BRIDGEWAY BEHAVIORAL HEALTH SERVICES

HOMESTEAD CLAIM WATCHER
HEALTH BENEFIT PLAN

PLAN DOCUMENT AND SUMMARY PLAN DESCRIPTION

Table of Contents

ESTABLISHMENT AND ADOPTION OF THE PLAN

THIS PLAN DOCUMENT AND SUMMARY PLAN DESCRIPTION, made by Bridgeway Behavioral Health Services (the "Company" or the "Plan Sponsor") as January 1, 2025 hereby sets forth the provisions of the Bridgeway Behavioral Health Services Homestead, Claim Watcher Health Benefit Plan (the "Plan"). Any wording which may be contrary to Federal Laws or Statutes is hereby understood to meet the standards set forth in such. Also, any changes in Federal Laws or Statutes which could affect the Plan are also automatically a part of the Plan, if required.

Effective Date

The Plan Document is effective as of the date first set forth above, and each amendment is effective as of the date set forth therein.

Adoption of the Plan Document

The Plan Sponsor, as the settlor of the Plan, hereby adopts this Plan Document as the written description of the Plan. This Plan Document represents both the Plan Document and the Summary Plan Description, which is required by Sections 402 and 102 of the Employee Retirement Income Security Act of 1974, 29 U.S.C. et seq. ("ERISA"). This Plan Document amends and replaces any prior statement of the health care coverage contained in the Plan or any predecessor to the Plan.

IN WITNESS WHEREOF, the Plan Sponsor has caused this Plan Document to be executed.

Bridgeway Behavioral Health Services

By: Gina Verne

Date: 6/26/25

Name: Gina Verne

Title: CHRO

INTRODUCTION AND PURPOSE; GENERAL PLAN INFORMATION

General Purpose

The Bridgeway Behavioral Health Services Health Benefit Plan (the "Plan") has been established by the Company (also referred to herein as the "Plan Sponsor"). Plan benefits are funded solely from the general assets of the Plan Sponsor. Covered Persons in the Plan may be required to contribute toward their benefits. Contributions received from Covered Persons are used to cover Plan costs and are expended immediately.

The Plan is designed to provide Hospital, Surgical, Medical, Major Medical, Prescription, and Vision benefits. The Plan is intended, subject to the limitations and contingencies set forth herein, to provide protection against various health risks, and is not intended to provide any form of deferred compensation. Accordingly, the Plan does not create any vested rights, and the Company reserves the right to amend, modify and suspend the Plan at any time and from time to time and to terminate the Plan in whole or in part at any time. Furthermore, the health benefits provided under the Plan provide solely for the payment of all or a portion of the health care expenses Incurred by a Covered Person. All decisions regarding health care, including decisions regarding whether to obtain health care, will be solely the responsibility of each Covered Person in consultation with the health care Providers selected by the Covered Person. The Plan only governs decisions as to the percentage of allowable health care expenses that will be reimbursed and whether particular treatments or health care expenses are eligible for reimbursement. Any decision with respect to the level of heath care reimbursement, or the coverage of a particular health care expense, may be disputed by the Covered Person in accordance with the Plan's claims procedure. Each Covered Person may use any source of care for health treatment and health coverage as selected by such individual, and neither the Plan, the Company or any of their agents shall have any obligation for the cost or legal liability for the outcome of such care, or as a result of a decision by a Covered Person not to seek or obtain such care, other than liability under the Plan for the payment of benefits.

Documentation

The Plan shall consist of:

1. This instrument.
2. Any instrument setting forth any amendment or modification of any provision set forth herein, or addition or deletion hereto.
3. Any instrument suspending any provision hereof in whole or in part (or ending any such suspension through reactivation).
4. Any instrument terminating in whole or in part the Plan.
5. Any document incorporated herein by reference (such as, by way of example, any policy statement setting forth eligibility provisions or schedules of benefits under the Plan, any trust or custodial agreement governing management of any assets of the Plan, or any insurance policy through which benefits of the Plan are funded).
6. Any schedule of benefits promulgated by the Company; and
7. Amendments and modifications to any of the foregoing.

Any properly executed or adopted document setting forth an amendment or modification of any provision of any of the instruments described in this section, or suspending, reactivating or terminating any of such instruments (or any provisions thereof) in whole or in part shall be deemed a part of the Plan, and shall, to

the extent required by context and to the extent inconsistent with prior affected provisions of any such instrument, be deemed to modify and supersede such affected provisions.

Plan Rules

Failure to follow the eligibility or enrollment requirements of this Plan may result in delay of coverage or no coverage at all. Reimbursement from the Plan can be reduced or denied because of certain provisions in the Plan, such as Coordination of Benefits, subrogation, exclusions, timeliness of COBRA elections, utilization review or other cost management requirements, lack of Medical Necessity, lack of timely filing of claims or lack of coverage. These provisions are explained in summary fashion in this document; additional information is available from the Plan Administrator at no extra cost.

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

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

If the Plan is terminated, amended, or benefits are eliminated, the rights of Covered Persons are limited to Covered Expenses Incurred before termination, amendment or elimination.

General Plan Information

Name of Plan:	**Bridgeway Behavioral Health Services**
Plan Sponsor:	**Bridgeway Behavioral Health Services 373 Clermont Terrace Union, NJ 07073**
Plan Administrator: (Named Fiduciary)	**Bridgeway Behavioral Health Services 373 Clermont Terrace Union, NJ 07073**
Plan Sponsor ID No. (EIN):	**22-2257891**
Source of Funding:	**Self-Funded**
Plan Status:	**Non-Grandfathered**
Applicable Law:	**ERISA**
Plan Year:	**January 1 through December 31**
Plan Type:	**Medical and Pharmacy**
Medical Third-Party Administrator:	**INDECS, a Homestead Company PO Box 46511 Cincinnati, OH 45246-0511**
Medical Claims Processor:	**INDECS, a Homestead Company PO Box 46511 Cincinnati, OH 45246-0511**
Prescription Drug Third Party Administrator:	**CVS Caremark PO Box 52136 Phoenix, AZ 85072-2136**
Claims Audit Decision Maker(s)	**Claim Watcher, LLC**

	50 S. 16th Street, Suite 3400 Philadelphia, PA 19102
Claims Fiduciary:	**The Phia Group LLC 40 Pequot Way Canton, MA 02021 781-535-5602**
Agent for Service of Process:	**Bridgeway Behavioral Health Services 373 Clermont Terrace Union, NJ 07073**

Non-English Language Notice

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

Legal Entity; Service of Process

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

Not a Contract

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

Applicable Law

This is a self-funded benefit Plan coming within the purview of the Employee Retirement Income Security Act of 1974 ("ERISA"). The Plan is funded with employee and/or employer contributions. As such, when applicable, Federal law and jurisdiction preempt State law and jurisdiction. The Plan intends to comply with all applicable requirements of Federal law and related regulations.

Conformity to Law

This Plan shall be deemed automatically to be amended to conform as required by any applicable law, regulation or the order or judgment of a court of competent jurisdiction governing provisions of this Plan, including, but not limited to, stated maximums, Exclusions or Limitations. In the event that any law, regulation or the order or judgment of a court of competent jurisdiction causes the Plan Administrator to pay claims that are otherwise limited or excluded under this Plan, such payments will be considered as being in accordance with the terms of this Plan Document and Summary Plan Description. It is intended that the Plan will conform to the requirements of ERISA, as it applies to employee welfare plans, as well as any other applicable laws or regulations.

Discretionary Authority

The Plan Administrator shall have sole, full and final discretionary authority to interpret all Plan provisions, including the right to remedy possible ambiguities, inconsistencies or omissions in the Plan and related documents; to make determinations regarding issues relating to eligibility for benefits in including granting

waivers or exceptions; to decide disputes that may arise relative to a Covered Person's rights; and to determine all questions of fact and law arising under the Plan.

Claims Processor Is Not A Fiduciary

A Claims Processor is not a fiduciary under the Plan by virtue of paying claims in accordance with the Plan's rules as established by the Plan Administrator, and this Plan Document.

REQUIRED NOTICES

Notwithstanding any other provisions of this Plan Document, the following applies in general:

Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA)

The Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA) was passed on October 3, 2008. This law applies to Calendar Years beginning on or after October 3, 2009.

Under MHPAEA, a group health plan providing both Mental Health benefits and medical/surgical benefits may comply with the MHPAEA requirements in any of the following general ways:

1. Any financial requirement or treatment limitation that applies to Mental Health or Substance Use Disorder benefits cannot be more restrictive than the "predominant" financial requirements or treatment limitations applied to substantially all medical and surgical benefits.
2. There cannot be separate cost sharing or treatment limitation requirements that apply to Mental Health or Substance Use Disorder benefits.
3. If a plan covers medical/surgical benefits provided by non--PPO Providers, it must provide non--PPO Mental Health or Substance Use Disorder benefits in a manner consistent with the law's parity requirements.

The Genetic Information Nondiscrimination Act

The Genetic Information Nondiscrimination Act of 2008 (GINA) prohibits employers and other entities covered by GINA Title II from requesting or requiring Genetic Information of an individual or family member of the individual, except as specifically allowed by this law. To comply with this law, we are asking that you not provide any Genetic Information when responding to a request for medical information.

Women's Health and Cancer Rights Act of 1998

If you have had or are going to have a mastectomy, you may be entitled to certain benefits under the Women's Health and Cancer Rights Act of 1998 (WHCRA). For individuals receiving mastectomy-related benefits, coverage will be provided in a manner determined in consultation with the attending Physician and the patient, for:

1. All stages of reconstruction of the breast on which the mastectomy was performed.
2. Surgery and reconstruction of the other breast to produce a symmetrical appearance.
3. Prostheses; and
4. Treatment of physical complications of the mastectomy, including lymphedema.

These benefits will be provided subject to the same Deductibles and Coinsurance applicable to other medical and surgical benefits provided under this Plan. If you would like more information on WHCRA benefits, call your Plan Administrator at the member phone number on your medical benefits card.

Newborns and Mothers' Health Protection Act of 1996

This Plan complies with all provisions of the Newborns' and Mothers' Health Protection Act of 1996.

On September 26, 1996, the Newborns' and Mothers' Health Protection Act of 1996 (NMHPA) was signed into law. NMHPA requires plans that offer maternity coverage to pay for at least a 48-hour Hospital stay following a vaginal delivery and a 96-hour Hospital stay after a cesarean section.

NMHPA and its regulations provide that health plans and insurance issuers may not restrict a mother's or newborn's benefits for a Hospital length of stay that is connected to childbirth to less than 48 hours following a vaginal delivery or 96 hours following a delivery by cesarean section. However, the attending Provider (who may be a Physician or nurse midwife) may decide, after consulting with the mother, to discharge the mother or newborn Child earlier.

NMHPA and its regulations prohibit incentives (either positive or negative) that could encourage less than the minimum protections under the Act as described above.

A mother cannot be encouraged to accept less than the minimum protections available to her under NMHPA, and an attending Provider cannot be induced to discharge a mother or newborn earlier than 48 hours following a vaginal delivery or earlier than 96 hours after cesarean section.

Under NMHPA, plans and issuers may not require that a Provider obtain authorization from the plan or the issuer for prescribing a length of stay not in excess of 48 hours following a vaginal delivery or 96 hours following a delivery by cesarean section.

Nondiscrimination Rights

The Covered Person has the right to receive health care services without discrimination:

1. Based on race, ethnicity, age, mental or physical disability, genetic information, color, religion, gender, national origin, source of payment, sexual orientation, or sex, including sex stereotypes and gender identity.
2. For Medically Necessary health services made available on the same terms for all individuals, regardless of sex assigned at birth, gender identity, or recorded gender.
3. Based on an individual's sex assigned at birth, gender identity, or recorded gender, if it is different from the one to which such health service is ordinarily available.
4. Related to gender transition if such denial or limitation results in discriminating against a transgender individual.

PLAN DEFINITIONS

The following words and phrases shall have the following meanings when used in the Plan Document. **The following definitions are not an indication that charges for particular care, supplies or services are eligible for payment under the Plan; please refer to the appropriate sections of the Plan Document for that information.**

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

"**Accidental Injury**" means bodily Injury which results from an accident directly and independently of all other causes.

"**Administrative Period**" means a period of 31 days beginning immediately following the end of the Measurement Period and ending immediately before the start of the associated Stability Period. This period of time is used by the Employer to determine if Variable Hour Employees and/or Ongoing Employees are eligible for coverage and, if so, to make an offer of coverage. An Administrative Period may not exceed 90 days.

"**Alcohol or Drug Abuse and Dependency**"

Any use of alcohol or other drugs which produces a pattern of pathological use that:

1. Causes impairment in the way people relate to others; or
2. Causes impairment in the way people function in their jobs or careers; or
3. Produces a dependency that makes a person physically ill when the alcohol or drug is taken away.

"**Alcohol or Drug Abuse and Dependency, Substance Abuse, and Substance Use Disorder"** –

A mental disorder is a clinically significant behavioral or psychological syndrome or pattern that occurs in an individual and that is associated with present distress or disability or with a significantly increased risk of suffering death, pain, disability, or an important loss of freedom.

"**Allowable Expense or Covered Expense**" Any medically necessary item of expense, for which the charge is reasonable and necessary, within Allowable Claim Limits, or is based on the contracted fee schedule of an alternate care delivery system. The Allowable Expense will be determined by the Plan Administrator, in its sole discretion.

"**Allowable Claim Limit**" means the amount of covered expenses that will be considered by THE PLAN for reimbursement in accordance with the results of the Claim Review and Audit Program and in keeping with the Patient Protection and Affordable Care Act. Please refer to the section entitled "Claim Review and Audit Program" for information regarding Plan provisions related to the audit and adjudication of certain eligible Claims under that Program.

"**Alternative Therapies**" means complementary and alternative medicine, as defined by the National Institute of Health's National Center for Complementary and Alternative Medicine (NCCAM) is a group of diverse medical and health care systems, practices, and products, currently not considered to be part of conventional medicine. NCCAM categorizes Complementary Medicine and Alternative Therapies into the following five classifications:

1. Alternative medical systems (e.g., homeopathy, naturopathy, Ayurveda, traditional Chinese medicine).

2. Mindbody interventions which include a variety of techniques designed to enhance the mind's capacity to affect bodily function and symptoms (e.g., meditation, prayer, mental healing, and therapies that use creative outlets such as art, music, or dance).

3. Biologically based therapies using natural substances such as herbs, foods, vitamins, or nutritional supplements to prevent and treat Illness, (e.g., diets, macrobiotics, megavitamin therapy).

4. Manipulative and body-based methods (e.g. massage, equestrian/hippotherapy); and

5. Energy therapies, involving the use of energy fields. The energy therapies are of two types:

a. Biofield therapies – intended to affect energy fields that purportedly surround and penetrate the human body. This includes forms of energy therapy that manipulate biofields by applying pressure and/or manipulating the body by placing the hands in or through these fields. Examples include Qi Gong, Reiki, and therapeutic touch.

b. Bioelectromagnetic based therapies involve the unconventional use of electromagnetic fields, such as pulsed fields, magnetic fields, or alternating current or -direct current- fields.

"Alternate Recipient" Alternate Recipient" shall mean any Child of a Participant who is recognized under a Medical Child Support Order as having a right to enrollment under this Plan as the Participant's eligible Dependent. For purposes of the benefits provided under this Plan, an Alternate Recipient shall be treated as an eligible Dependent, but for purposes of the reporting and disclosure requirements under ERISA, an Alternate Recipient shall have the same status as a Participant.

"**AMA**" means the American Medical Association.

"**Ambulance Service**" means the charges by a professional ambulance service, land, or air, for transporting a Covered Person when Medically Necessary and appropriate to:

1. A local Hospital if it can provide the needed care and treatment.

2. The nearest Hospital that can furnish the needed care and treatment if a local Hospital cannot provide it and the person is admitted as an Inpatient; or

3. Another Inpatient Facility.

"**Ambulatory Surgical Center**" means a Provider, with an organized staff of Physicians, which is licensed as required and which has been approved by the Joint Commission on Accreditation of Healthcare Organizations, or by the Accreditation Association for Ambulatory Health Care, Inc., or by the Plan Administrator and which:

1. Has permanent facilities and equipment for the primary purposes of performing surgical procedures on an Outpatient basis.

2. Provides treatment by or under the supervision of Physicians and nursing services whenever the patient is in the 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 Provider.

"**Ancillary Provider**" means an individual or entity that provides services, supplies, or equipment (such as, but not limited to, Infusion Therapy Services, Durable Medical Equipment and Ambulance Services), for which benefits are provided under this Plan.

"**Anesthesia**" means the administration of regional anesthetic or the administration of a drug or other anesthetic agent by injection or inhalation, the purpose and effect of which is to obtain muscular relaxation, loss of sensation or loss of consciousness.

"**Appeal**" means a request by a Covered Person, or the Covered Person's representative or Provider, acting on the Covered Person's behalf upon written consent, to change a previous decision made by the Plan Administrator.

1. **Administrative Appeal an-** Appeal by or on behalf of a Covered Person that focuses on unresolved disputes or objections regarding coverage terms such as contract exclusions and no covered benefits. Administrative Appeal may present issues related to Medical Necessity, but these are not the primary issues that affect the outcome of the Appeal.

2. **Medical Necessity Appeal a-** request for the Plan Administrator to change its decision, based primarily on Medical Necessity, to deny or limit the provision of a Covered Expense.

3. **Expedited Appeal a-** faster review of a Medical Necessity Appeal, conducted when the Plan Administrator determines that a delay in decision making would seriously jeopardize the Covered Person's life, health, or ability to regain maximum function.

"**Application**" means the request, either written or via electronic transfer, of the Employee for coverage, set forth in a format approved by the Plan Administrator.

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

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

A "qualified individual" is someone who is eligible to participate in an "Approved Clinical Trial" and either the individual's doctor has concluded that participation is appropriate, or the Covered Person provides medical and scientific information establishing that their participation is appropriate.

"Routine patient costs" include all items and services consistent with the coverage provided in the plan that is typically covered for a qualified individual who is not enrolled in a clinical trial. Routine patient costs do not include:

1. The Investigative item, device, or service itself.

2. Items and services that are provided solely to satisfy data collection and analysis needs and that are not used in the direct clinical management of the patient; and

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

A phase I, II, III, or IV clinical trial that is conducted in relation to the prevention, detection, or treatment of cancer or other Life-Threatening Disease or Condition and is described in any of the following:

1. Federally funded trials: the study or investigation is approved or funded (which may include funding through in-kind contributions) by one or more of the following:

    a. The National Institutes of Health (NIH).

b. The Centers for Disease Control and Prevention (CDC).

c. The Agency for Healthcare Research and Quality (AHRQ).

d. The Centers for Medicare and Medicaid Services (CMS).

e. Cooperative group or center of any of the entities described above or the Department of Defense (DOD) or the Department of Veterans Affairs (VA).

2. Any of the following if the Conditions for Departments are met:

   a. The Department of Veterans Affairs (VA).

   b. The Department of Defense (DOD); or

   c. The Department of Energy (DOE).

3. The study of investigation is conducted under an investigational new drug application reviewed by the Food and Drug Administration (FDA); or

4. The study or investigation is a drug trial that is exempt from having such an investigational new drug application.

In the absence of meeting the criteria listed above, the Clinical Trial must be approved by the Claims Administrator as a Qualifying Clinical Trial.

"**ASD Treatment Plan**" means a plan for the treatment of Autism Spectrum Disorders developed by a licensed Physician or licensed Psychologist pursuant to a comprehensive evaluation or reevaluation performed in a manner consistent with the most recent clinical report or recommendations of the American Academy of Pediatrics.

"**Assignment of Benefits**" means an arrangement whereby a Covered Person assigns their right to seek and receive payment of eligible Plan benefits, in strict accordance with the terms of this Plan Document, to a Provider. If a Provider accepts said arrangement, Providers' rights to receive Plan benefits are equal to those of a Covered Person and are limited by the terms of this Plan Document. A Provider that accepts this arrangement indicates acceptance of an "Assignment of Benefits" as consideration in full for services, supplies, and/or treatment rendered. The Plan Administrator and/or Claims Audit Decision Maker may elect to revoke or disregard an Assignment of Benefits, at its discretion, and continue to treat the Participant as the sole beneficiary.

"**Attention Deficit Disorder**" means a disease characterized by developmentally inappropriate inattention, impulsiveness, and hyperactivity.

"Authorized Representative" means a person specifically authorized in writing signed by a Claimant to act on behalf of the Claimant for a benefit claim submission or an appeal of an Adverse Benefit Determination.

"**Autism**" means one of the following disorders as defined in the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders of the American Psychiatric Association:

1. Autistic Disorder.

2. Rett's Disorder.

3. Childhood Disintegrative Disorder.

4. Asperger's Syndrome; and

5. Pervasive Developmental Disorder--Not Otherwise Specified.

"**Autism Service Provider**" means a person, entity or group providing treatment of Autism Spectrum Disorders, pursuant to an ASD Treatment Plan, which is either:

1. Licensed or certified; or
2. Enrolled in the state's medical assistance program on or before the effective date of the state's Autism Spectrum Disorders law.

An Autism Service Provider shall include a Behavior Specialist.

"**Autism Spectrum Disorder**" shall have the same meaning set forth in the definition of "Autism."

1. Autistic Disorder.
2. Rett's Disorder.
3. Childhood Disintegrative Disorder.
4. Asperger's Syndrome; and
5. Pervasive Developmental Disorder Not-- Otherwise Specified.

"**Behavior Specialist**" means an individual who designs, implements, or evaluates a behavior modification intervention component of an ASD Treatment Plan, including those based on applied behavioral analysis, to produce socially significant improvements in human behavior or to prevent loss of attained skill or function, through skill acquisition and the reduction of problematic behavior.

"**Benefit Period**" means the specified period during which charges for Covered Expenses must be Incurred in order to be eligible for payment by the Plan. A charge shall be considered Incurred on the date the service or supply was provided to a Covered Person.

"**Birthing Center**" means any freestanding health facility, place, professional office, or institution which is not a Hospital or in a Hospital, where births occur in a home like atmosphere. This facility must be licensed and operated in accordance with the laws pertaining to Birthing Centers in the jurisdiction where the facility is located.

The Birthing Center must provide facilities for obstetrical delivery and short-term recovery after delivery; provide care under the full-time supervision of a Physician and either a Registered Nurse or a licensed nurse midwife; and have a written agreement with a Hospital in the same locality for immediate acceptance of patients who develop complications or require pre- or post-delivery confinement.

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

"**Carrier**" means an insurance company or similar organization retained by the Plan Sponsor to arrange for Providers, Hospitals, Medical Facilities, Physicians, Dentists, and similar services such as Pharmacy Benefit Managers to be part of a Network. The Carrier or PPO Provider provides servicing and pricing advantages to the Plan or provides other insurance such as Stop Loss Insurance to reduce the risk of catastrophic claims in a self-insured- health plan. Carrier or PPO Provider or similar organization will support the Plan Administrator in the Plan's operations, as required.

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

1. It is solely for the care and treatment of critically ill patients who require special medical attention.

2. It provides within such an area special nursing care and observation of a continuous and constant nature not available in the regular rooms and wards of the Hospital.

3. It provides a concentration of special lifesaving equipment immediately available at all times for the treatment of patients confined within such an area.

4. It contains at least two beds for the accommodation of critically ill patients.

5. It provides at least one professional Registered Nurse, in continuous and constant attendance of the patient confined in such area on a 24 hour a day basis.

"**Case Management**" means Comprehensive Case Management programs serve individuals who have been diagnosed with a complex, catastrophic, or chronic Illness or Injury. The objectives of Case Management are to facilitate access by the Covered Person to ensure the efficient use of appropriate health care resources, link Covered Persons with appropriate health care or support services, assist Providers in coordinating prescribed services, monitor the quality of services delivered, and improve Covered Person outcomes. Case Management supports Covered Persons and Providers by locating, coordinating, and/or evaluating services for a Covered Person who has been diagnosed with a complex, catastrophic, or chronic Illness and/or Injury across various levels and sites of care.

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

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

If a Participant chooses not to use a Center of Excellence, the payment for services will be limited to what would have been the cost at the nearest Center of Excellence.

Additional information about this option, as well as a list of Centers of Excellence, will be given to covered Employees and updated as requested.

"**Certified Registered Nurse**" means a Certified Registered Nurse anesthetist, Certified Registered Nurse practitioner, certified entreostomal therapy nurse, certified community health nurse, certified psychiatric mental health nurse, or certified clinical nurse specialist, certified by the state Board of Nursing or a national nursing organization recognized by the State Board of Nursing. This excludes any registered professional nurses employed by a health care facility or by an anesthesiology group.

"**Child(ren)** " means in addition to an Eligible Employee's own blood descendant of the first degree or lawfully adopted Child, a Child placed with an Eligible Employee in anticipation of adoption, an Eligible Employee's Child who is an alternate recipient under a Qualified Medical Child Support Order as required by the Federal Omnibus Budget Reconciliation Act of 1993, any stepchild, an "eligible foster child" which is defined as an individual placed with the Employee by an authorized placement agency or by judgment, decree or other order of a court of competent jurisdiction or any other Child for whom an Eligible Employee has obtained Legal Guardianship. Child does not include a Child of a Dependent son or daughter. Child does not include grandchildren.

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

"**Chiropractic Care**" means skeletal adjustments, manipulation, or other treatment in connection with the detection and correction by manual or mechanical means of structural imbalance or subluxation in the human body. Such treatment is done by a Physician to remove nerve interference resulting from, or related to, distortion, misalignment, or subluxation of, or in, the vertebral column.

"Claim Determination Period" shall mean each Plan Year.

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

"**Claims Processor**" means a third party contracted by the Plan Sponsor to provide specified administrative services and to adjudicate claims in accordance with the Plan. The Claims Processor may work with a stop loss carrier, selected by the Plan Sponsor, as a reimbursement mechanism for catastrophic claims exceeding pre-determined levels. See the section entitled "General Plan Information" for a list of the Plan's Claims Processors.

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

Filing a Clean Claim.

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

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

"**COBRA**" means the Consolidated Omnibus Budget Reconciliation Act of 1985, as amended.

"**Cognitive Rehabilitation Therapy**" means medically prescribed therapeutic treatment approach designed to improve cognitive functioning after acquired central nervous system insult (e.g., trauma, stroke, acute brain insult, and encephalopathy). Cognitive rehabilitation is an integrated multidisciplinary approach that consists of tasks designed to reinforce or re-establish previously learned patterns of behavior or to establish new compensatory mechanisms for impaired neurological systems. It consists of a variety of therapy modalities which mitigate or alleviate problems caused by deficits in attention, visual processing, language, memory, reasoning, and problem solving. Cognitive rehabilitation is performed by a Physician, neuropsychologist, Psychologist as well as a physical, occupational or speech therapist using a team approach.

"Coinsurance" "Coinsurance" shall mean a cost sharing feature of many plans. It requires a Participant to pay out-of-pocket a prescribed portion of the cost of Covered Expenses. The defined Coinsurance that a

Participant must pay out-of-pocket is based upon his or her health plan design. Coinsurance is established as a predetermined percentage of the Maximum Allowable Charge for covered services and usually applies after a Deductible is met in a Deductible plan.

"**Complementary Medicine**" shall have the same meaning set forth in the definition of "Alternative Therapies."

"Contracted Services" means medical treatment and other Services and Supplies provided to a Participant by any Network Contracted or Directly Contracted Hospital, Facility, Physician or Provider.

"**Copayment**" means a type of cost sharing- in which the Covered Person pays a flat dollar amount each time a Covered Expense is provided (such as a $10 or $15 Copayment per office visit).

"Cost(s)" means: (a) as to Hospital Facility Services, the costs determined in accordance with applicable CMS Cost Ratios; (b) as to Independent Facility Services, costs determined in accordance with any relevant CMS Cost Ratios, or based on any other cost information, sources, lists or comparative data published or publicly available (free, for purchase or by subscription), or any combination thereof that are deemed sufficient, in the opinion of the Claims Delegate Claims Audit Decision Maker; (c) as to medical and surgical supplies, implants and devices, the costs to the Provider of such items, which may be established by a Provider invoice or a certified statement from a representative of the Provider or, in the absence of a such an invoice or statement, through other sources of cost information or comparative data, such as comparable invoices, receipts, cost lists or other documentation or resources published or publicly available (free, for purchase or by subscription), or any combination thereof, that are deemed sufficient, in the opinion of the Claims Delegate Claims Audit Decision Maker; (d) as to pharmaceuticals provided by a Hospital or Facility, acquisition cost determined by reference to the National Average Drug Acquisition Cost as calculated by CMS, or the Predictive Acquisition Cost calculated by Glass Box Analytics, or other comparable and recognized data source; and (e) as to medical and surgical supplies, implants and devices provided by a Hospital or Facility, acquisition cost determined by reference to an invoice submitted by a Hospital or Facility or, in the absence of such an invoice, a written statement from the Hospital or Facility specifying its actual acquisition cost or, in the absence of such an invoice or written statement, through other documentation or sources of cost data such as, but not be limited to, comparable invoices, receipts, cost lists or other commonly recognized data source, or other documentation or sources of cost information deemed appropriate by the Claims Delegate Claims Audit Decision Maker.

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

All treatment is subject to benefit payment Maximums shown in the Schedule of Covered Expenses and as set forth elsewhere in this document.

"**Covered Person**" means an Employee, and his or her Dependent(s) if entitled to coverage under the Plan.

"**Custodial Care**" means care provided primarily for Maintenance of the patient or which is designed essentially to assist the patient in meeting his or her activities of daily living (including room and board) and which is not primarily provided for its therapeutic value in the treatment of an Illness, disease, bodily Injury, or condition. 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, which do not require the technical skills or professional training of medical or nursing personnel in order to be performed safely and effectively.

"**Day Rehabilitation Program**" means a level of Outpatient Care consisting of four to seven hours of daily rehabilitative therapies and other medical services five days per week. Therapies provided may include a combination of therapies, such as Physical Therapy, Occupational Therapy, and Speech Therapy, as otherwise defined in this Plan and other medical services such as nursing services, psychological therapy, and Case Management services. Day rehabilitation sessions also include a combination of one to one- and group therapy. The Covered Person returns home each evening and for the entire weekend.

"**Deductible**" means a specified amount of Covered Expenses for the Covered Expenses that is Incurred by the Covered Person before the Plan will assume any liability. The Deductible is calculated using an Embedded Deductible.

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

"**Dependent**" means one or more of the following people(s):

1. An Employee's legal spouse possessing a marriage license.
2. An Employee's Child who is less than 26 years of age; or
3. An Employee's Domestic Partner who has the same principal place of abode for more than one half of the calendar year, and who relies on the Employee for more than one half of his or her support for the Calendar Year in which the Domestic Partner is enrolled for coverage under the Plan.

The Plan reserves the right to require documentation satisfactory to the Plan Administrator, which establishes a Dependent relationship.

"**Detoxification**" means the process by which an alcohol or drug intoxicated, or alcohol or drug dependent person is assisted, in a licensed facility, or in case of opiates, by an appropriately licensed behavioral health provider in an ambulatory setting. This treatment process will occur through the period of time necessary to eliminate, by metabolic or other means, the intoxicating alcohol or other drug, or alcohol and other drug dependency factors, or alcohol in combination with drugs, as determined by a licensed Physician, while keeping the physiological and psychological risk to the patient at a minimum.

"**Developmental Disability**" means a severe, chronic disability that:

1. Is attributable to a mental or physical impairment or a combination of mental and physical impairments.
2. Is manifested before the Covered Person:

a. Attains age 22 for purpose of the Diagnosis and Treatment of Autism and Other Developmental Disabilities provision; or

b. Attains age 26 for all other provisions.

c. Is likely to continue indefinitely.

d. Results in substantial functional limitations in three or more of the following areas of major life activity; selfcare; receptive and expressive language; learning; mobility; -self-direction; capacity for independent living; economic -self-sufficiency-.

e. Reflects the Covered Persons need for a combination and sequence of special interdisciplinary or generic care, treatment or other services which are of lifelong or of extended duration and are individually planned and coordinated. Developmental Disability includes but is not limited to severe

disabilities attributable to intellectual disability, Autism, cerebral palsy, epilepsy, spina-bifida and other neurological impairments where the above criteria is met.

"Diagnosis" "Diagnosis" shall mean the act or process of identifying or determining the nature and cause of a Disease or Injury through evaluation of patient history, examination, and review of laboratory data.

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

"Direct Contract" means a contract entered into directly by or for the direct benefit of the Plan with a Hospital, Facility, Physician or Practitioner to offer Services and Supplies to Participants at negotiated rates and fees.

"Directly Contracted" means that a Hospital, Facility, Physician or Provider is contracted directly with or for the benefit of the Plan to offer Services and Supplies to Participants at negotiated rates and fees.

"Directly Contracted Services" means medical treatment and other Services and Supplies provided to a Participant by any Directly Contracted Hospital, Facility, Physician or Provider.

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

"**Disease Management**" means a population-based approach to identify Covered Persons who have or are at risk for a particular chronic medical condition, intervene with specific programs of care, and measure and improve outcomes. Disease Management programs use evidence-based guidelines to educate and support Covered Persons and Providers, matching interventions to Covered Persons with the greatest opportunity for improved clinical or functional outcomes. Disease Management programs may employ education, Provider feedback and support statistics, compliance monitoring and reporting, and/or preventive medicine approaches to assist Covered Persons with chronic disease(s). Disease Management interventions are intended to both improve delivery of services in various active stages of the disease process as well as to reduce/prevent relapse or acute exacerbation of the condition.

"**Domestic Partner**" means a person who has been in a domestic partnership with an Employee for at least six months and who**:**

1. Are both at least 18 years of age?
2. Have resided together for at least one year and intend to do so permanently. "Reside together" means that the two individuals share the same residence. It is not necessary that the legal right to possess the residence be in both of their names (i.e., the lease or deed need not be in both names). Other proof that they and their Domestic Partner reside together, i.e., driver's licenses, passports, mortgage documents or a deed, utility bill or lease agreement, showing the same address.
3. Are financially interdependent and are able to prove such interdependence by providing documentation of at least three of the following arrangements.
    - A Domestic Partnership Agreement
    - Common ownership of real estate

- Common ownership of a motor vehicle
- A joint bank account, or joint credit card account
- Designation as a beneficiary for life insurance or retirement benefits or under each other's will
- Assignment of durable power of attorney
- Such other proof as is considered by Bridgeway Behavioral Health Services to be sufficient to establish financial interdependency under the circumstances of the particular situation.

4. Are not related by blood to a degree of closeness that would prohibit legal marriage in the state of legal residence.
5. Neither is legally married to, or legally separated from, anyone else nor is the Domestic Partner of anyone else.

The Plan Administrator reserves the right to require such evidence as it deems necessary that a Domestic Partner satisfies this definition.

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

"**Durable Medical Equipment**" means equipment which meets the following criteria:

1. It is durable and can withstand repeated use.
2. It is medical equipment, meaning it is primarily and customarily used to serve medical purposes.
3. It generally is not useful to a person in the absence of an Illness or Injury; and
4. It is appropriate for use in the home.

Durable Medical Equipment includes, but is not limited to diabetic supplies, canes, crutches, walkers, commode chairs, home oxygen equipment, Hospital beds, traction equipment and wheelchairs.

"**Effective Date**" means the date on which coverage for a Covered Person begins under this Plan. All coverage begins at 12:01 a.m. on the date reflected on the records of the Plan Administrator.

"**Eligible Employee**" means an employee, as defined in this Plan, who has met all of the eligibility requirements for participation in the Plan.

"**Embedded Deductible**" means the smaller, individual Deductible that applies to each Covered Person enrolled in a Plan that covers more than one person (a Family Unit). After a Covered Person meets the individual Deductible for a Plan Year, the Plan begins to pay Covered Expenses for that Covered Person, even if the Family Unit Deductible has not been met.

"**Emergency Medical Condition**" means a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) so that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in a condition described in clause (i), (ii), or (iii) of section 1867(e)(1)(A) of the Social Security Act (42

U.S.C. 1395dd(e)(1)(A)). In that provision of the Social Security Act, clause (i) refers to placing the health of the individual (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy; clause (ii) refers to serious impairment to bodily functions; and clause (iii) refers to serious dysfunction of any bodily organ or part.

"**Emergency Services**" means, with respect to an Emergency Medical Condition:

1. A medical screening examination (as required under section 1867 of the Social Security Act, 42 U.S.C. 1395dd) that is within the capability of the emergency department of a Hospital, including ancillary services routinely available to the emergency department to evaluate such Emergency Medical Condition; and

2. Such further medical examination and treatment, to the extent they are within the capabilities of the staff and facilities available at the Hospital, as are required under section 1867 of the Social Security Act (42 U.S.C. 1395dd(e)(3)) to Stabilize the individual.

"**Employee**" means an individual who is employed by an Employer and regularly scheduled to work at least 30 hours per week or 130 hours per month (non-variable- hour Employee) or a Variable Hour Employee who has averaged at least 30 hours per week or 130 hours per month for a complete Measurement Period and is currently in a Stability Period, as determined by the Plan Administrator. An Employee will remain eligible throughout the Stability Period regardless of a change in employment status (including, but not limited to, a reduction in hours) provided the individual continues to be an employee in accordance with the Patient Protection and Affordable Care Act (as amended).

"**Employer**" means Bridgeway Behavioral Health Services.

"**Equipment for Safety**" means items that are not primarily used for the diagnosis, care or treatment of disease or Injury but are primarily utilized to prevent Injury or provide a safe surrounding. Examples include restraints, safety straps, safety enclosures, car seats.

"**ERISA**" means the Employee Retirement Income Security Act of 1974, as amended.

"Errors" means any billing mistakes or improprieties including, but not limited to, up-coding, duplicate charges, charges for care, supplies, treatment, and/or services not actually rendered or performed, or charges otherwise determined to be invalid, impermissible, or improper based on any applicable law, regulation, rule, or professional standard.

"**Essential Health Benefits**" means, under section 1302(b) of the Patient Protection and Affordable Care Act, those health benefits to include at least the following general categories and the items and services covered within the categories: ambulatory patient services; Emergency Services; Hospitalization; maternity and newborn care; Mental Health and Substance Abuse disorder services, including behavioral health treatment; Prescription Drugs; rehabilitative and habilitative services and devices; laboratory services; preventive and wellness services and chronic Disease Management; and pediatric services, including oral and vision care.

"**Excess Charges**" means Care, supplies, treatment, and/or services that exceed Plan limits set forth herein and including (but not limited to) the Maximum Allowable Charge in the Plan Administrator's discretion and as determined by the Plan administrator, in accordance with the Plan terms as set forth by and within this document."

