BROWN INVESTMENTS PROPERTIES, INC.

EMPLOYEE BENEFIT PLAN

PLAN DOCUMENT

AND

SUMMARY PLAN DESCRIPTION

Effective Date: October 1, 2024

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ADOPTION....ERROR! BOOKMARK NOT DEFINED.

SUMMARY PLAN DESCRIPTION

Name of Plan:

Brown Investment Properties, Inc. Employee Benefit Plan

Name, Address and Phone Number of Employer/Plan Sponsor:

Brown Investment Properties, Inc.
1007 Battleground Avenue
Suite 401
Greensboro, North Carolina 27408
1-336-541-5511

Employer Identification Number:

56-6029496

Plan Number:

501

Group Number:

BN0000

Type of Plan:

Welfare Benefit Plan: medical and prescription drug benefits

Type of Administration:

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

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

Brown Investment Properties, Inc.
1007 Battleground Avenue
Suite 401
Greensboro, North Carolina 27408
1-336-541-5511

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

Eligibility Requirements:

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

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

Source of Plan Contributions:

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

Funding Method:

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

Ending Date of Plan Year:

September 30

Standards Relating to Benefits for Mothers and Newborns:

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

Procedures for Filing Claims:

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

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

Luminare Health Benefits, Inc.
P. O. Box 2920
Clinton, IA 52733-2920
1-800-990-9058
www.myLuminareBenefits.com

Except as otherwise provided herein, the designated ***claims processor*** for claims and benefits under the *Prescription Drug Program* is:

SmithRx
P.O. Box 77864
San Francisco, CA 94107
l 844.454.5201

Consumer Assistance Information:

Covered persons may seek consumer assistance information by contacting 1-800-990-9058 or www.myLuminareBenefits.com.

Statement of ERISA Rights:

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

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

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

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

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

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

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

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

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

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

Participants should contact the ***plan administrator*** for questions about the ***Plan***. For questions about this statement or about rights under ERISA, participants should contact the nearest office of the Employee Benefits Security Administration, U.S. Department of Labor listed in their telephone directory or the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue, N.W., Washington, D.C. 20210.

COBRA Continuation Coverage General Notice

Introduction

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

The right to COBRA continuation coverage was created by a federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA). COBRA continuation coverage can become available to you and other members of your family when group health coverage would otherwise end. For more information about your rights and obligations under the ***Plan*** and under federal law, you should contact the ***plan administrator***.
You may have other options available to you when you lose group health coverage. For example, you may be eligible to buy an individual plan through the Health Insurance Marketplace. By enrolling in coverage through the Marketplace, you may qualify for lower costs on your monthly premiums and lower out-of-pocket costs. Additionally, you may qualify for a 30-day special enrollment period for another group health plan for which you are eligible (such as a spouse's plan), even if that plan generally doesn't accept late enrollees.

What is COBRA continuation coverage?

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

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

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

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

- Your spouse dies;
- Your spouse's hours of employment are reduced;
- Your spouse's employment ends for any reason other than his or her gross misconduct;
- Your spouse becomes entitled to ***Medicare*** benefits (under Part A, Part B, or both); or
- 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:

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

When is COBRA continuation coverage available?

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

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

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

How is COBRA continuation coverage provided?

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

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

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

Disability extension of 18-month period of COBRA continuation coverage

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

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

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

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

MEDICAL SCHEDULE OF BENEFITS

Benefit Period: October 1 – September 30

MEDICAL BENEFITS	PREFERRED PROVIDER	NONPREFERRED PROVIDER
Deductible per benefit period (medical and prescription drug deductibles)		
Individual	$2,000	$8,000
Family (embedded)	$4,000	$16,000
Deductible does not share between preferred and nonpreferred		
Generally, each ***covered person*** must pay all of the costs from providers up to the deductible amount before the ***Plan*** begins to pay. **Embedded family deductible**: Any number of covered family members may help to satisfy the family deductible, but no family member will incur more than the individual embedded deductible amount.		
Out-of-Pocket Expense Limit per benefit period (includes deductible, ***coinsurance***, ***copays,*** and prescription drug cost-share)		
Individual	$6,600	$12,500
Family (embedded)	$13,200	$25,000
Out-of-pocket expense limit does not share between preferred and nonpreferred		
The out-of-pocket expense limit is the most the ***covered person*** could pay in a year for ***covered expenses***. The ***Plan*** will pay the designated percentage of ***covered expenses*** until the out-of-pocket expense limits are reached; at which time the ***Plan*** will pay 100% of the remainder of ***covered expenses*** for the rest of the benefit period unless stated otherwise. **Embedded family out-of-pocket expense limit:** Any number of covered family members may help to satisfy the family out-of-pocket expense limit, but no family member will incur more than the individual embedded out-of-pocket expense limit. The following charges do not apply to the out-of-pocket expense limit and are never paid at 100%: • expenses not covered by the ***Plan*** • expenses in excess of amounts covered by the ***Plan*** • expenses incurred as a result of failure to obtain pre-certification		
Standard *coinsurance* paid by the *Plan*	60%	50%

MEDICAL BENEFITS	PREFERRED PROVIDER	NONPREFERRED PROVIDER
Acupuncture	Not Covered	Not Covered
Allergy Services		
Allergy injections and serum	60%	50%
Allergy testing		
Primary Care Physician	100% after $25 ***copay***	50% after deductible
Specialist	100% after $25 ***copay***	50% after deductible
Ambulance		
Land	60% after deductible	***preferred provider*** benefit applies
Air	60% after deductible	***preferred provider*** benefit applies
Applied Behavior Analysis Therapy (ABA)	60% after deductible	50% after deductible
Bereavement Counseling	60% after deductible	50% after deductible
Birthing Center	60% after deductible	50% after deductible
Blood *(Blood storage and transfusions)*	60% after deductible	50% after deductible
Cardiac Rehabilitation	60% after deductible	50% after deductible
	Maximum: 60 visits combined for cardiac rehabilitation, physical, speech and occupational therapy per plan year	
Chemotherapy	60% after deductible	50% after deductible
Chiropractic Care Office visits, spinal manipulation, adjustments and x-rays	100% after $50 ***copay***	50% after deductible
	Maximum: 30 visits per plan year	
Contraceptives	See Women's Preventive Services	
Diagnostic Services – Major *(such as MRI, CT Scan, PET Scan)*	60% after deductible	50% after deductible
Diagnostic Services – Minor		
Laboratory services (includes independent labs)	60% after deductible	50% after deductible
X-ray services (includes freestanding facilities)	60% after deductible	50% after deductible
Dialysis Therapy or Treatment	60% after deductible	50% after deductible
Durable Medical Equipment	60% after deductible	50% after deductible

MEDICAL BENEFITS	PREFERRED PROVIDER	NONPREFERRED PROVIDER
Emergency Room Services		
***Emergency Medical Condition* Care**		
Facility	100% after $250 ***copay***	***preferred provider*** benefit applies
Physician	100% after $250 ***copay***	***preferred provider*** benefit applies
Non-***Emergency Medical Condition* Care**		
Facility	100% after $250 ***copay***	50% after deductible
Physician	100% after $250 ***copay***	50% after deductible
Extended Care Facility	60% after deductible	50% after deductible
	Maximum: 100 days per plan year	
Hearing Aids		
Prescription hearing aids and related services	60% after deductible	50% after deductible
Home Health Care		
Home health care visits	60% after deductible	Not covered
Home health care supplies & services	60% after deductible	Not covered
IV therapy	60% after deductible	Not covered
Hospice Care		
Inpatient	60% after deductible	50% after deductible
Outpatient	60% after deductible	50% after deductible
Hospital – Inpatient		
Facility	60% after deductible	50% after deductible
Physician/Surgeon	60% after deductible	50% after deductible
Hospital – Outpatient & Ambulatory Surgical Facility		
Facility	60% after deductible	50% after deductible
Physician/Surgeon	60% after deductible	50% after deductible
Infertility Services		
Diagnostic testing to determine infertility	60% after deductible	50% after deductible
Medications and treatments	Not covered	Not covered
Infusion Therapy	60% after deductible	50% after deductible
Occupational Therapy	60% after deductible	50% after deductible
	Maximum: 60 visits combined for cardiac rehabilitation, physical, speech and occupational therapy per plan year	

MEDICAL BENEFITS	PREFERRED PROVIDER	NONPREFERRED PROVIDER
Office Visit & Other Services		
Office visit		
Primary care physician (includes outpatient visits for ***mental health disorders/ substance use disorder***)	100% after $25 ***copay***	50% after deductible
Specialist	100% after $50 ***copay***	50% after deductible
Surgery	60% after deductible	50% after deductible
Lab	60% after deductible	50% after deductible
X-ray	60% after deductible	50% after deductible
Other services	60% after deductible	50% after deductible
Orthotics	60% after deductible	50% after deductible
Physical Therapy	60% after deductible	50% after deductible
	Maximum: 60 visits combined for cardiac rehabilitation, physical, speech and occupational therapy per plan year	
Podiatry Services	60% after deductible	50% after deductible
Pregnancy		
Initial pre-natal visit and urinalysis	100% deductible waived	50% after deductible
Subsequent pre-natal visits/care and breastfeeding services and supplies (as required by the ***Affordable Care Act***)	60% after deductible	50% after deductible
Post-natal care and other non-routine/non-preventive pregnancy related care.	60% after deductible	50% after deductible
Delivery	60% after deductible	50% after deductible
Private Duty Nursing		
Inpatient	Not Covered	Not Covered
Outpatient	Not Covered	Not Covered
Prostheses	60% after deductible	50% after deductible
Radiation Therapy	60% after deductible	50% after deductible
Respiratory Therapy	60% after deductible	50% after deductible
Retail Clinic Visits	100% after $25 ***copay***	50% after deductible

MEDICAL BENEFITS	PREFERRED PROVIDER	NONPREFERRED PROVIDER
Routine Preventive Care/Wellness Benefits Includes all evidence-based supplies or services that have in effect a rating of A or B in the current recommendations of the United States Preventive Services Task Force (USPSTF). For additional information visit: http://www.uspreventiveservicestaskforce.org	100% deductible waived	50% after deductible
Routine Prostate Examinations	100% deductible waived	50% after deductible
Second Surgical Opinion	100% after $50 ***copay***	50% after deductible
Speech Therapy	60% after deductible	50% after deductible
	Maximum: 60 visits combined for cardiac rehabilitation, physical, speech and occupational therapy per plan year	
Temporomandibular Joint Syndrome (TMJ) Treatment Orthodontia services not covered	Based on service provided	Based on service provided
Transplants (Organ or Tissue)		
Facility	60% after deductible	50% after deductible
Physician	60% after deductible	50% after deductible
Transportation and Lodging	Not covered	Not covered
Urgent Care Center		
Visit	100% after $25 ***copay***	50% after deductible
All other services	60% after deductible	50% after deductible
Vision – Routine Services *(Routine vision services required by the **Affordable Care Act** shall be covered under the Routine Preventive Care benefit)*	Not Covered	Not Covered
Weight Loss Services		
Office visit and basic diagnostic testing, including laboratory services and electrocardiograms (EKGs), but does not include advanced imaging services	Based on service provided	Based on service provided
Surgical treatment	Not Covered	Not Covered
Non-surgical treatment and programs	Not Covered	Not Covered
Wigs	Not Covered	Not Covered
Women's Preventive Services As required by the ***Affordable Care Act***	100% deductible waived	50% after deductible
All Other C*overed Expenses*	60% after deductible	50% after deductible

PRESCRIPTION DRUG PROGRAM SCHEDULE OF BENEFITS

Benefit Period: October 1 – September 30

PRESCRIPTION DRUG PROGRAM BENEFITS	PARTICIPATING PHARMACY	NONPARTICIPATING PHARMACY
Participating Pharmacy Out-of-Pocket Expense Limit (per benefit period) is combined with the Medical Preferred Provider Out-of-Pocket Expense Limit.		
The ***Plan*** will pay the designated percentage of ***covered expenses*** and will apply the applicable ***copay*** after deductible until the out-of-pocket expense limits are reached, at which time the ***Plan*** will pay 100% of the remainder of ***covered expenses*** for the rest of the benefit period unless stated otherwise.		
Retail Pharmacy (31-day supply)		
Routine preventive drugs required by the ***Affordable Care Act***	100% deductible waived	Not applicable
Generic	$10 ***copay***	Not Covered
Formulary Brand Name	$35 ***copay***	Not Covered
Non-Formulary Brand Name	$60 ***copay***	Not Covered
Specialty Drugs	$100 ***copay***	Not Covered
Mail Order Pharmacy (90-day supply)		
Routine preventive drugs required by the ***Affordable Care Act***	100% deductible waived	Not Covered
Generic	$25 ***copay***	Not Covered
Formulary Brand Name	$87.50 ***copay***	Not Covered
Non-Formulary Brand Name	$150 ***copay***	Not Covered
Specialty Drugs	$250 ***copay***	Not Covered
If the ***covered person*** selects a brand drug when a generic equivalent is available, the ***covered person*** is responsible for the brand ***copay*** plus the cost difference between the generic and brand equivalent.		

PREFERRED PROVIDER
OR NONPREFERRED PROVIDER

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

PREFERRED PROVIDER

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

NONPREFERRED PROVIDERS

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

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

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

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

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

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

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

    The ***covered person's cost sharing*** will be calculated based on the ***recognized amount*** and ***nonpreferred providers*** may not balance bill for amounts in excess of the ***covered person's cost sharing***. If the ***out-of-network rate*** exceeds the ***recognized amount***, the difference will not be subject to the deductible.
    The following types of services provided in a ***preferred provider facility*** by a ***nonpreferred provider*** will be covered as explained in this section, regardless of whether the ***nonpreferred provider*** satisfies the Notice and Consent Criteria described in section 6. below:

    d. Ancillary services, including:

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

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

iii. