified, responsible, relevant segment of the medical community or government oversight agencies at the time services were rendered.

The ***claims processor***, ***named fiduciary for post-service claim appeals***, ***named fiduciary for pre-service claim appeals***, ***employer/plan administrator***, or their designee must make an independent evaluation of the ***experimental***/non-experimental standings of specific technologies. The ***claims processor***, ***named fiduciary for post-service claim appeals***, ***named fiduciary for pre-service claim appeals***, ***employer/plan administrator*** or their designee shall be guided by a reasonable interpretation of ***Plan*** provisions and information provided by qualified independent vendors who have also reviewed the information provided. The decisions shall be made in good faith and rendered following a factual background investigation of the claim and the proposed treatment. The ***claims processor***, ***named fiduciary for post-***

service claim appeals, ***named fiduciary for pre-service claim appeals***, ***employer/plan administrator*** or their designee will be guided by the following examples of ***experimental*** services and supplies:

1. If the drug or device cannot be lawfully marketed without approval of the U.S. Food and Drug Administration and approval for marketing has not been given at the time the drug or device is furnished; or

2. If the drug, device, medical treatment or procedure, was not reviewed and approved by the treating facility's institutional review board or other body serving a similar function, or if federal law requires such review or approval; or

3. If "reliable evidence" shows that the drug, device, medical treatment or procedure is the subject of on-going Phase I or Phase II clinical trials, is in the research, ***experimental***, study or ***investigational*** arm of on-going Phase III clinical trials, or is otherwise under study to determine its maximum tolerated dose, its toxicity, its safety, or its efficacy as compared with a standard means of treatment or diagnosis; or

4. If "reliable evidence" shows that prevailing opinion among experts regarding the drug, device, medical treatment or procedure is that further studies or clinical trials are necessary to determine its maximum tolerated dose, its toxicity, its safety, or its efficacy as compared with standard means of treatment or diagnosis.

"Reliable evidence" shall mean only published reports and articles in the authoritative medical and scientific literature; the written protocol or protocols used by the treating facility or the protocol(s) of another facility studying substantially the same drug, device, medical treatment or procedure; or the written informed consent used by the treating facility or by another facility studying substantially the same drug, device, medical treatment or procedure.

Extended Care Facility

An institution, or distinct part thereof, operated pursuant to law and one which meets all of the following conditions:

1. It is licensed to provide, and is engaged in providing, on an ***inpatient*** basis, for persons convalescing from ***illness*** or ***injury***, professional nursing services, and physical restoration services to assist ***covered persons*** to reach a degree of body functioning to permit self-care in essential daily living activities. Such services must be rendered by a Registered Nurse or by a Licensed Practical Nurse under the direction of a Registered Nurse.

2. Its services are provided for compensation from its ***covered persons*** and under the full-time supervision of a ***physician*** or Registered Nurse.

3. It provides twenty-four (24) hour-a-day nursing services.

4. It maintains a complete medical record on each ***covered person***.

5. It is not, other than incidentally, a place for rest, a place for the aged, or a place for custodial or educational care.

6. It is approved and licensed by ***Medicare***.

This term shall also apply to expenses ***incurred*** in an institution referring to itself as a skilled nursing facility, convalescent nursing facility, or any such other similar designation.

Facility

A healthcare institution which meets all applicable state or local licensure requirements.

Final Internal Adverse Benefit Determination

An ***adverse benefit determination*** that has been upheld by this ***Plan*** at the conclusion of the internal claim and appeal process, or an ***adverse benefit determination*** with respect to which the internal claim and appeal process has been deemed exhausted.

Final Post-Service Claim Appeal

A post-service appeal, which constitutes the last internal level of appeal available to the ***covered person***, to be filed with the ***plan administrator*** (or its designee) or other ***named fiduciary*** assigned authority and the duty to otherwise handle appeals. A ***final post-service claim appeal*** shall only apply to medical claims. Upon and the conclusion of this level of appeal, this ***Plan's*** internal appeal process is deemed to be exhausted.

Facility

A healthcare institution which meets all applicable state or local licensure requirements.

Foster Child

A child who is placed with the ***employee*** or covered spouse or domestic partner by an authorized placement agency or by judgment, decree, or other order of any court of competent jurisdiction.

Full-time

Employees who are regularly scheduled to work not less than the hours per work week as listed in the section titled *Eligibility, Enrollment and Effective Date, Employee Eligibility*.

Generic Drug

A prescription drug that is generally equivalent to a higher-priced brand name drug with the same use and metabolic disintegration. The drug must meet all Federal Drug Administration (FDA) bioavailability standards and be dispensed according to the professional standards of a licensed pharmacist or ***physician*** and must be clearly designated by the pharmacist or ***physician*** as generic.

Habilitative and Rehabilitative Devices

Medically necessary devices that are designed to assist a ***covered person*** in acquiring, improving, or maintaining, partially or fully, skills and functioning for daily living. Such devices include, but are not limited to, ***durable medical equipment***, orthotics, prosthetics, and low vision aids.

Habilitative Services

Medically necessary health care services that help a ***covered person*** keep, learn or improve skills and functioning for daily living. Examples of ***habilitative services*** include therapy for a ***dependent*** child who is not walking or talking at the expected age. These services may include physical and occupational therapy, speech-language pathology and other ***medically necessary*** services for people with disabilities in a variety of inpatient and/or outpatient settings. ***Habilitative services*** that are not ***medically necessary***, for example when therapy has reached an end point and goals have been reached, will not be a ***covered expense***.

Health Care Management

A process of evaluating if services, supplies or treatment are ***medically necessary*** and appropriate to help ensure cost-effective care.

Health Care Management Organization

The individual or organization designated by the ***employer*** for the process of evaluating whether the service, supply, or treatment is ***medically necessary***. The ***Health Care Management Organization*** for pre-service claims and case management is Anthem.

Home Health Aide Services

Services which may be provided by a person, other than a Registered Nurse, which are ***medically necessary*** for the proper care and treatment of a person.

Home Health Care

Includes the following services: skilled nursing visits and IV Infusion therapy for the purposes of pre-service claims only.

Home Health Care Agency

An agency or organization which meets fully every one of the following requirements:

1. It is primarily engaged in and duly licensed, if licensing is required, by the appropriate licensing authority, to provide skilled nursing and other therapeutic services.

2. It has a policy established by a professional group associated with the agency or organization to govern the services provided. This professional group must include at least one ***physician*** and at least one Registered Nurse. It must provide for full-time supervision of such services by a ***physician*** or Registered Nurse.

3. It maintains a complete medical record on each ***covered person***.

4. It has a full-time administrator.

5. It qualifies as a reimbursable service under ***Medicare***.

Hospice

An agency that provides counseling and medical services and may provide ***room and board*** to a terminally ill ***covered person*** and which meets all of the following tests:

1. It has obtained any required state or governmental Certificate of Need approval.

2. It provides service twenty-four (24) hours-per-day, seven (7) days a week.

3. It is under the direct supervision of a ***physician***.

4. It has a Nurse coordinator who is a Registered Nurse.

5. It has a social service coordinator who is licensed.

6. It is an agency that has as its primary purpose the provision of ***hospice*** services.

7. It has a full-time administrator.

8. It maintains written records of services provided to the ***covered person***.

9. It is licensed, if licensing is required.

Hospital

An institution which meets the following conditions:

1. It is licensed and operated in accordance with the laws of the jurisdiction in which it is located which pertain to ***hospitals***.

2. It is engaged primarily in providing medical care and treatment to ***ill*** and ***injured*** persons on an ***inpatient*** basis at the ***covered person's*** expense.

3. It maintains on its premises all the facilities necessary to provide for the diagnosis and medical and surgical treatment of an ***illness*** or ***injury***; and such treatment is provided by or under the supervision of a ***physician*** with continuous twenty-four (24) hour nursing services by or under the supervision of Registered Nurses.

4. It qualifies as a ***hospital*** and is accredited by the Joint Commission on the Accreditation of Healthcare Organizations. This condition may be waived in the case of treatment for an ***emergency medical condition*** in a ***hospital*** outside of the United States.

5. It must be approved by ***Medicare***. This condition may be waived in the case of treatment for an ***emergency medical condition*** in a ***hospital*** outside of the United States.

Under no circumstances will a ***hospital*** be, other than incidentally, a place for rest, a place for the aged, or a nursing home.

Hospital shall include a facility designed exclusively for physical ***rehabilitative services*** where the ***covered person*** received treatment as a result of an ***illness*** or ***injury***.

The term ***hospital***, when used in conjunction with ***inpatient confinement*** for ***mental and nervous disorders*** or ***substance use disorder***, will be deemed to include an institution which is licensed as a mental ***hospital*** or ***substance use disorder*** rehabilitation and/or detoxification ***facility*** by the regulatory authority having responsibility for such licensing under the laws of the jurisdiction in which it is located.

Illness

A bodily disorder, disease, physical sickness, or ***pregnancy*** of a ***covered person***.

Incurred or Incurred Date

With respect to a ***covered expense***, the date the services, supplies or treatment are provided.

Independent Freestanding Emergency Department

A health care ***facility*** that is geographically separate and distinct and licensed separately from a ***hospital*** under applicable State law and provides ***emergency services***.

Injury

A physical harm or disability which is the result of a specific incident caused by external means. The physical harm or disability must have occurred at an identifiable time and place. ***Injury*** does not include ***illness*** or infection of a cut or wound.

Inpatient

A ***confinement*** of a ***covered person*** in a ***hospital***, ***hospice***, or ***extended care facility*** as a registered bed patient, for twenty-three (23) or more consecutive hours and for whom charges are made for ***room and board***.

Intensive Care

A service which is reserved for critically and seriously ill ***covered persons*** requiring constant audio-visual surveillance which is prescribed by the attending ***physician***.

Intensive Care Unit

1. A separate, clearly designated service area which is maintained within a ***hospital*** solely for the provision of ***intensive care***. It must meet the following conditions:

2. Facilities for special nursing care not available in regular rooms and wards of the ***hospital***;

3. Special life saving equipment which is immediately available at all times;

4. At least two beds for the accommodation of the critically ill; and

5. At least one Registered Nurse in continuous and constant attendance twenty-four (24) hours-per-day.

This term does not include care in a surgical recovery room, but does include cardiac care unit or any such other similar designation.

Intensive Outpatient Treatment

An ***outpatient substance use disorder*** program that operates a minimum of (3) three hours per day at least (3) three days per week, which includes an individualized treatment plan consisting of assessment, counseling; crisis intervention, and activity therapies or education.

Late Enrollee

A ***covered person*** who did not enroll in the ***Plan*** when first eligible or as the result of a special enrollment period.

Layoff

A period of time during which the ***employee***, at the ***employer's*** request, does not work for the ***employer***, but which is of a stated or limited duration and after which time the ***employee*** is expected to return to ***full-time***, active work. ***Layoffs*** will otherwise be in accordance with the ***employer's*** standard personnel practices and policies.

Leave of Absence

A period of time during which the ***employee*** does not work, but which is of a stated duration after which time the ***employee*** is expected to return to active work.

Maximum Benefit [for Essential Health Benefits/non-***Essential Health Benefits]***

Any one of the following, or any combination of the following ***Essential Health Benefits/***non-***Essential Health Benefits***:

1. The maximum amount paid by the ***Plan*** for any one ***covered person*** during the entire time he is covered by the ***Plan***.

2. The maximum amount paid by the ***Plan*** for any one ***covered person*** for a particular ***covered expense***. The maximum amount can be for:

    a. The entire time the ***covered person*** is covered under the ***Plan***, or

    b. A specified period of time, such as a calendar year.

3. The maximum number as outlined in the ***Plan*** as a ***covered expense***. The maximum number relates to the number of:

    a. Treatments during a specified period of time, or

    b. Days of ***confinement***, or

    c. Visits by a ***home health care agency***.

The ***maximum benefit*** for ***Essential Health Benefits*** and non-***Essential Health Benefits*** is tracked separately.

Measurement Period

The period of time, as determined by the ***employer*** and consistent with Federal law, regulation and guidance, utilized by the ***employer*** to determine whether a ***variable hour employee*** worked on average thirty (30) hours per week for the ***employer***.

Median Contracted Rate

The rate calculated by arranging in order from least to greatest all of the ***contracted rates*** in a geographic area for the same or similar item or service that is provided by a provider or ***facility*** in the same or similar specialty or ***facility*** type,

and selecting the middle number. If there are an even number of ***contracted rates***, the ***median contracted rate*** is the average of the middle two ***contracted rates***. ***Median contracted rates*** are:

a. calculated separately for CPT code modifiers 26 (professional component) and TC (technical component);
b. based on an ***anesthesia conversion factor*** for each anesthesia service code;
c. based on air mileage service codes (A0435 and A0436) for air ambulance services; and
d. calculated separately for each service code-modifier, when ***contracted rates*** vary based on application of a modifier.

Medically Necessary (or Medical Necessity)

Service, supply or treatment which is determined by the ***claims processor***, ***named fiduciary for post-service claim appeals***, ***named fiduciary for pre-service claim appeals***, ***employer/plan administrator*** (or its designee) to be:

1. Appropriate and consistent with the symptoms and provided for the diagnosis or treatment of the ***covered person's illness*** or ***injury*** and which could not have been omitted without adversely affecting the ***covered person's*** condition or the quality of the care rendered; and

2. Supplied or performed in accordance with current standards of medical practice within the United States; and

3. Not primarily for the convenience of the ***covered person*** or the ***covered person's*** family or ***professional provider***; and

4. Is an appropriate supply or level of service that safely can be provided; and

5. Is recommended or approved by the attending ***professional provider***.

The fact that a ***professional provider*** may prescribe, order, recommend, perform or approve a service, supply or treatment does not, in and of itself, make the service, supply or treatment ***medically necessary*** and the ***claims processor***, ***named fiduciary for post-service claim appeals***, ***named fiduciary for pre-service claim appeals***, ***employer/plan administrator*** (or its designee), may request and rely upon the opinion of a ***physician*** or ***physicians***. The determination of the ***claims processor***, ***named fiduciary for post-service claim appeals***, ***named fiduciary for pre-service claim appeals***, ***employer/plan administrator*** (or its designee) shall be final and binding.

Medicare

The programs established by Title XVIII known as the Health Insurance for the Aged Act, which includes: Part A, Hospital Benefits For The Aged; Part B, Supplementary Medical Insurance Benefits For The Aged; Part C, Miscellaneous provisions regarding both programs; and Part D, Medicare Prescription Drug Benefit, including any subsequent changes or additions to those programs.

Mental and Nervous Disorder

An emotional or mental condition characterized by abnormal functioning of the mind or emotions. Diagnosis and classifications of these conditions will be determined based on standard DSM (diagnostic and statistical manual of mental disorders) or the current edition of International Classification of Diseases, published by the U.S. Department of Health and Human Services.

Named Fiduciary for Post-Service Claim Appeals

Trustmark Health Benefits, Inc.

Named Fiduciary for Pre-Service Claim Appeals

Anthem.

Negotiated Rate

The rate the ***preferred providers*** have contracted to accept as payment in full for ***covered expenses*** of the ***Plan***.

Nonparticipating Pharmacy

Any pharmacy, including a ***hospital*** pharmacy, ***physician*** or other organization, licensed to dispense prescription drugs which does not fall within the definition of a ***participating pharmacy***.

Nonpreferred Provider

A ***physician***, ***hospital***, or other health care provider who does not have an agreement in effect with the ***Preferred Provider Organization*** at the time services are rendered.

Nurse

A licensed person holding the degree Registered Nurse (R.N.), Licensed Practical Nurse (L.P.N.), Licensed Vocational Nurse (L.V.N.) or Doctorate of Nursing Practice (D.N.P.) who is practicing within the scope of their license.

Out-of-Network Rate

The final payment amount under this ***Plan*** for ***covered expenses*** from a ***nonpreferred provider*** is:

1. Subject to number 3. below, in a State that has in effect an applicable specified State law, the amount determined in accordance with such law.

2. Subject to number 3. below, if no applicable specified State law:

    a. Subject to number 2.b. below, the agreed amount if the ***nonpreferred provider*** and this ***Plan*** agree on an amount of payment (including if the amount agreed upon is the initial amount paid by this ***Plan*** or is agreed through negotiations); or

    b. The amount determined by the ***certified IDR entity***.

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

Outpatient

A ***covered person*** shall be considered to be an ***outpatient*** if he is treated at:

1. A ***hospital*** as other than an ***inpatient***;

2. A ***physician's*** office, laboratory or x-ray ***facility***; or

3. An ***ambulatory surgical facility***; and

The stay is less than twenty-three (23) consecutive hours.

Partial Confinement

A period of at least six (6) hours but less than twenty-four (24) hours per day of active treatment up to five (5) days per week in a ***facility*** licensed or certified by the state in which treatment is received to provide one or more of the following:

1. Psychiatric services.

2. Treatment of ***mental and nervous disorders***.

3. ***Substance use disorder*** treatment.

It may include day, early evening, evening, night care, or a combination of these four.

Participating Pharmacy

Any pharmacy licensed to dispense prescription drugs which is contracted with the ***pharmacy benefit manager***.

Part-time

Employees who are regularly scheduled to work less than the hours per work week as listed in the section titled *Eligibility, Enrollment and Effective Date, Employee Eligibility*.

Pharmacy Benefit Manager

The ***pharmacy benefit manager*** is Caremark.

Physical Status Modifier

The standard modifier describing the physical status of the patient used to distinguish between various levels of complexity of an anesthesia service provided expressed as a unit with a value between zero (0) and three (3).

Physician

A Doctor of Medicine (M.D.) or a Doctor of Osteopathy (D.O.), other than a ***close relative*** of the ***covered person*** who is practicing within the scope of his license.

Placed For Adoption

The date the ***employee*** assumes legal obligation for the total or partial financial support of a child during the adoption process.

Plan

"***Plan***" refers to the benefits and provisions for payment of same as described herein. The ***Plan*** is the Wente Family Estates PPO Medical Plan with Health Reimbursement Account.

Plan Administrator

The ***plan administrator*** is responsible for the day-to-day functions and management of the ***Plan***. The ***plan administrator*** is the ***employer***.

Plan Sponsor

The ***plan sponsor*** is Wente Family Estates.

Preferred Provider

A ***physician***, ***facility*** or other health care provider who has an agreement in effect with the ***Preferred Provider Organization*** at the time services are rendered. ***Preferred providers*** agree to accept the ***negotiated rate*** as payment in full.

Preferred Provider Organization

The organization, designated by the ***plan administrator***, who selects and contracts with certain ***hospitals***, ***physicians***, and other health care providers to provide services, supplies and treatment to ***covered persons*** at a ***negotiated rate***. The ***Preferred Provider Organization's*** name and/or logo is shown on the front of the ***covered person's*** ID card.

Pregnancy

The physical state which results in childbirth or miscarriage.

Primary Care Physician (PCP)

A licensed Doctor of Medicine (M.D.) or Doctor of Osteopathy (D.O.) who is a general or family practitioner, pediatrician, gynecologist/obstetrician or general internist.

Prior Plan

Any plan of group accident and health benefits provided by the ***employer*** (or its predecessor) for an employee group which has been replaced by coverage under this ***Plan***.

Privacy Rule

Health Insurance Portability and Accountability Act of 1996 (HIPAA) and its implementing regulation concerning privacy of individually identifiable health information, as published in 65 Fed. Reg. 82461 (Dec. 28, 2000) and as modified and published in 67 Fed. Reg. 53181 (Aug. 14, 2002).

Professional Provider

A licensed ***physician***; surgeon; or any other licensed practitioner required to be recognized by state law, if applicable, and performing services within the scope of such license, who is not a family member.

Qualified Prescriber

A ***physician***, ***dentist*** or other health care practitioner who may, in the legal scope of their license, prescribe drugs or medicines.

Qualifying Payment Amount

a. For items or services furnished during 2022, the ***median contracted rate*** on January 31, 2019;

b. For items or services furnished after 2022, the ***median contracted rate*** in the immediately preceding year;

c. For items or services for which there is insufficient information to calculate the ***median contracted rate***, the ***qualifying payment amount*** will be calculated by identifying the rate that is equal to the median of the ***negotiated rates*** for the same or similar item or service provided in the geographic region in the year immediately preceding the year in which the item or service is furnished determined through the use of any eligible database;

The amount in a., b., or c. above is increased for inflation in accordance with the CPI-U published by the Bureau of Labor Statistics of the Department of Labor.

d. For items or services furnished during 2022 and billed under a new service code where there is insufficient information to calculate the ***median contracted rates***, a reasonably related service code that existed in the immediately preceding year will be identified.

    i. If the Centers for Medicare & Medicaid Services has established a ***Medicare*** payment rate for the item or service billed under the new service code, the ***qualifying payment amount*** will be calculated by first calculating the ratio of the rate that ***Medicare*** pays for the new service code compared to the rate that ***Medicare*** pays for the related service code. This ratio is then multiplied by the ***qualifying payment amount*** for the related service code for the year in which the item or service is furnished.

    ii. If the Centers for Medicare & Medicaid Services has not established a ***Medicare*** payment rate for the item or service billed under the new service code, the ***qualifying payment amount*** will be calculated by first calculating the ratio of the rate that this ***Plan*** reimburses for the new service code compared to the rate this ***Plan*** reimburses for the related service code. This ratio is then multiplied by the ***qualifying payment amount*** for the related service code.

e. For items or services furnished after 2022 and billed under a new service code, the ***qualifying payment amount*** described in letter d. above will be increased for inflation in accordance with the percentage increase in the

CPI-U published by federal regulators.

f. For anesthesia services furnished during 2022, the ***median contracted rate*** for the ***anesthesia conversion factor*** on January 31, 2019 increased for inflation in accordance with the increase in the CPI-U published by federal regulators (referred to as the indexed ***median contracted rate*** for the ***anesthesia conversion factor***), multiplied by the sum of the ***base unit***, time unit (measured in 15-minute increments or a fraction thereof), and ***physical status modifier*** unit. For anesthesia services furnished during 2023 or later, the indexed ***median contracted rate*** for the ***anesthesia conversion factor*** will be based on the same or similar item or service in the immediately preceding year.

g. For air ambulance services billed using air mileage service codes (A0435 and A0436), the ***median contracted rate*** increased for inflation in accordance with the increase in the CPI-U published by federal regulators (referred to as the indexed median ***air mileage rate***), multiplied by the number of loaded miles (the number of miles a patient is transported in the air ambulance vehicle).The ***qualifying payment amount*** for other service codes associated with air ambulance services is calculated consistent with a. through e above.

h. For any other items or services where payment is determined by multiplying a ***contracted rate*** by another unit value, the ***qualifying payment amount*** for such items or services will be based on a calculation methodology similar to f. and g. above.

Recognized Amount

With respect to ***covered expenses*** furnished by a ***nonpreferred provider***:

a. Subject to letter c. of this definition, in a State that has in effect an applicable specified State law, the amount determined in accordance with such law;

b. Subject to letter c. of this definition, in a State that does not have in effect an applicable specified State law, the lesser of:

   i. The provider's actual charge; or

   ii. The ***qualifying payment amount***;

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

Reconstructive Surgery

Surgical repair of abnormal structures of the body, caused by congenital defects, developmental abnormalities, trauma, infection, tumors or disease.

Rehabilitative Services

Medically necessary health care services that help a ***covered person*** get back, keep, or improve skills for daily living that have been lost or impaired after sickness, ***injury***, or disability. These services assist individuals in improving or maintaining, partially or fully, skills and functioning for daily living. ***Rehabilitative services*** include, but are not limited to, physical therapy, occupational therapy, speech-language pathology and audiology, and psychiatric rehabilitation.

Relevant Information

Relevant information, when used in connection with a claim for benefits or a claim appeal, means any document, record or other information:

1. Relied on in making the benefit determination; or

2. That was submitted, considered or generated in the course of making a benefit determination, whether or not relied upon; or

3. That demonstrates compliance with the duties to make benefit decisions in accordance with ***Plan*** documents and to make consistent decisions; or

4. That constitutes a statement of policy or guidance for the ***Plan*** concerning the denied treatment or benefit for the ***covered person's*** diagnosis, even if not relied upon.

Required By Law

The same meaning as the term "required by law" as defined in 45 CFR 164.501, to the extent not preempted by ERISA or other Federal law.

Retail Clinic

A clinic whose primary function is to provide limited routine medical services in a retail-based store location staffed with licensed ***professional providers***.

Room and Board

Room and linen service, dietary service, including meals, special diets and nourishments, and general nursing service. ***Room and board*** does not include personal items.

Semiprivate

The daily ***room and board*** charge which a ***facility*** applies to the greatest number of beds in its ***semiprivate*** rooms containing two (2) or more beds.

Serious and Complex Condition

In the case of an acute ***illness***, a condition that is serious enough to require specialized medical treatment to avoid the reasonable possibility of death or permanent harm. In the case of a chronic ***illness*** or condition, a condition that:

1. Is life-threatening, degenerative, potentially disabling, or congenital; and
2. Requires specialized medical care over a prolonged period of time.

Stability Period

The period of time as determined by the ***employer*** and consistent with Federal law, regulation and guidance, after the ***measurement period*** has been completed.

Stabilize

To provide medical treatment of an ***emergency medical condition*** as necessary, to assure within reasonable medical probability, that no material deterioration of the condition is likely to result from or occur during the transfer of the ***covered person*** from a ***facility***, including delivery with respect to a pregnant woman who is having contractions.

Substance Use Disorder

Any disease or condition that is classified as a ***substance use disorder*** in the current edition of the International Classification of Diseases, in effect at the time services are rendered. The fact that a disorder is listed in the International Classification of Diseases or any other publication does not mean that treatment of the disorder is covered by this ***Plan***.

Telemedicine Services

Telephone or web-based video consultations and health information provided by a state licensed ***physician***.

Telemedicine Services Vendor

The ***telemedicine services vendor*** is Teladoc.

Treatment Center

1. An institution which does not qualify as a ***hospital***, but which does provide a program of effective medical and therapeutic treatment for ***substance use disorder***, and

2. Where coverage of such treatment is mandated by law, has been licensed and approved by the regulatory authority having responsibility for such licensing and approval under the law, or

3. Where coverage of such treatment is not mandated by law, meets all of the following requirements:

    a. It is established and operated in accordance with the applicable laws of the jurisdiction in which it is located.

    b. It provides a program of treatment approved by the ***physician***.

    c. It has or maintains a written, specific, and detailed regimen requiring full-time residence and full-time participation by the ***covered person***.

    d. It provides at least the following basic services:

        (i.) ***Room and board***

        (ii.) Evaluation and diagnosis

        (iii.) Counseling

        (iv.) Referral and orientation to specialized community resources.

Urgent Care

An ***emergency medical condition*** or an onset of severe pain that cannot be managed without immediate treatment.

Urgent Care Center

A ***facility*** which is engaged primarily in providing minor emergency and episodic medical care and which has:

1. a board-certified ***physician***, a Registered Nurse (RN) and a registered x-ray technician in attendance at all times;

2. has x-ray and laboratory equipment and life support systems.

An ***urgent care center*** may include a clinic located at, operated in conjunction with, or which is part of a regular ***hospital***.

Variable Hour Employee

An ***employee*** as defined by Federal law, regulation and guidance.

ADOPTION

Wente Family Estates has caused this Wente Family Estates PPO Medical Plan (***Plan***) with Health Reimbursement Account to take effect as of the first day of January 1, 2021, at Livermore, CA. This is a revision of the ***Plan*** previously adopted January ,1 2021. I have read the document herein and certify the document reflects the terms and conditions of the employee welfare benefit plan as established by Wente Family Estates.

BY: Regina Geranen DATE: May 23, 2022