"**Exclusions or Limitations**" means items not covered by this Plan, or items provided on a limited basis.

"**Experimental**" means a drug, biological product, device, medical treatment, or procedure which meets any of the following criteria:

1. Is the subject of ongoing Phase I or Phase II Clinical Trials, unless related to the conduct of an Approved Clinical Trial, as such term is defined herein.

2. Is the research, experimental, study or investigational arm of ongoing Phase III Clinical Trials, unless related to the conduct of an Approved Clinical Trial, as such term is defined herein, or is otherwise under a systematic, intensive investigation to determine its maximum tolerated dose, its toxicity, its safety, its efficacy, or its efficacy as compared with a standard means of treatment or diagnosis;

3. Is not of proven benefit for the particular diagnosis or treatment of the Covered Person's particular condition.

4. Is not generally recognized by the medical community, as clearly demonstrated by Reliable Evidence, as effective and appropriate for the diagnosis or treatment of the Covered Person's particular condition; or

5. Is generally recognized, based on Reliable Evidence, by the medical community as a diagnostic or treatment intervention for which additional study regarding its safety and efficacy for the diagnosis or treatment of the Covered Person's particular condition, is recommended.

A drug will not be considered Experimental if it has received final approval by the U.S. Food and Drug Administration (FDA) to market with a specific indication for the particular diagnosis or condition present. Any other approval granted as an interim step in the FDA regulatory process, e.g., an Investigational New Drug Exemption (as defined by the FDA), is not sufficient. Once FDA approval has been granted for a particular diagnosis or condition, use of the drug for another diagnosis or condition shall require that one or more of the established referenced compendia identified in the Plan's policies recognize the usage as appropriate medical treatment.

Any biological product, device, medical treatment, or procedure is not considered Experimental if it meets all of the criteria listed below:

1. Reliable Evidence demonstrates that the biological product, device, medical treatment, or procedure has a definite positive effect on health outcomes.

2. Reliable Evidence demonstrates that the biological product, device, medical treatment, or procedure leads to measurable improvement in health outcomes, i.e., the beneficial effects outweigh any harmful effects.

3. Reliable Evidence clearly demonstrates that the biological product, device, medical treatment, or procedure is at least as effective in improving health outcomes as established technology or is usable in appropriate clinical contexts in which established technology is not employable.

4. Reliable Evidence clearly demonstrates that improvement in health outcomes, as defined in paragraph 3 above, is possible in standard conditions of medical practice, outside clinical investigatory settings.

5. Reliable Evidence shows that the prevailing opinion among experts regarding the biological product, device, medical treatment, or procedure is that studies or clinical trials have determined its maximum tolerated dose, its toxicity, its safety, its efficacy, or its efficacy as compared with a standard means of treatment for a particular diagnosis.

While the Plan does not cover treatment, it determines to be Experimental, it routinely performs technology assessments in order to determine when new treatment modalities are safe and effective. A technology assessment is the review and evaluation of available clinical and scientific information from expert sources. These sources include but are not limited to articles published by governmental agencies, national peer

review journals, national experts, clinical trials, and manufacturer's literature. The Plan Administrator with support of qualified professionals, such as a Health Insurance Provider or Pharmacy Benefit Manager, uses the technology assessment process to assure that new drugs, procedures, or devices ("emerging technology") are safe and effective before approving them as Covered Expenses. When new technology becomes available or at the request of a practitioner or Covered Person, the Plan may research all scientific information available from these expert sources. Following this analysis, the Plan Administrator makes a decision about when a new drug, procedure or device has been proven to be safe and effective and uses this information to determine when an item becomes a Covered Expense for the condition being treated or not approved as required by federal or governmental agencies. A Covered Person or his or her Provider should contact the Plan Administrator to determine whether a proposed treatment is considered "emerging technology."

"**Facility**" means an institution or entity licensed, where required, to provide care. Such facilities include:

1. Ambulatory Surgical Facility.
2. Birth Center.
3. Free Standing Dialysis Facility.
4. Free Standing Ambulatory Care Facility.
5. Home Health Care Agency.
6. Hospice.
7. Hospital.
8. Non-Hospital Facility.
9. Psychiatric Hospital.
10. Rehabilitation Hospital.
11. Residential Treatment Facility.
12. Short Procedure Unit; and/or
13. Skilled Nursing Facility.

"**Family Unit**" means the Employee and the family members who are covered as Dependents under the Plan.

"FDA" "FDA" shall mean Food and Drug Administration.

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

"FMLA" means the Family and Medical Leave Act of 1993, as amended.

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

"**Free Standing Ambulatory Care Facility**" means a Provider, other than a hospital, which provides treatment or services on an Outpatient or partial basis and is not, other than incidentally, used as an office

or clinic for the private practice of a Physician. This facility shall be licensed by the state in which it is located and be accredited by the appropriate regulatory body.

"**Free Standing Dialysis Facility**" means a Provider, licensed, or approved by the appropriate governmental agency and approved by the Provider, which is primarily engaged in providing Dialysis treatment, Maintenance or training to patients on an Outpatient or home care basis.

"**Genetic Information**" means information about genes, gene products and inherited characteristics that may be derived from an individual or a family member. This includes information regarding carrier status and information derived from laboratory tests that identify mutations in specific genes or chromosomes, physical medical examinations, family histories and direct analysis of genes or chromosomes. Genetic Information will not be considered for purposes of:

1. Determining eligibility for benefits under the Plan (including initial enrollment and continued eligibility); or
2. Establishing contribution or premium accounts for coverage under the Plan.

"**GINA**" means the Genetic Information Nondiscrimination Act of 2008 (Public Law No. 110-233), which prohibits group health plans, issuers of individual health care policies, and employers from discriminating on the basis of Genetic Information.

"**Hearing Aid**" means a Prosthetic that amplifies sound through simple acoustic amplification or through transduction of sound waves into mechanical energy that is perceived as sound. A Hearing Aid is comprised of:

1. A microphone to pick up sound.
2. An amplifier to increase the sound.
3. A receiver to transmit the sound to the ear; and
4. A battery for power.

A Hearing Aid may also have a transducer that changes sound energy into a different form of energy. The separate parts of a Hearing Aid can be packaged together into a small self-contained unit or may remain separate or even require surgical implantation into the ear or part of the ear. Generally, a Hearing Aid will be categorized into one of the following common styles:

1. Behind the ear.
2. In the ear.
3. In the canal.
4. Completely in the canal; and
5. Implantable (can be partial or complete).

A Hearing Aid is not a cochlear implant.

"**HIPAA**" means the Health Insurance Portability and Accountability Act of 1996, as amended.

"**HITECH**" means the Health Information Technology for Economic and Clinical Health Act, as amended.

"**Home Health Care**" means mean the continual care and treatment of an individual if:

1. The institutionalization of the individual would otherwise have been required if Home Health Care was not provided.
2. The treatment plan covering the Home Health Care service is established and approved in writing by the attending Physician; and
3. Home Health Care is the result of an Illness or Injury.

"**Home Health Care Agency**" means an organization that meets all of these tests:

1. Its main function is to provide Home Health Care Services and Supplies.
2. It is federally certified as a Home Health Care Agency; and
3. It is licensed by the state in which it is located if licensing is required.

"**Home Health Care Plan**" must meet these tests:

1. It must be a formal written plan made by the patient's attending Physician which is reviewed at least every 30 days.
2. It must state the diagnosis.
3. It must certify that the Home Health Care is in place of Hospital confinement; and
4. It must specify the type and extent of Home Health Care required for the treatment of the patient.

"**Home Health Care Services and Supplies**" means:

1. Part-time or intermittent nursing care by or under the supervision of a Registered Nurse.
2. Part-time or intermittent home health aide services provided through a Home Health Care Agency (this does not include general housekeeping services).
3. Physical, Occupational and Speech Therapy; and
4. Medical supplies and laboratory services by or on behalf of the Hospital.

"**Hospice**" means a Provider that is engaged in providing palliative care rather than curative care to terminally ill individuals. The Hospice must be:

1. Certified by Medicare to provide Hospice services, or accredited as a Hospice by the appropriate regulatory agency; and
2. Appropriately licensed in the state where it is located.

"**Hospice Care Plan**" means a plan of terminal patient care that is established and conducted by a Hospice agency and supervised by a Physician.

"**Hospice Care Services and Supplies**" means those services and supplies provided through a Hospice agency and under a Hospice Care Plan and include Inpatient care in a Hospice Unit or other licensed facility, home care, and family counseling during the bereavement period.

"**Hospice Unit**" means a facility or separate Hospital Unit that provides treatment under a Hospice Care Plan and admits at least two unrelated persons who are expected to die within six months.

"**Hospital**" means a short-term-, acute care, general Hospital which has been approved by the Joint Commission on Accreditation of Healthcare Organizations and/or by the American Osteopathic Hospital Association or by the Plan Administrator and which:

1. Is a duly licensed institution.
2. Is primarily engaged in providing Inpatient diagnostic and therapeutic services for the diagnosis, treatment, and care of injured and sick persons by or under the supervision of Physicians.
3. Has organized departments of medicine.
4. Provides 24-hour nursing service by or under the supervision of Registered Nurses.
5. Is not, other than incidentally, a: Skilled Nursing Facility; nursing home; Custodial Care home; health resort, spa, or sanitarium; place for rest; place for aged; place for treatment of Mental Illness; place for treatment of Alcohol or Drug Abuse; place for provision of rehabilitation care; place for treatment of pulmonary tuberculosis; place for provision of Hospice care;
6. A facility operating legally as a Psychiatric Hospital or Residential Treatment Facility for mental health and licensed as such by the state in which the facility operates.
7. A facility operating primarily for the treatment of Substance Abuse if it meets these tests: maintains permanent and full-time facilities for bed care and full-time confinement of a least 15 resident patients; has a Physician in regular attendance; continuously provides 24-hour a day nursing service by a Registered Nurse; has full-time psychiatrist or Psychologist on the staff; and is primarily engaged in providing diagnostic and therapeutic services and facilities for treatment of Substance Abuse.

"Hospital-Affiliated Facility" means an Ambulatory Surgical Center or other facility that provides medical services on an Outpatient basis and is owned, controlled, managed, or otherwise formally affiliated with a Hospital.

"Hospital and Facility Claims" means Post-service Claims for charges by any Hospital, Hospital-Affiliated Facility, or Independent Facility.

"Hospital Facilities" means Hospitals and Hospital-Affiliated Facilities (individually referred to each as a "Hospital Facility").

"**Identification Card**" means the currently effective card issued to the Covered Person by the Plan which must be presented when a Covered Expense is requested.

"**Illness**" means a bodily disorder, disease, physical sickness or Mental or Substance Abuse Disorder. Illness includes Pregnancy, childbirth, miscarriage, or complications of Pregnancy.

"**Incurred**" means that a Covered Expense is Incurred on the date the service is rendered or the supply is obtained. With respect to a course of treatment or procedure, which includes several steps or phases of treatment, covered expenses are Incurred for the various steps or phases as the services related to each step are rendered and not when services relating to the initial step or phase are rendered. More specifically, covered expenses for the entire procedure or course of treatment are not Incurred upon commencement of the first stage of the procedure or course of treatment.

"**Independent Clinical Laboratory**" means a laboratory that performs clinical pathology procedures and that is not affiliated or associated with a Hospital, Physician or Provider.

"Independent Facility" means an independent, free-standing facility that provides medical services on an Outpatient basis (e.g., an Ambulatory Surgical Center or a Nephrology center, clinic, or facility) and is not owned, controlled, managed, or otherwise affiliated with a Hospital.

"**Independent Review Organization**" means an entity qualified by applicable licensure and/or accreditation standards to function as the independent decision maker on external Medical Necessity Appeals requiring

evaluation of issues related to Medical Necessity of a Covered Person's request for Covered Expenses. The Plan Administrator arranges for the availability of IROs and assigns them to external Medical Necessity Appeals. IROs are not corporate affiliates of the Claims Processor.

"**Independent Physicians**" means Physicians who are not in the PPO Network and are not Directly Contracted.

"Independent Practitioners" means Practitioners who are not in the PPO Network and are not Directly Contracted.

"**Independent Professionals"** means Independent Physicians, Independent Practitioners, and Independent Providers.

"Independent Providers" means Providers who are not in the PPO Network and are not Directly Contracted.

"**Infertility**" means a Disease or condition that results in the abnormal function of the reproductive system such that:

1. A male is not able to impregnate a female.
2. A female is unable to conceive after 12 months of unprotected sexual intercourse.
3. The male or female is determined to be medically sterile; or
4. The female is not able to carry a Pregnancy to live birth.

Additionally, a female without a male partner may be considered infertile if:

1. For females under age 35, she is unable to conceive after at least 12 cycles of donor insemination.
2. For females aged 35 or older, unable to conceive after at least 12 cycles of donor insemination.

The term does not apply to a person who has been voluntarily sterilized, regardless of whether the person has attempted to reverse the sterilization.

"Inherited Metabolic Disease" "Inherited Metabolic Disease" shall mean a Disease caused by an inherited abnormality of body chemistry for which testing is mandated pursuant to P. L. 1977, c. 321.

"**Initial Measurement Period**" means, for a newly hired Variable Hour Employee, the Measurement Period starting from the date of hire and ending after 12 consecutive months of service.

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

"**Inpatient**" means a Covered Person's actual entry into a Hospital, extended care facility or Provider to receive Inpatient services as a registered bed patient in such Hospital, extended care facility or Provider and for whom a room and board charge is made. A Covered Person will be considered an Inpatient until such time as he or she is actually discharged from the facility.

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

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

"**Intensive Outpatient Program**" means the planned, structured services comprised of coordinated and integrated multidisciplinary services designed to treat a patient often in crisis who suffers from Mental Illness, Serious Mental Illness or Alcohol or Drug Abuse/Dependency. Intensive Outpatient Program treatment is an alternative to Inpatient Hospital treatment or Partial Hospitalization Program treatment and focuses on alleviation of symptoms and improvement in the level of functioning required to Stabilize the patient until he or she is able to transition to less intensive outpatient treatment, as required.

"Invalid Charges" means: (a) charges that are found to be based on Errors, Unbundling, Misidentification or Unclear Description; (b) charges for Medical Care, Services and/or Supplies determined not to have been Medically Necessary; (c) charges for Medical Care, Services and/or Supplies determined to exceed the Usual, Customary and Reasonable Fees for such Medical Care, Services and/or Supplies; or (d) charges that are otherwise determined by the Claims Audit Decision Maker or the Plan Administrator to be invalid or impermissible based on any applicable law, regulation, rule or professional standard.

"**Investigative**" shall have the same meaning set forth in the definition of "Experimental."

"**Legal Guardian**" means a person recognized by a court of law as having the duty of taking care of the person and managing the property and rights of a minor Child.

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

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

"Low Protein Modified Food Product" "Low Protein Modified Food Product" shall mean a food product that is: (a) specially formulated to have less than one gram of protein per serving; and (b) intended to be used under the direction of a Physician for the dietary treatment of an Inherited Metabolic Disease. The term does not include a natural food that is naturally low in protein.

"**Licensed Clinical Social Worker**" means a social worker who has graduated from a school accredited by the Council on Social Work Education with a Doctoral or master's degree and is licensed by the appropriate state authority.

"**Licensed Practical Nurse**" means a nurse who has graduated from a formal practical or nursing education program and is licensed by the appropriate state authority.

"**Maintenance**" means continuation of care and management of the Covered Person when the maximum therapeutic value of a Medically Necessary treatment plan has been achieved, no additional functional improvement is apparent or expected to occur, and the provision of Covered Expenses for a condition cease to be of therapeutic value and is no longer Medically Necessary. This includes Maintenance services that seek to prevent disease, promote health, and prolong and enhance the quality of life.

"**Master's Prepared Therapist**" means (for Mental Health/Psychiatric Services) a therapist who holds a Master's Degree in an acceptable human services related field of study and is licensed as a therapist at an independent practice level by the appropriate state authority to provide therapeutic services for the treatment of Mental Health/Psychiatric Services (including treatment of Serious Mental Illness).

"**Maximum**" means a limit on the amount of Covered Expenses that a Covered Person may receive. The Maximum may apply to all Covered Expenses or selected types. When the Maximum is expressed in

dollars, this Maximum is measured by the Covered Expenses, less Deductibles, Coinsurance and Copayment amounts paid by Covered Persons for the Covered Expenses to which the Maximum applies.

1. **Benefit Maximum the** greatest amount of a specific Covered Expense that a Covered Person may receive.

2. **Patient Protection and Affordable Care Act (PPACA) Maximums** will be in keeping with the requirements of PPACA.

"With respect to Non-Network Emergency Services, the Plan allowance is the greater of:

1. The negotiated amount for In-Network Providers (the median amount if more than one amount to In-Network Providers).

2. The Plan's normal Non-Network payable amount after consideration of the criteria described below (reduced for cost-sharing).

3. The amount that Medicare Parts A or B would pay (reduced for cost-sharing).

"**Maximum Payable Amount and/or Maximum Allowable Charge**" means the benefit payable for a specific coverage item or benefit under the Plan. Maximum Allowable Charge(s) will be the lesser of:

1. The Usual and Customary amount.

2. The allowable charge is specified under the terms of the Plan.

3. The negotiated rate established in a contractual arrangement with a Provider.

4. The actual billed charges for the covered services; or

5. The Allowable Claim Limits.

The Plan will reimburse the actual charge billed if it is less than the Usual and Customary amount. The Plan has the discretionary authority to decide if a charge is Usual and Customary and for a Medically Necessary and Reasonable service.

If and only if there is no negotiated rate for a given claim, the Plan Administrator will exercise its discretion to determine the Maximum Allowable Charge based on any of the following: Medicare reimbursement rates, Medicare cost data, amounts actually collected by providers in the area for similar services, or average wholesale price (AWP) or manufacturer's retail pricing (MRP). These ancillary factors will consider generally accepted billing standards and practices.

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

"**Measurement Period**" means a period of time selected by the Employer during which Variable Hour Employee's and/or Ongoing Employee's hours of service are tracked to determine his or her employment status for benefit purposes.

"**Medical Care**" means Services and Supplies rendered by a Provider within the scope of his or her license for the treatment of an Illness or Injury.

"**Medical Foods**" means liquid nutritional products which are specifically formulated to treat one of the following genetic diseases: phenylketonuria, branched chain- ketonuria, galactosemia, homocystinuria.

"**Medical Record Review**" means, in the event that the Plan, based upon a Medical Record Review and/or audit, determines that a different treatment or different quantity of a drug or supply was provided which is not supported in the billing, then the Plan Administrator may determine the Maximum Allowable Charge according to the Medical Record Review and audit results. Please refer to the section entitled "Claim Review and Audit Program" for the Plan provisions related to the audit and adjudication of certain eligible Claims under that Program.

"Medically Necessary" means care and treatment that is recommended or approved by a Physician or Dentist (as defined in this Plan). The terms Medically Necessary and Medical Necessity and similar language refers only to health care services ordered by a Physician or Dental Services ordered by a Dentist exercising prudent clinical judgment provided to a Covered Person for the purposes of evaluation, diagnosis or treatment of that Covered Person's sickness or Injury. Such services, to be considered Medically Necessary, must be clinically appropriate in terms of type, frequency, extent, site and duration for the diagnosis or treatment of the Covered Person's sickness or Injury. The Medically Necessary setting and level of service is that setting and level of service which, considering the Covered Person's medical symptoms and conditions, cannot be provided in a less intensive medical setting. Such services, to be considered Medically Necessary must be no more costly than alternative interventions, including no intervention and are at least as likely to produce equivalent therapeutic or diagnostic results as to the diagnosis or treatment of the Covered Person's sickness or Injury without adversely affecting the Covered Person's medical condition.

1. It must not be maintenance therapy or maintenance treatment.
2. Its purpose must be to restore health.
3. It must not be primarily custodial in nature.
4. It must not be a listed item or treatment not reimbursed by CMS (Medicare).
5. The Plan reserves the right to incorporate CMS (Medicare) guidelines in effect on the date of treatment as additional criteria for determination of Medical Necessity and/or an Allowable Charge, whenever the Medical Necessity of a Covered Expense is being reviewed for Coverage Eligibility.

All of these criteria must be met; merely because a Physician recommends or approves certain care does not mean that it is Medically Necessary.

In consultation with Physicians, the Plan Administrator, in conjunction with the Claims Audit Decision Maker, when necessary, has the discretionary authority to decide whether care or treatment is Medically Necessary.

"**Medically Necessary**" shall have the same meaning set forth in "Medical Necessity."

"**Medicare**" means the programs of health care for the aged and disabled established by Title XVIII of the Social Security Act of 1965, as amended.

"**Medicare Allowable Amount**" or **"Medicare Allowed Amount"** means the payment amount, as determined by the Medicare program, for the Covered Expense for a Provider.

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

"**Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA)**" means in the case of a group health plan (or health insurance coverage offered in connection with such a plan) that provides both medical and surgical benefits and mental health or Substance Abuse Disorder benefits, such plan or coverage shall ensure that:

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

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

"**Mental Illness**" means any of various conditions categorized as Mental Disorders by the most current edition of the International Classification of Diseases (ICD), wherein mental treatment is provided by a qualified mental health Provider. For purposes of this Plan, conditions categorized as Mental Illness do not include those conditions listed under Serious Mental Illness or Autism Spectrum Disorder. The benefit limits for Mental Illness, Serious Mental Illness, and Autism Spectrum Disorders are separate and not cumulative.

"Misidentification" means that it is determined under the Plan, based upon the Claim Review and Audit Program or otherwise, that any Service or type or quantity of a drug or other Supply shown on a bill is not supported in the billing and medical records, and that some different Service or type or quantity of a drug or other Supply was actually provided.

"**Morbid Obesity**" means a diagnosed medical condition in which the body weight exceeds the medically recommended weight by either 100 pounds or is twice the medically recommended weight for a person of the same height, age, and mobility as the Covered Person. This condition could have a significant effect on cardiac risk factors, incidence of diabetes, and other medical issues.

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

1. The name of an issuing State child support enforcement agency.

2. The name and mailing address (if any) of the Employee who is a Participant under the Plan or eligible for enrollment.

3. The name and mailing address of each of the Alternate Recipients (i.e., the Child or Children of the Participant) or the name and address of a State or local official may be substituted for the mailing address of the Alternate Recipients(s).

4. Identity of an underlying child support order.

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

"Network Contracted" means that a Hospital, Facility, Physician or Provider is contracted with a Network through which the Plan has an arrangement for the Hospital, Facility, Physician or Provider to provide Services and Supplies to Participants at negotiated rates and fees.

"Network Professionals" means Physicians, Practitioners and Providers who are Network Contracted.

"No-Fault Auto Insurance" "No-Fault Auto Insurance" is the basic reparations provision of a law providing for payments without determining fault in connection with automobile Accidents.

"**Non-Contracted**" means Hospitals, Facilities, Physicians, Practitioners and Providers that are neither Network Contracted nor Directly Contracted.

"**Non-Hospital- Residential Treatment**" means the provision of medical, nursing, counseling, or therapeutic services to Covered Persons suffering from Alcohol or Drug Abuse or dependency in a residential environment, according to individualized treatment plans.

"**Non-PPO- Provider**" means a health care practitioner that has not contracted directly with the Plan or an entity contracting on behalf of the Plan to provide health care services to Plan enrollees.

"**Nutritional Formula**" means liquid nutritional products which are formulated to supplement or replace normal food products.

"**Ongoing Employee**" means an Employee who has been employed by the Employer for at least one complete Measurement Period.

"**Open Enrollment Period"** The period of time specified by the Plan Administrator if any.

"**Other Plan**" shall include, but is not limited to:

1. Any primary payer besides the Plan.
2. Any other group health plan.
3. Any other coverage or policy covering the Covered Person.
4. Any first party insurance through medical payment coverage, personal injury protection, no-fault coverage, uninsured or underinsured motorist coverage.
5. Any policy of insurance from any insurance company or guarantor of a responsible party.
6. Any policy of insurance from any insurance company or guarantor of a third party.
7. Workers' compensation or other liability insurance company; or
8. Any other source, including but not limited to crime victim restitution funds, any medical, disability or other benefit payments, and school insurance coverage.

"**Out-of-Pocket Expense**" means the cost to the Covered Person for Deductibles, Coinsurance, Copayments, penalties and non-Covered- Expenses. This amount will be calculated using an embedded method, as follows:

1. Once a Covered Person reaches the individual Out of Pocket Expense Maximum, the Plan will pay 100% of all Covered Expenses for that Covered Person.
2. Once the Out-of-Pocket Expense Maximum is reached for a Family Unit, the Plan will pay 100% of all Covered Expenses for all Covered Persons, regardless of whether each individual Covered Person has reached their individual Out of Pocket Expense Maximum.

"**Out-of-Pocket Maximum**" means the most that a Covered Person or Family Unit should have to pay for their health care, including medical and prescription benefits, during a plan period (usually one year). Before reaching the Out-of-Pocket Maximum, the Covered Person or Family Unit pays for part of their Medical Care, such as Deductibles, Copays and Coinsurance. Once the Out-of-Pocket Maximum is reached, the Plan will pay 100% of the allowed amount for covered healthcare expenses. The Plan will follow the requirements of PPACA regarding the Out-of-Pocket Maximum.

"**Outpatient Care**" means treatment including services, supplies and medicines provided and used at a Hospital under the direction of a Physician to a person not admitted as a registered bed patient; or services rendered in a Physician's office, laboratory or X-ray facility, an Ambulatory Surgical Facility, or the patient's home, including medical, nursing, counseling or therapeutic treatment provided to a Covered Person who does not require an overnight stay in a Hospital or other Inpatient Facility.

"**Outpatient Diabetic Education Service**" means an Outpatient Diabetic Education Program provided by a Provider which has been recognized by the Department of Health or the American Diabetes Association as meeting the national standards for Diabetes Patient Education Programs established by the National Diabetes Advisory Board.

"**Partial Hospitalization Program**" means medical, nursing, counseling or therapeutic services provided on a planned and regularly scheduled basis in a Hospital or Provider, designed for a patient who would benefit from more intensive services than are offered in Outpatient treatment (Intensive Outpatient Program or Outpatient office visit) but who does not require Inpatient confinement.

"Permitted Payment Level(s)" means charges for Services and Supplies, listed and included as Covered Expenses under the Plan, which are Medically Necessary for the care and treatment of Illness or Injury, but only to the extent that such fees are within applicable limits established in this Plan including, but without limitation, under the Claim Review and Audit Program".

"**Pervasive Developmental Disorders**" means disorders characterized by severe and pervasive impairment in several areas of development: reciprocal social interaction skills, communication skills, or the presence of stereotyped behavior, interests, and activities. Examples are Asperger's syndrome and childhood disintegrative disorder.

"**Physician**" means a duly licensed member of a medical profession, who has an M.D. or D.O. degree, who is properly licensed or certified to provide Medical Care under the laws of the state where the individual practices, and who provides Medical Services which are within the scope of the individual's license or certificate.

For the purpose of Applied Behavior Analysis as included in the Diagnosis and Treatment of Autism and Other Developmental Disabilities provision, Physician also means a person who is credentialed by the national Behavior Analyst Certification Board as either a Board-Certified Behavior Analyst – Doctoral or as a Board-Certified Behavior Analyst.

"**Plan**" means the Bridgeway Behavioral Health Services Health Benefit Plan adopted by the Company, which is described in this document.

"**Plan of Treatment**" means a plan of care which is prescribed in writing by a Provider for the treatment of an Injury or Illness. The Plan of Treatment should include goals and duration of treatment and be limited in scope and extent to that care which is Medically Necessary for the Covered Person's diagnosis and condition.

"**Plan Sponsor**" means Bridgeway Behavioral Health Services

"**Plan Year**" means January 1 through December 31 of each year.

"**PPACA**" means the Patient Protection and Affordable Care Act enacted on March 23, 2010, or any provision or section thereof, which is herein specifically referred to, as such act, provision or section may be amended from time to time.

"**PPO**" means the Practitioner Only Preferred Provider Organization network of providers offering discounted fees for services and supplies to Covered Persons. The network will be identified on the Covered Person's Plan Identification Card.

"**PPO Provider**" This Plan has entered into an agreement with certain Physicians and other health care providers, which are called PPO or Network Providers. These PPO or Network Providers have agreed to charge reduced fees to persons covered under the Plan.

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

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

"**Pre-certification**" means prior assessment by the Plan Administrator that proposed services, such as Hospitalization, are Medically Necessary for a Covered Person and covered by this Plan. Payment for services depends on whether the Covered Person and the category of service are covered under this Plan. See the section entitled "Services that Require Pre-certification."

"**Pregnancy**" means childbirth and conditions associated with Pregnancy, including complications. Pregnancy is considered a Sickness for the purpose of determining benefits under this Plan.

"**Prescription Drug**" means any of the following: A Food and Drug Administration approved- drug or medicine which, under federal law, is required to bear the legend: "Caution: federal law prohibits dispensing without prescription"; injectable insulin; hypodermic needles or syringes, but only when dispensed upon a written prescription of a licensed Physician. Such drug must be Medically Necessary in the treatment of a sickness or Injury.

"Preventive Care" shall mean certain Preventive Care services.

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

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

Copies of the recommendations and guidelines may be found at the following websites:

https://www.healthcare.gov/coverage/preventive-care-benefits/;
https://www.uspreventiveservicestaskforce.org/Page/Name/uspstf-a-and-b-recommendations/;

https://www.cdc.gov/vaccines/hcp/acip-recs/index.html;

https://www.aap.org/en-us/Documents/periodicity_schedule.pdf;

https://www.hrsa.gov/womensguidelines/.

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

"Primary Care Physician (PCP)" "Primary Care Physician (PCP)" shall mean family practitioners, general practitioners, internists, OBGYNs, pediatricians, and office-based nurse practitioners and physician's assistants. All other Physicians are considered specialists.

"**Private Duty Nursing**" means Medically Necessary Outpatient continuous Skilled Nursing services provided to a Covered Person by a Registered Nurse or a Licensed Practical Nurse.

"**Professionals**" means Physicians, Practitioners and Providers.

"**Prosthetic**" means devices (except dental prosthetics), which replace all or part of:

1. An absent body organ including contiguous tissue; or
2. The function of a permanently inoperative or malfunctioning body organ.

"**Provider**" means a person or practitioner licensed where required and performing services within the scope of such licensure. The Providers are:

1. Autism Service Provider.
2. Audiologist.
3. Behavior Specialist.
4. Certified Registered Nurse.
5. Chiropractor.
6. Dentist.
7. Independent Clinical Laboratory.
8. Licensed Clinical Social Worker.
9. Master's Prepared Therapist.
10. Nurse Midwife.
11. Optometrist.
12. Physical Therapist.
13. Physician.
14. Podiatrist.
15. Psychologist.
16. Registered Dietitian.

17. Speech language- Pathologist; and/or

18. Teacher of the hearing impaired.

"**Psychiatric Hospital**" means an institution constituted, licensed, and operated as set forth in the laws that apply to Hospitals, which meets all of the following requirements:

1. It is primarily engaged in providing psychiatric services for the diagnosis and treatment of mentally ill persons either by, or under the supervision of, a Physician.

2. It maintains clinical records on all patients and keeps records as needed to determine the degree and intensity of treatment provided.

3. It is licensed as a Psychiatric Hospital.

4. It requires that every patient be under the care of a Physician; and

5. It provides 24-hour a day nursing service.

The term Psychiatric Hospital does not include an institution or that part of an institution, used mainly for nursing care, rest care, convalescent care, care of the aged, Custodial Care or educational care.

"**Psychologist**" means a Psychologist who is licensed in the state in which he or she practices; or a Psychologist who is otherwise duly qualified to practice by a state in which there is no Psychologist licensure.

"Reasonable and/or Reasonableness" means in the administrator's discretion, Medical Care, Services or Supplies, or fees for Medical Care, Services or Supplies, which are necessary for the care and treatment of illness or injury not caused by the treating Provider. Determination that Medical Care, Services or Supplies, or fees for Medical Care, Services or Supplies are reasonable will be made by the Plan Administrator, taking into consideration unusual circumstances or complications requiring additional time, skill, and experience in connection with a particular service or supply; industry standards and practices as they relate to similar scenarios; and the cause of injury or illness necessitating the service(s) and/or charge(s).

This determination will consider, but will not be limited to, the findings and assessments of the following entities: (a) The National Medical Associations, Societies, and organizations; (b) The Food and Drug Administration, and CMS. To be Reasonable, service(s) and/or fee(s) must be in compliance with generally accepted billing practices for unbundling or multiple procedures. Services, supplies, care and/or treatment that results from errors in medical care that are clearly identifiable, preventable, and serious in their consequence for patients, are not Reasonable. The Plan Administrator retains discretionary authority to determine whether service(s) and/or fee(s) are Reasonable based upon information presented to the Plan Administrator. A finding of Provider negligence and/or malpractice is not required for service(s) and/or fee(s) to be considered not Reasonable.

Charge(s) and/or services are not considered to be Reasonable, and as such are not eligible for payment (exceed the Maximum Allowable Charge), when they result from Provider error(s) and/or facility-acquired conditions deemed "reasonably preventable" through the use of evidence-based guidelines, taking into consideration but not limited to CMS guidelines.

The Plan reserves for itself and parties acting on its behalf the right to review charges processed and/or paid by the Plan, to identify charge(s) and/or service(s) that are not Reasonable and therefore not eligible for payment by the Plan. The Plan will only pay fee(s) that, in the administrator's discretion, are for services or supplies, which are necessary for the care and treatment of illness or injury not caused by the treating

provider. Determination that fee(s) are reasonable will be made by the Plan Administrator, taking into consideration unusual circumstances or complications requiring additional time, skill, and experience in connection with a particular service or supply; industry standards and practices as they relate to similar scenarios; and the cause of injury or illness necessitating the charge(s).

This determination will consider, but will not be limited to, the findings and assessments of the following entities: (a) The National Medical Associations, Societies, and organizations; (b) The Food and Drug Administration; and (c) CMS. To be reasonable, fee(s) must be in compliance with generally accepted billing practices for unbundling or multiple procedures. Services, supplies, care and/or treatment that results from errors in medical care that are clearly identifiable, preventable, and serious in their consequence for patients, are not Reasonable. The Plan Administrator retains discretionary authority to determine whether fee(s) are Reasonable based upon information presented to the Plan Administrator. A finding of provider negligence and/or malpractice is not required for fee(s) to be considered not Reasonable.

With regard to Contracted Services, charges at negotiated rates or fees specifically established under any contract for Directly Contracted Provider Services or any Physician Network Contract shall be presumed to be Reasonable, but only to the extent that such rates or fees do not include Invalid Charges.

"**Registered Dietitian**" means a dietitian registered by a nationally recognized professional association of dietitians. A Registered Dietitian is a food and nutrition expert who has met the minimum academic and professional requirements to qualify for the credential "RD."

"**Registered Nurse**" means a nurse who has graduated from a formal program of nursing education (diploma school, associate degree, or baccalaureate program) and is licensed by the appropriate state authority.

"**Rehabilitation Hospital**" means a Facility, approved by the Health Insurance Provider, which is primarily engaged in providing rehabilitation care services on an Inpatient basis. Rehabilitation care services consist of the combined use of medical, social, educational, and vocational services to enable patients disabled by disease or Injury to achieve the highest possible level of functional ability. Services are provided by or under the supervision of an organized staff of Physicians. Continuous nursing services are provided under the supervision of a Registered Nurse.

"**Reliable Evidence**" means peer reviewed reports of clinical studies that have been designed according to accepted scientific standards such that potential biases are minimized to the fullest extent, and generalizations may be made about safety and effectiveness of the technology outside of the research setting. Studies are to be published or accepted for publication in medical or scientific journals that meet nationally recognized requirements for scientific manuscripts and that are generally recognized by the relevant medical community as authoritative. Furthermore, evidence-based guidelines from respected professional organizations and governmental entities may be considered Reliable Evidence if generally accepted by the relevant medical community.

"**Residential Treatment Facility**" means a Facility, licensed and approved by the appropriate government agency and approved by the Health Insurance Provider, which provides treatment for Mental Illness and Serious Mental Illness or for Alcohol and Drug Abuse and Dependency to partial, outpatient or live-in- patients who do not require acute Medical Care.

"**Retail Clinics**" means those which are staffed by certified nurse practitioners trained to diagnose, treat, and write prescriptions when clinically appropriate. Services are available to treat basic medical needs for Urgent Care. Examples of needs are sore throat, ear, eye or sinus infection, allergies, minor burns, skin infections or rashes and Pregnancy testing.

"Room and Board" "Room and Board" shall mean a Hospital's charge for any of the following:

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

"**Routine Costs Associated with Approved Clinical Trials**" means:

1. Covered Expenses under this Plan that would typically be provided absent an Approved Clinical Trial.
2. Services and supplies required solely for the provision of the Experimental drug, biological product, device, medical treatment, or procedure.
3. The clinically appropriate monitoring of the effects of the drug, biological product, device, medical treatment, or procedure required for the prevention of complications; and
4. The services and supplies required for the diagnosis or treatment of complications.

Routine costs do not include the Experimental drug, biological product, device, medical treatment, or procedure itself, the services and supplies provided solely to satisfy data collection and analysis needs and that are not used in the direct clinical management of the patient; and services and supplies customarily provided by the research sponsors free of charge for any enrollee in the Approved Clinical Trial.

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

"Service Waiting Period" "Service Waiting Period" shall mean an interval of time that must pass before an Employee or Dependent is eligible to enroll under the terms of the Plan. The Employee must be a continuously Active Employee of the Employer during this interval of time.

"Service(s)" or **"Services and/or Supplies"** or **"Service and/or Supply"** means services, procedures, treatment, care, goods and supplies the provision of use of which is meant to improve the condition or health of a Participant. A reference to Services with regard to a procedure, treatment, or care, unless otherwise indicated, shall be deemed to refer also to the goods and supplies provided or used in such procedure, treatment, or care.

"**Self-Injectable Drug**" means a Prescription Drug that:

1. Is introduced into a muscle or under the skin by means of a syringe and needle.
2. Can be administered safely and effectively by the patient or caregiver outside of medical supervision, regardless of whether initial medical supervision and/or instruction is required; and
3. Is administered by the patient or caregiver.

"**Serious Mental Illness**" means any of the following Mental Illnesses as defined by the American Psychiatric Association in the most current edition of the Diagnostic and Statistical Manual: schizophrenia, bipolar disorder, obsessive-compulsive- disorder, major depressive disorder, panic disorder, anorexia nervosa, bulimia nervosa, schizo-affective disorder and delusional disorder.

"**Short Procedure Unit**" means a unit which is approved by the Health Insurance Provider, and which is designed to manage either lengthy diagnostic or minor surgical procedures on an Outpatient basis which would otherwise have resulted in an Inpatient stay in the absence of a Short Procedure Unit.

"Sickness" "Sickness" shall have the meaning set forth in the definition of "Disease."

"**Skilled Nursing Facility**" means a facility that fully meets all of these tests:

1. It is licensed to provide professional nursing services on an Inpatient basis to persons convalescing from Injury or Illness. The service must be rendered by a Registered Nurse or by a Licensed Practical Nurse under the direction of a Registered Nurse. Services to help restore patients to self-care in essential daily living activities must be provided.
2. Its services are provided for compensation and under the full-time supervision of a Physician.
3. It provides 24-hour per day nursing services by licensed nurses, under the direction of a full-time Registered Nurse.
4. It maintains a complete medical record on each patient.
5. It has an effective utilization review plan.
6. It is not, other than incidentally, a place for rest, the aged, drug addicts, alcoholics, mentally disabled, Custodial, or educational care or care of Mental Disorders.
7. It is approved and licensed by Medicare.

This term also applies to charges Incurred in a facility referring to itself as an extended care facility, convalescent nursing home, Rehabilitation Hospital, long term- acute care facility or any other similar nomenclature.

"**Specialty Drug**" means a medication that meets certain criteria including, but not limited to:

1. The drug is used in the treatment of a rare, complex, or chronic disease.
2. A high level of involvement is required by a healthcare Provider to administer the drug.
3. Complex storage and/or shipping requirements are necessary to maintain the drug's stability.
4. The drug requires comprehensive patient monitoring and education by a healthcare Provider regarding safety, side effects, and compliance.
5. Access to the drug may be limited.
6. Drugs designated by the Pharmacy Benefit Manager (PBM) as "Specialty" drugs.

"**Spinal Manipulation**" shall have the same meaning as the definition of "Chiropractic Care."

"**Stability Period**" means a period selected by the Employer that immediately follows, and is associated with, a Standard Measurement Period or an Initial Measurement Period and is used by the Employer as part of the Look-back Measurement Method. The Stability Period is the remainder of the year after the end of the Administrative Period in which the Variable Hour Employee's and/or Ongoing Employee's eligibility status is fixed.

"**Stabilize**" means, with respect to an Emergency Medical Condition, to provide such medical treatment of the condition as may be necessary to assure, within reasonable medical probability, that no material deterioration of the condition is likely to result from or occur during the transfer of the individual from a facility; or for an Emergency Medical Condition of a pregnant woman who is having contractions and:

1. There is inadequate time to affect a safe transfer to another Hospital before delivery; or

2. Transfer may pose a threat to the health or safety of the woman or her unborn child, to deliver (including the placenta).

"**Standard Injectable Drug**" means a medication that is either injectable or infusible but is not defined by the drug manufacturer to be a Self-Injectable Drug or a Specialty Drug. Standard Injectable Drugs include but are not limited to:- allergy injections and extractions and injectable medications such as antibiotics and steroid injections that are administered by a Provider.

"**Standard Measurement Period**" means, for Ongoing Employees, the period that starts on January 1st each plan year and will last for 12 consecutive months.

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

The fact that a disorder is listed in any of the above publications does not mean that treatment of the disorder is covered by the Plan.

"Substance Abuse Treatment Center" "Substance Abuse Treatment Center" shall mean an Institution whose facility is licensed, certified, or approved as a Substance Abuse Treatment Center by a Federal, State, or other agency having legal authority to so license; which is affiliated with a Hospital and whose primary purpose is providing diagnostic and therapeutic services for treatment of Substance Abuse. To be deemed a "Substance Abuse Treatment Center," the Institution must have a contractual agreement with the affiliated Hospital by which a system for patient referral is established and implement treatment by means of a written treatment plan approved and monitored by a Physician. Where applicable, the "Substance Abuse Treatment Center" must also be appropriately accredited by the Joint Commission on Accreditation of Hospitals.

"**Summary Plan Description**" means this document, as required by the Employee Retirement Income Security Act (ERISA), which is a summary of the provisions described in this Plan, prepared by the Plan Administrator from time to time and provided to the Covered Person.

"**Surgery**" means the performance of generally accepted operative and cutting procedures including specialized instrumentations, endoscopic examinations, and other invasive procedures. Payment for Surgery includes an allowance for related Inpatient preoperative and postoperative care. Treatment of burns, fractures and dislocations are also considered Surgery.

"Telehealth Services" "Telehealth Services" shall mean the use of information and communications technologies, including telephones, remote patient monitoring devices, or other electronic means, to support clinical healthcare, Provider consultation, patient and professional health-related education, public health, health administration, and other services in accordance with the provisions of P.L.2017, c.117.

"Telemedicine Services" "Telemedicine Services" shall mean the delivery of health care services including Diagnosis, consultation, or treatment through the use of live interactive audio and video over a secure connection.

"**Therapy Service**" means the following services or supplies prescribed by a Physician and used for the treatment of an Illness or Injury to promote the recovery of the Covered Person:

1. **Cardiac Rehabilitation Therapy is a medically-** supervised rehabilitation program designed to improve a Covered Person's tolerance for physical activity or exercise.

2. **Chemotherapy treatment**- of malignant disease by chemical or biological antineoplastic agents, monoclonal antibodies, bone marrow stimulants, antiemetics, and other related biotech products.

3. **Dialysis treatment**- of an acute renal failure or chronic irreversible renal insufficiency for removal of waste materials from the body.

4. **Infusion Therapy Treatment** including, but not limited to, infusion or inhalation, parenteral and enteral nutrition, antibiotic therapy, pain management, hydration therapy, or any other drug that requires administration by a healthcare Provider. Infusion Therapy includes all professional services, supplies, and equipment that are required to administer the therapy safely and effectively. Infusion may be provided in a variety of settings (e.g., home, office, Outpatient) depending on the level of skill required to prepare the drug, administer the infusion, and monitor the Covered Person. The type of healthcare Provider who can administer the infusion depends on whether the drug is considered to be- a Specialty Drug infusion or a Standard Injectable Drug infusion.

5. **Occupational Therapy** medically prescribed treatment concerned with improving or restoring neuromusculoskeletal functions which have been impaired by Illness or Injury, congenital anomaly, or prior therapeutic intervention. Occupational Therapy also includes medically prescribed treatment concerned with improving the Covered Person's ability to perform those tasks required for independent functioning where such function has been permanently lost or reduced by Illness or Injury, congenital anomaly, or prior therapeutic intervention. This does not include services specifically directed towards the improvement of vocational skills and social functioning.

6. **Orthoptic/Pleoptics Therapy** medically prescribed treatment for the correction of oculomotor dysfunction resulting in the lack of vision depth perception. Such dysfunction results from vision disorder, eye Surgery, or Injury. Treatment involves a program which includes evaluation and training sessions.

7. **Physical Therapy** medically prescribed treatment of physical disabilities or impairments resulting from disease, Injury, congenital anomaly, or prior therapeutic intervention by the use of therapeutic exercise and other interventions that focus on improving posture, locomotion, strength, endurance, balance, coordination, joint mobility, flexibility, and the functional activities of daily living.

8. **Pulmonary Rehabilitation Therapy** multidisciplinary- treatment which combines Physical Therapy with an educational process directed at stabilizing pulmonary diseases and improving functional status.

9. **Radiation Therapy** treatment of disease by Xray, gamma ray, accelerated particles, mesons, neutrons, radium, radioactive isotopes, or other radioactive substances regardless of the method of delivery.

10. **Speech Therapy** medically prescribed treatment of speech and language disorders due to disease, Surgery, Injury, congenital and developmental anomalies, or previous therapeutic processes that result in communication disabilities and/or swallowing disorders.

"Third Party Administrator" "Third Party Administrator" shall mean the claims administrator, which provides customer service and claims payment services only and does not assume any financial risk or obligation with respect to those claims. The Third-Party Administrator is not an insurer of health benefits under this Plan, is not a fiduciary of the Plan, and does not exercise any of the discretionary authority and responsibility granted to the Plan Administrator. The Third-Party Administrator is not responsible for Plan financing and does not guarantee the availability of benefits under this Plan.

"Unbundling" means charges for any items billed separately that are customarily included in a global billing procedure code in accordance with the American Medical Association's CPT® (Current Procedural Terminology) and/or the Healthcare Common Procedure Coding System (HCPCS) codes used by CMS.

"Unclear Description" means, as to any amounts included in any claim, a description from which the Claims Audit Decision Maker cannot clearly identify or understand the Service or Supply being billed.

"**Urgent Care**" means care which is for sudden Illness or Accidental Injury that requires prompt medical attention but is not life threatening and is not an Emergency Medical Condition when your Provider is unavailable. Examples of Urgent Care needs include stitches, fractures, sprains, ear infections, sore throats, rashes, -X-rays- that are not Preventive Care.

"**Urgent Care Center**" means a Facility designed to offer immediate evaluation and treatment for acute health conditions that required medical attention in a non-Emergency- situation when your Provider's office is unavailable. Urgent Care is different from Emergency Services.

"**USERRA**" means the Uniformed Services Employment and Reemployment Rights Act of 1994 ("USERRA").

"**Usual and Customary**" means covered expenses which are identified by the Plan Administrator, in conjunction with the Claims Audit Decision Maker, taking into consideration the fee(s) which the Provider most frequently charges and/or accepts as payment from the majority of patients for the service or supply, the cost to the Provider for providing the services, the prevailing range of fees charged and/or accepted in the same "area" by Providers of similar training and experience for the service or supply, and the Medicare reimbursement rates. The term(s) "same geographic locale" and/or "area" shall be defined as a metropolitan area, county, or such greater area as is necessary to obtain a representative cross section of Providers, persons or organizations rendering such treatment, services, or supplies for which a specific charge is made. To be Usual and Customary, fee(s) must follow generally accepted billing practices for unbundling or multiple procedures.

The term "Usual" refers to the amount of a charge made for medical services, care, or supplies, to the extent that the charge does not exceed the common level of charges made or reimbursements accepted by other medical professionals with similar credentials, or health care facilities, pharmacies, or equipment suppliers of similar standing, which are located in the same geographic locale in which the charge is Incurred.

The term "Customary" refers to the form and substance of a service, supply, or treatment provided in accordance with accepted standards of medical practice to one individual, which is appropriate for the care or treatment of the same sex, comparable age and who receive such services or supplies within the same geographic locale.

The term "Usual and Customary" does not necessarily mean the actual charge made nor the specific service or supply furnished to a Covered Person by a Provider of services or supplies, such as a Physician, therapist, nurse, Hospital, or pharmacist. The Plan Administrator, in conjunction with the Claims Audit Decision Maker, will determine what the Usual and Customary charge is, for any procedure, service, or supply, and whether a specific procedure, service or supply is Usual and Customary.

Usual and Customary charges may, at the discretion of the Plan Administrator, in conjunction with the Claims Audit Decision Maker, when necessary, alternatively be determined and established by the Plan using normative data such as, but not limited to, Medicare reimbursement rates and cost to charge ratios, average wholesale price (AWP) for prescriptions and/or manufacturer's retail pricing (MRP) for supplies and devices and the 75th percentile as reflected in the Wasserman Physician's Fee Reference (PFR), Context 4, Healthcare, Inc. Database, or a similar nationally recognized prevailing fee data base as designated by the Plan Administrator.

"Usual, Customary and Reasonable Fees" means actual fees for Reasonably provided Medical Care, Services and/or Supplies, but only the amount of those fees that constitute a Reasonable charge for such Medical Care, Services and/or Supplies and that does not exceed the Usual and Customary amount charged for such Medical Care, Services and/or Supplies.

"**Variable Hour Employee**" means an Employee, based on the facts and circumstances at the Employee's start date, whose reasonable expectation of average hours per week cannot be determined.

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

ELIGIBILITY, TERMINATION, AND CONTINUATION OF COVERAGE

Eligibility to Participate in the Plan

Employee's Participation

At the discretion of the Employer, each non-variable hour Employee will become eligible for coverage under this Plan with respect to himself or herself no later than the 30 days from the date of hire, provided the Employee has begun work for his or her Participating Employer.

Each Variable Hour Employee who has averaged the requisite hours of service, as defined by PPACA, will become eligible for coverage under this Plan with respect to himself or herself upon completion of the 90th day or sooner.

You must actually begin work for the Participating Employer in order to be eligible for benefits. If you are unable to begin work as scheduled, then your coverage will become effective on the date when you begin work.

Dependent Participation

1. Each person who is an eligible Dependent of an Employee on the date that the Employee becomes eligible for coverage under the Plan shall become eligible on the same date for the Dependent coverages then applicable.

2. A person who first becomes an eligible Dependent after the Employee's initial eligibility shall become eligible for coverage under the Plan on the date such person first becomes an eligible Dependent (e.g., date of marriage, birth, or adoption), however, coverage for such new eligible Dependent shall become effective on the first day of the month on or following the eligibility date.

3. An Employee or his or her spouse's newborn Child shall be temporarily covered for benefits for 31 days immediately following the birth. During that 31-day period, the Employee must contact the Plan and complete the necessary enrollment forms to enroll such Dependent in the Plan.

4. An Employee's Dependent Child shall be eligible for coverage after the Employee's initial eligibility under the plan until the Dependent Child's 26th birthday.

Affiliated Organizations – if applicable

1. If an individual is eligible and employed by two or more affiliated Employers, the individual may elect coverage as an Employee under only one employer.

2. An individual who is employed by affiliated Employers may be covered as an employee or as a dependent spouse but cannot be covered under both. This limitation applies to spouses working for the same or different affiliated Employers.

3. If both parents are employed and eligible for coverage under affiliated Employers, the eligible dependent child(ren) may be covered by one employee but not both.

Enrollment Form. Coverage for an Employee or his or her Dependents must be requested by the Employee on a form furnished by the Plan Administrator and will become effective on the date such Employee or Dependents are eligible, provided the Employee has enrolled for such coverage on a form satisfactory to the Plan Administrator within the 15-day period (for initial enrollment), or within the 30-day period (for special enrollment) immediately following the date of eligibility.

Special Enrollment Rights

At the discretion of the Employer or if applicable. If you are declining enrollment for yourself or your Dependents (including your spouse) because of other health insurance or group health plan coverage, you may be able to enroll yourself and your Dependents in this Plan if you or your Dependents lose eligibility for that other coverage (or if the employer stops contributing toward your or your Dependents' other coverage). However, you must request enrollment within 30 days after your or your Dependents' other coverage ends (or after the employer stops contributing toward the other coverage). In addition, if you have a new Dependent as a result of marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and your Dependents. However, you must request enrollment within 30 days after the marriage, birth, adoption, or placement for adoption. To request special enrollment or obtain more information, contact the Plan Administrator. Dependent means any individual who is or may become eligible for coverage under the terms of a group health plan because of a relationship to a participant. See: https://www.law.cornell.edu/cfr/text/29/2590.701-2; https://www.law.cornell.edu/cfr/text/29/2590.701-6

Open Enrollment

Covered Persons may enroll for coverage during the Open Enrollment Period. There is no open enrollment for this Plan except for the initial enrollment period. Eligible members must enroll during this period unless they have a Special Qualifying Event. Coverage for Covered Persons enrolling during an Open Enrollment Period will become effective on the Effective Date of the Plan, unless the Employee has not satisfied the Service Waiting Period, in which event coverage for the Employee and his or her Dependents will become effective on the first day of the month following completion of the Service Waiting Period.

Additional Special Enrollment Rights

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

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

If the conditions for special enrollment are satisfied, coverage for the Employee and/or his or her Dependent(s) will be effective at 12:01 A.M. on the first day of the first calendar month beginning after the date the written or electronic request, as applicable, (including the Covered Person's enrollment Application, either paper or electronic as applicable, in the case of enrollment) is received by the Plan.

Termination of Coverage

Employee Termination

The coverage of an Employee shall terminate at 12:01 a.m. on whichever of the following dates occurs first:

1. The first day following his or her date of death.
2. The first day following the date the Plan is discontinued.
3. The end of the month following termination date in which the Employee is no longer eligible for such coverage under the Plan; or
4. The date following the end of the Stability Period for Variable Hour Employees, if the Employee failed to qualify during the previous Measurement Period.

Dependent Termination

Coverage for Dependents shall terminate at 12:01 a.m. on whichever of the following dates occurs first:

1. The first day following the date on which a Dependent, other than a Dependent Child, as defined herein, is no longer a Dependent.
2. The last day of the month of the Dependent Child's 26th birthday, on which such person ceases to be a Dependent Child, as defined herein, except as may be provided for in other areas of this section or within this document.
3. The first day following the date the Employee's coverage terminates; or
4. The first day following the date the Plan is discontinued.

Reinstatement of Eligibility

An Employee who is terminated and rehired will be treated as a new Employee upon rehire only if the Employee was not credited with an hour of service, as defined under the PPACA, with the Employer (or any member of the controlled or affiliated group) for a period of at least 13 consecutive weeks immediately preceding the date of rehire.

A Variable Hour Employee who is terminated and rehired will be treated as a continuing Employee upon rehire only if the Employee break in service does not exceed 13 weeks.

Upon return, coverage will be effective on the first of the month following the date of rehire, so long as all other eligibility criteria are satisfied.

Temporary Lay-Off

Employees may be temporarily laid off without pay and without using their sick time or FMLA time due to restrictions due to the Corona Virus on the employer's business. While laid-off, the employees and their dependents may retain their coverage under the Health Plan and the cost of such coverage may be paid by the Plan sponsor.

Furloughs/Layoffs Due to Covid-19.

Employees may be temporarily laid off or furloughed without pay and without using leave time due to the impact of COVID-19 on the company. While laid-off or furloughed, employees and their dependents may retain their coverage under the Health Plan and the cost of such coverage may be paid by the Plan Sponsor

Retroactive Termination of Coverage

Except in cases where an Employee or other Covered Person fails to pay any required contribution to the cost of coverage, the Plan will not retroactively terminate coverage under the Plan for any Covered Person unless the Covered Person (or a person seeking coverage on behalf of that person) performs an act, practice, or omission that constitutes fraud with respect to the Plan, or unless the individual makes an intentional misrepresentation of material fact. In such cases, the Plan will provide at least thirty days' advance written notice to each Participant or Dependent who would be affected before coverage will be retroactively terminated. As provided above, coverage may be retroactively terminated in cases where required employee contributions have not been paid by the applicable deadline. In those cases, no advance written notice is required.

Employer-Sponsored Continuation of Coverage –

Eligible Participants may seek to continue coverage upon the occurrence of any of the following:

1. Layoff: coverage will continue for one (1) month following the date of layoff.
2. Short-Term Disability Leave: coverage will continue for one month following termination of Active Employment.
3. Long-Term Disability Leave: coverage will continue for one (1) month following termination of Active Employment.
4. Americans with Disabilities Act Leave; A non-FMLA leave granted by the Employer in accordance with the Americans with Disabilities Act; coverage will continue for a period not to exceed one (1) month.
5. Leave of Absence (not meeting the definition of a FMLA Leave); coverage will continue for one (1) month.
6. COVID-19 Leave; Leave taken in accordance with the Families First Coronavirus Response Act "FFCRA," including the Emergency Family and Medical Leave Expansion Act (see the Plan's "Continuation During Family and Medical Leave Act (FMLA)" section) and Emergency Paid Sick Leave Act: coverage will continue for the duration of the permitted leave under the FFCRA, as amended.

The above noted leave(s) do not run concurrently with FMLA, USERRA or any State-mandated family or medical leave, and/or any other applicable leaves of absence, as applicable and subject to applicable law. At the end of the period(s) listed above, the Participant's coverage will be deemed to have been terminated for purposes of Continuation of Coverage under COBRA.

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

Continuation During FMLA Leave

The Family and Medical Leave Act is a federal law that applies to employers with 50 or more Employees, and provides that an Eligible Employee may elect to continue coverage under this Plan during a period of approved FMLA Leave at the same cost as if the FMLA Leave not been taken.

If provisions under the Plan change while an Employee is on FMLA Leave, the changes will be effective for him or her on the same date as they would have been had he or she not taken leave.

Eligible Employees

Employees are eligible for FMLA Leave if all of the following conditions are met:

1. The Employee has been employed with the Participating Employer for at least 12 months.
2. The Employee has been employed with the Participating Employer at least 1,250 hours during the 12 consecutive months prior to the request for FMLA Leave; and
3. The Employee is employed at a worksite that employs at least 50 employees within a 75-mile radius.

Qualifying Circumstances for FMLA Leave

Coverage under FMLA Leave is limited to a total of 12 workweeks during any 12-month period that follows:

1. The birth of, and to care for, a Child.
2. The placement of a Child with the Employee for adoption or foster care.
3. The Employee's taking leave to care for his or her Spouse, Son or Daughter, or Parent who has a Serious Health Condition; or
4. The Employee's taking leave due to a Serious Health Condition which makes him or her unable to perform the functions of his or her position.
5. A Qualifying Exigency arising out of the fact that a Spouse, Son or Daughter, Parent, or Next of Kin of the Employee is a regular component, reserve component, or Covered Veteran of the Armed Forces.

Coverage under FMLA Leave is limited to a total of 26 workweeks during any 12-month period for the following situations:

1. To care for a service member following a Serious Illness or Injury to that service member, when the Employee is that service member's Spouse, Son or Daughter, Parent, or Next of Kin; or
2. To care for a veteran who is undergoing medical treatment, recuperation, or therapy for a Serious Illness or Injury that occurred any time during the five years preceding the date of treatment, when the Employee is that veteran's Spouse, Son or Daughter, Parent, or Next of Kin.

This leave may be paid (accrued vacation time, personal leave or family or sick leave, as applicable) or unpaid. The Participating Employer has the right to require that all paid leave be used prior to providing any unpaid leave.

An Employee must continue to pay his or her portion of the Plan contribution, if any, during the FMLA Leave. Payment must be made within 30 days of the due date established by the Plan Administrator. If payment is not received, coverage will terminate on the last date for which the contribution was received in a timely manner.

Notice Requirements

An Employee must provide at least 30 days' notice to his or her Participating Employer prior to beginning any leave under FMLA. If the nature of the leave does not permit such notice, the Employee must provide notice of the leave as soon as possible. The Participating Employer has the right to require medical certification to support the Employee's request for leave due to a Serious Health Condition for the Employee or his or her eligible family members.

Length of Leave

During any one 12-month period, the maximum amount of FMLA Leave may not exceed 12 workweeks for most FMLA related situations. The maximum periods for an Employee who is the primary care giver of a service member with a Serious Illness or Injury that was Incurred in the line of active duty may take up to 26 weeks of FMLA Leave in a single 12month period to care for that service member. The Participating Employer may use any of four methods for determining this 12-month period.

If the Employee and his or her Spouse are both employed by the Participating Employer, FMLA Leave may be limited to a combined period of 12 workweeks, for both Spouses, when FMLA Leave is due to:

1. The birth or placement for adoption or foster care of a Child; or
2. The need to care for a Parent who has a Serious Health Condition.

Termination of FMLA Leave

Coverage may end before the maximum 12-week (or 26-week) period under the following circumstances:

1. When the Employee informs his or her Participating Employer of his or her intent not to return from leave.
2. When the employment relationship would have terminated but for leave (such as during a reduction in force).
3. When the Employee fails to return from the leave; or
4. If any required Plan contribution is not paid within 30 days of its due date.

If an Employee does not return to work when coverage under FMLA Leave ends, he or she will be eligible for COBRA continuation of coverage at that time.

Recovery of Plan Contributions

The Participating Employer has the right to recover the portion of the Plan contributions it paid to maintain coverage under the Plan during an unpaid FMLA Leave if an Employee does not return to work at the end of the leave. This right will not apply if failure to return is due to the continuation, recurrence or onset of a Serious Health Condition that entitles the Employee to FMLA Leave (in which case the Participating Employer may require medical certification) or other circumstances beyond the Employee's control.

Reinstatement of Coverage

The law requires that coverage be reinstated upon the Employee's return to work following an FMLA Leave whether or not the Employee maintained coverage under the Plan during the FMLA Leave. On reinstatement, all provisions and limits of the Plan will apply as they would have applied if FMLA Leave had not been taken. The Service Waiting Period will be credited as if the Employee had been continually covered under the Plan.

Definitions

For this provision only, the following terms are defined as stated.

"Activities of Daily Living" shall include but are not limited to adaptive search activities such as caring appropriately for one's grooming and hygiene, bathing, dressing, and eating.

"Covered Veteran" shall mean a member of the armed forces, National Guard, or reserves who was discharged or released under conditions other than dishonorable at any time during the five-year period prior to the first date the Eligible Employee takes FMLA Leave to care for the Covered Veteran.

"Incapable of Self Care" means that the Parent requires active assistance or supervision to provide daily selfcare in three or more of the "Activities of Daily Living" or "Instrumental Activities of Daily Living."

"Instrumental Activities of Daily Living" shall include, but are not limited to cooking, cleaning, shopping, taking public transportation, paying bills, maintaining a residence, using telephones and directories, using a post office, etc.

"Next of Kin" means the nearest blood relative of the covered service member, other than the covered service member's Spouse, Parent, Son or Daughter, in the following order of priority: blood relatives who have been granted legal custody of the service member by court decree or statutory provisions, brothers and sisters, grandparents, aunts and uncles, and first cousins, unless the covered service member has specifically designated in writing another blood relative as his or her nearest blood relative for purposes of military caregiver leave under FMLA.

"Parent" means your biological parent or someone who has acted as your parent in place of your biological parent when you were a Child.

"Qualifying Exigency" includes the following situations:

1. Short Notice deployment.

    a. To address any issue that arises from the fact that a covered military member is notified seven or less calendar days prior to the date of deployment of an impending call or order to active duty in support of a contingency operation; and

    b. Leave taken for this purpose can be used for a period of seven calendar days beginning on the date a covered military member is notified of an impending call or order to active duty in support of a contingency operation.

2. Military events and related activities.

a. To attend any official ceremony, program, or event sponsored by the military that is related to the active duty or call to active-duty status of a covered military member; and

b. To attend family support or assistance programs and informational briefings sponsored or promoted by the military, military service organizations, or the American Red Cross that are related to the active duty or call to active-duty status of a covered military member.

3. Parental Care.

    a. To arrange for alternative care for a Parent of the military member when the Parent is Incapable of Self Care and the covered active duty or call to covered active-duty status of the military member necessitates a change in the existing care arrangements.

    b. To provide care for a Parent of the military member on an urgent, immediate need basis (but not on a routine, regular, or everyday basis) when the Parent is Incapable of Self Care and the need to provide such care arises from covered active duty or call to covered active-duty status of the military member;

    c. To admit or transfer a Parent of the military member to a care facility when the admittance or transfer is necessitated by the covered active duty or call to covered active-duty status of the military member; and

    d. To attend meetings with staff at a care facility for the Parent of the military member, such as meeting with Hospice or social service providers, when such meetings are necessitated by the covered active duty or call to covered active-duty status of the military member basis (but not on a routine, regular, or everyday basis).

4. Childcare and school activities.

a. To arrange for alternative childcare when the active duty or call to active duty status of a covered military member necessitates a change in the existing childcare arrangement for a biological, adopted, or foster child, a stepchild, or a legal ward of a covered military member, or a child for whom a covered military member stands in loco parentis, who is either under age 18, or age 18 or older and Incapable of Self Care because of a mental or physical disability at the time that FMLA Leave is to commence;

b. To provide childcare on an urgent, immediate need basis (but not on a routine, regular, or everyday basis) when the need to provide such care arises from the active duty or call to active duty status of a covered military member for a biological, adopted, or foster child, a stepchild, or a legal ward

of a covered military member, or a child for whom a covered military member stands in loco parentis, who is either under age 18, or age 18 or older and Incapable of Self Care because of a mental or physical disability at the time that FMLA Leave is to commence;

c. To enroll in or transfer to a new school or daycare facility, a biological, adopted, or foster child, a stepchild, or a legal ward of the covered military member, or a child for whom the covered military member stands in loco parentis, who is either under age 18, or age 18 or older and Incapable of Self Care because of a mental or physical disability at the time that FMLA Leave is to commence, when enrollment or transfer is necessitated by the active duty or call to active duty status of a covered military member; and

d. To attend meetings with staff at a school or a daycare facility, such as meetings with school officials regarding disciplinary measures, parent teacher conferences, or meetings with school counselors, for a biological, adopted, or foster child, a stepchild, or a legal ward of the covered military member, or a child for whom the covered military member stands in loco parentis, who is either under age 18, or age 18 or older and Incapable of Self Care because of a mental or physical disability at the time that FMLA Leave is to commence, when such meetings are necessary due to circumstances arising from the active duty or call to active duty status of a covered military member;

5. Financial and legal arrangements.

a. To make or update financial or legal arrangements to address the covered military member's absence while on active duty or call to active-duty status, such as preparing and executing financial and healthcare powers of attorney, transferring bank account signature authority, enrolling in the Defense Enrollment Eligibility Reporting System (DEERS), obtaining military identification cards, or preparing or updating a will or living trust; and

b. To act as the covered military member's representative before a federal, state, or local agency for purposes of obtaining, arranging, or appealing military service benefits while the covered military member is on active duty or call to active-duty status, and for a period of 90 days following the termination of the covered military member's active-duty status.

6. Counseling. To attend counseling provided by someone other than a health care provider for oneself, for the covered military member, or for the biological, adopted, or foster child, a stepchild, or a legal ward of the covered military member, or a child for whom the covered military member stands in loco parentis, who is either under age 18, or age 18 or older and Incapable of Self Care because of a mental or physical disability at the time that FMLA Leave is to commence, provided that the need for counseling arises from the active duty or call to active duty status of a covered military member;

7. Rest and recuperation. To spend time with a covered military member who is on short term, temporary, rest and recuperation leave during the period of deployment. Eligible Employees may take up to 15 days of leave for each instance of rest and recuperation.

8. Post deployment activities.

    a. To attend arrival ceremonies, reintegration briefings and events, and any other official ceremony or program sponsored by the military for a period of 90 days following the termination of the covered military member's active-duty status; and

    b. To address issues that arise from the death of a covered military member while on active-duty status, such as meeting and recovering the body of the covered military member and making funeral arrangements; and

9. Additional activities. To address other events which arise out of the covered military member's active duty or call to active-duty status provided that the Participating Employer and Employee agree that such leave shall qualify as an exigency and agree to both the timing and duration of such leave.

"Serious Health Condition" is an Illness, Injury, impairment, or physical or mental condition that involves:

1. Inpatient care in a Hospital, Hospice, or residential medical facility; or
2. Continuing treatment by a health care provider (a Doctor of Medicine or osteopathy who is authorized to practice medicine or Surgery, as appropriate, by the state in which the doctor practices, or any other person determined by the Secretary of Labor to be capable of providing health care services).

"Serious Illness or Injury" for a current member of the Armed Forces is defined as an Illness or Injury Incurred in the line of duty of the Armed Forces, or that existed before the beginning of the member's active duty and was aggravated by the service in the line of duty on active duty in the Armed Forces and that may render the member medically unfit to perform the duties of the member's office, grade, rank, or rating.

"Serious Illness or Injury" of a veteran is defined as an Illness or Injury Incurred in the line of duty of the Armed Forces and manifested itself before or after the service member became a Veteran, and is:

1. A continuation of a Serious Illness or Injury that was Incurred or aggravated when the Covered Veteran was a member of the Armed Forces and rendered the service member unable to perform the duties of the service member's office, grade, rank, or rating; or a physical or mental condition for which the Covered Veteran has received a US Department of Veterans Affairs Service Related Disability Rating of 50 percent or greater, and such rating is based, in whole or in part, on the condition precipitating the need for military caregiver leave; or
2. A physical or mental condition that impairs the Covered Veteran's ability to secure or follow a substantially gainful occupation by reason of disability or disabilities related to military service, or would do so absent treatment; or
3. An Injury, including a psychological Injury, on the basis of which the Covered Veteran has been enrolled in the Department of Veterans Affairs Program of Comprehensive Assistance for Family Caregivers.

"Son or Daughter" means a biological, adopted, or foster child, a stepchild, a legal ward, or a child of a person standing in loco parentis, who is either under age 18, or age 18 or older and "Incapable of Self Care because of a mental or physical disability" at the time that FMLA Leave is to commence.

"Son or Daughter" of a covered service member means a covered service member's biological, adopted, or foster child, stepchild, legal ward, or a child for whom the covered service member stood in loco parentis, and who is of any age.

"Son or Daughter" of covered active duty or call to covered active-duty status means the Employee's biological, adopted, or foster child, stepchild, legal ward, or a child for whom the Employee stood in loco parentis, who is on covered active duty or call to covered active-duty status, and who is of any age.

"Spouse" means an individual who is legally married to an Eligible Employee, including common law marriage (in States where it is recognized) and same-sex marriage.

NOTE: For complete information regarding your rights under FMLA, contact your Participating Employer.

Continuation During FMLA Leave Due to Covid-19

Coverage of a participant and his or her covered dependents will continue during an expanded FMLA paid leave or paid sick leave, as provided under the Families First Coronavirus Response Act of 2020, as amended. This section is effective April 1, 2020, and will remain in effect until December 31, 2020, or, until the end of the declared public health emergency in the United States.

Employees on Military Leave

An Employee going into or returning from military service may elect to continue Plan coverage (Medical, Prescription Drug, Dental and Vision) as mandated by the Uniformed Services Employment and Reemployment Rights Act (USERRA) under the following circumstances. These rights apply only to Employees and their Dependents who are covered under the Plan immediately before leaving for military service.

1. The maximum period of coverage of an Employee and his or her Dependents under such an election shall be the lesser of:

a. The 24-month period begins on the date on which the Employee's absence begins; or

b. the day after the date on which the Employee was required to apply for or return to a position of employment and fails to do so.

2. An Employee who elects to continue health plan coverage must pay up to 102% of the full contribution under the Plan, except an Employee on active duty for 30 days or less cannot be required to pay more than the Employee's share, if any, for the coverage.

3. An exclusion or Waiting Period may not be imposed in connection with the reinstatement of coverage upon reemployment if one would not have been imposed had coverage not been terminated because of service. However, an exclusion or Waiting Period may be imposed for coverage of any Illness or Injury determined by the Secretary of Veterans Affairs to have been Incurred in, or aggravated during, the performance of uniformed service.

If the Employee wishes to choose this coverage or obtain more detailed information, he or she shall contact the Plan Administrator. The Employee may also have continuation rights under USERRA. In general, the Employee must meet the same requirements for electing USERRA coverage as are required under requirements for COBRA continuation coverage. Coverage elected under these circumstances is concurrent not cumulative. The Employee may elect USERRA continuation coverage for himself or herself and his or her Dependents. Only the Employee has election rights. Dependents do not have any independent right to elect USERRA health plan continuation.

Continuation During COBRA

The right to COBRA Continuation Coverage was created by a federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985, as amended ("COBRA"). COBRA Continuation Coverage can become available to Covered Persons when they otherwise would lose their group health coverage. It also can become available to other members of the Covered Persons family who are covered under the Plan when they otherwise would lose their group health coverage. The entire cost (plus a reasonable administration fee) must be paid by the person. Coverage will end in certain instances, including if the Covered Person fails to make timely payment of premiums. Covered Persons should check with their employer to see if COBRA applies to them.

COBRA Continuation Coverage

"COBRA Continuation Coverage" is a continuation of Plan coverage when coverage otherwise would end because of a life event known as a "Qualifying Event."

Qualifying Events

Specific Qualifying Events are listed below. After a Qualifying Event, COBRA Continuation Coverage must be offered to each person who is a "Qualified Beneficiary." The Employee, the Employee's spouse, and the Employee's Dependent Children could become Qualified Beneficiaries if coverage under the Plan is lost because of the Qualifying Event.

If you are an Employee, you will become a Qualified Beneficiary if you lose your coverage under the Plan because of the following Qualifying Events:

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

If you are the spouse of an Employee, you will become a Qualified Beneficiary if you lose your coverage under the Plan because of the following Qualifying Events:

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

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

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

Employer Notice of Qualifying Events

When the Qualifying Event is the end of employment, reduction of hours of employment, death of the covered Employee, or the covered Employee's becoming entitled to Medicare benefits (under Part A, Part B, or both), the Employer must notify the Plan Administrator of the Qualifying Event.

Employee Notice of Qualifying Events

Each covered Employee or Qualified Beneficiary is responsible for providing the Plan Administrator with the following notices, in writing, either by U.S. First Class Mail or hand delivery:

1. Notice of the occurrence of a Qualifying Event that is a divorce or legal separation of a covered Employee (or former employee) from his or her spouse.
2. Notice of the occurrence of a Qualifying Event that is an individual's ceasing to be eligible as a Dependent Child under the terms of the Plan.

3. Notice of the occurrence of a second Qualifying Event after a Qualified Beneficiary has become entitled to COBRA Continuation Coverage with a maximum duration of 18 (or 29) months.

4. Notice that a Qualified Beneficiary entitled to receive Continuation Coverage with a maximum duration of 18 months has been determined by the Social Security Administration ("SSA") to be disabled at any time during the first 60 days of Continuation Coverage; and

5. Notice that a Qualified Beneficiary, with respect to whom a notice described above has been provided, has subsequently been determined by the SSA to no longer be disabled.

The Plan Administrator is: **Bridgeway Behavioral Health Services**

A form of notice is available, free of charge, from the Plan Administrator and must be used when providing the notice.

Deadline for providing the notice.

For Qualifying Events described above, the notice must be furnished by the date that is 60 days after the latest of:

1. The date on which the relevant Qualifying Event occurs.

2. The date on which the Qualified Beneficiary loses (or would lose) coverage under the Plan as a result of the Qualifying Event; or

3. The date on which the Qualified Beneficiary is informed, through the furnishing of the Plan's Summary Plan Description or the general notice, of both the responsibility to provide the notice and the Plan's procedures for providing such notice to the Plan Administrator.

For the disability determination described above, the notice must be furnished by the date that is 60 days after the latest of:

1. The date of the disability determination by the SSA.

2. The date on which a Qualifying Event occurs.

3. The date on which the Qualified Beneficiary loses (or would lose) coverage under the Plan as a result of the Qualifying Event; or

4. The date on which the Qualified Beneficiary is informed, through the furnishing of the Plan's Summary Plan Description or the general notice, of both the responsibility to provide the notice and the Plan's procedures for providing such notice to the Plan Administrator.

In any event, this notice must be furnished before the end of the first 18 months of Continuation Coverage.

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

1. The date of the final determination by the SSA that the Qualified Beneficiary is no longer disabled; or

2. The date on which the Qualified Beneficiary is informed, through the furnishing of the Plan's Summary Plan Description or the general notice, of both the responsibility to provide the notice and the Plan's procedures for providing such notice to the Plan Administrator.

The notice must be postmarked (if mailed) or received by the Plan Administrator (if hand delivered), by the deadline set forth above. If the notice is late, the opportunity to elect or extend COBRA

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

Who Can Provide the Notice

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

Required Contents of the Notice

The notice must contain the following information:

1. Name and address of the covered Employee or former employee.
2. Identification of the initial Qualifying Event and its date of occurrence if the person is already receiving COBRA Continuation Coverage and wishes to extend the maximum coverage period.
3. A description of the Qualifying Event (for example, divorce, legal separation, cessation of dependent status, entitlement to Medicare by the covered Employee or former employee, death of the covered Employee or former employee, disability of a Qualified Beneficiary or loss of disability status).
4. In the case of a Qualifying Event that is divorce or legal separation, name(s) and address(es) of spouse and Dependent Child(ren) covered under the Plan, date of divorce or legal separation, and a copy of the decree of divorce or legal separation.
5. In the case of a Qualifying Event that is Medicare entitlement of the covered Employee or former employee, date of entitlement, and name(s) and address(es) of spouse and Dependent Child(ren) covered under the Plan.
6. In the case of a Qualifying Event that is a Dependent Child's cessation of dependent status under the Plan, name and address of the Child, reason the Child ceased to be an eligible Dependent (for example, attained limiting age, lost student status, married or other).
7. In the case of a Qualifying Event that is the death of the covered Employee or former employee, the date of death, and name(s) and address(es) of spouse and Dependent Child(ren) covered under the Plan.
8. In the case of a Qualifying Event that is disability of a Qualified Beneficiary, name and address of the disabled Qualified Beneficiary, name(s) and address(es) of other family members covered under the Plan, the date the disability began, the date of the SSA's determination, and a copy of the SSA's determination.
9. In the case of a Qualifying Event that is loss of disability status, name and address of the Qualified Beneficiary who is no longer disabled, name(s) and address(es) of other family members covered under the Plan, the date the disability ended and the date of the SSA's determination; and
10. A certification that the information is true and correct, a signature and date.

If a copy of the decree of divorce or legal separation or the SSA's determination cannot be provided by the deadline for providing the notice, complete and provide the notice, as instructed, by the deadline and submit

the copy of the decree of divorce or legal separation or the SSA's determination within 30 days after the deadline. The notice will be timely if done so. However, no COBRA Continuation Coverage, or extension of such Coverage, will be available until the copy of the decree of divorce or legal separation or the SSA's determination is provided.

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

Electing COBRA Continuation Coverage

Complete instructions on how to elect COBRA Continuation Coverage will be provided by the Plan Administrator within 14 days of receiving the notice of the Qualifying Event. The individual then has 60 days in which to elect COBRA Continuation Coverage. The 60-day period is measured from the later date coverage terminates and the date of the notice containing the instructions. If COBRA Continuation Coverage is not elected in that 60-day period, then the right to elect it ceases.

Each Qualified Beneficiary will have an independent right to elect COBRA Continuation Coverage. Covered Employees may elect COBRA Continuation Coverage on behalf of their spouses, and parents may elect COBRA Continuation Coverage on behalf of their Children.

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

Duration of COBRA Continuation Coverage

COBRA Continuation Coverage will be available up to the maximum time period shown below. Generally, multiple Qualifying Events which may be combined under COBRA will not continue coverage for more than 36 months beyond the date of the original Qualifying Event. When the Qualifying Event is "entitlement to Medicare," the 36-month continuation period is measured from the date of the original Qualifying Event. For all other Qualifying Events, the continuation period is measured from the date of the Qualifying Event, not the date of loss of coverage.

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

When the Qualifying Event is the end of employment or reduction of the covered Employee's hours of employment, and the covered Employee became entitled to Medicare benefits less than 18 months before the Qualifying Event, COBRA Continuation Coverage for Qualified Beneficiaries other than the covered Employee lasts until 36 months after the date of Medicare entitlement. For example, if a covered Employee becomes entitled to Medicare eight months before the date on which his or her employment terminates, COBRA Continuation Coverage for his or her spouse and Children can last up to 36 months after the date of Medicare entitlement, which is equal to 28 months after the date of the Qualifying Event (36 months minus 8 months).

Otherwise, when the Qualifying Event is the end of employment (for reasons other than gross misconduct) or reduction of the covered Employee's hours of employment, COBRA Continuation Coverage lasts for only

up to a total of 18 months. There are two ways in which this 18-month period of COBRA Continuation Coverage can be extended.

Disability Extension of COBRA Continuation Coverage

If an Employee or anyone in an Employee's family covered under the Plan is determined by the SSA to be disabled and the Employee notifies the Plan Administrator as set forth above, the Employee and his or her entire family may be entitled to receive up to an additional 11 months of COBRA Continuation Coverage, for a total maximum of 29 months. The disability would have to have started at some time before the 60th day of COBRA Continuation Coverage and must last at least until the end of the 18-month period of COBRA Continuation Coverage. An extra fee will be charged for this extended COBRA Continuation Coverage.

Second Qualifying Event Extension of COBRA Continuation Coverage

If an Employee's family experiences another Qualifying Event while receiving 18 months of COBRA Continuation Coverage, the spouse and Dependent Children in the family can get up to 18 additional months of COBRA Continuation Coverage, for a maximum of 36 months, if notice of the second Qualifying Event properly is given to the Plan as set forth above. This extension may be available to the spouse and any Dependent Children receiving COBRA Continuation Coverage if the covered Employee or former employee dies, becomes entitled to Medicare benefits (under Part A, Part B, or both), or gets divorced or legally separated, or if the Dependent Child stops being eligible under the Plan as a Dependent Child, but only if the event would have caused the spouse or Dependent Child to lose coverage under the Plan had the first Qualifying Event not occurred.

Shorter Duration of COBRA Continuation Coverage

COBRA Continuation Coverage also may end before the end of the maximum period on the earliest of the following dates:

1. The date the employer ceases to provide a group health plan to any employee.
2. The date on which coverage ceases because of the Qualified Beneficiary's failure to make timely payment of any required premium.
3. The date that the Qualified Beneficiary first becomes, after the date of election, covered under any other group health plan (as an employee or otherwise), or entitled to either Medicare Part A or Part B (whichever comes first) (except as stated under COBRA's special bankruptcy rules); or
4. The first day of the month that begins more than 30 days after the date of the SSA's determination that the Qualified Beneficiary is no longer disabled, but in no event before the end of the maximum coverage period that applied without taking into consideration the disability extension.

Premium Requirements

Once COBRA Continuation Coverage is elected, the individual must pay for the cost of the initial period of coverage within 45 days. Payments then are due on the first day of each month to continue coverage for that month. If a payment is not received within 30 days of the due date, COBRA Continuation Coverage will be canceled and will not be reinstated.

MEDICAL & PRESCRIPTION – SCHEDULE OF BENEFITS

GENERAL INFORMATION		
Maximum Benefits	Unlimited	
Claim Determination Period *(accumulation period for out-of-pocket expenses)*		01/01/2025 12/31/2025
DEDUCTIBLE		
Individual	Tier 1: Neighborhood Health $0 Tier 2: All Other Providers $0	
Family	Tier 1: Neighborhood Health $0 Tier 2: All Other Providers $0	
The Plan will pay the designated percentage of Covered Expenses until the out-of-pocket maximum(s) is reached. At that time, the Plan will pay 100% of Covered Expenses for the remainder of the Claim Determination Period. The following charges do not apply to the out-of-pocket maximum: • *Non-covered Expenses (includes penalties, exclusions and limitations)* • *Amounts that exceed the Maximum Allowable Charge or benefit maximum.* *The Deductible is embedded and does not combine between in-network and out-of-network.*		
OUT OF POCKET MAXIMUM		
Individual	$2,000	
Family	$4,000	
The Plan will pay the designated percentage of Covered Expenses until the out-of-pocket maximum(s) is reached. At that time, the Plan will pay 100% of Covered Expenses for the remainder of the Claim Determination Period. The following charges do not apply to the out-of-pocket maximum: • *Non-covered Expenses (includes penalties, exclusions and limitations)* • *Amounts that exceed the Maximum Allowable Charge or benefit maximum.* *The Out-of-Pocket is embedded and does not combine between in-network and out-of-network.*		
PRECERTIFICATION / EMERGENCY		
Precertification (P-Cert) - *(Required for all Admissions and other services as noted in schedule)*		
• If Precertification is not obtained the services will be denied. *Penalties are not considered Covered Expenses and do not accumulate towards a Participant's out-of-pocket maximum.* • Precertification is not required for a Hospital length of stay in connection with childbirth for the mother or newborn child of less than 48 hours following a normal vaginal delivery, or less than 96 hours following a cesarean section delivery. • The precertification contact information may be found on your benefits ID card.		
COVERED SERVICES SUMMARY		
PRIMARY CARE		
Primary Care Service	**P-Cert Required**	**Member Cost Share**
Office Visit	No	Tier 1: Neighborhood Health $0 copay Tier 2: All Other Providers $20 copay
Labs and x-rays performed during office visit	No	Tier 1: Neighborhood Health $0 copay Tier 2: All Other Providers $0 copay
PREVENTIVE SERVICES *(ACA required only)*		

Contraceptive Management	No	Covered 100%
Immunization	No	Covered 100%
Routine Annual Physical Exam	No	Covered 100%
Routine Colorectal Screening	No	Covered 100%
Routine Diagnostic Procedures	No	Covered 100%
Routine Eye Exams	No	Covered 100%
Routine Gynecological Procedure	No	Covered 100%
Routine Hearing Screening	No	Covered 100%
Routine & Digital 3D Mammography	No	Covered 100%
Routine Vision Exam	No	Covered 100%
Well-Child Care	No	Covered 100%
For more information, please refer to the following websites:		
https://www.healthcare.gov/coverage/preventive-care-benefits/ https://www.uspreventiveservicestaskforce.org/Page/Name/uspstf-a-and-b-recommendations/ https://www.cdc.gov/vaccines/hcp/acip-recs/index.html https://www.aap.org/en-us/Documents/periodicity_schedule.pdf https://www.hrsa.gov/womensguidelines/		
GALILEO / TELEMEDICINE		
General Services	**P-Cert Required**	**Member Cost Share**
Galileo/Digital Multi Specialty	No	$0 copay
Telehealth – Mental Health *(Non-Galileo)*	No	$30 copay
Telehealth – PCP *(Non-Galileo)*	No	$20 copay
Telehealth – Specialist *(Non-Galileo)*	No	$30 copay
SPECIALIST SERVICES		
General Services	**P-Cert Required**	**Member Cost Share**
Office Visit	No	Tier 1: Neighborhood Health $0 copay Tier 2: All Other Providers $30 copay
Retail/Walk-in/Convenient Care Clinic	No	$10 copay
Allergy Injections and Serum (Office visit)	No	Tier 1: Neighborhood Health $20 copay Tier 2: All Other Providers $30 copay
Allergy Injections and Serum (Without Office visit)	No	Tier 1: Neighborhood Health $0 copay Tier 2: All Other Providers $30 copay
Allergy Testing	No	Tier 1: Neighborhood Health $0 copay Tier 2: All Other Providers $30 copay
Diabetic Education and Training	No	Covered 100%
Genetic Testing and Counseling (Medically Necessary)	Yes	Covered 100%
Hearing Aids	No	Limited to 1 hearing aid per ear to $1,000 maximum per ear; every 24 months up to the age of 19.
Nutritional Counseling	No	Covered 100%
Pre-natal Maternity initial visit	No	Tier 1: Neighborhood Health $0 copay

		Tier 2: All Other Providers $20 copay
Sleep Studies (Medically Necessary)	Yes	$250 outpatient facility copay and $250 professional facility; $50 copay for home
Surgery Related Services	**P-Cert Required**	**Member Cost Share**
Inpatient Surgery	No	Tier 1: N/A Tier 2: All Other Providers $500 copay
Outpatient Surgery (Hospital/Ambulatory Surgery Center)	Yes	Tier 1: Neighborhood Health $0 copay Tier 2: All Other Providers $250 copay
Outpatient Surgery (Office)	No	Tier 1: Neighborhood Health $0 copay Tier 2: All Other Providers $250 copay
Anesthesia	No	Covered 100%
Voluntary Termination of Pregnancy - Outpatient	No	Covered 100%
Tubal Ligation	No	Covered 100%
Sterilization - Male	No	Covered 100%
Bariatric / Gastric Bypass Surgery	No	Facility - $500 Facility copay; Surgeon- $250 copay. Lifetime Maximum Benefit - 1 surgery
Therapy Services	**P-Cert Required**	**Member Cost Share**
Applied Behavior Analysis (ABA) Therapy	No	Tier 1: Neighborhood Health $0 copay Tier 2: All Other Providers $20 copay
Autism Physical, Occupational, and Speech Therapy	No	Tier 1: Neighborhood Health $0 copay Tier 2: All Other Providers $20 copay
Autism Spectrum Disorder	No	Tier 1: Neighborhood Health $0 copay Tier 2: All Other Providers $20 copay
Cardiac Rehabilitation Therapy* (*See* **BENEFIT LIMITATIONS & MAXIMUMS** *section below*)	No	Tier 1: Neighborhood Health $0 copay Tier 2: All Other Providers $30 copay
Chemotherapy/Radiation Therapy	Yes	Facility Service - $250 Copay then 100% covered: $1,000 Copay Maximum per Calendar Year. Professional Provider Service - $30 Copay then 100% covered: $500 Copay Maximum per Calendar Year.
Dialysis	Yes	Covered 100%

Occupational Therapy* (*See* **BENEFIT LIMITATIONS & MAXIMUMS** *section below*)	Yes after 12th visit	Tier 1: Neighborhood Health $0 copay Tier 2: All Other Providers $20 copay
Infusion Therapy	Yes	Freestanding Facility - $10 copay Home Infusion - $30 copay Hospital Facility - $50 copay
Massage Therapy	N/A	Not Covered
Chiropractic / Manipulative Therapy* (*See* **BENEFIT LIMITATIONS & MAXIMUMS** *section below*)	Yes after 12th visit	Tier 1: Neighborhood Health $0 copay Tier 2: All Other Providers $30 copay
Physical Therapy* (*See* **BENEFIT LIMITATIONS & MAXIMUMS** *section below*)	Yes after 12th visit	Tier 1: Neighborhood Health $0 copay Tier 2: All Other Providers $20 copay
Pulmonary Rehabilitation & Cognitive Therapy* (*See* **BENEFIT LIMITATIONS & MAXIMUMS** *section below*)	No	Tier 1: Neighborhood Health $0 copay Tier 2: All Other Providers $20 copay
Respiratory Therapy Office	No	Tier 1: Neighborhood Health $0 copay Tier 2: All Other Providers $20 copay
Speech Therapy* (*See* **BENEFIT LIMITATIONS & MAXIMUMS** *section below*)	Yes after 12th visit	Tier 1: Neighborhood Health $0 copay Tier 2: All Other Providers $20 copay
HOSPITAL / HOME HEALTH CARE		
Service	**P-Cert Required**	**Member Cost Share**
HOSPITAL – Inpatient		
Inpatient Room & Board (including ancillary)	Yes	Tier 1: N/A Tier 2: All Other Providers $500 copay
Inpatient Maternity Care	Yes	Tier 1: N/A Tier 2: All Other Providers $250 copay
Inpatient Physician Visits	No	Tier 1: N/A Tier 2: All Other Providers $0 copay
Skilled Nursing Facility* (*See* **BENEFIT LIMITATIONS & MAXIMUMS** *section below*)	Yes	Tier 1: N/A Tier 2: All Other Providers $250 copay
Hospice Care (Inpatient)	Yes	Covered 100%
HOSPITAL – Outpatient		
Outpatient Facility (surgery)	Yes	Tier 1: Neighborhood Health $0 copay Tier 2: All Other Providers $250 copay
Outpatient Surgery (Hosp/ASC)	Yes	Tier 1: Neighborhood Health $0 copay Tier 2: All Other Providers $250 copay
Outpatient Facility (Diagnostic X-ray/Lab)	No	Tier 1: Neighborhood Health $0 copay Tier 2: All Other Providers $75 copay

Outpatient Physician Visits	No	Tier 1: Neighborhood Health $0 copay Tier 2: All Other Providers $250 copay
Advanced Imaging (MRI, CT, PET)	Yes	Tier 1: Neighborhood Health $0 copay Tier 2: All Other Providers $250 copay
Home Health Care* (*See* **BENEFIT LIMITATIONS & MAXIMUMS** *section below*)	Yes	Tier 1: Neighborhood Health $0 copay Tier 2: All Other Providers $40 copay
Hospice Care - Outpatient	No	Tier 1: Neighborhood Health $0 copay Tier 2: All Other Providers $0 copay
Family Bereavement Counseling	No	Covered 100%
Respite Care* (*See* **BENEFIT LIMITATIONS & MAXIMUMS** *section below*)	No	Covered 100%
Pre-admission Testing	No	No Cost
Private Duty Nursing – Outpatient	Yes	Not covered, except for Home Healthcare Services in home only $30 copay. 4-hour maximum per visit limited to 60 visits per Calendar Year (per condition)
OTHER COVERED SERVICES		
Laboratory & Radiology *(non-Hospital Based)*	**P-Cert Required**	**Member Cost Share**
Advanced Imaging (CT, MRI, PET)	Yes	Tier 1: Neighborhood Health $0 copay Tier 2: All Other Providers $250 copay
Diagnostic X-ray and Lab (Independent and Free-Standing Facility)	No	Tier 1: Neighborhood Health $0 copay Tier 2: All Other Providers $75 copay
Maternity		
Prenatal Care Office Visit	No	$20 copay 1st visit only
Childbirth / Delivery Professional Services	No	Covered 100%
Breast Feeding Support	No	Covered 100%
Breast Pump and Supplies	Yes	$50 copay per item
Childbirth/Delivery Facility Services/Inpatient Birth Center	Yes	$250 copay
Mental Health		
Inpatient Hospital	Yes	Tier 1: N/A 2: All Other Providers $500 copay
Inpatient Residential Treatment	Yes	$500 copay
Inpatient Physician Visit	No	Tier 1: N/A Tier 2: All Other Providers $0 copay
Intensive Outpatient Services	No	Tier 1: N/A Tier 2: All Other Providers $30 copay
Partial Hospitalization	No	Tier 1: N/A Tier 2: All Other Providers $30 copay

Outpatient Office Visits	No	Tier 1: Neighborhood Health $0 copay Tier 2: All Other Providers $30 copay
Substance Abuse		
Inpatient Hospital	Yes	Tier 1: N/A Tier 2: All Other Providers $500 copay
Inpatient Residential Treatment	Yes	$500 copay
Inpatient Physician Visit	No	Tier 1: N/A Tier 2: All Other Providers $0 copay
Intensive Outpatient Services	No	Tier 1: Neighborhood Health $0 copay Tier 2: All Other Providers $30 copay
Partial Hospitalization	No	Tier 1: N/A Tier 2: All Other Providers $30 copay
Outpatient Office Visits	No	Tier 1: Neighborhood Health $0 copay Tier 2: All Other Providers $30 copay
Miscellaneous Services		
Ambulance *(Ground)*	No	Tier 1: N/A Tier 2: All Other Providers $100 copay
Ambulance *(Air and Water)*	Yes	Tier 1: N/A Tier 2: All Other Providers $100 copay
Gender Reassignment Services	No	Payable at the same level as other conditions depending on the Provider rendering the Service
Durable Medical and Surgical Equipment (DMSE)* (*See* **BENEFIT LIMITATIONS & MAXIMUMS** *section below*)	Yes	$50 Copay per item
High Blood Pressure Machines	Yes	Covered with prescription; 100% maximum of $50
Foot Orthotics *(For treatment / complications of Diabetes)*	No	Tier 1: Neighborhood Health $0 copay Tier 2: All Other Providers $50 copay per item
Orthosis/Prosthetic Devices	Yes	Tier 1: Neighborhood Health $0 copay Tier 2: All Other Providers $50 copay per item
Wigs* (*See* **BENEFIT LIMITATIONS & MAXIMUMS** *section below*)	N/A	Not Covered

Infertility	Yes	Basic Infertility Expenses - Must be diagnosed by a Physician. Payment at the same level as other conditions depending on the Provider rendering the Services. Infertility - AI/IUI - Payment at the same level as other conditions depending on the Provider rendering the Services. IVF- Payment at the same level as other conditions depending on the Provider rendering the Services.
ORGAN TRANSPLANTS		
Transplant Facility Expense (Center of Excellence)	Yes	$500 Copay
Transplant Physician Services including office visits	Yes	Payable in accordance with the type of expense incurred and the place where service is provided
Transplant Meals, Lodging & Transportation	Yes	Maximum Benefit of $10,000 per Transplant
DENTAL SERVICES		
Service	**P-Cert Required**	**Member Cost Share**
As a result of Accidental Injury	No	Office: $250 copay Surgeon: $250 copay Outpatient Facility: $250 copay Inpatient Facility: $500 copay
Oral Surgery to Impacted Teeth	No	Office: $250 copay Surgeon: $250 copay Outpatient Facility: $250 copay Inpatient Facility: $500 copay
Dental TMJ Services	No	Office: $250 copay Surgeon: $250 copay Inpatient/Outpatient Facility: $500 copay Non-Surgical Treatment, Procedures and Devices: $40 copay
EMERGENCY SERVICES		
Service	**P-Cert Required**	**Member Cost Share**
Emergency Room (ER) - Hospital	No	Tier 1: N/A Tier 2: All Other Providers $250 copay
Urgent Care Facility	No	Tier 1: Neighborhood Health $0 copay Tier 2: All Other Providers $40 copay
Non-Emergent use of ER	No	$750 copay

Prescription Drugs		
Deductible	**$150 per person (excluding Generic)**	
Out of Pocket Maximum	**$1,000 Single / $2,000 Family**	
Retail Pharmacy – up to 30 days	**P-Cert Required**	**Member Cost Share**
Generic	No	$10 copay
Formulary Brand	No	$30 copay
Non-Formulary Brand	No	$60 copay
Prudent Rx	No	Deductible - $0 copay through Prudent Rx
Mail Order – up to 90 days		
Generic	No	$20 copay
Formulary Brand	No	$60 copay
Non-Formulary Brand	No	$120 copay
Prudent Rx	No	Deductible - $0 copay through Prudent Rx
Specialty Medication – up to 30 days		
Specialty Medications	No	30 Day Retail only: 30%

*BENEFIT LIMITATIONS & MAXIMUMS	
Service	**Maximum Benefit per Participant**
Cardiac Rehabilitation Therapy	Limited to 30 visits per calendar year.
Chiropractic / Manipulative Therapy	Precertification required after 12th visit per calendar year.
Durable Medical and Surgical Equipment (DMSE)	Precertification required for DME over $1,500.00.
Home Health Care – (in home only)	4 hours max per visit. Limited to 60 visits per calendar year.
Mastectomy Bra	Limited to 2 bras per calendar year.
Occupational Therapy	Precertification required after 12th visit per calendar year. Limited to 30 visits per calendar year.
Physical Therapy	Precertification required after 12th visit per calendar year. Limited to 30 visits per calendar year.
Pulmonary Rehabilitation & Cognitive Therapy	Limited to 30 visits per calendar year.
Respite Care	Limited to 7 days every 6 months.
Speech Therapy	Precertification required after 12th visit per calendar year. Limited to 30 visits per calendar year.
Skilled Nursing Facility	Limited to 60 days per calendar year.
Wig after Chemotherapy	Not covered.

Description of Covered Medical Services

Subject to the exclusions, conditions and limitations of this Plan, a Covered Person is entitled to benefits for the Covered Expenses described in this Article during a Benefit Period, subject to any Copayment, Deductible, Coinsurance or Out-of-pocket Maximum. These amounts and percentages, and other cost sharing requirements are specified in the Schedule of Covered Expenses.

Free Choice of Hospital and Physician

Nothing contained in this 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 Provider. However, benefits will be paid in accordance with the provisions of this Plan, and the Covered Person may have lower Out of Pocket Expenses if the Covered Person uses the services of a Contracted Provider or Physician

Preferred Provider Information

For Physicians and all other providers of service, this Plan contains provisions under which a Covered Person will receive the same level of benefits by using PPO or Non-PPO Providers.

Some Covered Expenses must be Pre-certified before the Covered Person receives the services. Precertification of services is a vital program feature that reviews Medical Necessity of certain procedures and/or admissions. In certain cases, Precertification helps determine whether a different treatment may be available that is equally effective yet less traumatic. Precertification also helps determine the most appropriate setting for certain services.

Primary and Preventive Care Services

A Covered Person is entitled to benefits for Primary Care and “Preventive Care” Covered Expenses when deemed Medically Necessary and billed for by a Provider. Payment allowances for Covered Expenses and other cost sharing- requirements are specified in the Schedule of Covered Expenses.

“Preventive Care” services describe health care services performed to catch the early warning signs of health problems. These services are performed when the Covered Person has no symptoms of disease. Services performed to treat an Illness or Injury are not covered as Preventive Care under this benefit.

The Plan Administrator periodically reviews the Schedule of Covered Expenses based on recommendations from organizations such as The American Academy of Pediatrics, The American College of Physicians, the U.S. Preventive Services Task Force and The American Cancer Society. Accordingly, the frequency and eligibility of Covered Expenses are subject to change. The Plan Administrator reserves the right to modify the schedule at any time after written notice of the change has been given to the Covered Person.

Inpatient Services

A Covered Person is entitled to benefits for Covered Expenses while an Inpatient in a Facility when deemed Medically Necessary and billed for by a Provider. Payment allowances for Covered Expenses and other cost sharing- requirements are specified in the Schedule of Covered Expenses.

Office Visits / Retail Clinic

Medical Care visits for the examination, diagnosis and treatment of an Illness or Injury by a Primary Care Provider. For the purpose of this benefit, “Office Visits” include Medical Care visits to a Provider’s office, Medical Care visits by a Provider to a Covered Person’s residence, or Medical Care consultations by a Provider on an Outpatient basis.

In addition to Office Visits, a Covered Person may receive Medical Care at a Retail Clinic. Retail Clinics are staffed by certified family nurse practitioners, who are trained to diagnose, treat, and write prescriptions when clinically appropriate. Nurse practitioners are supported by a local Physician who is on call during clinic hours to provide guidance and direction when necessary. Examples of treatment and services that are provided at a Retail Clinic include but are not limited to: sore throat; ear, eye, or sinus infection; allergies; minor burns, skin infections or rashes and Pregnancy testing.

Preventive Care

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

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

See http://www.uspreventiveservicestaskforce.org or https://www.healthcare.gov/coverage/preventive-care-benefits/ for more details.

NOTE: *The Preventive Care services identified through the above links are recommended services. It is up to the Provider and/or Physician of care to determine which services to provide; the Plan Administrator has the authority to determine which services will be covered.*

1. Preventive and Wellness Services for Adults and Children

In compliance with section 2713 of the Affordable Care Act, benefits are available for evidence-based items or services that have in effect a rating of "A" or "B" in the current recommendations of the United States Preventive Services Task Force (USPSTF).

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

A description of Preventive and Wellness Services can be found at: https://www.healthcare.gov/coverage/preventive-care-benefits/.

2. Women's Preventive Services

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

a. Well women- visits.

b. Gestational diabetes screening.

c. Human papillomavirus (HPV) Deoxyribonucleic Acid (DNA) testing.

d. Sexually transmitted infection counseling.

e. Human Immunodeficiency Virus (HIV) screening and counseling.

f. Food and Drug Administration (FDA) approved contraception methods and contraceptive counseling.

g. Breastfeeding support supplies and counseling.

h. Domestic violence screening and counseling.

A description of Women's Preventive Services can be found at: http://www.hrsa.gov/womensguidelines/ or at https://www.healthcare.gov/coverage/preventive-care-benefits/

Adult Preventive Care

In addition to the above federally mandated- Preventive Care benefits, the Plan will cover one Prostate Specific Antigen (PSA) test every Benefit Period, beginning at 50 years of age. This blood test may be used to detect tumors of the prostate.

Hospital Services

1. **Ancillary Services**

Benefits are payable for all ancillary services usually provided and billed for by Hospitals (except for personal convenience items) including, but not limited to, the following:

(a) Meals, including special meals or dietary services as required by the Covered Person's condition.

(b) Use of operating, delivery, recovery, or other specialty service rooms and any equipment or supplies therein.

(c) Casts, surgical dressings, and supplies, devices or appliances surgically inserted within the body.

(d) Oxygen and oxygen therapy.

(e) Anesthesia when administered by a Hospital employee, and the supplies and use of anesthetic equipment.

(f) Cardiac Rehabilitation Therapy, Chemotherapy, Dialysis, Occupational Therapy, Physical Therapy, Pulmonary Rehabilitation Therapy, Radiation Therapy, respiratory therapy, and Speech Therapy when administered by a person who is appropriately licensed and authorized to perform such services.

(g) All drugs and medications (including intravenous injections and solutions) for use while in the Hospital and which are released for general use and are commercially available to Hospitals.

(h) Use of special care units, including, but not limited to, intensive or coronary care; and

(i) Pre-admission testing.

2. **Room and Board**

Benefits are payable for general nursing care and such other services as are covered by the Hospital's regular charges for accommodations in the following:

(a) An average semiprivate room, as designated by the Hospital; or a private room, when designated- as semi-private for the purposes of this Plan in Hospitals having primarily private rooms.

(b) A private room, when Medically Necessary.

(c) A special care unit, such as intensive or coronary care, when such a designated unit with concentrated facilities, equipment and supportive services is required to provide an intensive level of care for a critically ill patient.

(d) A bed in a general ward; and

(e) Nursery facilities.

Benefits are provided up to the number of days specified in the Schedule of Covered Expenses.

In computing the number of days of benefits, the day of admission, but not the date of discharge shall be counted. If the Covered Person is admitted and discharged on the same day, it shall be counted as one day.

Days available shall be allowed only during uninterrupted stays in a Hospital. Benefits shall not be provided:

(a) During the absence of a Covered Person who interrupts his or her stay and remains past midnight of the day on which the interruption occurred; or

(b) after the discharge hour that the Covered Person's attending Physician has recommended that further Inpatient care is not required.

Medical Care

Medical Care rendered by the Provider in charge of the case to a Covered Person who is an Inpatient in a Hospital, Rehabilitation Hospital or Skilled Nursing Facility for a condition not related to Surgery, Pregnancy, Radiation Therapy, or Mental Illness, except as specifically provided. Such care includes Inpatient intensive Medical Care rendered to a Covered Person whose condition requires a Provider's constant attendance and treatment for a prolonged period of time.

1. **Concurrent Care**

Services rendered to an Inpatient in a Hospital, Rehabilitation Hospital or Skilled Nursing Facility by a Provider who is not in charge of the case but whose particular skills are required for the treatment of complicated conditions. This does not include observation or reassurance of the Covered Person, standby services, routine preoperative physical examinations, or Medical Care routinely performed in the pre- or post-operative or pre- or post-natal periods or Medical Care required by a Facility's rules and regulations.

2. **Consultations**

Consultation services when rendered to an Inpatient in a Hospital, Rehabilitation Hospital or Skilled Nursing Facility by a Provider at the request of the attending Provider. Consultations do not include staff consultations which are required by the Facility's rules and regulations. Benefits are limited to one consultation per consultant during any Inpatient confinement.

Skilled Nursing Care Facility

Benefits are provided for a Skilled Nursing Care Facility, when Medically Necessary as determined by the Health Insurance Provider, up to the maximum days specified in the Schedule of Covered Expenses. The Covered Person must require treatment by skilled nursing personnel which can be provided only on an Inpatient basis in a Skilled Nursing Care Facility.

In computing the number of days of benefits, the day of admission, but not the date of discharge shall be counted. If the Covered Person is admitted and discharged on the same day, it shall be counted as one day.

Days available shall be allowed only during uninterrupted stays in a Skilled Nursing Care Facility. Benefits shall not be provided:

1. During the absence of a Covered Person who interrupts the Covered Person's stay and remains past midnight of the day on which the interruption occurred; or

2. After the discharge hour that the Covered Person's attending Physician has recommended that further Inpatient care is not required.

Medically Necessary Provider visits to a Skilled Nursing Facility are provided as shown in the Schedule of Covered Expenses.

No Skilled Nursing Care Facility benefits are payable:

1. When confinement in a Skilled Nursing Facility is intended solely to assist the Covered Person with the activities of daily living or to provide an institutional environment for the convenience of a Covered Person.
2. For the treatment of Alcohol and Drug Abuse or dependency, and Mental Illness; or
3. After the Covered Person has reached the maximum level of recovery possible for his or her particular condition and no longer requires definitive treatment other than routine Custodial Care.

Inpatient / Outpatient Services

A Covered Person is entitled to benefits for Covered Expenses either while an Inpatient in a Facility or on an Outpatient basis when deemed Medically Necessary and billed for by a Provider. Payment allowances for Covered Expenses and other cost sharing- requirements are specified in the Schedule of Covered Expenses.

Blood

Benefits shall be payable for the administration of Blood and Blood processing from donors. Benefits shall be payable for autologous Blood drawing, storage, or transfusion i.e., an individual having his or her own Blood drawn and stored for personal use, such as self-donation in advance of planned Surgery. Benefits shall be payable for whole Blood, Blood plasma and Blood derivatives, which are not classified as drugs in the official formularies, and which have not been replaced by a donor.

Gender Equality

This Plan shall comply with all non-discrimination rules, not limited to:

Women and men will be treated equally in both the health care they receive and the insurance they obtain.

1. Covered Persons will be treated consistent with their gender identity, including in access to facilities.
2. Covered Persons will not be denied healthcare or health coverage based on their sex, including their gender identity and sex stereotyping; and
3. No Provider shall deny or limit treatment for any health services that are ordinarily or exclusively available to individuals of one gender based on the fact that the Covered Person seeking such services identifies as belonging to another gender.

Genetic Testing

Covered expenses include molecular laboratory procedures related to genetic testing for histocompatibility/blood typing, neoplasia, hereditary disorders, or other conditions. These services must be certified as Medically Necessary by the attending Physician and approved by the Plan.

Hospice Services

When the Covered Person's attending Physician certifies that the Covered Person has a terminal Illness with a medical prognosis of six months or less and when the Covered Person elects to receive care primarily to relieve pain, the Covered Person shall be eligible for Hospice benefits. Hospice care is primarily comfort

care, including pain relief, physical care, counseling, and other services that will help the Covered Person cope with a terminal Illness rather than cure it. Hospice care provides services to make the Covered Person as comfortable and pain free- as possible. When a Covered Person elects to receive Hospice care, benefits for treatment provided to cure the terminal Illness are no longer provided. However, the Covered Person may elect to revoke the election of Hospice care at any time.

Respite Care: When Hospice care is provided primarily in the home, such care on a short-term Inpatient basis in a Medicare certified Skilled Nursing Facility will also be covered when the Hospice considers such care necessary to relieve primary caregivers in the Covered Person's home. Up to seven days of such care every six months will be covered.

Benefits for covered Hospice services shall be provided until the earlier of the Covered Person's death or discharge from Hospice care.

Special Hospice services exclusions: No Hospice care benefits will be provided for:

1. Services and supplies for which there is no charge.
2. Research studies directed to life lengthening methods of treatment.
3. Services or expenses Incurred in regard to the Covered Person's personal, legal, and financial affairs (such as preparation and execution of a will or other dispositions of personal and real property).
4. Care provided by family members, relatives, and friends; and
5. Private Duty Nursing care.

Maternity / OB-GYN / Family Services

1. **Maternity / Obstetrical Care**

Services rendered in the care and management of a Pregnancy for a Covered Person are a Covered Expense under this Plan as specified in the Schedule of Covered Expenses. Pre-notification of maternity care should occur within one month of the first prenatal visit to the Physician or midwife. Benefits are payable for:

a. Facility services provided by a Hospital or Birth Center; and

b. Professional services performed by a Provider or certified nurse midwife.

Benefits payable for a delivery shall include pre- and postnatal care. Maternity care Inpatient benefits will be provided for 48 hours for vaginal deliveries and 96 hours- for cesarean deliveries, except where otherwise approved by the Plan Administrator.

In the event of early post-partum discharge from an Inpatient Admission, benefits are provided for Home Health Care as provided for in the Home Health Care benefit.

2. **Elective Abortions Services**

Facility services provided by a Hospital or Birth Center and services performed by a Provider for the voluntary termination of a Pregnancy by a Covered Person are a Covered Expense under this Plan.

3. **Newborn Care**

The newborn Child of a Covered Person shall be entitled to benefits provided by this Plan from the date of birth up to a maximum of 31 days. Such coverage within the 31 days shall include care which is

necessary for the treatment of medically diagnosed congenital defects, birth abnormalities, premature and routine nursery care.

Mental Health and Substance Abuse/Substance Use Disorder Benefits

Benefits for the treatment of Mental Illness and Serious Mental Illness are based on the services provided and reported by the Provider. When a Provider renders Medical Care, other than Mental or Nervous Disorder Care, for a Covered Person with Mental Illness and Serious Mental Illness, payment for such Medical Care will be based on the Medical Benefits available and will not be subject to the Mental or Nervous Disorder limitations. Emergency Services will be considered Participating Care.

1. **Inpatient Treatment**

Benefits are provided, subject to the Benefit Period limitations stated in the Schedule of Covered Expenses, for an Inpatient Admission for treatment of Mental Illness and Serious Mental Illness. Covered Expenses include treatments such as: psychiatric visits, psychiatric consultations, individual and group psychotherapy, electroconvulsive therapy, psychological testing, and psychopharmacologic management.

2. **Outpatient Treatment**

Benefits are provided for Outpatient treatment of Mental Illness and Serious Mental Illness. Covered Expenses include treatments such as: psychiatric visits, psychiatric consultations, individual and group psychotherapy, Licensed Clinical Social Worker visits, Master's Prepared Therapist visits, electroconvulsive therapy, psychological testing, psychopharmacologic management, and psychoanalysis.

3. **Benefits are not payable for the following services:**

   a. Vocational or religious counseling.

   b. Activities that are primarily of an educational nature.

   c. Treatment modalities that have not been incorporated into the commonly accepted therapeutic repertoire as determined by broad based- professional consensus, such as primal therapy, Rolfing, or structural integration, bioenergetic therapy, and obesity control therapy.

4. **Benefit Period Maximums for Mental or Nervous Disorder**

All Inpatient Mental or Nervous Disorder for both Mental Illness and Serious Mental Illness are covered up to the maximum day amount(s) per Benefit Period specified in the Schedule of Covered Expenses. Non-Participating Benefit Period Maximums are part of, not separate from, Participating Benefit Period Maximums. The Benefit Period Maximum Inpatient day and Outpatient visit limitation amounts for Serious Mental Illness are separate from, not aggregate of, the Inpatient day and Outpatient visit limitation amounts for all other Mental or Nervous Disorder other than Serious Mental Illness.

Routine Costs Associated With Approved Clinical Trials

Benefits are provided for Routine Costs Associated with Participation in an Approved Clinical Trial, as defined. To ensure coverage, the Claims Processor must be notified in advance of the Covered Person's participation in an Approved Clinical Trial.

Surgical Services

Surgery benefits will be provided for services rendered by a Provider and/or Facility for the treatment of disease or Injury. Separate payment will not be made for Inpatient preoperative care, or all postoperative care normally provided by the surgeon as part of the surgical procedure. Also covered is:

1. The orthodontic treatment of congenital cleft palates involving the maxillary arch, performed in conjunction with bone graft Surgery to correct the bony deficits associated with extremely wide clefts affecting the alveolus; and

2. Coverage for the following when performed subsequent to mastectomy: Surgery to reestablish symmetry or alleviate functional impairment, including, but not limited to augmentation, mammoplasty, reduction mammoplasty and mastopexy.

Coverage is also provided for:

1. The surgical procedure performed in connection with the initial and subsequent insertion or removal of Prosthetics to replace the removed breast or portions thereof; and

2. The treatment of physical complications at all stages of the mastectomy, including lymphedemas. Treatment of lymphedema is not subject to any benefit. Maximum amounts that apply to "Physical Therapy" services as provided under the Schedule of Covered Expenses.

Covered surgical procedures shall include routine neonatal circumcisions and any voluntary surgical procedure for sterilization.

1. **Hospital Admission for Dental Procedures or Dental Surgery**

Benefits will be payable for a Hospital admission in connection with dental procedures or Surgery only when the Covered Person has an existing nondental physical disorder or condition and Hospitalization is Medically Necessary to ensure the Covered Person's health. Coverage for such Hospitalization does not imply coverage of the dental procedures or Surgery performed during such a confinement. Only oral surgical procedures or Surgery performed during such a confinement. Only oral surgical procedures specifically identified as covered under the "Oral Surgery" terms of this Plan will be covered during such a confinement.

2. **Oral Surgery**

Benefits will be payable for Covered Expenses provided by a Provider and/or Facility for:

a. Orthognathic Surgery – Surgery on the bones of the jaw (maxilla or mandible) to correct their position and/or structure for the following clinical indications only:

(1) The initial treatment of Accidental Injury/trauma (i.e., fractured facial bones and fractured jaws), in order to restore proper function.

(2) In cases where it is documented that a severe congenital defect (i.e., cleft palate) results in speech difficulties that have not responded to non-surgical interventions.

(3) In cases where it is documented (using objective measurements) that chewing or breathing function is materially compromised (defined as greater than two standard deviations from normal) where such compromise is not amenable to non-surgical treatments and where it is shown that orthognathic surgery will decrease airway resistance, improve breathing, or restore swallowing.

b. Other oral Surgery – defined as Surgery on or involving the teeth, mouth, tongue, lips, gums, and contiguous structures. Benefits will be provided only for:

(1) Surgical removal of impacted teeth which are partially or completely covered by one.

(2) The surgical treatment of cysts, infections, and tumors performed on the structures of the mouth; and

(3) Surgical removal of teeth prior to cardiac Surgery, Radiation Therapy, or organ transplantation.

3. **Assistant at Surgery**

Services for a Covered Person by an assistant surgeon who actively assists the operating surgeon in the performance of covered Surgery. Benefits will be provided for an assistant at Surgery only if an intern, resident, or house staff member is not available.

The condition of the Covered Person or the type of Surgery must require the active assistance of an assistant surgeon as determined by the Health Insurance Provider. Surgical assistance is not covered when performed by a Provider who himself or herself performs and bills for another surgical procedure during the same operative session.

4. **Anesthesia**

Administration of Anesthesia in connection with the performance of Covered Expenses when rendered by or under the direct supervision of a Provider other than the surgeon, assistant surgeon or attending Provider (except an Obstetrician providing Anesthesia during labor and delivery and an oral surgeon providing services otherwise covered).

5. **Second Surgical Opinion (Voluntary)**

Consultations for Surgery to determine the Medical Necessity of an elective surgical procedure. Elective Surgery is that Surgery which is not of an Emergency or life-threatening nature. Such Covered Expenses must be performed and billed by a Provider other than the one who initially recommended performing the Surgery.

Transplant Services

Transplant Benefits. Transplant benefits include all eligible charges made for human organ and tissue transplant services at designated facilities throughout the United States, which include solid organ and bone marrow/stem cell procedures. This coverage is subject to the following conditions and limitations:

1) Transplant services include the recipient's medical, surgical and hospital services.

2) Inpatient immunosuppressive medications; and

3) Costs for organ or bone marrow/stern cell procurement.

4) The covered person has received approval obtained through the pre-certification process– refer to Case Management Section of this Summary Plan Description.

5) The organ transplant procedure will apply only to such human-to-human transplant; and

6) The medical charges are incurred within the period of time commencing five (5) days before the covered organ transplant and ending 365 days later and are incurred prior to termination of the covered transplant recipient's coverage under this Section.

Transplant services are covered at 100% benefit level only if they are required to perform any of the following human to human organ or tissue transplants: allogeneic bone marrow/stem cell, autologous bone marrow/stem cell, heart, heart/lung, kidney, kidney/pancreas, liver, lung, pancreas or intestinal which includes small bowel, liver or multivesicular.

Corneal transplants are payable when received from the Plan's Providers or Facilities.

Coverage for organ procurement cost is limited to costs related to the procurement of an organ, from a cadaver or live donor. Organ procurement costs shall consist of surgery necessary for organ removal, organ transportation and the transportation, hospitalization, and surgery of a live donor, including evaluation and up to 30 days of post-donation follow-up care. Compatibility testing undertaken prior to procurements are covered if Medically Necessary. Costs related to the search for, and identification of a bone marrow or stem cell donor for an allogeneic transplant are also covered.

1. When both the recipient and the donor are Covered Persons, each is entitled to the benefits of this Plan.
2. When only the recipient is a Covered Person, both the donor and the recipient are entitled to the benefits of this Plan. The donor benefits are limited to only those not provided or available to the donor from any other source. This includes, but is not limited to, other insurance or financial coverage, or any government program. Benefits provided to the donor will be charged against the recipient's coverage under this Plan.
3. When the donor is a Covered Person, no benefits will be provided for Transplant Services.
4. If any organ or tissue is sold rather than donated to the Covered Person recipient, no benefits will be payable for the purchase price of such organ or tissue.

Treatment for Substance Use Disorder

Alcohol or Drug Abuse and Dependency means a pattern of pathological use of alcohol or other drugs which causes impairment in social and/or occupational functioning, and which results in a psychological dependency evidenced by physical tolerance or withdrawal.

Benefits are payable for the care and treatment of Alcohol or Drug Abuse and Dependency provided by a Hospital or Facility, subject to the Maximum(s) shown in the Schedule of Covered Expenses, according to the provisions outlined below.

1. **Inpatient Treatment**

a. **Inpatient Detoxification**. Covered Expenses include:

- Lodging and dietary services.
- Physician, Psychologist, nurse, certified addictions counselor and trained staff services.
- Diagnostic x-rays.
- Psychiatric, psychological, and medical laboratory testing.
- Drugs, medicines, use of equipment and supplies.

b. **Hospital and Non-Hospital Residential Treatment**. Hospital or Non--Hospital Residential Treatment of Alcohol or Drug Abuse and Dependency shall be covered on the same basis as any other Illness covered under this Plan.

Covered Expenses include:

(1) Lodging and dietary services.

(2) Physician, Psychologist, nurse, certified addictions counselor and trained staff services.

(3) Rehabilitation therapy and counseling.

(4) Family counseling and intervention.

(5) Psychiatric, psychological, and medical laboratory testing.

(6) Drugs, medicines, use of equipment and supplies.

2. **Outpatient Treatment**. Covered Expenses include:

   a. Diagnosis and treatment of Substance Abuse, including Outpatient Detoxification by the appropriately licensed behavioral health provider.

   b. Physician, Psychologist, nurse, certified addictions counselor and trained staff services.

   c. Rehabilitation therapy and counseling.

   d. Family counseling and intervention.

   e. Psychiatric, psychological, and medical laboratory testing.

   f. Medication management and use of equipment and supplies

Outpatient Services

A Covered Person is entitled to benefits for Covered Expenses on an Outpatient basis when deemed Medically Necessary and billed for by a Provider. Payment allowances for Covered Expenses and other cost sharing requirements are specified in the Schedule of Covered Expenses.

Ambulance Services

1. Benefits are provided for a professional land Ambulance Service for services that are Medically Necessary and appropriate, as determined by the Plan Administrator, in conjunction with the Claims Audit Decision Maker, for transportation in a specially designed and equipped vehicle used only to transport the sick or injured, but only when:

   a. The vehicle is licensed as an ambulance where required by applicable law.

   b. The ambulance transport is appropriate for the patient's clinical condition.

   c. The use of any other method of transportation, such as taxi, private car, wheel-chair van, or other type of private or public vehicle transport would be contraindicated (i.e., would endanger the patient's medical condition); and

   d. The ambulance transport satisfies the destination and other requirements stated below. Benefits are payable for air or sea transportation only if the patient's condition, and the distance to the nearest facility able to treat the Covered Person's condition, justify the use of an alternative to land transport.

      (1) For Emergency Ambulance transport

      The ambulance must be transporting the Covered Person from the Covered Person's home or the scene of an accident or Medical Emergency to the nearest Hospital or other Emergency Services Facility that can provide the Medically Necessary Covered Expenses for the Covered Person's condition.

      (2) For Non--Emergency Ambulance transport

      Non-Emergency ambulance transport is not provided for the convenience of the Covered Person, the family, or the Provider treating the Covered Person.

2. Emergency Air Ambulance – Benefits are provided when needed to transport a Covered Person to the nearest acute care Hospital in connection with an Emergency Inpatient Admission or Emergency Outpatient Care subject to the cost sharing obligations listed in the Schedule of Covered Expenses only when the following conditions are met:

    a. A Covered Person's medical condition requires immediate and rapid ambulance transportation and services cannot be provided by land ambulance due to great distances or other geographic obstacles, and the use of land transportation would pose an immediate threat to the Covered Person's health. Benefits are not available for transfers of covered members between healthcare facilities.

    b. Services will be covered for an air ambulance used to transport a Covered Person from one acute care Hospital to another, only if the transferring Hospital does not have adequate facilities to provide the Medically Necessary services needed for the Covered Person's treatment as determined by the Plan's Pre-certification firm and use of a land ambulance would pose an immediate threat to the Covered Person's health. Benefits are not available for transfers of Covered Persons between healthcare facilities.

Chiropractic Care Services

Benefits shall be provided up to the limits specified in the Schedule of Covered Expenses for Chiropractic Care for the detection and correction by manual or mechanical means of structural imbalance or subluxation resulting from or related to distortion, misalignment, or subluxation of or in the vertebral column.

Day Rehabilitation Program

Subject to the limits in the Schedule of Covered Expenses, benefits will be provided for a Medically Necessary Day Rehabilitation Program when provided by a Facility under the following conditions:

1. The Covered Person requires intensive Therapy Services, such as Physical, Occupational and/or Speech Therapy five days per week for 47 hours per day.

2. The Covered Person has the ability to communicate (verbally or nonverbally) his or her needs; the ability to consistently follow directions and to manage his or her own behavior with minimal to moderate intervention by professional staff.

3. The Covered Person is willing to participate in a Day Rehabilitation Program; and

4. The Covered Person's family must be able to provide adequate support and assistance in the home and must demonstrate the ability to continue the rehabilitation program in the home.

Diabetic Education Program

Benefits are provided for diabetes Outpatient self-management- training and education, including medical nutrition, for the treatment of insulin dependent- diabetes, insulin using- diabetes, gestational diabetes and noninsulin using- diabetes when prescribed by a Provider legally authorized to prescribe such items under law.

The attending Physician must certify that a Covered Person requires diabetic education on an Outpatient basis under the following circumstances:

1. Upon the initial diagnosis of diabetes; A significant change in the patient's symptoms or condition; or

2. The introduction of new medication or a therapeutic process in the treatment or management of the Covered Person's symptoms or condition.

Outpatient Diabetic Education Services will be covered when provided by a licensed Provider. The diabetic education program must be conducted under the supervision of a licensed health care professional with expertise in diabetes, and subject to the requirements of the Plan. These requirements are based on the certification programs for Outpatient Diabetic Education developed by the American Diabetes Association and the New Jersey Department of Health.

Covered Expenses include Outpatient sessions that include, but may not be limited to, the following information:

1. Initial assessment of the Covered Person's needs.
2. Family involvement and/or social support.
3. Psychological adjustment for the Covered Person.
4. General facts/overview of diabetes.
5. Nutrition including its impact on blood glucose levels.
6. Exercise and activity.
7. Medications.
8. Monitoring and use of the monitoring results.
9. Prevention and treatment of complications for chronic diabetes, (i.e., foot, skin, and eye care).
10. Use of community resources; and
11. Pregnancy and gestational diabetes, if applicable.

Diabetic Equipment and Supplies

Benefits shall be provided, subject to any applicable Deductible, Copayment and/or Coinsurance applicable to Durable Medical Equipment benefits, for diabetic equipment and supplies purchased from a Durable Medical Equipment Provider. If this Plan provides benefits for Prescription Drugs, certain Diabetic Equipment and Supplies, including insulin and oral agents, may be purchased at a pharmacy, if available**,** subject to the cost sharing arrangements applicable to the Prescription Drug coverage under the Plan's Prescription Drug Benefit. Certain diabetic equipment is not available at a pharmacy. In these instances, the diabetic equipment will be provided under the Durable Medical Equipment benefit subject to the cost sharing arrangements applicable to Durable Medical Equipment.

1. **Diabetic Equipment**
    a. Blood glucose monitors.
    b. Insulin pumps.
    c. Insulin infusion devices; and
    d. Orthotics and podiatric appliances for the prevention of complications associated with diabetes.
2. **Diabetic Supplies**
    a. Blood testing strips.
    b. Visual reading and urine test strips.

a. Insulin and insulin analogs*.

b. Injection aids.

c. Insulin syringes.

d. Lancets and lancet devices.

e. Monitor supplies.

f. Pharmacological agents for controlling blood sugar levels*; and

g. Glucagon emergency kits.

*Insulin and oral agents are covered as provided under the Plan's Prescription Drug Benefit.

Diagnostic Services

The following Diagnostic Services when ordered by a Provider and billed by a Provider, and/or a Facility:

1. Routine Diagnostic Services, including routine radiology (consisting of x-rays-, ultrasound, and nuclear medicine), routine medical procedures (consisting of ECG, EEG, and other diagnostic medical procedures approved by the Plan Administrator), and allergy testing (consisting of percutaneous, intracutaneous and patch tests).

2. Non-Routine Diagnostic Services, including MRI/MRA, CT Scans, and PET Scans.

3. Diagnostic laboratory and pathology tests.

4. If medically necessary, benefits are provided for genetic testing and counseling. Genetic testing and counseling include services provided to a Covered Person at risk Due to family history or because of exposure to environmental factors that are known to cause physical or Mental Disorders. When clinical usefulness of specific genetic tests has been established by the Plan Administrator these services are covered for the purpose of diagnosis, screening, predicting the course of a disease, judging the response to a therapy, examining risk for a disease, or reproductive decision making.

Durable Medical Equipment

Benefits will be provided for the rental (but not to exceed the total allowance of purchase) or, at the option of the Plan Administrator, in conjunction with the Claims Audit Decision Maker, the purchase of Durable Medical Equipment when prescribed by a Provider and required for therapeutic use, when determined to be Medically Necessary by the Plan Administrator, in conjunction with the Claims Audit Decision Maker.

Although an item may be classified as Durable Medical Equipment, it may not be covered in every instance.

1. Durable Medical Equipment includes equipment that meets the following criteria:

a. It is durable and can withstand repeated use. An item is considered durable if it can withstand repeated use, i.e., the type of item that could normally be rented. Medical supplies of an expendable nature are not considered "durable."

b. It customarily and primarily serves a medical purpose.

c. It is generally not useful to a person without an Illness or Injury. The item must be expected to make a meaningful contribution to the treatment of the Covered Person's Illness, Injury, or to improvement of a malformed body part.

d. It is appropriate for home use.

2. Replacement and repair: The Claims Processor will provide benefits for the repair or replacement of Durable Medical Equipment when the equipment does not function properly and is no longer useful for its intended purpose in the following limited situations:

a. When a change in the Covered Person's condition requires a change in the Durable Medical Equipment, the Provider will provide repair or replacement of the equipment.

b. When the Durable Medical Equipment is broken due to significant damage, defect, or wear, the Provider will provide repair or replacement only if the equipment's warranty has expired and it has exceeded its reasonable useful life as determined by the Provider.

If the Durable Medical Equipment breaks while it is under warranty, replacement and repair is subject to the terms of the warranty. Contacts with the manufacturer or other responsible party to obtain replacement or repairs based on the warranty are the responsibility of:

1. The Provider in the case of rented equipment; and

2. The Covered Person in the case of purchased equipment.

The Provider will not be responsible if the Durable Medical Equipment breaks during its reasonable useful lifetime for any reason not covered by warranty; for example, the Provider will not provide benefits for repairs and replacements needed because the equipment was abused or misplaced.

The Provider will provide benefits to repair Durable Medical Equipment when the cost to repair is less than the cost to replace it. For the purposes of replacement or repair of Durable Medical Equipment, replacement means the removal and substitution of Durable Medical Equipment or one of its components necessary for proper functioning. A repair is a restoration of the Durable Medical Equipment or one of its components to correct problems due to wear, damage, or defect.

Emergency Services

Benefits for Emergency Services provided by a Hospital Emergency Room or other Outpatient Emergency Facility are provided by the Plan at the Participating level of benefits. If Emergency Services are required, the Covered Person should call 911 or seek treatment immediately at the emergency department of the closest Hospital or Outpatient Emergency Facility.

Emergency Services are Outpatient Services and supplies provided by a Hospital or Facility and/or Provider for initial treatment of the Emergency.

Examples of an Emergency include heart attack, loss of consciousness or respiration, cardiovascular accident, convulsions, severe Accidental Injury, and other acute medical conditions as determined by the Plan Administrator. Should any dispute arise as to whether an Emergency existed or as to the duration of an Emergency, the determination by the Plan Administrator shall be final.

Home Health Care

1. Benefits will be provided for the following services when performed by a licensed Home Health Care Agency:

a. Professional services of appropriately licensed and certified individuals.

b. Intermittent skilled nursing care.

c. Physical Therapy.

d. Speech Therapy.

e. Well mother/well baby care following release from an Inpatient maternity stay; and

f. Care within 48 hours following release from an Inpatient Admission when the discharge occurs within 48 hours following a mastectomy.

With respect to item (e) above, Home Health Care services will be provided within 48 hours if discharge occurs earlier than 48 hours of a vaginal delivery or 96 hours of a cesarean delivery. No Deductible, Copayment or Coinsurance shall apply to these benefits when they are provided after an early discharge from the Inpatient maternity stay.

Benefits are also provided for certain other medical services and supplies when provided along with a primary service. Such other services and supplies include Occupational Therapy, medical social services, home health aides in conjunction with skilled services and other services which may be approved by the Plan.

Home Health Care benefits will be provided only when prescribed by the Covered Person's attending Physician in a written Plan of Treatment and approved by the Plan as Medically Necessary.

There is no requirement that the Covered Person be previously confined in a Hospital or Skilled Nursing Facility prior to receiving Home Health Care.

With the exception of Home Health Care provided to a Covered Person immediately following an Inpatient release for maternity care, the Covered Person must be Homebound in order to be eligible to receive Home Health Care benefits.

2. **Definitions.** For purposes of this Home Health Care benefit, the following definitions apply:

a. **Home** – means a Covered Person's place of residence (e.g., private residence/domicile, assisted living facility, long term care facility, Skilled Nursing Facility (SNF) at a custodial level of care.

b. **Homebound** – means there exists a normal inability to leave home due to severe restrictions on the Covered Person's mobility and when leaving the home:

(1) It would involve a considerable and taxing effort by the Covered Person; and

(2) The Covered Person is unable to use transportation without another's assistance.

A Child, unlicensed driver or an individual who cannot drive will not automatically be considered Homebound but must meet both requirements listed above.

3. **Exclusions.** For purposes of this Home Health Care benefit, the following exclusions apply:

a. Custodial services, food, housing, homemaker services, home delivered meals and supplementary dietary assistance.

b. Rental or purchase of Durable Medical Equipment.

c. Rental or purchase of medical appliances (e.g., braces) and Prosthetics (e.g., artificial limbs); supportive environmental materials and equipment, such as handrails, ramps, telephones, air conditioners and similar services, appliances, and devices.

d. Prescription Drugs.

e. Services provided by a member of the Covered Person's Immediate Family.

f. Covered Person's transportation, including services provided by voluntary ambulance associations for which the Covered Person is not obligated to pay.

g. Emergency or non-Emergency Ambulance Services.

h. Visiting teachers, friendly visitors, vocational guidance and other counselors, and services related to diversional Occupational Therapy and/or social services.

i. Services provided to individuals (other than a Covered Person released from an Inpatient maternity stay), who are not essentially homebound for medical reasons; and

j. Visits by any Provider personnel solely for the purpose of assessing a Covered Person's condition and determining whether or not the Covered Person requires and qualifies for Home Health Care services and will or will not be provided services by the Provider.

Injectable Medications

Benefits will be provided for injectable medications required in the treatment of an Injury or Illness when administered by a Provider.

1. Specialty Drugs

Specialty Drugs refer to a medication that meets certain criteria including, but not limited to: the drug is used in the treatment of a rare, complex, or chronic disease (e.g., hemophilia); a high level of involvement is required by a healthcare Provider to administer the drug; complex storage and/or shipping requirements are necessary to maintain the drug's stability; the drug requires comprehensive patient monitoring and education by a healthcare Provider regarding safety, side effects, and compliance and access to the drug may be limited. The Copayment and Coinsurance amounts are shown in the Schedule of Covered Expenses. Copayment amounts will apply:

a. To each 30-day supply of medication dispensed for medications administered on a regularly scheduled basis; or

b. To each course/series of injections if administered on an intermittent basis.

A 90-day supply of medication may be dispensed for some medications that are used for the treatment of a chronic Illness; in such a case, the Covered Person will be subject to three Copayments, if applicable.

The Plan allows the initial fill of a specialty drug to be provided by the Provider or at retail but then requires subsequent fills to be through the Pharmacy Benefit Program as described in that section of the Plan.

2. Standard Injectable Drugs

a. Standard Injectable Drugs refer to a medication that is either injectable or infusible but is not defined by the company to be a Self-Injectable- Drug or a Specialty Drug. Standard Injectable Drugs include but are not limited to allergy injections and extractions and injectable medications such as antibiotics and steroid injections that are administered by a Provider.

b. Self-Injectable- Drugs generally are not covered. For more information on Self Injectable- Drugs (Self Injectable- Drugs), refer to the section entitled "Plan Exclusions and Limitations."

Insulin and Oral Agents

Benefits will be provided for insulin and oral agents to control blood sugar as prescribed by a Physician and dispensed by a licensed pharmacy under the Plan's Prescription Drug Plan. Benefits are available as provided in the Prescription Drug Plan.

Non-Surgical Dental Services (Dental Services as a Result of Accidental Injury)

Benefits will be provided only for the initial treatment of Accidental Injury/trauma, (i.e., fractured facial bones and fractured jaws), in order to restore proper function. Restoration of proper function includes the dental services required for the initial restoration or replacement of sound Natural Teeth, including the first caps, crowns, bridges, and dentures (but not including dental implants), required for the initial treatment for the Accidental Injury/trauma. Also covered is the preparation of the jaws and gums required for initial replacement of Sound Natural Teeth. (Sound, Natural Teeth are teeth that are stable, functional, free from decay and advanced periodontal disease, in good repair at the time of the Accidental Injury/trauma). Injury as a result of chewing or biting is not considered an Accidental Injury. (See the section entitled "Plan Exclusions and Limitations," for more information on what dental services are not covered.)

Orthotics

Benefits are provided for:

1. The initial purchase and fitting (per medical episode) of orthotic devices which are Medically Necessary as determined by the Plan Administrator, except foot orthotics unless the Covered Person requires foot orthotics as a result of diabetes.
2. The replacement of covered orthotics for Dependent Children when required due to natural growth.

Podiatric Care

Benefits are provided for podiatric care including capsular or surgical treatment of bunions; ingrown toenail Surgery; and other nonroutine Medically Necessary foot care. In addition, for Covered Persons with peripheral vascular and/or peripheral neuropathic diseases, including but not limited to diabetes, benefits for routine foot care services are provided.

Private Duty Nursing Services

Benefits will be provided up to the number of hours specified in the Schedule of Covered Expenses for Outpatient Services for Private Duty Nursing performed by a Licensed Registered Nurse or a Licensed Practical Nurse when ordered by a Physician and which are Medically Necessary as determined by the Plan Administrator.

Benefits are not payable for:

1. Nursing care which is primarily custodial in nature, such as care that primarily consists of: bathing, feeding, exercising, homemaking, moving the patient, giving oral medication.
2. Services provided by a nurse who ordinarily resides in the Covered Person's home or is a member of the Covered Person's Immediate Family; and
3. Services provided by a home health aide or a nurse's aide.

Prosthetics

Expenses Incurred for Prosthetics (except dental prostheses) required as a result of Illness or Injury. Expenses for Prosthetics are subject to medical review by the Plan to determine eligibility and Medical Necessity.

Such expenses may include, but not be limited to:

1. The purchase, fitting, necessary adjustments, and repairs of Prosthetics which replace all or part of an absent body organ including contiguous tissue, or which replace all or part of the function of an inoperative or malfunctioning body organ; and
2. The supplies and replacement of parts necessary for the proper functioning of the Prosthetic.
3. Breast prostheses are required to replace the removed breast or portions thereof as a result of mastectomy and prostheses inserted during reconstructive Surgery incident and subsequent to mastectomy.
4. Benefits are provided for the following visual Prosthetics when Medically Necessary and prescribed for one of the following conditions:
    a. Initial contact lenses prescribed for treatment of infantile glaucoma.
    b. Initial pinhole glasses prescribed for use after Surgery for detached retina.
    c. Initial corneal or scleral lenses prescribed.
        (1) In connection with the treatment of keratoconus; or
        (2) To reduce corneal irregularity other than astigmatism.
    d. Initial scleral lenses prescribed to retain moisture in cases where normal tearing is not present or adequate; and
    e. Initial pair of basic eyeglasses when prescribed to perform the function of a human lens (aphakia) lost as a result of:
        (1) Accidental Injury.
        (2) Trauma; or
        (3) Ocular Surgery.

Benefits are not provided for:

a. Lenses which do not require a prescription.
b. Any lens customization such as, but not limited to tinting, oversize or progressive lenses, antireflective coatings, UV lenses or coatings, scratch resistant coatings, mirror coatings, or polarization.
c. Deluxe frames; or
d. Eyeglass accessories, such as cases, cleaning solution and equipment.

The repair and replacement provisions below do not apply to this subsection (4).

Benefits for replacement of a Prosthetic or its parts will be provided:

1. When there has been a significant change in the Covered Person’s medical condition that requires replacement,
2. If the prostheses breaks because it is defective, or
3. If the prostheses breaks because it exceeds its life expectancy, as determined by the manufacturer, or

4. For a Dependent Child due to the normal growth process when Medically Necessary.

The Plan will provide benefits to repair Prosthetics when the cost to repair is less than the cost to replace it. For the purposes of replacement or repair of a prostheses, replacement means the removal and substitution of the prostheses or one of its components necessary for proper functioning. A repair is a restoration of the prostheses or one of its components to correct problems due to wear or damage. However, the Plan will not provide benefits for repairs and replacements needed because the prostheses was abused or misplaced.

If a Prosthetic breaks and is under warranty, it is the responsibility of the Covered Person to work with the manufacturer to replace or repair it.

Specialist Office Visit

Benefits will be provided for Specialist Service Medical Care provided in the office by a Provider other than a Primary Care Provider. For the purpose of this benefit, "in the office" includes Medical Care visits to a Provider's office, Medical Care visits by a Provider to a Covered Person's residence, or Medical Care consultations by a Provider on an Outpatient basis.

Therapy Services

Benefits shall be provided, subject to the Benefit Period Maximums specified in the Schedule of Covered Expenses, for the following services prescribed by a Physician and performed by a Provider, a therapist who is registered or licensed by the appropriate authority to perform the applicable therapeutic service, and/or Facility, which are used in treatment of an Illness or Injury to promote recovery of the Covered Person.

Therapies for the treatment of delays in development, unless resulting from acute Illness or Injury, or congenital defects amenable to surgical repair (such as cleft lip/palate), are covered. The limitations on Therapy Services do not apply to the Diagnosis and Treatment of Autism or Other Developmental Disabilities or to Mental or Nervous Disorders, which will be paid subject to the same terms and conditions as any other Illness.

1. **Cardiac Rehabilitation Therapy**

   Refers to a medically supervised rehabilitation program designed to improve a patient's tolerance for physical activity or exercise.

2. **Chemotherapy**

   Chemotherapy means the treatment of malignant disease by chemical or biological antineoplastic agents, monoclonal antibodies, bone marrow stimulants, antiemetics and other related biotech products. Such chemotherapeutic agents are eligible if administered intravenously or intramuscularly (through intra-arterial injection, infusion, perfusion or subcutaneous, intracavitary and oral routes). The cost of drugs, approved by the Federal Food and Drug Administration (FDA) and only for those uses for which such drugs have been specifically approved by the FDA as antineoplastic agents is covered, provided they are administered as described in this paragraph.

3. **Dialysis**

   The treatment of acute renal failure or chronic irreversible renal insufficiency for removal of waste materials from the body by hemodialysis, peritoneal dialysis, hemoperfusion, or chronic ambulatory peritoneal dialysis (CAPD), or continuous cyclical peritoneal dialysis (CCPD).

4. **Infusion Therapy**

Treatment including, but not limited to, infusion or inhalation, parenteral and enteral nutrition, antibiotic therapy, pain management, hydration therapy, or any other drug that requires administration by a healthcare Provider. Infusion Therapy includes all professional services, supplies, and equipment that are required to administer the therapy safely and effectively. Infusion may be provided in a variety of settings (e.g., home, office, outpatient) depending on the level of skill required to prepare the drug, administer the infusion, and monitor the Covered Person. The type of healthcare Provider who can administer the infusion depends on whether the drug is considered to be a Specialty Drug infusion or a Standard Injectable Drug infusion, as determined by the Plan. The Plan also has requirements for pre-certification of Specialty Drugs, quantity limits, and where such Specialty Drugs may be purchased in the Pharmacy Benefit Section of the Plan.

5. **Occupational Therapy**

Includes treatment of a physically disabled person by means of constructive activities designed and adapted to promote the restoration of the person's ability to satisfactorily accomplish the ordinary tasks of daily living. Coverage will also include services rendered by a registered, licensed occupational therapist.

6. **Orthoptic / Pleoptics Therapy**

Includes treatment through an evaluation and training session program for the correction of oculomotor dysfunction as a result of a vision disorder, eye Surgery, or Injury resulting in the lack of vision depth perception.

7. **Pulmonary Rehabilitation Therapy**

Includes treatment through a multidisciplinary program which combines Physical Therapy with an educational process directed towards the stabilization of pulmonary diseases and the improvement of functional status.

8. **Physical Therapy**

Includes treatment by physical means, heat, hydrotherapy or similar modalities, physical agents, bio-mechanical and neuro-physiological principles, and devices to relieve pain, restore maximum function, and prevent disability following disease, Injury, or loss of body part, including the treatment of functional loss following hand and/or foot Surgery.

9. **Radiation Therapy**

The treatment of disease by x-ray, radium, radioactive isotopes, or other radioactive substances regardless of the method of delivery, including the cost of radioactive materials supplied and billed by the Provider.

10. **Speech Therapy**

Includes treatment for the correction of a speech impairment resulting from disease, Surgery, Injury, congenital anomalies, or previous therapeutic processes. Coverage will also include services by a speech therapist.

Urgent Care Center

Benefits are provided for Urgent Care Centers, when Medically Necessary as determined by the Plan Administrator, in conjunction with the Claims Audit Decision Maker. Urgent Care Centers are designed to offer immediate evaluation and treatment for health conditions that require medical attention in a non--Emergency situation that cannot wait to be addressed by your Provider or Retail Clinic. Cost sharing- requirements are specified in the Schedule of Covered Expenses.

MEDICAL MANAGEMENT PROGRAM

Medical Management Phone Number Care Counselors at HealthCare Strategies, Inc. **1-800-764-3433.**

The Covered Person or a family member, patient or Provider must call this number to receive certification of certain health care services. This call must be made at least 48 hours in advance of services being rendered or within 2 business days after admission due to an Emergency Medical Condition.

Medical Management is a program designed to help ensure that all Covered Persons receive necessary and appropriate health care while avoiding unnecessary expenses.

The program consists of:

1) Precertification of Medical Necessity for the following non-emergency services before medical and/or surgical services are provided:

Member, Patient or Provider must obtain pre- treatment authorization for the following services at least 48 hours in advance:

- Inpatient Admissions (including partial hospitalization and intensive out-patient programs for mental health conditions and substance abuse), other than an inpatient admission related to Emergency Services (notification only required)
- Outpatient Surgery (except if performed in a physician's office)
- Physical therapy, Occupational therapy, Speech Therapy
- Durable Medical Equipment with a purchase price over $1500
- Home Health Care/Hospice
- All Complex Imaging MRA's, MRI's, PET Scans, CT Scans
- Air Ambulance
- Chemotherapy/Radiation Therapy
- Specialty Drugs and Injectables
- Transplants
- I.V. Therapy

*Any course of treatment requiring more than 12 visits

2) Retrospective review of Medical Necessity of the listed services.

3) Concurrent review, based on the admitting diagnosis, of the listed services requested by the attending Physician; and

4) Certification of services and planning for discharge from a Medical Care Facility.

This program is not intended to diagnose or treat medical conditions, guarantee benefits, validate eligibility or to be a substitute for the medical judgment of the attending Physician or other health care provider.

The Covered Person will not be required to obtain precertification from the Plan for a maternity length of stay that is 48 hours or less for a vaginal delivery or 96 hours or less for a cesarean delivery.

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

PRECERTIFICATION

Before a Covered Person enters a Medical Care Facility on a non-emergency basis or receives the other listed medical services, Medical Management will, in conjunction with the attending Physician, be required to certify the care as Medically Necessary. A non-emergency stay in a Medical Care Facility is one that can be scheduled in advance.

Medical Management is set in motion by a telephone call from the Covered Person or a family member. Medical Management must be called, **at least 48 hours before** the listed medical services are scheduled to be rendered, with the following information:

1. The name of the Covered Person and relationship to the covered employee
2. The name, Social Security (or member id number) and address of the covered employee
3. The name of the Employer
4. The name and telephone number of the attending Physician
5. The name of the Medical Care Facility, proposed date of admission or procedure, and proposed length of stay
6. The diagnosis and/or type of surgery or procedure.

If there is an admission to a Medical Care Facility due to an Emergency Medical Condition, the Covered Person, a family member, Medical Care Facility or attending Physician must notify Medical Management **within 48 hours** of the first business day after the admission. Medical Management will determine the number of days of Medical Care Facility confinement that is Medically Necessary. When the required review procedures outlined above are followed, benefits will be unaffected, and the Plan Participant and the Plan will avoid expenses related to unnecessary health care.

FAILURE TO FOLLOW REQUIRED REVIEW PROCEDURES

If a Covered Person does not obtain precertification, as required for benefits under the Plan (other than related to an Emergency Services admission due to an Emergency Medical Condition) or fails to notify the Plan within 48 hours of the first business day after an admission due to an Emergency Medical Condition, a penalty or reduction in eligible expenses may result. However, any charges not deemed Medically Necessary will be denied.

The amount the Covered Person pays when HealthCare Strategies, Inc. review procedures are not followed does not apply to the Plan's out-of-pocket maximum.

CONCURRENT REVIEW AND DISCHARGE PLANNING

Concurrent review of a course of treatment and discharge planning from a Medical Care Facility are part of Medical Management. Medical Management will monitor the Covered Person's Medical Care Facility stay or use of other medical services and coordinate with the attending Physician, Medical Care Facilities and Covered Person either the scheduled release or an extension of the Medical Care Facility stay or extension or cessation of the use of other medical services.

If the attending Physician feels that it is Medically Necessary for a Covered Person to receive additional services or to stay in the Medical Care Facility for a greater length of time that was initially pre-certified, the attending Physician must request the additional services or days.

PREADMISSION TESTING SERVICE

The Medical Benefits percentage payable will be for diagnostic lab tests and x-ray exams when:

1. Performed on an outpatient basis within seven days of a Hospital confinement.
2. Related to the condition which causes the confinement; and
3. Tests are performed in an outpatient setting instead of diagnostic tests performed while the Hospital is confined.

Case Management

Case Management is a program whereby a case manager monitors patients and explores, discusses, and recommends coordinated and/or alternate types of appropriate Medically Necessary care. The case manager consults with the patient, the family, and the attending Physician in order to develop a plan of care for approval by the patient's attending Physician and the patient. The plan of care may include some or all of the following:

1. personal support to the patient.
2. contacting the family to offer assistance and support.
3. monitoring Hospital, Skilled Nursing Facility, extended care facility or rehabilitation facility.
4. determining alternative care options; and
5. assisting in obtaining any necessary equipment and services.

Once agreement has been reached, the Plan will reimburse for Medically Necessary expenses as stated in the treatment plan, even if these expenses normally would not be paid by the Plan.(Refer to Schedule of Benefits)

Note: Case Management is a voluntary service. However, if a Covered Person fails to participate in the program, the covered Employee may be charged a Penalty surcharge per occurrence.

If it is unreasonably difficult due to a medical condition for you to comply with the Case Management program to avoid the surcharge, or if it is medically inadvisable for you to attempt to comply with the Case Management program to avoid the surcharge, call Medical Management at 1-800-764-3433 and we will work with you to develop another way to avoid the surcharge. If it is unreasonably difficult or medically inadvisable due to a medical condition for you to comply with the Case Management program to avoid the surcharge, you must provide the Plan with a verification statement from your Physician identifying the condition or circumstances that make it unreasonably difficult or medically inadvisable for you to satisfy the Case Management requirements.

Examples of Illnesses or Injuries that would be appropriate for Case Management include, but are not limited to:

1. Terminal Illnesses
    a. Cancer
    b. AIDS (Acquired Immunodeficiency Syndrome)
2. Chronic Illnesses
    a. Multiple Sclerosis
    b. Renal Failure

c. Chronic Obstructive Pulmonary Disease

d. Cardiac Conditions

3. Accident Victims Requiring Long-Term Rehabilitative Therapy
4. Newborns with High-Risk Complications or Multiple Birth Defects
5. Diagnosis Involving Long-Term IV Therapy
6. Illnesses Not Responding to Medical Care

MATERNITY MANAGEMENT PROGRAM- MaterniCare® – if applicable

The Maternity Management Program, in addition to the prenatal care provided by a Physician, can assist expectant mothers in achieving a healthy pregnancy and a healthy newborn.

The Maternity Management Program is designed especially to provide expectant mothers with guidance and information during pregnancy. When an expectant mother enrolls in the Maternity Management Program, she will receive a series of brochures, pamphlets, coupons, and other materials.

It is highly recommended, but not a requirement of the Plan, that an expectant mother call Medical Management HealthCare Strategies, Inc. **1-800-764-3433** during the first trimester of Pregnancy or upon confirmation of Pregnancy. At this time, an R.N. will ask questions about the expectant mother's general health and medical history. This information may be discussed with the patient's Physician to help determine the risk factor of the Pregnancy.

As part of the program, a nurse will be available as an advisor and maternal/newborn specialist. The nurse can:

1. Discuss health history.
2. Discuss diet and exercise routines.
3. Identify potential pregnancy risk factors.
4. Discuss ways to minimize these risks for mother and baby.
5. Answer questions and provide written material on pregnancy and childcare issues that are a concern.
6. Provide community resources where to find additional information.
7. Contact the expectant mother's physician to assist in the coordination of her care, and.
8. Provide education and support related to labor and delivery.

GENERAL PLAN PROVISIONS

Coordination of Benefits with Other Plans

The Plan shall coordinate benefits, as provided below, when a Covered Person has health coverage under more than one plan, program, or other arrangement for the provision of similar benefits.

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

2. Benefit Plan. This provision will coordinate the medical and dental benefits of a benefit plan. The term benefit plan means this Plan or any one of the following plans:

    a. Group or group-type plans, including franchise or blanket benefit plans.

    b. Group practice and other group prepayment plans.

    c. Federal government plans or programs. This includes, but is not limited to, Medicare and Tricare.

    d. Other plans required or provided by law. This does not include Medicaid or any benefit plan like it that, by its terms, does not allow coordination.

    e. No Fault Auto Insurance, by whatever name it is called, when not prohibited by law.

3. **Allowable Charge**. The Usual and Customary charge for any Medically Necessary, Reasonable, and eligible item of expense, at least a portion of which is covered under a plan. When some Other Plan pays first, for example for Coordination of Benefits, this Plan's Allowable Charges shall in no event exceed the Other Plan's Allowable Charges. When some Other Plan provides benefits in the form of services rather than cash payments, the reasonable cash value of each service rendered, in the amount that would be payable in accordance with the terms of the Plan, shall be deemed to be the benefit. Benefits payable under any Other Plan include the benefits that would have been payable had the claim been duly made, therefore.

4. **Excess Insurance.** If at the time of Injury, sickness, Disease, or disability there is available, or potentially available any other source of coverage (including but not limited to coverage resulting from a judgment at law or settlements), the benefits under this Plan shall apply only as an excess over such other sources of Coverage. The Plan's benefits shall be excess to:

    a. Any responsible third party, its insurer, or any other source on behalf of that party.

    b. Any first party insurance through medical payment coverage, personal injury protection, no fault coverage, uninsured or underinsured motorist coverage.

    c. Any policy of insurance from any insurance company or guarantor of a third party.

    d. Worker's compensation or other liability insurance company; or

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

5. **Vehicle Limitations**. When medical payments are available under any vehicle insurance, the Plan shall pay excess benefits only, without reimbursement for vehicle plan and/or policy deductibles. This Plan shall always be considered secondary to such plans and/or policies. This applies to all

forms of medical payments under vehicle plans and/or policies regardless of its name, title, or classification.

6. **Benefit Plan Payment Order.** When two or more plans provide benefits for the same Allowable Charge, benefit payment will follow these rules:

    a. Plans that do not have a coordination provision, or one like it, will pay first. Plans with such a provision will be considered after those without one.

    b. Plans with a coordination provision will pay their benefits up to the Allowable Charge:

        a. The benefits of the plan which covers the person directly (that is, as an employee, member, or subscriber) ("Plan A") are determined before those of the plan which covers the person as a dependent ("Plan B").

        b. The benefits of a benefit plan which covers a person as an Employee who is neither laid off nor retired are determined before those of a benefit plan which covers that person as a laid off or retired employee. The benefits of a benefit plan which covers a person as a Dependent of an Employee who is neither laid off nor retired are determined before those of a benefit plan which covers a person as a Dependent of a laid off or retired employee. If the other benefit plan does not have this rule, and if, as a result, the plans do not agree on the order of benefits, this rule does not apply.

        c. The benefits of a benefit plan which covers a person as an Employee who is neither laid off nor retired or a Dependent of an Employee who is neither laid off nor retired are determined before those of a plan which covers the person as a COBRA beneficiary.

        d. When a Child is covered as a Dependent and the parents are not separated or divorced, these rules will apply:

            (a) The benefits of the benefit plan of the parent whose birthday falls earlier in a year are determined before those of the benefit plan of the parent whose birthday falls later in that year.

            (b) If both parents have the same birthday, the benefits of the benefit plan which has covered the parent for the longer time are determined before those of the benefit plan which covers the other parent.

            (2) When a Child's parents are divorced or legally separated, these rules will apply:

            (a) This rule applies when the parent with custody of the Child has not remarried. The benefit plan of the parent with custody will be considered before the benefit plan of the parent without custody.

            (b) This rule applies when the parent with custody of the Child has remarried. The benefit plan of the parent with custody will be considered first. The benefit plan of the stepparent that covers the Child as a Dependent will be considered next. The benefit plan of the parent without custody will be considered last.

            (c) This rule will be in place of items (a) and (b) above when it applies. A court decree may state which parent is financially responsible for medical and dental benefits of the Child. In this case, the benefit plan of that parent will be considered before Other Plans that cover the Child as a Dependent.

(d) If the specific terms of the court decree state that the parents shall share joint custody, without stating that one of the parents is responsible for the health care expenses of the Child, the plans covering the Child shall follow the order of benefit determination rules outlined above when a Child is covered as a Dependent and the parents are not separated or divorced.

(e) For parents who were never married to each other, the rules apply as set out above as long as paternity has been established.

(3) If there is still a conflict after these rules have been applied, the benefit plan which has covered the patient for the longer time will be considered first. When there is a conflict in coordination of benefit rules, the Plan will never pay more than 50% of Allowable Charges when paying secondary.

a. If a Covered Person is under a disability extension from a previous benefit plan, that benefit plan will pay first and this Plan will pay second.

b. The Plan will pay primary to Tricare to the extent required by federal law.

c. Non-Dependent or Dependent. Subject to subparagraph (1) of this paragraph, the plan that covers the person other than as a dependent, for example as an employee, member, subscriber, policyholder, or retiree, is the primary plan and the plan that covers the person as a dependent is the secondary plan.

(1) If the person is a Medicare beneficiary, and, as a result of the provisions of Title XVIII of the Social Security Act and implementing regulations, Medicare is:

(a) Secondary to the plan covering the person as a dependent; and

(b) Primary to the plan covering the person as other than a dependent (e.g., a retired employee).

(2) Then the order of benefits is reversed so that the plan covering the person as an employee, member, subscriber, policyholder, or retiree is the secondary plan and the Other Plan covering the person as a dependent is the primary plan.

Affiliated Organizations - if applicable

1. If an individual is eligible and employed by two or more affiliated Employers, the individual may elect coverage as an Employee under only one employer.

2. An individual who is employed by affiliated Employers may be covered as an employee or as a dependent spouse but cannot be covered under both. This limitation applies to spouses working for the same or different affiliated Employers.

3. If both parents are employed and eligible for coverage under affiliated Employers, the eligible dependent child(ren) may be covered by one employee but not both.

4. **Claims determination period.** Benefits will be coordinated on a Plan Year basis. The first day of the Plan Year is the Effective Date of the Plan. Deductibles and other Covered Person Out-of-pocket Expenses will be coordinated on a plan year basis unless specifically noted as calendar year on the Schedule of Benefits.

5. **Right to receive or release necessary information.** To make this provision work, this Plan may give or obtain needed information from another insurer or any other organization or person. This information may be given or obtained without the consent of or notice of any other person. A

Covered Person will give this Plan the information it asks for about Other Plans and their payment of Allowable Charges.

6. **Facility of payment.** This Plan may repay Other Plans for benefits paid that the Plan Administrator, determines it should have paid. That repayment will count as a valid payment under this Plan.

7. **Right of recovery.** In accordance with the Plan whenever payments have been made by this Plan with respect to Allowable Charges in a total amount, at any time, in excess of the maximum amount of payment necessary at that time to satisfy the intent of this section, the Plan shall have the right to recover such payments, to the extent of such excess, from any one or more of the following as this Plan shall determine: any person to or with respect to whom such payments were made, or such person's legal representative, any insurance companies, or any other individuals or organizations which the Plan determines are responsible for payment of such Allowable Charges, and any future benefits payable to the Covered Person or his or her Dependents.

Coordination with Medicare for Active Covered Persons

If a Covered Person other than a retiree is eligible for Medicare, this Plan will be considered the primary plan and Medicare will be considered the secondary plan unless the Covered Person has elected Medicare as his or her only plan of benefits.

1. The Working Aged Provisions. If the Covered Person is over age 65 and chooses to continue coverage under the Plan, the benefits paid will be the same as to active employees under age 65.

2. Disabled Employees Provision. If the Covered Person is disabled, this Plan will be the primary plan. Medicare will be the secondary plan if the disabled Covered Person qualifies for Medicare disability coverage based on the length of the disability.

Qualified Beneficiaries Under COBRA Continuation Program

This Plan will be the secondary Plan when a Qualified Beneficiary is eligible for continued coverage under this Plan and is enrolled in another group health plan either as an employee or Dependent. This Plan will be secondary to all claims and will not pay any claims until and unless the Qualified Beneficiary produces evidence of the amount paid and/or denied under the other group health plan.

Medical Child Support Orders

In the event the Plan Administrator receives a medical child support order (within the meaning of section 609(a)(2)(B) of ERISA), the Plan Administrator shall notify the affected Employee and any alternate recipient identified in the order of the receipt of the order and the Plan's procedures for determining whether such an order is a qualified medical child support order (within the meaning of section 609(a)(2)(A) of ERISA). Within a reasonable period, the Plan Administrator shall determine whether the order is a qualified medical child support order and shall notify the Employee and alternate recipient of such determination.

Coordination With Medicaid Provisions

The Plan shall comply with the provisions of section 609(b) of ERISA as follows:

1. The payment of benefits with respect to a covered Employee shall be made in accordance with any assignment of rights made by or on behalf of such Covered Person under the Medicaid laws of any state.

2. The enrollment of and provision of benefits to a covered Employee shall be made without regard to the covered Employee's eligibility for Medicaid under the laws of any state; and

3. To the extent that payment has been made under the Medicaid laws of any state in a case where the Plan has legal liability for such payments, payment of benefits under the Plan shall be made in accordance with any state law which provides that such state has acquired the rights of the Covered Person to such payment.

Plan's Right of Recovery in Third-Party Actions / Subrogation

Payment Condition

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

Covered Person(s), his or her attorney, and/or Legal Guardian of a minor or incapacitated individual agrees that acceptance of the Plan's conditional payment of medical benefits is constructive notice of these provisions in their entirety and agrees to maintain 100% of the Plan's conditional payment of benefits or the full extent of payment from any one or combination of first- and third-party sources in trust, without disruption except for reimbursement to the Plan or the Plan's assignee. The Plan shall have the equitable first lien on any funds received by the Covered Person(s) and/or their attorney from any source and said funds shall be held in trust until such time as the obligations under this provision are fully satisfied. The Covered Person(s) agrees to include the Plan's name as a copayee on any and all settlement drafts. Further, by accepting benefits the Covered Person(s) understands that any recovery obtained pursuant to this section is an asset of the Plan to the extent of the amount of benefits paid by the Plan and that the Covered Person shall be a trustee over those Plan assets.

In the event a Covered Person(s) settles, recovers, or is reimbursed by any Coverage, the Covered Person(s) agrees to reimburse the Plan for all benefits paid or that will be paid by the Plan on behalf of the Covered Person(s). If the Covered Person(s) fails to reimburse the Plan out of any judgment or settlement received, the Covered Person(s) will be responsible for any and all expenses (fees and costs) associated with the Plan's attempt to recover such money.

If there is more than one party responsible for charges paid by the Plan or may be responsible for charges paid by the Plan, the Plan will not be required to select a particular party from whom reimbursement is due. Furthermore, unallocated settlement funds meant to compensate multiple injured parties of which the Covered Person(s) is/are only one or a few, that unallocated settlement fund is considered designated as an "identifiable" fund from which the plan may seek reimbursement.

Subrogation

As a condition to participating in and receiving benefits under this Plan, the Covered Person(s) agrees to assign to the Plan the right to subrogate and pursue any and all claims, causes of action or rights that may arise against any person, corporation and/or entity and to any Coverage to which the Covered Person(s) is entitled, regardless of how classified or characterized, at the Plan's discretion, if the Covered Person(s) fails to so pursue said rights and/or action.

If a Covered Person(s) receives or becomes entitled to receive benefits, the automatic equitable first lien attaches in favor of the Plan to any claim, which any Covered Person(s) may have against any Coverage and/or party causing the sickness or Injury to the extent of such conditional payment by the Plan plus reasonable costs of collection. The Covered Person is obligated to notify the Plan or its authorized

representative of any settlement prior to finalization of the settlement, execution of a release, or receipt of applicable funds. The Covered Person is also obligated to hold any and all funds so received in trust on the Plan's behalf and function as a trustee as it applies to those funds until the Plan's rights described herein are honored and the Plan is reimbursed.

The Plan may, at its discretion, in its own name or in the name of the Covered Person(s) commence a proceeding or pursue a claim against any party or Coverage for the recovery of all damages to the full extent of the value of any such benefits or conditional payments advanced by the Plan.

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

1. The responsible party, its insurer, or any other source on behalf of that party.
2. Any first party insurance through medical payment coverage, personal injury protection, no-fault coverage, uninsured or underinsured motorist coverage.
3. Any policy of insurance from any insurance company or guarantor of a third party.
4. Workers' compensation or other liability insurance company.
5. Any other source, including but not limited to crime victim restitution funds, any medical, disability or other benefit payments, and school insurance coverage.

The Covered Person(s) authorizes the Plan to pursue, sue, compromise and/or settle any such claims in the Covered Person's/Covered Persons' and/or the Plan's name and agrees to fully cooperate with the Plan in the prosecution of any such claims. The Covered Person(s) assigns all rights to the Plan or its assignee to pursue a claim and the recovery of all expenses from any and all sources listed above.

Right of Reimbursement

The Plan shall be entitled to recover 100% of the benefits paid, without deduction for attorneys' fees and costs or application of the common fund doctrine, made whole doctrine, or any other similar legal or equitable theory, without regard to whether the Covered Person(s) is fully compensated by his or her recovery from all sources. The Plan shall have the equitable first lien which supersedes all common law or statutory rules, doctrines, and laws of any State prohibiting assignment of rights which interferes with or compromises in any way the Plan's equitable lien and right to reimbursement. The obligation to reimburse the Plan in full exists regardless of how the judgment or settlement is classified and whether or not the judgment or settlement specifically designates the recovery or a portion of it as including medical, disability, or other expenses. If the Covered Person's/Covered Persons' recovery is less than the benefits paid, then the Plan is entitled to be paid all of the recovery achieved. Any funds received by the Covered Person are deemed held in constructive trust and should not be dissipated or disbursed until such time as the Covered Person's obligation to reimburse the Plan has been satisfied in accordance with these provisions. The Covered Person is also obligated to hold any and all funds so received in trust on the Plan's behalf and function as a trustee as it applies to those funds until the Plan's rights described herein are honored and the Plan is reimbursed.

No court costs, experts' fees, attorneys' fees, filing fees, or other costs or expenses of litigation may be deducted from the Plan's recovery without the prior, express written consent of the Plan.

The Plan's right of subrogation and reimbursement will not be reduced or affected as a result of any fault or claim on the part of the Covered Person(s), whether under the doctrines of causation, comparative fault or contributory negligence, or other similar doctrine in law. Accordingly, any lien reduction statutes, which attempt to apply such laws and reduce a subrogating Plan's recovery will not be applicable to the Plan and will not reduce the Plan's reimbursement rights.

These rights of subrogation and reimbursement shall apply without regard to whether any separate written acknowledgment of these rights is required by the Plan and signed by the Covered Person(s).

This provision shall not limit any other remedies of the Plan provided by law. These rights of subrogation and reimbursement shall apply without regard to the location of the event that led to or caused the applicable sickness, Injury, Disease, or disability.

Covered Person is a Trustee Over Plan Assets

Any Covered Person who receives benefits and is therefore subject to the terms of this section is hereby deemed a recipient and holder of Plan assets and is therefore deemed a trustee of the Plan solely as it relates to possession of any funds which may be owed to the Plan as a result of any settlement, judgment or recovery through any other means arising from any Injury or accident. By virtue of this status, the Covered Person understands that he or she is required to:

1. Notify the Plan or its authorized representative of any settlement prior to finalization of the settlement, execution of a release, or receipt of applicable funds.
2. Instruct his or her attorney to ensure that the Plan and/or its authorized representative is included as a payee on all settlement drafts.
3. In circumstances where the Covered Person is not represented by an attorney, instruct the insurance company or any third party from whom the Covered Person obtains a settlement, judgment, or other source of coverage to include the Plan or its authorized representative as a payee on the settlement draft.
4. Hold any and all funds so received in trust, on the Plan's behalf, and function as a trustee as it applies to those funds, until the Plan's rights described herein are honored and the Plan is reimbursed.

To the extent the Covered Person disputes this obligation to the Plan under this section, the Covered Person or any of its agents or representatives is also required to hold any/all settlement funds, including the entire settlement if the settlement is less than the Plan's interests, and without reduction in consideration of attorney's fees, for which he or she exercises control, in an account segregated from their general accounts or general assets until such time as the dispute is resolved.

No Covered Person, beneficiary, or the agents or representatives thereof, exercising control over plan assets and incurring trustee responsibility in accordance with this section will have any authority to accept any reduction of the Plan's interest on the Plan's behalf.

Excess Insurance

If at the time of Injury, sickness, Disease or disability there is available, or potentially available any Coverage (including but not limited to Coverage resulting from a judgment at law or settlements), the benefits under this Plan shall apply only as an excess over such other sources of Coverage, except as otherwise provided for under the Plan's Coordination of Benefits section.

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

1. The responsible party, its insurer, or any other source on behalf of that party.
2. Any first party insurance through medical payment coverage, personal injury protection, no-fault coverage, uninsured or underinsured motorist coverage.
3. Any policy of insurance from any insurance company or guarantor of a third party.
4. Workers' compensation or other liability insurance company.

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

Separation of Funds

Benefits paid by the Plan, funds recovered by the Covered Person(s), and funds held in trust over which the Plan has an equitable lien exist separately from the property and estate of the Covered Person(s), such that the death of the Covered Person(s) or filing of bankruptcy by the Covered Person(s), will not affect the Plan's equitable first lien, the funds over which the Plan has a lien, or the Plan's right to subrogation and reimbursement.

The following exist separately from the property and estate of a Covered Person:

1. Benefits paid by the Plan.
2. Funds recovered by the Covered Person*;* or
3. Funds held in trust over which the Plan has an equitable line.

As such, neither the death of a Covered Person*,* nor the filing of bankruptcy by a Covered Person*,* will affect the Plan's equitable lien (funds over which the Plan has a lien) or the Plan's right to subrogation and reimbursement.

Wrongful Death

In the event that the Covered Person(s) dies as a result of his or her Injuries and a wrongful death or survivor claim is asserted against a third party, or any Coverage, the Plan's subrogation and reimbursement rights shall still apply, and the entity pursuing said claim shall honor and enforce these Plan rights and terms by which benefits are paid on behalf of the Covered Person(s) and all others that benefit from such payment.

Obligations

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

1. To cooperate with the Plan, or any representatives of the Plan, in protecting its rights, including discovery, attending depositions, and/or cooperating in trial to preserve the Plan's rights.
2. To provide the Plan with pertinent information regarding the sickness, Disease, disability, or Injury, including accident reports, settlement information and any other requested additional information.
3. To take such action and execute such documents as the Plan may require, facilitate enforcement of its subrogation and reimbursement rights.
4. To do nothing to prejudice the Plan's rights of subrogation and reimbursement.
5. To promptly reimburse the Plan when a recovery through settlement, judgment, award, or other payment is received.
6. To notify the Plan or its authorized representative of any settlement prior to finalization of the settlement.
7. To not settle or release, without the prior consent of the Plan, any claim to the extent that the Covered Person may have against any responsible party or Coverage.
8. To instruct his or her attorney to ensure that the Plan and/or its authorized representative is included as a payee on any settlement draft.

9. In circumstances where the Covered Person is not represented by an attorney, instruct the insurance company or any third party from whom the Covered Person obtains a settlement to include the Plan or its authorized representative as a payee on the settlement draft.

10. To make good faith efforts to prevent disbursement of settlement funds until such time as any dispute between the Plan and Covered Person over settlement funds is resolved.

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

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

Offset

If timely repayment is not made, or the Covered Person and/or his or her attorney fails to comply with any of the requirements of the Plan, the Plan has the right, in addition to any other lawful means of recovery, to deduct the value of the Covered Person's amount owed to the Plan. To do this, the Plan may refuse payment of any future medical benefits and any funds or payments due under this Plan on behalf of the Covered Person(s) in an amount equivalent to any outstanding amounts owed by the Covered Person to the Plan. This provision applies even if the Covered Person has disbursed settlement funds.

Minor Status

In the event the Covered Person(s) is a minor as that term is defined by applicable law, the minor's parents or court appointed guardian shall cooperate in any and all actions by the Plan to seek and obtain requisite court approval to bind the minor and his or her estate insofar as these subrogation and reimbursement provisions are concerned.

If the minor's parents or court appointed guardian fail to take such action, the Plan shall have no obligation to advance payment of medical benefits on behalf of the minor. Any court costs or legal fees associated with obtaining such approval shall be paid by the minor's parents or court appointed guardian.

Language Interpretation

The Plan Administrator retains sole, full, and final discretionary authority to construe and interpret the language of this provision, to determine all questions of fact and law arising under this provision, and to administer the Plan's subrogation and reimbursement rights. The Plan Administrator may amend the Plan at any time without notice.

Severability

In the event that any section of this provision is considered invalid or illegal for any reason, said invalidity or illegality shall not affect the remaining sections of this provision and Plan. The section shall be fully severable. The Plan shall be construed and enforced as if such invalid or illegal sections had never been inserted in the Plan.

Recovery of Overpayments

In the event that the Plan mistakenly pays or overpays a Covered Person, regardless of the reason, the Covered Person shall return such overpayment or mistaken payment to the Plan. In the event that a Covered Person fails to return a mistaken payment or overpayment to the Plan, the Plan shall suspend all further benefit payments on any account to the Covered Person until the mistaken payment or overpayment

(along with interest thereon and any expenses associated with such recovery) is returned to the Plan or offset against amounts which would otherwise be paid to the Covered Person.

Fraud, Misrepresentation or Misconduct

The Plan Administrator or its designee may request information from a Covered Person to process a claim. No benefits will be paid by the Plan if there is a fraud or attempted fraud in any information or claim submitted to the Plan. Additionally, no benefits will be paid if there has been any misrepresentation or misconduct as defined below.

A fraud, misrepresentation or misconduct may be considered when any Covered Person directly or indirectly attempts to undermine the financial integrity of the Plan by his or her actions or where such action poses risk to the continued viability of the benefit program. Fraud, misrepresentation, or misconduct also includes, but is not limited to, turning in false claims; seeking benefits for non-dependents; failing to return monies under a subrogation agreement; working for cash with a signatory employer such that benefit contributions are not paid to the Plan.

The Company, in its discretion, may elect to pay no further benefits to the Covered Person for the greater of 12 months following the discovery of the attempted fraud, misrepresentation or misconduct, or the period of time necessary to recapture any monies improperly paid due to the fraud, misrepresentation or misconduct. The Plan has the right to determine whether fraud, misrepresentation or misconduct has been attempted or committed, and its decision shall be final, conclusive, and binding.

MEDICARE

Applicable to Active Employees and Their Spouses Ages 65 and Over

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

Applicable to All Other Participants Eligible for Medicare Benefits

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

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

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

BENEFIT CLAIMS PROCEDURE; PROCEDURES FOR CLAIMS AND APPEALS

The procedures outlined below must be followed by Claimants to obtain payment of benefits under this Plan.

Notice and Proof of Claim

Written notice and proof of an Incurred Claim should always be filed with the Third-Party Administrator as soon as possible. ***Claims must be filed within 12 months from the date the charge for the service to be covered by the Plan is Incurred.*** If an individual's coverage under the Plan ceases, all Claims Incurred prior to termination of coverage **must** be filed within 12 months from the date the charge for the service is Incurred, or the Claims will not be covered by the Plan.

Claims **must** be filed sooner in certain circumstances:

If the Plan is terminated, all Claims Incurred prior to the Plan termination **must** be received within 90 days after the termination, or the Claims will not be covered. Any Claims Incurred after termination of Plan coverage for any reason are not covered under the Plan.

For purposes of the Plan's provisions for internal claims and Appeals and external review processes, a "claim" for benefits is defined as a request for a plan benefit made by a claimant in accordance with a plan's reasonable procedure for filing benefit claims. A call from a Provider who wants to know if an individual is covered under the Plan, or if a certain procedure or treatment is a covered expense before the treatment is rendered, is not a "claim" since an actual claim for benefits is not being filed with the Plan. Likewise, presentation of a prescription to a pharmacy does not constitute a claim.

Under the claims regulations adopted by the U.S. Department of Labor, the Plan possibly could have four types of claims: Pre-service (Urgent and Non-urgent), Concurrent Care and Post-service. However, because the Plan does not require the Covered Person to obtain approval of any medical service prior to getting treatment, the Plan only has post service- claims.

1. A "Pre-service Claim" is a claim for a benefit under the Plan where the Plan conditions receipt of the benefit, in whole or in part, on approval of the benefit in advance of obtaining Medical Care.

A "pre-service urgent care claim" is any claim for Medical Care or treatment with respect to which the application of the time periods for making non-urgent care determinations could seriously jeopardize the life or health of the Covered Person or the Covered Person's ability to regain maximum function, or, in the opinion of a Physician with knowledge of the Covered Person's medical condition, would subject the Covered Person to severe pain that cannot be adequately managed without the care or treatment that is the subject of the claim.

Because the Plan does not require Claimants to obtain approval of a medical service prior to getting treatment on an urgent or non-urgent basis, there are no "Pre-service Claims." The Claimant simply follows the Plan's procedures with respect to notice that is required after receipt of treatment, and files the Claim as a Post service- Claim.

2. A "Concurrent Claim" arises when the Plan has approved an on-going course of treatment to be provided over a period of time or number of treatments, and either:

a. The Plan determines that the course of treatment should be reduced or terminated; or

b. The Claimant requests an extension of the course of treatment beyond that which the Plan has approved.

Because the Plan does not require Claimants to obtain approval of medical services prior to getting treatment, there is no need to contact the Utilization Review Company to request an extension of a course of treatment. The Claimant simply follows the Plan's procedures with respect to notice that is required after receipt of treatment, and files the Claim as a Post service- Claim.

3. "Post service Claim" is a Claim for a benefit under the Plan after the services have been rendered. A Post service Claim is considered to be filed when the following information is received by the Third-Party Administrator with a Form CMS1500 or Form UB92 or any successor forms:

    a. The date of service.

    b. The name, address, telephone number, and tax identification number of the Provider of the services or supplies.

    c. The place where the services were rendered.

    d. The diagnosis and procedure codes.

    e. The number of charges (including any repricing information).

    f. The name of the Plan.

    g. The name of the Employee; and

    h. The name of the patient.

Each Claimant claiming benefits under the Plan shall be responsible for supplying, at such times and in such manner as the Plan Administrator in its sole discretion may require, written proof that the expenses were Incurred, or that the benefit is covered under the Plan. If the Plan Administrator in its sole discretion determines that the Claimant has not Incurred a Covered Expense, or that the benefit is not covered under the Plan, or if the Claimant fails to furnish such proof as is requested, no benefits shall be payable under the Plan.

Claims Determination

The Plan Administrator shall notify the Claimant, in accordance with the provisions set forth below, of any Adverse Benefit Determination within the following times:

1. If the Claimant has provided all of the information needed to process the Claim in a reasonable period of time, but not later than 30 days after receipt of the Claim. This period may be extended by the Plan for up to 15 days, provided that the Plan Administrator:

a. Determines that such an extension is necessary due to matters beyond the control of the Plan; and

b. Notifies the Claimant, prior to the expiration of the initial 30-day processing period of the circumstances requiring the extension of time, and the date by which the Plan expects to render a decision.

If an extension has been requested, then the Plan Administrator shall notify the Claimant of any Adverse Benefit Determination prior to the end of the 15-day extension period.

2. If additional information is requested from the Claimant to process the Claim during the initial processing period, then the Claimant will be notified of a determination of benefits prior to the end of the extension period. If additional information is requested from the Claimant during the extension period, then the Claimant will be notified of the determination by a date agreed to by the Plan Administrator and the Claimant.

3. Notice to the Claimant of a rescission of coverage will be provided at least 30 days in advance of the retroactive termination of coverage by the Plan.

A Benefit Determination is required to be made within the period of time beginning when a Claim is deemed to be filed in accordance with the procedures of the Plan.

Notice Of Adverse Benefit Determination

An “adverse benefit determination” is defined as a denial, reduction, or termination of, or a failure to provide or make a payment (in whole or in part) for a benefit, including any such denial, reduction, termination, or failure to provide or make a payment for a claim that is based on:

1. The determination of an individual’s eligibility to participate in a plan or health insurance coverage.
2. A determination that a benefit is not a covered benefit.
3. The imposition of a source-of-injury exclusion, PPO provider network exclusion, or other limitation on otherwise covered benefits; or
4. A determination that a benefit is Experimental, Investigational, or not Medically Necessary or appropriate.

Although it is not a claim for benefits, the definition of an adverse benefit determination also includes a rescission of coverage under the Plan. A “rescission of coverage” is defined as a cancellation or discontinuance of coverage that has retroactive effect, except to the extent it is attributable to a failure to timely pay required premiums or contributions towards the cost of coverage.

If the initial Benefit Determination is an Adverse Benefit Determination, notification will be sent to the Claimant and will include the following information:

1. Information sufficient to identify the claim involved, including the date of the service, the health care provider, the claim amount (if applicable), and, upon request, the diagnosis code and its corresponding meaning, and the treatment code and its corresponding meaning.
2. The reason or reasons for an adverse benefit determination or final internal adverse benefit determination, including the denial code and its corresponding meaning, as well as a description of the Plan's standard, if any, used in denying the claim. In the case of a final internal adverse benefit determination, this description must also include a discussion of the decision.
3. A reference to the specific portion(s) of the plan document and summary plan description upon which a denial is based.
4. A description of any additional information necessary for the claimant to perfect the claim and an explanation of why such information is necessary.
5. A description of the Plan’s review procedures and the time limits applicable to the procedures, including a statement of the claimant’s right to bring a civil action under Section 502(a) of ERISA following an adverse benefit determination on final review.
6. A statement that the claimant is entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records and other information relevant to the claimant’s claim for benefits.
7. The identity of any medical or vocational experts consulted in connection with a claim, even if the Plan did not rely upon their advice (or a statement that the identity of the expert will be provided, upon request).

8. Any rule, guideline, protocol or similar criterion that was relied upon in making the determination (or a statement that it was relied upon and that a copy will be provided to the claimant, free of charge, upon request); and

9. In the case of denials based upon a medical judgment (such as whether the treatment is medically necessary or experimental), either an explanation of the scientific or clinical judgment for the determination, applying the terms of the Plan to the claimant's medical circumstances, or a statement that such explanation will be provided to the claimant, free of charge, upon request.

Physical Examination

The Plan Administrator or Third-Party Administrator has the right to have the Claimant examined as often as reasonably necessary while a Claim is pending. Benefits are payable under this Plan only if they are Medically Necessary for the Illness or Accidental Injury of the Covered Person. This Plan reserves the right to make a Utilization Review to determine whether services are Medically Necessary for the proper treatment of the Covered Person. All such information will be confidential.

Claims Audit

Once a written Claim for benefits is received, the Claims Administrator, acting on the discretionary authority of the Plan Administrator, may elect to have such Claim reviewed or audited for accuracy and limited to, identifying: (a) charges for items/services that may not be covered or may not have been delivered, (b) duplicate charges, and (c) charges beyond the reasonable, necessary, and U&C guidelines as determined by the Plan. In addition, please refer to the section entitled "Claim Review and Audit Program" for information regarding Plan provisions related to the audit and adjudication of certain eligible Claims under that Program.

Payment Of Claims

Plan benefits are payable to the covered Employee, unless the Claimant gives written direction, at the time of filing proof of such loss, to directly pay the health care Provider rendering such services. Such payment to a health care Provider is subject to the approval of the Plan Administrator. If any such benefit remains unpaid at the death of the covered Employee, if the Claimant is a minor, or if the Claimant is (in the opinion of the Plan Administrator) legally incapable of giving a valid receipt and discharge for any payment, the Plan Administrator may, at its option, pay such benefits to any one or more of the following relatives of the Claimant: wife, husband, mother, father, Child or Children, brother or brothers, sister or sisters. Such payment will constitute a complete discharge of the Plan's obligation to the extent of such payment, and the Plan Administrator will not be required to follow up and determine how such paid money was used.

Recovery of Payments

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

A Claimant, Dependent, Provider, another benefit plan, insurer, or any other person or entity who receives a payment exceeding the amount of benefits payable under the terms of the Plan or on whose behalf such payment was made, shall return or refund the amount of such erroneous payment to the Plan within 30

days of discovery or demand. The Plan Administrator shall have no obligation to secure payment for the expense for which the erroneous payment was made or to which it was applied.

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

Providers and any other person or entity accepting payment from the Plan or to whom a right to benefits has been assigned, in consideration of services rendered, payments and/or rights, agrees to be bound by the terms of this Plan and agree to submit claims for reimbursement in strict accordance with their State's health care practice acts, ICD or CPT standards, Medicare guidelines, HCPCS standards, or other standards approved by the Plan Administrator or insurer. Any payments made on claims for reimbursement not in accordance with the above provisions shall be repaid to the Plan within 30 days of discovery or demand or incur prejudgment interest of 1.5% per month. If the Plan must bring an action against a Claimant, Provider or other person or entity to enforce the provisions of this section, then that Claimant, Provider or other person or entity agrees to pay the Plan's attorneys' fees and costs, regardless of the action's outcome.

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

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

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

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

If the Plan seeks to recoup funds from a Provider, due to a claim being made in error, a claim being fraudulent on the part of the Provider, and/or the claim that is the result of the Provider's misstatement, said

Provider shall, as part of its assignment to benefits from the Plan, abstain from billing the Claimant for any outstanding amount(s).

SUBROGATION AND REIMBURSEMENT RIGHTS

By accepting benefits for Covered Services, the Member agrees that the Claims Administrator has the right to enforce subrogation and reimbursement rights. This section explains these rights and the responsibilities of each Member pertaining to subrogation and reimbursement. The term Member includes Eligible Dependents. The term Responsible Third Party refers to any person or entity, including any insurance company, health benefits plan or other third party, which has an obligation (whether by contract, common law or otherwise) to pay damages, pay compensation, provide benefits or make any type of payment to the Member for an injury or illness.

The Claims Administrator or the Plan Administrator, as applicable, retains full discretionary authority to interpret and apply these subrogation and reimbursement rights based on the facts presented.

Subrogation Rights

Subrogation rights arise when the Claims Administrator pays benefits on behalf of a Member and the Member has a right to receive damages, compensation, benefits or payments of any kind (whether by a court judgment, settlement or otherwise) from a Responsible Third Party. The Claims Administrator is subrogated to the Member's right to recover from the Responsible Third Party. This means that the Claims Administrator "stands in your shoes" - and assumes the Member's right to pursue and receive the damages, compensation, benefits or payments from the Responsible Third Party to the full extent that the Claims Administrator has reimbursed the Member for medical expenses or paid medical expenses on the Member's behalf, plus the costs and fees that are incurred by the Claims Administrator to enforce these rights. The right to pursue a subrogation claim is not contingent upon whether or not the Member pursues the Responsible Third Party for any recovery.

Reimbursement Rights

If a Member obtains any recovery - regardless of how it's described or structured - from a Responsible Third Party, the Member must fully reimburse the Claims Administrator for all medical expenses that were paid to the Member or on the Member's behalf, plus the costs and fees that are incurred by the Claims Administrator to enforce these rights. The Claims Administrator has a right to full reimbursement.

Disposition of Unclaimed Benefit Payments. In the event that a payee of a benefit check issued in payment of the Plan’s obligations, fails within 90 days of the date of its issuance to cash such a benefit check (a “Stale Check”), such monies shall be **forfeited by the Payee and shall revert back to the Plan.** Neither the payee nor any person covered under this Plan shall have any right to have a Stale Check reissued or to make any claim for benefits related to the services for which the check was originally issued.

Appeal Process

Full and Fair Review of All Claims

The Plan provides for two levels of appeal following an Adverse Benefit Determination. The Claimant has 180 days following an initial Adverse Benefit Determination to file an appeal of that determination, and 60 days following an Adverse Benefit Determination on the First Level Appeal to file a Second Level Appeal of that determination. The appeal process will provide the Claimant with a reasonable opportunity for a full and fair review of the Claim and Adverse Benefit Determination and will include the following:

a. Receipt of written request by the Claims Administrator from the Claimant, or an Authorized Representative of the Claimant, with the proper form for review of Adverse Benefit Determination, which initiates the appeal process.

b. The Claimant will have the opportunity to submit written comments, documents, records, and other information relating to the Claim.

c. The Claimant will be provided, on request and free of charge: (a) reasonable access to and copies of all documents, records, and other information relevant to the Claimant's Claim in possession of the Plan Administrator, the Claims Audit Decision Maker (DDM) or the Claims Administrator; (b) information regarding any rule, guideline, protocol or other similar criterion relied upon in making the Adverse Benefit Determination; (c) information regarding any voluntary appeals procedures offered by the Plan; and (d) an explanation of the scientific or clinical judgment for the determination, applying the terms of the Plan to the Claimant's medical circumstances.

d. The review of the Adverse Benefit Determination will consider all comments, documents, records and other information submitted by the Claimant relating to the Claim, without regard to whether such information was submitted or considered in the initial Benefit Determination.

e. No deference will be afforded to the previous Adverse Benefit or Appeal Determination. The party reviewing the appeal may be neither the party who made the prior Adverse Benefit Determination, nor a subordinate of the party who made the prior Adverse Benefit Determination.

f. In deciding an appeal on which the Adverse Benefit Determination was based in whole or in part on a medical judgment, including whether a particular treatment, drug, or other item is Experimental, Investigational, or not Medically Necessary or appropriate, the Claims Administrator, the Claims Audit Decision Maker or the Plan Administrator, as appropriate depending on the level of appeal, will consult with a health care professional who has appropriate training and experience in the field of medicine involving the medical judgment. The health care professional consulted for the appeal will not be the health care professional or a subordinate of the health care professional consulted in connection with the Adverse Benefit Determination that is the subject of the appeal.

g. Medical or vocational experts whose advice was obtained on behalf of the Plan in connection with the Adverse Benefit Determination will be identified, even if the Plan did not rely upon their advice.

h. The first level of appeal will be decided within 30 days of the Claims Administrator's receipt of the request. The second level of appeal will be decided within 30 days of the Plan's receipt of the request.

First Appeal Level

Requirements for First Appeal

The Claimant must file the first Appeal, in writing, within 180 days following receipt of the notice of an Adverse Benefit Determination. The Claimant's Appeal must be addressed as follows:

I INDECS, a Homestead Company
PO Box 46511
Cincinnati, OH 45246-0511

It shall be the responsibility of the Claimant to submit proof that the Claim is covered and payable under the provisions of the Plan. An appeal must include:

1. The name of the Employee/Claimant.

2. The Employee's/Claimant's Social Security number.

3. The group name or identification number.

4. All facts and theories supporting the Claim for benefits. **Failure to include any theories or facts in the appeal will result in such facts being inadmissible. In other words, the Claimant will lose the right to raise such factual arguments and theories that support this Claim if the Claimant fails to include them in the appeal.**

5. A statement in clear and concise terms of the reason or reasons for the disagreement with the handling of the Claim; and

6. Any material or information that the Claimant has which indicates that the Claimant is entitled to benefits under the Plan.

If the Claimant provides all of the required information, it may be that the expenses will be eligible for payment under the Plan.

Timing of Notification of Benefit Determination on First Appeal

The Plan shall notify the Claimant of the Plan's Benefit Determination of review within a reasonable period of time, but not later than 30 days after receipt of the appeal.

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

Notice of Benefit Determination on First Appeal

The Claimant will be notified of the Benefit Determination on appeal. If there is an Adverse Benefit Determination on appeal, the notification will include the following information:

1. The reason or reasons for the Adverse Benefit Determination.

2. References to the Plan provisions on which the Adverse Benefit Determination is based.

3. A description of any additional material or information necessary for the Claimant to perfect the Claim, and an explanation of why such material or information is necessary.

4. A statement that the Claimant is entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the Claimant's Claim.

5. A description of the Plan's review procedures and the time limits applicable to such procedures, including a statement of the Claimant's right to bring a civil action under Section 502(a) of ERISA following an Adverse Benefit Determination on final review.

6. A description of voluntary appeal procedures offered by the Plan and, upon the Claimant's request, any additional information about the voluntary appeal procedures.

7. If an internal rule, guideline, protocol, or other similar criterion was relied on in making the Adverse Benefit Determination, either the specific rule, guideline, protocol or other similar criterion or a statement that such was relied on in making the Adverse Benefit Determination, and that a copy of the rule, guideline, protocol or other criterion will be provided free of charge on request;

8. If the Adverse Benefit Determination is based on a medical judgment (such as Medical Necessity or whether or not treatment is Experimental), either an explanation of the scientific or clinical judgment for the determination, applying the terms of the Plan to the Claimant's medical circumstances, or a statement that such explanation will be provided free of charge on request;

9. The identity of any medical or vocational experts consulted in connection with the Claim, even if the Plan did not rely upon their advice; and

10. The following statement: "You and your Plan may have other voluntary alternative dispute resolution options, such as mediation. One way to find out what may be available is to contact your local U.S. Department of Labor Office and your State Insurance Regulatory Agency."

Furnishing Documents in the Event of an Adverse Determination

In the case of an Adverse Benefit Determination on review, the Plan Administrator shall provide such access to, and copies of, documents, records, and other information described in the section relating to Notice of Benefit Determination on First Appeal, as appropriate.

Second Appeal Level

Adverse Decision on First Appeal; Requirements for Second Appeal

Upon receipt of notice of the Plan's Adverse Benefit Determination regarding the first appeal, the Claimant has 60 days to file a second appeal of the denial of benefits. The Claimant again is entitled to a "full and fair review" of any denial made at the first appeal, which means the Claimant has the same rights during the second appeal as he or she had during the first appeal. As with the first appeal, the Claimant's second appeal must be in writing and must include all of the items set forth in the section entitled "Requirements for First Appeal."

Timing of Notification of Benefit Determination on Second Appeal

The Plan shall notify the Claimant of the Plan's Benefit Determination of review within a reasonable period of time, but not later than 30 days after receipt of the second appeal.

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

Manner and Content of Notification of Adverse Benefit Determination on Second Appeal

The same information must be included in the Plan's response to a second appeal as a first appeal, except for: (a) a description of any additional information necessary for the Claimant to perfect the Claim and an explanation of why such information is needed; and (b) a description of the Plan's review procedures and the time limits applicable to the procedures. See the section entitled "Notice of Benefit Determination on First Appeal."

Furnishing Documents in the Event of an Adverse Determination

In the case of an Adverse Benefit Determination on the second appeal, the Plan Administrator shall provide such access to, and copies of, documents, records, and other information described in the section relating to the Notice of Benefit Determination on First Appeal, as appropriate.

Decision on Second Appeal to be Final.

If, for any reason, the Claimant does not receive a written response to the appeal within the appropriate time period set forth above, the Claimant may assume that the appeal has been denied. The decision will be final, binding and conclusive, and will be afforded the maximum deference permitted by law.

All Claim review procedures provided for in the Plan must be exhausted before any legal action is brought. Any legal action for the recovery of any benefits must be commenced within three years after the Plan's Claim review procedures have been exhausted. Any action with respect to a fiduciary's breach of any responsibility, duty or obligation hereunder must be brought within three years after the date of service.

Expedited External Review for Urgent or Emergency Care

This Plan does not require a claimant to obtain prior approval for pre-service urgent care claims or emergency care services before getting treatment; therefore, neither the internal appeals nor the external review procedures will apply to these claims. In an emergency or urgent care situation, the claimant

should follow instructions from his or her health care provider and file the claim as a post-service claim. If the post-service claim results in an adverse benefit determination, the claimant may file an appeal in accordance with the Plan's provisions for "Appeal Process", which are explained above.

Appeals of claims involving concurrent care will be subject to the Plan's provisions for expedited external review, as explained below.

PACE – If applicable "PACE" stands for Plan Appointed Claim Evaluator. It is a service whereby The Phia Group assumes fiduciary duties as they relate to the internal, final post-service appeals of benefit denials for claims that have not gone through the CW Claim Review and Audit program. When a plan participant appeals an adverse benefit determination, and such appeal is the last internal appeal available to that participant (prior to submitting an external appeal to an Independent Review Organization ["IRO"] or filing a civil suit to appeal), The Phia Group will make the claims payment determination and assume the fiduciary liability associated with such determination for claims that have not gone through the CW Claim Review and Audit program. The Phia Group will also both facilitate and pay for an IRO appeal if the participant appeals the PACE's determination to an IRO.

Procedures for Initiation of an External Review

Standard External Review

A request for an external review must include the same information that is required for an internal appeal, listed above in the section, "Appeal Process". Once the request for a standard external review is filed, the Plan will have five business days to do a preliminary review of the request to determine whether it is eligible and whether all of the information and forms required to process the external review have been provided.

Within one business day following completion of the preliminary review, the Plan will notify the claimant in writing whether the request is eligible for external review.

- If the request is complete but is not eligible for external review, the notice will contain an explanation of the reason that the request is ineligible.
- If the request is incomplete, the notice will describe the information or materials needed to make the request complete. The claimant must submit the information or materials needed within 48 hours following receipt of the notice, or the expiration of the original four-month filing period, whichever is later.

An eligible request, which is complete and timely filed, will be assigned to an independent review organization (IRO) by the Plan. The Plan will have arrangements to access at least three accredited IROs to which external reviews will be assigned on a random or rotated basis to ensure an independent and unbiased review. The assigned IRO will notify the claimant in writing of the request's eligibility and acceptance for external review. This notice will include a statement that the claimant may submit to the IRO, in writing and within 10 business days following receipt of the notice, any additional information that the IRO must consider when conducting the external review.

Within five business days after the date of assignment of the IRO, the Plan must provide the assigned IRO the documents and any information considered in making the adverse benefit determination or final internal adverse benefit determination. Failure by the Plan to timely provide the documents and information will not delay the conduct of the external review, and the IRO may decide to reverse the adverse benefit determination or final internal adverse benefit determination. In this case, the IRO will notify the Plan and the claimant within one business day following the decision to reverse the determination.

The assigned IRO will forward any information, which is submitted by the claimant to the Plan, and the Plan may reconsider its adverse benefit determination or final internal adverse benefit determination; however, reconsideration by the Plan will not delay the external review. If the Plan decides to reverse its adverse

benefit determination or final internal adverse benefit determination, it may terminate the external review and notify the IRO and the claimant within one business day of the decision.

The IRO will provide written notice to the claimant and the Plan of the final external review decision with 45 days following receipt of the request for review. The notice will contain:

1. A general description of the reason for the request for external review, including information sufficient to identify the claim (including the date or dates of service, the health care provider, the claim amount (if applicable), the diagnosis code and its corresponding meaning, the treatment code and its corresponding meaning, and the reason for the previous denial;
2. The date the IRO received the request for external review and the date on which it made the decision.
3. References to the evidence or documentation, including the specific coverage provisions and evidence-based standards, considered in reaching its decision.
4. A discussion of the principal reason or reasons for its decision, including the rationale for its decision and the evidence-based standards that were relied on in making the decision.
5. A statement that the determination is binding except to the extent that other remedies may be available under State or Federal law to either the group health plan or to the claimant.
6. A statement that judicial review may be available to the claimant; and
7. Current contact information, including a phone number, for any applicable office of health insurance consumer assistance or ombudsman established under PHS Act section 2793.

Expedited External Review

A final internal adverse benefit determination concerning an admission, availability of care, continued stay, or health care item or service for which the claimant received emergency services but has not yet been discharged from the facility will be considered for an expedited external review. These are considered to be pre-service **non-urgent** care claims and concurrent claims. The procedures that apply to standard external reviews will apply to expedited external reviews, except that:

a. The preliminary review of the request to determine whether it is eligible and whether all of the information and forms required to process the external review have been provided must be conducted immediately, and the Plan must immediately notify the claimant regarding the eligibility determination.

b. Upon a determination that a request is eligible for external review following the preliminary review, the Plan will immediately assign an IRO pursuant to the requirements set forth for standard external reviews.

c. The Plan must provide or transmit all necessary documents and information considered in making the adverse benefit determination or final internal adverse benefit determination to the assigned IRO electronically, by phone, facsimile or any other available expeditious method; and

d. The IRO must provide notice of the final external review decision as expeditiously as the claimant's medical condition or circumstances require, but in no event more than 72 hours after the IRO receives the request for an expedited external review. If the notice is not in writing, the assigned IRO must provide written confirmation of the decision to the claimant and the Plan within 48 hours following the notice.

Decision Following an External Review

Upon receipt of a notice from the IRO reversing the decision of an adverse benefit determination or final internal adverse benefit determination, the Plan will immediately provide coverage or payment for the claim. An external review decision is binding on the Plan as well as the claimant, except to the extent other remedies are available under State or Federal law.

Time Limit for Legal Action

All claim review procedures provided for in the Plan must be exhausted before any legal action is brought. Any legal action for the recovery of any benefits must commence within 3 years after the Plan's claim review procedures have been exhausted. Any action with respect to a fiduciary's breach of any responsibility, duty or obligation hereunder must be brought within 3 years after the date of service.

Appointment of Authorized Representative

A Claimant is permitted to appoint an Authorized Representative to act on his behalf with respect to a benefit claim or appeal of an Adverse Benefit Determination. An assignment of benefits by a Claimant to a provider will not constitute appointment of that provider as an Authorized Representative. To appoint such a representative, the Claimant must complete a form which can be obtained from the Plan Administrator or the Claims Administrator. In the event a Claimant designates an Authorized Representative, all future communications from the Plan will be with the Authorized Representative, rather than the Claimant, unless the Claimant directs the Plan Administrator, in writing, to the contrary.

Provider of Service Appeal Rights

A Claimant may appoint the provider of service as the Authorized Representative with full authority to act on his or her behalf in the appeal of a denied claim. An assignment of benefits by a Claimant to a provider of service will not constitute appointment of that provider as an Authorized Representative. However, in an effort to ensure a full and fair review of the denied claim, and as a courtesy to a provider of service that is not an Authorized Representative, the Plan will consider an appeal received from the provider in the same manner as a Claimant's appeal and will respond to the provider and the Claimant with the results of the review accordingly. Any such appeal from a provider of service must be made within the time limits and under the conditions for filing an appeal specified under the section, "Appeal Process," above.

Providers requesting such appeal rights under the Plan must agree to pursue reimbursement for Covered Medical Expenses directly from the Plan, waiving any right to recover such expenses from the Claimant, and comply with the conditions of the section, "Requirements for Appeal," above.

For purposes of this section, the provider's waiver to pursue Covered Medical Expenses does not include the following amounts, which will remain the responsibility of the Claimant:

- Deductibles.
- Copayments.
- Coinsurance.
- Penalties for failure to comply with the terms of the Plan.
- Charges for services and supplies which are not included for coverage under the Plan; and
- Amounts which are in excess of any stated Plan maximums or limits.

Note: This does not apply to amounts found to be in excess of Allowable Claim Limits. Please refer to the section entitled "Claim Review and Audit Program" for information regarding Plan provisions related to the audit and adjudication of certain eligible Claims under that Program. The Claimant will not be held responsible for any amounts found to be in excess of the Allowable Claim Limits. Also, for purposes of this

section, if a provider indicates on a Form UB92 or on a Form HCFA (or similar claim form) that the provider has an assignment of benefits, then the Plan will require no further evidence that benefits are legally assigned to that provider.

Contact the Claims Administrator or the Plan Administrator for additional information regarding provider of service appeals.

Claim Review and Audit Program

The Plan has been arranged with the Claims Administrator ("TPA") for a program of claim review and auditing in order to identify charges billed in error, charges for excessive or unreasonable fees and charges for services that are not medically appropriate. Benefits for claims selected for review and auditing may be reduced for any charges that are determined to be in excess of Allowable Claim Limits (as defined below). The determination of Allowable Claim Limits under this Program will supersede any other Plan provisions related to application of a usual, customary or reasonable fee determination.

Claim Payment Guidelines

"Allowable Claim Limits" means the charges for services and supplies, listed and included as Covered Medical Expenses under the Plan, which are Medically Necessary for the care and treatment of Illness or Injury, but only to the extent that such fees are within the Allowable Claim Limits. Determination that a charge is within the Allowable Claim Limit will be made by the Administrator and will include, but not be limited to, the following guidelines:

Egregious billing is defined as charges that exceed three times the Medicare rate.

Hospital – The Allowable Claim Limit for charges by a Hospital facility and for charges by facilities which are owned and operated by a Hospital may be based upon 120% of the Hospital's most recent departmental cost ratio, reported to the Centers for Medicare and Medicaid Services ("CMS") and published in the American Hospital Directory as the "Medicare Cost Report" (the "CMS Cost Ratio"), or may be based upon the Medicare Allowed Amount for the services in the geographic region plus an additional 25%, whichever is higher, not to exceed a maximum of 300% of the Medicare Allowable Amount.

For hospitals which do not report cost-to-charge ratios or participate with Medicare such as Children's Hospitals, Independently Owned Cancer Centers, and Physician Owned Hospitals, the Allowable Claim Limits for charges by these types of facilities may be based on 130% of the average of the contracted/discounted rates accepted by nearby hospitals offering the same or similar services. A maximum of three hospitals will be used for comparison based on the information available from the most recent American Hospital Directory for each of the facilities.

All hospital billing must follow Medicare guidelines.

If a provider or facility is a Hospital or is owned or operated by a Hospital, or if the Plan is able to identify a current CMS Cost Ratio that applies to the provider, to the facility, or to the geographic areas in which services are rendered, then the CMS Cost Ratio will be used to determine the Allowable Claim Limit as set forth above.

Outpatient services will be payable at no more than 300% of Medicare. The allowable payment for outpatient observation services for a 24-hour period or more will never exceed the cost to charge reimbursement equivalent for an in-patient general medical-surgical room at the same facility. The Plan may utilize 300% of the Medicare DRG to determine the maximum allowable payment.

Pre-admission testing prior to surgery or other planned confinement in-patient or outpatient stay will be included as part of the planned confinement and will not be separately payable.

Anesthesia services billed in addition to anesthesia medications, supplies, and/or use of the operating room will not be considered for payment to the hospital as it represents duplicate billing.

Mental Health and Substance Use Disorder – Programs that do not have cost-to-charge ratios or Medicare pricing will be paid the Average Federal per diem rate *plus* 25%.

Rehabilitation Facilities, Long Term Care, and Home Care – Services are payable in accordance with the applicable cost-to charge ratio. If there is the absence of a cost-to charge ratio an allowance of 125% of Medicare will be paid. All billing must be submitted using the required Medicare billing format, including but not limited to RUG and HHRG scores.

Pharmaceuticals – The Allowable Claim Limit for pharmacy charges by a provider which does not report cost ratios to CMS will be determined by applying 125% of the Medicare allowable fee for all medications. In the absence of a Medicare fee, the Average Wholesale Price (AWP) as defined by REDBOOK at the rate of 100% of the AWP will be allowed. The provider must submit the NDC Number, dosage and route of administration for each medication subject to the Medicare Allowable Amount exclusion prior to payment.

Medical and Surgical Supplies, Implants, Devices – The Allowable Claim Limit for charges for medical and surgical supplies from a provider which does not report cost ratios to CMS will be based upon invoice price to the provider, plus 25%. The implant record and operative report must be submitted in addition to a copy of the actual invoice for the implants billed. The documentation used as the resource for this determination will include, but not be limited to, invoices, receipts, cost lists or other documentation as deemed appropriate by the Plan Administrator. Implanted items are those items that remain implanted in the patient following the completion of surgery and upon discharge.

Lab, X-ray, Therapy and Physician Services – The Allowable Claim Limit for these services which are rendered by a provider which does not report cost ratios to CMS will be determined based upon a comparison with the fees of other providers rendering the same type of service in the same geographic region. The Allowable Claim Limit for such service will not exceed the amount of the fees for comparable services in the geographic region at the 75th percentile as reflected in the Physician Fee Reference ("PFR"), the 75th percentile as reflected in Context 4 Healthcare; the National Fee Analyzer by Optum/Ingenix or Medical Fees in the United States by PMIC, or the Medicare Allowed Amount for the service plus 25% at the Auditor's discretion.

Ambulatory Surgery Centers – The Allowable Claim Limit for Ambulatory Surgical Centers that are independent facilities that do not report cost ratios to CMS will be based upon the Medicare Allowed Amount for the services in the geographic region, plus 25%. Operative reports must accompany billing. All billing and payments will follow Medicare ASC guidelines.

Assistant Surgeons, Co-Surgeons, Team Surgeons and Non-Physician Assistant at Surgery – Allowable limit will be paid in accordance with the Medicare guidelines for reimbursement as listed in the RBRVS and at the same percentage of reimbursement allowed by Medicare.

Unbundling, Medical Unlikely Edits, Standard Coding Convention, Global Fee Periods – The Allowable Claim Limit will be determined in accordance with the Medicare Reimbursement guidelines and regulations. The RBRVS will apply to modifiers. The provider must bill utilizing modifiers as appropriate for all charges. Use of modifier-59 which overrides CCI edits will not be considered for payment without supporting medical documentation.

Errors – The Allowable Claim Limits will not include any identifiable billing mistakes including, but not limited to, upcoding, duplicate charges, and charges for services not performed or not ordered by the physician. Allowable Claim Limits also will not include charges that are required to treat Injuries sustained or Illnesses contracted, including infections and complications, which, in the opinion of the Plan Administrator and based upon the medical records of the treatment, can be attributed to a medical error by the provider.

Medical Record Review – In the event that the Plan, based upon a medical record review and audit, determines that a different treatment or different quantity of a drug or supply was provided which is not supported in the billing, then the Plan Administrator may determine the Allowable Claim Limit according to the medical record review and audit results.

Ambulance Services – The Medicare Guidelines will apply to ambulance and medical transportation services. The maximum allowable limit is 125% of the Medicare rate.

Dialysis – Claims will be paid at 125% of the Medicare ESRD composite payment. In addition to the ESRD rate, Epoetin may be paid at the allowable Medicare fee.

Hospital Acquired Conditions – The Plan will not be financially responsible for care and treatment of conditions acquired while the patient is in the hospital.

Medical Necessity – The level of treatment and services billed must be supported in the document. Treatment and services deemed not medically necessary following review of medical documentation will not be paid.

Not Able to Identify or Understand - The Allowable Claim Limits will not include any charges for which the Plan Administrator cannot identify or understand the item(s) being billed.

Non-Emergent Surgical Care and Courses of treatment involving 12 or more visits – Non-emergent surgery and treatment involving 12 or more visits must be pre-authorized by the Plan.

Trauma Care – Trauma care will be allowed in accordance with the American College of Surgeons Triage Guidelines.

Durable Medical Equipment – The allowable claim limit may be determined utilizing cost-to-charge ratios, Medicare plus 25%, or merchant's prices for the same or similar equipment available on the retail market.

Ancillary (other) Medical and/or Surgical Services – The Allowable Claim Limit for services not otherwise listed.

above will be calculated based upon industry-standard resources including, but not limited to, CMS Cost Ratios, Medicare allowed fees (by geographic region), published and publicly available fee and cost lists and comparisons, any resources listed in the categories above, or any combination of such resources that results in the determination of a reasonable expense under the Plan, in the opinion of the Plan Administrator. The Allowable Claim Limit for these services will be calculated using one or more of the industry-standard resources, plus 25%.

Direct Contracts with Medical Providers-The Allowable Claim Limits for services listed above may be calculated pursuant to a Direct Contract or Agreement negotiated by Claim Watcher on behalf of the Plan.

In the event that the Plan Administrator determines that insufficient information is available to identify the Allowable Claim Limit for a specific service or supply using the listed guidelines above, consideration will be given to such fees for the geographic location, the most comparable services or supplies and based upon comparative severity. The Plan Administrator reserves the right, in its sole discretion, to determine any Allowable Claim Limit amount for certain conditions, services and supplies using accepted industry-standard documentation, uniformly applied without discrimination to any Covered Person.

Notwithstanding any conflicting contracts or agreements, the Plan may consider the Allowable Claim Limits as the maximum amount of Covered Medical Expense that may be considered for reimbursement under the Plan and may apply this determination in lieu of any hospital's per diem, DRG rates or PPO discounted rates as the amount considered for reimbursement under the Plan.

DIRECT CONTRACTS WITH A HOSPITAL, OTHER MEDICAL FACILITY OR PROVIDER

In the event that the Plan Administrator authorizes a direct contract for services with a hospital, other medical facility, or provider to provide necessary and appropriate services to Covered Persons, then the terms of those contracts shall be utilized to determine the Allowable Claim limits in lieu of other limits under this Program.

Balance Billing In the event that a claim submitted by a Network or non-Network Provider is subject to a medical bill review or medical audit under the Claim Review and Audit Program and some or all of the charges in connection with such claim are repriced because of billing errors and/or overcharges or in determining the Allowable Claim Limit, it is the Plan's position that the Participant should not be responsible for payment of any charges denied as a result of the Audit Adjustments and should not be balance billed for the difference between the billed charges and the amount determined to be payable by the Audit Program. However, balance billing is legal in many areas, and the Plan has no control over non-Network Providers that engage in balance billing practices. The Plan grants Providers a Direct Right of Appeal to object to any such reductions in reimbursements of claims. In return for this right the Provider is required to waive the right to balance bill a member. In the event that a Provider does not appeal, or files and appeal but still balance bills a member for Audit reductions, the Claim Review and Audit Program provides a full legal defense for the Member against the Balance Bill.

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

In either case, in network or out of network or no network, the Participant is responsible for any applicable payment of co-insurances, Deductibles, and out-of-pocket maximums and may be billed for any or all of these claims.

PLAN ADMINISTRATION

Responsibilities for Plan Administration

Plan Administrator, Plan Appointed Claims Evaluator (PACE) and Claims Audit Decision Maker

The Plan is administered by the Plan Administrator in accordance with the provisions of the Employee Retirement Income Security Act of 1974, as amended ("ERISA"). An individual or entity may be appointed by the Plan Sponsor to be Plan Administrator and serve at the convenience of the Plan Sponsor. If the Plan Administrator resigns, dies, is otherwise unable to perform, is dissolved, or is removed from the position, the Plan Sponsor shall appoint a new Plan Administrator as soon as reasonably possible. Notwithstanding any provisions of this Plan Document and Summary Plan Description to the contrary, the Plan Administrator has the authority to, and hereby does, allocate certain fiduciary responsibility to the Claims Audit Decision Maker. The fiduciary responsibility allocated to the Claims Audit Decision Maker includes the discretionary authority and ultimate decision-making authority with respect to any Appeals of denied claims, which shall be referred to the Claims Audit Decision Maker by the Third-Party Administrator (the "Referred Appeals"). The Plan Sponsor has allocated additional fiduciary responsibility to the Plan Administrator and the Claims Audit Decision Maker(s) referenced in the section entitled "General Plan Information," including discretionary authority and ultimate decision-making authority with respect to the review and audit of certain claims in accordance with the applicable Plan provisions under the section, "Claim Review and Audit Program". Such claims selected as eligible for review and audit shall be identified by the Third-Party Administrator under guidelines to which the Plan Sponsor has agreed and shall be referred to the Claims Audit Decision Maker by the Third-Party Administrator.

The Plan Sponsor shall establish the policies, practices and procedures of this Plan. The Plan Administrator shall administer this Plan in accordance with its terms. It is the express intent of this Plan that the Plan Administrator and the Claims Audit Decision Maker (for Referred Appeals only) shall have maximum legal discretionary authority to construe and interpret the terms and provisions of the Plan, to make determinations regarding issues which relate to eligibility for benefits (including the determination of what services, supplies, care and treatments are Experimental), to decide disputes which may arise relative to a Covered Person's rights, and to decide questions of Plan interpretation and those of fact relating to the Plan. The decisions of the Plan Administrator and the Claims Audit Decision Maker (for Referred Appeals only) as to the facts related to any claim for benefits and the meaning and intent of any provision of the Plan, or its application to any claim, shall receive the maximum deference provided by law and will be final and binding on all interested parties. Benefits under this Plan will be paid only if the Plan Administrator or the Claims Audit Decision Maker (for Referred Appeals) are at their discretion, that the Covered Person is entitled to them.

Duties of the Plan Administrator

The duties of the Plan Administrator and where applicable to the Claim Review and Audit Program the duties of the Claims Audit Decision Maker include the following:

1. To administer the Plan in accordance with its terms.
2. To determine all questions of eligibility, status and coverage under the Plan.
3. To interpret the Plan, including the authority to construe possible ambiguities, inconsistencies, omissions and disputed terms.
4. To make factual findings.
5. To decide disputes which may arise relative to a Covered Person's rights.

6. To prescribe procedures for filing a claim for benefits, to review claim denials and Appeals relating to them and to uphold or reverse such denials.

7. To keep and maintain the Plan documents and all other records pertaining to the Plan.

8. To appoint and supervise a third-party administrator to pay claims.

9. To perform all necessary reporting as required by ERISA.

10. To establish and communicate procedures to determine whether a medical child support order or national medical support notice is a QMCSO.

11. To delegate to any person or entity such powers, duties and responsibilities as it deems appropriate.

12. To perform each and every function necessary for or related to the Plan's administration.

13. To perform the duties in conjunction with the provisions of the Claim Review and Audit Program; and

14. To keep and maintain records pertaining to the Claim Review and Audit Program.

Claims Audit Decision Maker

The Claims Audit Decision Maker shall have the following duties with respect to the Referred Appeals:

1. To administer the Plan in accordance with its terms.

2. To determine all questions of eligibility, status and coverage under the Plan.

3. To interpret the Plan, including the authority to construe possible ambiguities, inconsistencies, omissions, and disputed terms.

4. To make factual findings.

5. To decide disputes which may arise relative to a Covered Person's rights.

6. To review Referred Appeals and to uphold or reverse any denials; and

7. To keep and maintain records pertaining to the Referred Appeals.

The duties of the Claims Audit Decision Maker shall be limited to those set forth above.

THE NAMED FIDUCIARY. A "named fiduciary" is the one named in the Plan. A named fiduciary can appoint others to fulfill fiduciary responsibilities (other than as a trustee) under the Plan. These other persons become fiduciaries themselves and are responsible for their acts under the Plan. To the extent that the named fiduciary allocates its responsibility to other persons, the named fiduciary shall not be liable for any act or omission of such person unless either:

1. The named fiduciary has violated its stated duties under ERISA in appointing the fiduciary, establishing the procedures to appoint the fiduciary or continuing either the appointment or the procedures; or

2. The named fiduciary breached its fiduciary responsibility under Section 405(a) of ERISA.

claims processor is not a fiduciary. A Claims Processor is not a fiduciary under the Plan by virtue of paying claims in accordance with the Plan's rules as established by the Plan Administrator, and this Plan Document.

Funding the Plan and Payment of Benefits

The cost of the Plan is funded as follows:

1. For Employee Coverage: Funding is derived from the funds of the Employer and contributions made by the covered Employees.
2. For Dependent Coverage: Funding is derived from contributions made by the covered Employees, but the Employer may provide funding to reduce the Employee's contribution.
3. The level of any Employee contributions will be set by the Plan Administrator. These Employee contributions will be used in funding the cost of the Plan as soon as practicable after they have been received from the Employee or withheld from the Employee's pay through payroll deduction.
4. Benefits are paid directly from the Plan through the Claims Processor.

Recordkeeping

The Company may engage the services of a Claims Processor to assist in the maintenance of records of the Plan, its Covered Persons, and Beneficiaries, the interests of all parties having interest under the Plan, and elections and consents made by, or given by, persons making elections or giving consents under the Plan. In connection with the discharge of its duties as recordkeeper, the Plan Administrator shall make available for inspection to each Covered Person and Beneficiary (and their respective representatives) such documents and records as they may have access to by operation of law, and such other documents and records as the Plan Administrator deems should be made available under the circumstances then prevailing. Except as to documents and records of general applicability, each Covered Person and Beneficiary shall be restricted to inspection (and, where appropriate, copying) of those documents and records relevant to their individual circumstances under the Plan.

Correction of Administrative Errors

The Company and the Plan Administrator shall take such steps as they consider it necessary and appropriate to remedy any inequity that results from incorrect information received or communicated in good faith, or as a consequence of administrative error. Such steps may include, but shall not be limited to, the institution of action to recover payments for benefits made in error or on the basis of incorrect or incomplete information.

Interpretation of Plan Provisions

The Plan Administrator shall interpret the Plan and shall determine all questions arising in connection with the administration and application of the provisions of the Plan. Notwithstanding the foregoing, policies and practices associated with administration of the Plan may be changed at any time and from time to time without notice, and action taken at one time in a particular context shall not constitute binding precedent for future action of the Plan Administrator, whether in the same or a similar context. The Plan Administrator may correct any defect in the provisions of the Plan, reconcile any inconsistency, and supply any omission. All such interpretations, corrections, reconciliations and supplied omissions shall be final and binding on the parties to any dispute or issue. Decisions of the Plan Administrator shall not be overturned by a court of law unless such decisions are arbitrary or capricious.

Engagement of Advisers and Assistants

The Plan shall have the right to engage the services of such professional assistants and consultants as it, in its sole discretion, deems necessary or desirable, including, but not limited to:

1. Investment and fiduciary performance analysts.
2. Accountants.

3. Actuaries.
4. Attorneys.
5. Consultants, administrative service organizations and third-party administrators.
6. Clerical and office personnel.
7. Medical practitioners and health care service Providers; and
8. Organizations commonly known as third party- or contract administrators.

The expenses Incurred by the Company in connection with the operation of the Plan, including, but not limited to, the expenses Incurred by reason of the engagement of professional assistants and consultants, shall be expenses of the Plan and, if there exists a funding vehicle associated with the Plan, shall be payable from such funding vehicle at the direction of the Company.

Bonding

The Company, through the Plan Administrator, shall arrange for such bonding as is required by law, but no bonding in excess of the amount required by law shall be considered required by the Plan.

Amending and Terminating the Plan

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

The process whereby amendments, suspension and/or termination of the Plan is accomplished, or any part thereof, shall be decided upon and/or enacted by resolution of the Plan Sponsor's directors and officers if it is incorporated (in compliance with its articles of incorporation or bylaws and if these provisions are deemed applicable), or by the sole proprietor in his or her own discretion if the Plan Sponsor is a sole proprietorship, but always in accordance with applicable Federal and State law, including – where applicable – notification rules provided for and as required by ERISA.

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

MISCELLANEOUS PROVISIONS

Nonalienation of Benefits

1. General Rule. Except as provided in below, other than to reduce the obligations of the payee to an Employer, none of the payments, benefits or rights of any Covered Person shall be subject to any claim of any creditor, and, in particular, to the fullest extent permitted by law, all such payments, benefits and rights shall be free from attachment, garnishment, or any other legal or equitable process available to any creditor of such Covered Person. Except as herein provided and as provided in below, no Covered Person shall have the right to alienate, anticipate, commute, pledge, encumber or assign any of the benefits or payments which he or she may expect to receive, contingently or otherwise, under the Plan, except any right to designate a beneficiary or beneficiaries as may be hereinabove provided.

2. Exceptions

    a. Service Providers. If the nature of the benefits under the Plan is such that it is customary and appropriate for service Providers (such as, by way of example, medical service Providers) to accept assignments of benefit payments, and such assignments are made pursuant to procedures promulgated by the Company or its delegate, such assignments may be honored by insurers and health care service provider organizations, and disbursement of benefits may be made on behalf of any Covered Person to such service Provider. However, such service Provider shall have no greater rights or remedies than would be available to a Covered Person and the adjudication of any claim for payment by such service Provider shall be determined in accordance with the Article entitled “Benefit Claims Procedure.”

    b. Court Orders. If any order of a court requires the payment of any benefit under the Plan to a party other than a Covered Person or beneficiary, the Company, the Plan Administrator and its delegates, the insurers, health care service provider organizations, and each of them, shall be fully protected in honoring such order.

    c. Taxes. The withholding of taxes from payments and the honoring of liens and garnishments by taxing authorities, to the extent permitted by law, shall not be deemed inconsistent with paragraph (a) hereof.

    d. Claim by Plan. The Plan is entitled to garnish any amount, to recover prior overpayments, to coordinate benefits, or to be subrogated to the claim of any other person or entity.

Employment Relationship

Neither the existence of the Plan or any associated Contract, nor participation or the entitlement to an interest therein by any person shall either establish an employer/employee relationship or give any person the right to be retained in the service of any Employer. All covered Employees and other employees shall remain subject to discharge or layoff to the same extent as if the Plan had never been established.

Severability of Provisions

If any provision of the Plan shall be held invalid or unenforceable, such invalidity or unenforceability shall not affect any other provisions of the Plan.

Legal Enforceability of Rights

The rights of each Employee to coverage under the Plan and to the benefits provided by such coverage, all as set forth herein and subject to the conditions, limitations, restrictions and reservations associated with such rights, are intended to be enforceable in an appropriate court of law, and the Employer agrees to be bound hereby.

Headings and Captions

The headings and captions in this document are provided for reference and convenience only and shall not be considered part of the Plan or employed in the construction of the provisions thereof.

Gender and Number

Except where otherwise clearly indicated by context to the contrary, any gender -specific word used herein shall include the opposite gender and the neuter, any word in the singular shall include the plural, and any word in the plural shall include the singular.

Controlling Law

The Plan shall be construed and enforced according to federal law.

Title to Assets

No Covered Person or assignee of any of the foregoing shall have any right to, or interest in, any insurance policies or assets of the Plan, except as provided from time to time under the Plan, and then only to the extent of the benefits payable under the Plan to or on account of such person.

Payments To or For the Benefit of Legally Incapacitated Persons

Any benefit payable to or for the benefit of a minor, an incompetent person, or other person incapable of receipting therefor shall be deemed paid when paid to such person's personal representative or to Providers of services covered by the Plan to such person. Each such payment shall fully discharge the paying insurer or health care service provider organization, the Plan Administrator, the Employer, and all other parties with respect thereto.

Reliance on Data and Consents

The Company, Sponsor, the insurers, each health care service provider organization, the Plan Administrator, all fiduciaries and funding agents with respect to the Plan, and all other persons or entities associated with the operation of the Plan, the management of its assets, and the provision of benefits thereunder, may reasonably rely on the truth, accuracy and completeness of all statements, representations and data provided by any Covered Person including, without limitation, data with respect to age, marital status, dependent status and health. Furthermore, the Employer, Sponsor, Plan Administrator, insurers, health care service provider organizations, and fiduciaries may reasonably rely on all consents, elections and designations filed with the Plan Administrator or those associated with the operation of the Plan and its corresponding Contracts by any Covered Person or the representatives of any such person without duty to inquire into the genuineness of any such consent, election or designation, the authority under which it is given, or the legal capacity of the party granting such consent or making such election or designation. No person or entity associated with the operation of the Plan shall (nor shall any insurer or health care service provider organization) have any duty to inquire into any such data as may be presented by Covered Persons (or their respective representatives), and all may rely on such data being current to the date of reference. It shall be and shall remain the duty of Covered Persons and their respective representatives to advise the Company, the Plan Administrator, insurers, and health care service provider organizations providing coverage to them, of any change in data relevant to their respective rights and entitlement. To the extent that any incorrect, inaccurate, incomplete, misleading or false statement, representation or data provided by any Covered Person results, directly or indirectly, in the payment of benefits under the Plan in excess of any benefit to which a Claimant would have been entitled had such statement, representation or data been correct, accurate, complete, true and not misleading, the Plan and the Company shall have the right to recover the amount of such excess (along with interest thereon and the reasonable expenses associated with such recovery); such recovery to be made directly, by setoff against other current or future claims, by any other mechanism permitted by law, or by any combination of the foregoing, as determined in the discretion of the Company.

Lost Payees

A benefit shall be deemed forfeited if neither the Plan Administrator nor the insurer or other organization prepared to disburse payment is able to locate the proper payee thereof; provided, however, that such benefit shall be reinstated if a claim is made therefor by a proper payee on a timely basis.

Counterparts

The Plan instruments and any amendments thereto may be executed in several counterparts, each of which shall be deemed an original and all of which shall constitute a single instrument, which may be sufficiently evidenced for all purposes by the production of any one such counterparts.

Protection Against Creditors

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

Binding Arbitration

NOTE*: The Employee is enrolled in a plan provided by the Employer that is subject to ERISA. Any dispute involving an Adverse Benefit Determination must be resolved under ERISA's claims procedure rules and is not subject to mandatory binding arbitration. The individual may pursue voluntary binding arbitration after he or she has completed an Appeal under ERISA.*

Any dispute or claim, of whatever nature, arising out of, in connection with, or in relation to this Plan, or breach or rescission thereof, or in relation to care or delivery of care, including any claim based on contract, tort or statute, must be resolved by arbitration if the amount sought exceeds the jurisdictional limit of the small claims court. Any dispute regarding a claim for damages within the jurisdictional limits of the small claims court will be resolved in such court.

The Federal Arbitration Act shall govern the interpretation and enforcement of all proceedings under this Binding Arbitration provision. To the extent that the Federal Arbitration Act is inapplicable or is held not to require arbitration of a particular claim, State law governing agreements to arbitrate shall apply.

The Covered Person and the Plan Administrator agree to be bound by this Binding Arbitration provision and acknowledge that they are each giving up their right to a trial by court or jury.

The Covered Person and the Plan Administrator agree to give up the right to participate in class arbitration against each other. Even if applicable law permits class actions or class arbitrations, the Covered Person waives any right to pursue, on a class basis, any such controversy or claim against the Plan Administrator and the Plan Administrator waives any right to pursue on a class basis any such controversy or claim against the Covered Person.

The arbitration findings will be final and binding except to the extent that State or Federal law provides for the judicial review of arbitration proceedings.

The arbitration is begun by the Covered Person making written demand on the Plan Administrator. The arbitration will be conducted by Judicial Arbitration and Mediation Services ("JAMS") according to its applicable Rules and Procedures. If, for any reason, JAMS is unavailable to conduct the arbitration, the arbitration will be conducted by another neutral arbitration entity, by mutual agreement of the Covered Person and the Plan Administrator, or by order of the court, if the Covered Person and the Plan Administrator cannot agree.

The costs of the arbitration will be allocated per the JAMS Policy on Consumer Arbitrations. If the arbitration is not conducted by JAMS, the costs will be shared equally by the parties, except in cases of extreme financial hardship, upon application to the neutral arbitration entity to which the parties have agreed, in which cases, the Plan Administrator will assume all or a portion of the costs of the arbitration.

HIPAA PRIVACY

Disclosure of Summary Health Information to the Plan Sponsor

In accordance with the Privacy Standards, the Plan may disclose Summary Health Information to the Plan Sponsor, if the Plan Sponsor requests the Summary Health Information for the purpose of:

1. Obtaining premium bids from health plans for providing health insurance coverage under this Plan; or

2. Modifying, amending or terminating the Plan.

The Plan is prohibited from using or disclosing Genetic Information for underwriting purposes, such as determining eligibility or determination of benefits, computation of premium or contribution amounts, application of pre-existing exclusions and other activities related to the creation, replacement, or renewal of a contract of health insurance or health benefits.

"Summary Health Information" may be individually identifiable health information and it summarizes the claims history, claims expenses or the type of claims experienced by individuals in the plan, but it excludes all identifiers that must be removed for the information to be deidentified, except that it may contain geographic information to the extent that it is aggregated by five-digit zip code.

Disclosure of Protected Health Information ("PHI") to the Plan Sponsor for Plan Administration Purposes

In order that the Plan Sponsor may receive and use PHI for Plan Administration purposes, the Plan Sponsor agrees to:

1. Not use or further disclose PHI other than as permitted or required by the Plan Documents or as required by law (as defined in the Privacy Standards).

2. Ensure that any agents, including a subcontractor, to whom the Plan Sponsor provides PHI received from the Plan agree to the same restrictions and conditions that apply to the Plan Sponsor with respect to such PHI.

3. Not use or disclose PHI for employment related actions and decisions or in connection with any other benefit or employee benefit plan of the Plan Sponsor, except pursuant to an authorization which meets the requirements of the Privacy Standards.

4. Notify Covered Persons of any PHI use or disclosure that is inconsistent with the uses or disclosures provided for of which the Plan Sponsor, or any Business Associate of the Plan Sponsor becomes aware, in accordance with the Health Breach Notification Rule (16 CFR Part 318).

5. Notify the Federal Trade Commission of any PHI use or disclosure that is inconsistent with the uses or disclosures provided for of which the Plan Sponsor, or any Business Associate of the Plan Sponsor becomes aware, in accordance with the Health Breach Notification Rule (16 CFR Part 318).

6. Report to the Plan any PHI use or disclosure that is inconsistent with the uses or disclosures provided for of which the Plan Sponsor becomes aware.

7. Make available PHI in accordance with Section 164.524 of the Privacy Standards (45 CFR 164.524).

8. Make available PHI for amendment and incorporate any amendments to PHI in accordance with Section 164.526 of the Privacy Standards (45 CFR 164.526).

9. Make available the information required to provide an accounting of disclosures in accordance with Section 164.528 of the Privacy Standards (45 CFR 164.528).

10. Make its internal practices, books and records relating to the use and disclosure of PHI received from the Plan available to the Secretary of the U.S. Department of Health and Human Services ("HHS"), or any other officer or employee of HHS to whom the authority involved has been delegated, for purposes of determining compliance by the Plan with Part 164, Subpart E, of the Privacy Standards (45 CFR 164.500 et seq);

11. Obtain authorization prior to the sale of any PHI.

12. If feasible, return or destroy all PHI received from the Plan that the Plan Sponsor still maintains in any form and retain no copies of such PHI when no longer needed for the purpose for which disclosure was made, except that, if such return or destruction is not feasible, limit further uses and disclosures to those purposes that make the return or destruction of the PHI infeasible; and

13. Ensure that adequate separation between the Plan and the Plan Sponsor, as required in Section 164.504(f)(2)(iii) of the Privacy Standards (45 CFR 164.504(f)(2)(iii)), is established as follows:

    a. The following employees, or classes of employees, or other persons under control of the Plan Sponsor, shall be given access to the PHI to be disclosed:

        - Vice President of Human Resources
        - Benefits Manager

    b. The access to and use of PHI by the individuals described in subsection (a) above shall be restricted to the Plan Administration functions that the Plan Sponsor performs for the Plan.

    c. In the event any of the individuals described in subsection (a) above do not comply with the provisions of the Plan Documents relating to use and disclosure of PHI, the Plan Administrator shall impose reasonable sanctions as necessary, in its discretion, to ensure that no further non-compliance occurs. Such sanctions shall be imposed progressively (for example, an oral warning, a written warning, time off without pay and termination), if appropriate, and shall be imposed so that they are commensurate with the severity of the violation.

"Plan Administration" activities are limited to activities that would meet the definition of payment or health care operations, but do not include functions to modify, amend or terminate the Plan or solicit bids from prospective issuers. "Plan Administration" functions include quality assurance, claims processing, auditing, monitoring and management of carve-out plans, such as vision and dental. It does not include any employment related- functions or functions in connection with any other benefit or benefit plans.

The Plan shall disclose PHI to the Plan Sponsor only upon receipt of a certification by the Plan Sponsor that:

1. The Plan Documents have been amended to incorporate the above provisions; and

2. The Plan Sponsor agrees to comply with such provisions.

Disclosure of Certain Enrollment Information to the Plan Sponsor

Pursuant to Section 164.504(f)(1)(iii) of the Privacy Standards (45 CFR 164.504(f)(1)(iii)), the Plan may disclose to the Plan Sponsor information on whether an individual is participating in the Plan or is enrolled in or has disenrolled from a health insurance issuer or health maintenance organization offered by the Plan to the Plan Sponsor.

Disclosure of PHI to Obtain Stop-loss or Excess Loss Coverage

The Plan Sponsor hereby authorizes and directs the Plan, through the Plan Administrator or the Third-Party Administrator, to disclose PHI to stoploss carriers, excess loss carriers or managing general underwriters (MGUs) for underwriting and other purposes in order to obtain and maintain stoploss or excess loss coverage related to benefit claims under the Plan. Such disclosures shall be made in accordance with the Privacy Standards.

Other Disclosures and Uses of PHI

With respect to all other uses and disclosures of PHI, the Plan shall comply with the Privacy Standards.

HIPAA SECURITY

Disclosure of Electronic Protected Health Information ("Electronic PHI") to the Plan Sponsor for Plan Administration Functions

To enable the Plan Sponsor to receive and use Electronic PHI for Plan Administration functions (as defined in 45 CFR § 164.504(a)), the Plan Sponsor agrees to:

1. Implement administrative, physical, and technical safeguards that reasonably and appropriately protect the confidentiality, integrity, and availability of the Electronic PHI that it creates, receives, maintains, or transmits on behalf of the Plan.
2. Ensure that adequate separation between the Plan and the Plan Sponsor, as required in 45 CFR § 164.504(f)(2)(iii), is supported by reasonable and appropriate security measures.
3. Ensure that any agent, including a subcontractor, to whom the Plan Sponsor provides Electronic PHI created, received, maintained, or transmitted on behalf of the Plan, agrees to implement reasonable and appropriate security measures to protect the Electronic PHI.
4. Report to the Plan any security incident of which it becomes aware.
5. Notify Covered Persons of any PHI Security Incident of which the Plan Sponsor, or any Business Associate of the Plan Sponsor becomes aware, in accordance with the Health Breach Notification Rule (16 CFR Part 318); and
6. Notify the Federal Trade Commission of any PHI Security Incident of which the Plan Sponsor, or any Business Associate of the Plan Sponsor becomes aware, in accordance with the Health Breach Notification Rule (16 CFR Part 318).

Any terms not otherwise defined in this section shall have the meanings set forth in the Security Standards.

COVERED PERSON'S RIGHTS

As a Covered Person in the Plan, the Covered Person is entitled to certain rights and protections under ERISA. ERISA provides that all Covered Persons are entitled to:

Receive Information About the Plan and Benefits

Examine, without charge, at the Plan Administrator's office and at other specified locations, such as worksites and union halls (if any), all documents governing the Plan, including insurance contracts, collective bargaining agreements (if any), and copies of the latest annual report (Form 5500 Series) filed by the Plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Employee Benefits Security Administration.

Obtain, upon written request to the Plan Administrator, copies of documents governing the operation of the Plan, including insurance contracts and collective bargaining agreements (if any), and copies of the latest annual report (Form 5500 Series) and updated Summary Plan Description. The Administrator may make a reasonable charge for the copies. Receive a summary of the Plan's annual financial report. The Plan Administrator is required by law to furnish each Covered Person with a copy of this summary annual report.

Continue Group Health Plan Coverage

Continue health care coverage for the Employee and eligible Dependents if there is a loss of coverage under the Plan as a result of a Qualifying Event. The Employee or eligible Dependents may have to pay for such coverage. Review this Plan Document and the documents governing the Plan on the rules governing the Covered Person's COBRA Continuation Coverage rights.

Prudent Actions by Plan Fiduciaries

In addition to creating rights for Covered Persons, ERISA imposes duties 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 the Covered Persons and beneficiaries. No one, including the Employer, the union (if any), or any other person, may fire the Employee or otherwise discriminate against the Employee in any way to prevent the Employee from obtaining a welfare benefit or exercising the Covered Person's rights under ERISA.

Enforce the Covered Person's Rights

If a Covered Person's claim for a welfare benefit is denied or ignored, in whole or in part, the Covered Person has a right to know why this was done, to obtain copies of documents relating to the decision without charge, and to Appeal any denial, all within certain time schedules. Under ERISA, there are steps the Covered Person can take to enforce the above rights. For instance, if the Covered Person requests a copy of Plan documents or the latest annual report from the Plan and do not receive them within 30 days, the Covered Person may file suit in a Federal court. In such a case, the court may require the Plan Administrator to provide the materials and pay the Covered Person up to $110 a day until the Covered Person receives the materials, unless the materials were not sent because of reasons beyond the control of the Plan Administrator. If the Covered Person has a claim for benefits which is denied or ignored, in whole or in part, the Covered Person may file suit in a State or Federal court. In addition, if the Covered Person disagrees with the Plan's decision or lack thereof concerning the qualified status of a domestic relations order or a Medical Child Support Order, the Covered Person may file suit in Federal court. If it should happen that Plan fiduciaries misuse the Plan's money, or if the Covered Person is discriminated against for asserting his or her rights, the Covered Person may seek assistance from the U.S. Department of Labor, or the Covered Person may file suit in a Federal court. The court will decide who will pay court costs and legal fees. If the Covered Person is successful, the court may order the person the Covered Person sued to pay

these costs and fees. If the Covered Person loses, the court may order the Covered Person to pay these costs and fees, for example, if it finds the Covered Person's claim is frivolous.

Assistance with the Covered Person's Questions

If the Covered Person has any questions about the Plan, the Covered Person should contact the Plan Administrator. If the Covered Person has any questions about this statement or about rights under ERISA, or needs assistance in obtaining documents from the Plan Administrator, the Covered Person should contact the nearest Office of the Employee Benefits Security Administration, U.S. Department of Labor, listed in the 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. The Covered Person may also obtain certain publications about his or her rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefits Security Administration.

(Sales Comm Version; revisions highlighted, no Schedule_kab3.7.22)

PLAN EXCLUSIONS AND LIMITATIONS

For all Medical Benefits shown in the Schedule of Covered Expenses, a Charge for the following is not covered:

1. **Alcohol.** Services, supplies, care or treatment that arise from a Covered Person taking part in any activity made illegal due to the use of alcohol. Expenses will be covered for Injured Covered Persons other than the person partaking in an activity made illegal due to the use of alcohol, and expenses may be covered for Substance Abuse treatment as specified in this Plan, if applicable. This exclusion does not apply if the Injury:

   (1) Resulted from being the victim of an act of domestic violence; or
   (2) Resulted from a documented medical condition (including both physical and mental health conditions).

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

3. **Alternative Therapies.** For Alternative Therapies and/or Complementary Medicine, including but not limited to, acupuncture, music therapy, dance therapy, equestrian/hippotherapy, homeopathy, primal therapy, rolfing, psychodrama, vitamin or other dietary supplements and therapy, aromatherapy, massage therapy, therapeutic touch, recreational, wilderness, educational and sleep therapies.

4. **Ambulance.** For Ambulance Services, except as specifically provided in the Plan. Chartered air flights and other travel or communication expenses of patients, practitioners, nurses or family members are not covered.

5. **Biofeedback.**

6. **Breast Reduction.** Charges Incurred for breast reductions, for breast implants or charges for removal of breast implants, unless necessitated by a mastectomy, reconstructive Surgery related to a mastectomy, or other Medically Necessary reason.

7. **Cognitive Rehabilitation Therapy.** For Cognitive Rehabilitative Therapy, except when provided integral to other supportive therapies, such as, but not limited to physical, occupational and speech therapies in a multidisciplinary, goal oriented and integrated treatment program designed to improve management and independence following neurological damage to the central nervous system caused by Illness or trauma (e.g., stroke, acute brain insult, encephalopathy).

8. **Complications of Non--Covered Treatments.** Care, services or treatment required as a result of complications from a treatment not covered under the Plan are not covered.

9. **Contraceptives.** Oral contraceptives, as they are covered under the Plan's Prescription Drug Benefit.

10. **Cosmetic Services.** For services and operations for cosmetic purposes which are done to improve the appearance of any portion of the body, and from which no improvement in physiologic function can be expected. However, benefits are payable to correct a condition resulting from an accident. Benefits are also payable to correct functional impairment which results from a covered disease, Injury or congenital birth defect. This exclusion does not apply to mastectomy related- charges.

    The Plan does not cover treatment which it determines is for cosmetic purposes because it is not necessitated as part of the Medically Necessary treatment of an Illness, Injury or congenital birth defect. However, the Plan acknowledges that situations exist when a Covered Person and his or her Physician decide to pursue a course of treatment for

cosmetic purposes. In such cases, the Covered Person is responsible for the cost of the treatment. A Covered Person or his or her Physician should contact the Plan Administrator to determine whether treatment is for cosmetic purposes.

11. **Custodial Care.** Services or supplies provided mainly for Custodial Care, domiciliary care or rest cures.

12. **Dental.** For dental services related to the care, filling, removal or replacement of teeth (including dental implants to replace teeth or to treat congenital anodontia, ectodermal dysplasia or dentinogenesis imperfecta), and the treatment of injuries to or diseases of the teeth, gums or structures directly supporting or attached to the teeth. Services not covered include, but are not limited to, apicoectomy (dental root resection), prophylaxis of any kind, root canal treatments, soft tissue impactions, alveolectomy, bone grafts or other procedures provided to augment an atrophic mandible or maxilla in preparation of the mouth for dentures or dental implants; and treatment of periodontal disease unless otherwise indicated. For dental implants for any reason. For dentures, unless for the initial treatment of an Accidental Injury/trauma.

13. **Developmental Delay.** Services or care related to the educational treatment of behavioral disorders together with services for remedial education, evaluation or treatment of learning disabilities, minimal brain dysfunction, developmental and learning disorders, behavioral training and cognitive rehabilitation. This exclusion applies to services, treatment, educational testing and training related to behavior (conduct) problems, learning disabilities, or developmental delays, unless otherwise covered as a preventive service.

14. **Diagnostic Imaging.** For diagnostic screening examinations, except for mammograms and preventive care as provided in the Plan.

15. **Durable Medical Equipment.** Examples of equipment that do not meet the definition of Durable Medical Equipment include, but are not limited to:

    a. **Comfort and convenience items,** such as massage devices, portable whirlpool pumps, telephone alert systems, bed-wetting alarms, and ramps.
    b. **Equipment used for environmental control,** such as air cleaners, air conditioners, dehumidifiers, portable room heaters, and heating and cooling plants.
    c. **Equipment inappropriate for home use.** This is an item that generally requires professional supervision for proper operation, such as diathermy machines, medcolator, pulse tachometer, data transmission devices used for telemedicine purposes, trans lift chairs and traction units.
    d. **Non-reusable supplies** other than a supply that is an integral part of the Durable Medical Equipment item required for the Durable Medical Equipment function. This means the equipment is not durable or is not a component of the Durable Medical Equipment. Items not covered include, but are not limited to, incontinence pads, lamb's wool pads, ace bandages, catheters (non-urinary), face masks (surgical), disposable gloves, disposable sheets and bags, and irrigating kits.
    e. **Equipment that is not primarily medical in nature.** Equipment which is primarily and customarily used for a nonmedical purpose may or may not be considered “medical” in nature. This is true even though the item may have some medically related use. Such items include, but are not limited to, ear plugs, Equipment for Safety, exercise equipment, ice pack, speech teaching machines, strollers, feeding chairs, silverware/utensils, toileting systems, -electronically controlled heating and cooling units for pain relief, toilet seats, bathtub lifts, stair glides, and elevators.
    f. **Equipment with features of a medical nature** which are not required by the Covered Person’s condition, such as a gait trainer. The therapeutic benefits of the item cannot be clearly disproportionate to its cost, if there exists a Medical Necessary and realistically feasible alternative item that serves essentially the same purpose.
    g. **Duplicate equipment** for use when traveling or for an additional residence, whether or not prescribed by a Provider.
    h. **Services not primarily billed by a Provider** such as delivery, set-up and service activities and installation and labor of rented or purchased equipment.
    i. M**odifications to vehicles, dwellings and other structures.** This includes any modifications made to a vehicle, dwelling or other structure to accommodate a Covered Person’s disability or any modifications made to a vehicle, dwelling or other structure to accommodate a Durable Medical Equipment item, such as a wheelchair.

j. **Equipment related to services performed on high-cost technological equipment** as defined by the Plan Administrator, such as, but not limited to, computer tomography (CT) scanners, magnetic resonance imagers (MRI) and linear accelerators, unless the acquisition of such equipment by a Provider was approved by the Plan Administrator.

16. **Educational or Vocational Testing.** Services for educational or vocational testing or training.

17. **Error**. Care, supplies, treatment, and/or services that are required to treat injuries that are sustained or an Illness that is contracted, including infections and complications, while the Covered Person was under, and due to, the care of a Provider wherein such Illness, Injury, infection or complication is not reasonably expected to occur. This exclusion will apply to expenses directly or indirectly resulting from the circumstances of the course of treatment that, in the opinion of the Plan Administrator, in its sole discretion, unreasonably gave rise to the expense.

18. **Excess Charges.** Care, supplies, treatment, and/or services that exceed Plan limits, set forth herein and including (but not limited to) the Maximum Allowable Charge in the Plan Administrator's discretion and as determined by the Plan Administrator, in accordance with the Plan terms as set forth by and within this document.

19. **Exercise Programs.** Exercise programs for treatment of any condition, except for Physician supervised-Cardiac Rehabilitation, Occupational or Physical Therapy covered by this Plan.

20. **Experimental.** The Plan does not cover treatment it determines to be Experimental in nature because that treatment is not accepted by the general medical community for the condition being treated or not approved as required by Federal or governmental agencies. However, the Plan acknowledges that situations exist when a Covered Person and his or her Physician agree to utilize Experimental treatment. If a Covered Person receives Experimental treatment, the Covered Person shall be responsible for the cost
of the treatment. A Covered Person or his or her Physician should contact the Plan Administrator to determine whether a treatment is considered Experimental.

21. **Eye Care.** For eyeglasses, lenses or contact lenses and the vision examination for prescribing or fitting eyeglasses or contact lenses unless otherwise indicated. For correction of myopia or hyperopia by means of corneal microsurgery, such as keratomileusis, keratophakic, and radial keratotomy and all related services.

22. **Failure to keep a scheduled visit or to complete a claim form**. Charges for failure to keep a scheduled visit or charges for completion of a claim form.

23. **Fertilization.** Procedures involving in-vitro fertilization (IVF), gamete intrafallopian transfer (GIFT) and zygote intra-fallopian transfer (ZIFT) are covered under the Plan but are subject to the following limitations:

    (1) These procedures are covered only if a successful Pregnancy cannot be attained through all reasonable, less expensive and medically appropriate treatments available under this plan.
    (2) No more than four cycles of all types of IVF services are covered. All health and pharmacy benefits covered under Infertility and has no family lifetime maximum.

    The following Infertility services and supplies are not covered:

    a. Reversal of prior voluntary sterilization procedures.

    b. Services rendered to a surrogate for the purposes of childbearing, if the surrogate is not a Covered Person;

    c. Charges associated with cryopreservation, storage of cryopreserved sperm, eggs, or embryos;

    d. Infertility treatment that results from voluntary sterilization (even if the person has attempted to reverse sterilization) or gender reassignment Surgery (male to female or female to male);

e. Non-medical costs of an egg or sperm donor

f. Infertility treatments that are Experimental in nature;

g. Home ovulation predictor kits, sperm testing kits and supplies;

h. Any charges associated with obtaining sperm for non-Covered Person; and

i. Any service provided under the separate pharmacy benefit plan in lieu of such coverage under this Plan.

This exclusion does not apply to services required to treat or correct underlying causes of infertility.

24. **Foot Care.** For palliative or cosmetic foot care including treatment of bunions (except for capsular or bone Surgery), toenails (except Surgery for ingrown nails), the treatment of subluxations of the foot, are of corns, calluses, fallen arches, pes planus (flat feet), weak feet, chronic foot strain, and other routine podiatry care, unless associated with the Medically Necessary treatment of peripheral vascular disease and/or peripheral neuropathic disease, including but not limited to diabetes.

25. **Foreign Travel.** Care, treatment or supplies out of the U.S. if travel is for the sole purpose of obtaining medical services.

26. **Genetic Testing**, except as otherwise permitted under the Plan.

27. **Government Coverage.** Care, treatment or supplies furnished by a program or agency funded by any government or paid by an association or foundation. This does not apply to Medicaid or when otherwise prohibited by law.

28. **Hair Loss.** Care and treatment for hair loss including hair transplants or any drug that promises hair growth, whether or not prescribed by a Physician.

29. **Hearing Aids.** For Hearing Aids, including cochlear electromagnetic hearing devices, and hearing examinations or tests for the prescription or fitting of Hearing Aids. Services and supplies related to these items are not covered.

30. **Hospital Employees.** Professional services billed by a Physician or nurse who is an employee of a Hospital or Skilled Nursing Facility and paid by the Hospital or facility for the service.

31. **Illegal Acts.** For any Injury or Illness which is Incurred while taking part or attempting to take part in an illegal activity, including but not limited to misdemeanors and felonies. It is not necessary that an arrest occur, criminal charges be filed, or, if filed, that a conviction result. Proof beyond a reasonable doubt is not required in order for the act 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 physical and mental health conditions).

32. **Immunizations.** For immunizations required for employment purposes, or for travel.

33. **Impotence.** For treatment of sexual dysfunction not related to organic disease except for sexual dysfunction resulting from an Injury.

34. **Incurred by Other Persons.** Care, supplies, treatment, and/or services that are expenses actually Incurred by other persons.

35. **Marital, Premarital and Other Counseling, Tests or Exams.** Premarital blood tests and care and treatment for

marital, premarital, family, family planning, financial, or relationship counseling or sex therapy.

36. **Medical Necessity.** The Plan only covers treatment which it determines Medically Necessary by the Plan Administrator. A Provider accepts the Plan Administrator's, in conjunction with the Claims Audit Decision Maker's, decision and contractually is not permitted to bill the Covered Person for treatment which the Plan determines is not Medically Necessary unless the Provider specifically advises the Covered Person in writing, and the Covered Person agrees in writing that such services are not covered by the Plan, and that the Covered Person will be financially responsible for such services.

37. **Medical Supplies.** For medical supplies such as but not limited to thermometers, ovulation kits, early pregnancy or home pregnancy testing kits.

38. **Military Service.** For any loss sustained or expenses Incurred during military service while on active duty as a member of the armed forces of any nation, or as a result of enemy action or act of war, whether declared or undeclared.

39. **Miscellaneous.** No benefits will be provided for services, supplies or charges:

    a. For which a Covered Person would have no legal obligation to pay, or another party has primary responsibility.

    b. Received from a dental or medical department maintained by or on behalf of a mutual benefit association, labor union, trust, or similar person or group.

    c. To the extent a Covered Person is legally entitled to receive when provided by the Veteran's Administration or by the Department of Defense in a government facility reasonably accessible by the Covered Person.

    d. Performed by a Provider enrolled in an education or training program when such services are related to the education or training program and are provided through a Hospital or university.

    e. For Injury as a result of chewing or biting (neither is considered an Accidental Injury).

    f. For counseling or consultation with a Covered Person's relatives, or Hospital charges for a Covered Person's relatives or guests, except as may be specifically provided or allowed in "Treatment for Substance Use Disorder" or "Transplant Services."

    g. For any care that extends beyond traditional medical management for Pervasive Development Disorders, Attention Deficit Disorder, learning disabilities, behavioral problems, intellectual disability or Autism Spectrum Disorders (ASD); or treatment or care to effect environmental or social change.

    h. For charges Incurred for expenses in excess of Benefit Maximums as specified in the Schedule of Covered Expenses.

    i. For any Therapy Service provided for the following: the ongoing Outpatient treatment of chronic medical conditions that are not subject to significant functional improvement; additional therapy beyond this Plan's limits, if any, shown in the Schedule of Covered Expenses; work hardening; evaluations not associated with therapy; or therapy for back pain in Pregnancy without specific medical conditions.

    j. For any other service or treatment except as provided under this Plan.

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

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

42. **No Coverage.** Care, supplies, treatment, and/or services that are Incurred at a time when no coverage is in force

for the applicable Covered Person and/or Dependent.

43. **No Obligation to Pay.** Charges Incurred for which the Plan has no legal obligation to pay.

44. **Non-Emergency Hospital Admissions.** Hospital admission from Saturday 12:01 a.m. through Sunday Midnight, unless Surgery is performed or due to an Emergency Medical Condition.

45. **Not Acceptable.** Charges for services that are not accepted as standard practice by the American Medical Association (AMA), American Dental Association (ADA), or the Food and Drug Administration (FDA).

46. **Not Specified as Covered.** Non-traditional medical services, treatments and supplies which are not specified as covered under this Plan.

47. **Nursing Facility.** For care in a nursing home, home for the aged, convalescent home, school, camp, institution for Intellectually Disabled Children, Custodial Care in a Skilled Nursing Facility.

48. **Obesity/Weight Loss.** Any treatment, drug, service or supply intended to decrease or increase body weight, control weight or treat obesity, including Morbid Obesity, regardless of the existence of co-morbid conditions; except as provided herein, including but not limited to:
    (1) Drugs, stimulants, preparations, food or diet supplements, dietary regimens and supplements, food or food supplements (will not apply to the dietary treatment of a disease or condition based on inherited metabolic disease), appetite suppressants and other medications;
    (2) Counseling, coaching, training, hypnosis or other forms of therapy except as provided in an annual consultation with a health care Provider to discuss lifestyle behaviors that promote health and well-being including nutrition and diet recommendations, exercise plans and weight control; and
    (3) Exercise programs, exercise equipment, membership to health or fitness clubs, recreational therapy or other forms of activity or activity enhancement.

    This exclusion does not apply to nutrition visits as part of Preventive Care Services.

49. **Oral Rehabilitation.** Orthognathic Surgery, dental treatment resulting from chewing injuries, subperiosteal and endosseous implants, or surgical treatment of temporomandibular joint syndrome (TMJ).

50. **Orthodontia.** For orthodontic treatment, except for appliances used for palatal expansion to treat congenital cleft palate.

51. **Orthotics.** For supportive devices for the foot (orthotics), such as, but not limited to, foot inserts, arch supports, heel pads and heel cups, and orthopedic/corrective shoes. This exclusion does not apply to orthotics and podiatric appliances required for the prevention of complications associated with diabetes, peripheral vascular- disease, or due to infection or other medical disease.

52. **Other than Attending Physician.** Care, supplies, treatment, and/or services that are other than those certified by a Physician who is attending the Covered Person as being required for the treatment of Injury or disease and performed by an appropriate Provider.

53. **Over The Counter-- Drugs.** For over-the-counter-- drugs and any other medications that may be dispensed without a Physician's prescription, except for medications administered during an Inpatient Admission, and except as required under the PPACA preventive service regulations.

54. **Personal Comfort Items.** Purchase or rental of items or devices not requiring a Physician's prescription, or primarily used for comfort or convenience, including but not limited to: air conditioner, air purification unit, humidifier, dehumidifier, whirlpool, electric heating unit, water bed, hypo-allergenic pillow or mattress, orthopedic mattress, blood pressure instruments, scales, elastic bandages or stockings, exercise equipment, ultraviolet lighting, toilet seat, shower chair, first aid- supplies, and non--Hospital adjustable beds.

55. **Plan Design Exclusions.** Charges limited or excluded by the Plan design as described in this document.

56. **Postage, Shipping, Handling Charges, Etc.** Any postage, shipping or handling charges which occur in the transmittal of information to the Claims Processor. Interest or financing charges are also not covered.

57. **Prescription Drugs.** For prescription drugs. This exclusion applies to insulin, insulin analogs and pharmacological agents for controlling blood sugar levels as provided for the treatment of diabetes that are covered by the Plan's Prescription Drug Benefit.

    For Self-Injectable- Drugs, regardless of whether the drugs are provided or administered by a Provider. Drugs are considered Self Injectable- Drugs even when initial medical supervision and/or instruction is required prior to patient self-administration-. This exclusion does not apply to Self-Injectable- Drugs that are:

    a) Mandated to be covered by law, such as insulin or any drugs required for the treatment of diabetes, unless these drugs are covered by the Plan's Prescription Drug Benefit; or
    b) Required for treatment of an emergency condition that requires a Self-Injectable- Drug.

58. **Private Duty Nursing.** Charges in connection with care, treatment or services of a private duty nurse as an Inpatient.

59. **Professional Services.** Which are not billed and performed by a Provider as defined under this coverage as a "Provider," "Facility" or "Ancillary Provider" except as otherwise indicated under "Ambulance Services," and "Therapy Services."

60. **Prohibited by Law.** Care, supplies, treatment, and/or services that are to the extent that payment under this Plan is prohibited by law.

61. **Provider Error –**
    Charges for services that are required as a result of unreasonable Provider error.

62. **Relative Giving Services.** Professional services performed by a person who ordinarily resides in the Covered Person's home or is related to the Covered Person as a spouse, parent, Child, brother or sister, whether the relationship is by blood or exists in law.

63. **Replacement Braces.** Replacement of braces of the leg, arm, back, neck, or artificial arms or legs, unless there is sufficient change in the Covered Person's physical condition to make the original device no longer functional.

64. **Reversal of Surgical Sterilization.** Care and treatment for reversal of surgical sterilizations.

65. **Routine Care** (only those services not covered as preventive services as shown in the Schedule of Covered Expenses)**.** Charges for routine or periodic examinations, screening examinations, evaluation procedures, preventive Medical Care, or treatment or services not directly related to the diagnosis or treatment of a specific Injury, Illness or Pregnancy related- condition which is known or reasonably suspected, unless such care is specifically covered as Preventive Services in the Plan.

66. **Routine Examinations.** For routine physical examinations for non--preventive purposes, such as pre-marital examinations, physicals for college, camp or travel, and examinations for insurance, licensing and employment.

67. **Scope of License.** Services and supplies that are not rendered within the scope of the Physician's license.

68. **Self-Inflicted.** Care, supplies, treatment, and/or services that are Incurred due to an intentionally self- inflicted Injury or Illness, not definitively:

a. Resulting from being the victim of an act of domestic violence; or
b. Resulting from a documented medical condition (including both physical and mental health conditions).

69. **Services Before or After Coverage.** Care, treatment or supplies for which a charge was Incurred before a person was covered under this Plan or after coverage ceased under this Plan.

70. **Sleep Disorders.** Care and treatment for sleep disorders unless deemed Medically Necessary.

71. **Smoking Cessation.** Care and treatment for smoking cessation programs, including smoking deterrent patches, unless Medically Necessary due to a severe active lung Illness such as emphysema or asthma or unless covered under an approved wellness program by Medical Management. This exclusion does not apply to any item or service that may be covered as a preventive service.
72. **Subrogation, Reimbursement, and/or Third-Party Responsibility.** Care, supplies, treatment, and/or services that are for an Illness, Injury or sickness not payable by virtue of the Plan's subrogation, reimbursement, and/or third-party responsibility provisions.

73. **Surrogate Expenses**. Any expense for medical services rendered to a surrogate mother or her unborn child, except as otherwise provided under the Preventive Care benefit.

74. **Transplants.** Care and treatment directly related to tissue or human organ transplants except as specifically covered under this Plan. For organ transplants and donor expenses, except as provided under this Plan and as further defined below:

    a. Donor benefits are considered only when the donor and the recipient are Covered Persons under this Plan.
    b. If any organ or tissue is sold rather than donated to the Covered Person recipient, no benefits will be payable for the purchase price of such organ or tissue.

75. **Unreasonable.** Care, supplies, treatment, and/or services that are not "Reasonable" and are required to treat Illness or Injuries arising from and due to a Provider's error, wherein such Illness, Injury, infection or complication is not reasonably expected to occur. This exclusion will apply to expenses directly or indirectly resulting from circumstances that, in the opinion of the Plan Administrator in its sole discretion, gave rise to the expense and are not generally foreseeable or expected amongst professionals practicing the same or similar type(s) of medicine as the treating Provider whose error caused the loss(es).

76. **War.** Charges Incurred for Injury or Illness caused by an act of declared or undeclared war; service in the military forces of any country, including non-military units supporting such forces.

77. **Workers' Compensation.** Charges Incurred for any occupational Illness or bodily Injury which occurs in the course of employment if benefits or compensation are available, in whole or in part, under the provisions of the Workers' Compensation Law or any similar Occupational Disease Law or Act. This exclusion applies whether or not the Covered Person claims the benefits or compensation.

Additional Limitations and Exclusions. Additional coverage limitations determined by plan or provider type are shown in the Schedule of Medical Benefits. Payment for the following is specifically excluded from this plan:

a. Blood products storage when not necessary or not in conjunction with a scheduled covered Surgery or blood products that are replaced by donation.
b. Programs, treatment and services relating to community re-entry, transitional living, residential, school based- or vocational programs.
c. Sclerotherapy for the treatment of varicose veins of the extremities.
d. Physical exams and related services, including but not limited to, x-ray- and lab expenses when

rendered for the Covered Person's job, employment, school, travel, immigration or to buy insurance.

e. Services and supplies (including, but not limited to splints and braces) prescribed or rendered solely to allow for participation in any sports-related activity.
f. Charges Incurred for failure to keep a scheduled appointment.
g. Charges for the release and review of medical records.
h. Duplicative charges.
i. Complications of a condition not covered by this Plan. Physician charges for interpretation of automated pathology tests.
j. Charges for tattoos (not including nipple tattoos after breast reconstruction) or body piercing, regardless of reason.
k. Charges for Specialty Drugs and injectables other than the first fill at the Facility providing treatment. All subsequent fills need to be pre-certified.

Note: The fact that a Physician may prescribe, order, recommend or approve a service or supply does not, by itself, make it Medically Necessary or make the charge an Allowable Charge.

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

The Plan Administrator retains discretionary authority to interpret the Plan and the facts presented to make benefit determinations. Benefits under this Plan will be provided only if the Plan Administrator, as applicable, determines in its discretion that the Covered Person is entitled to them.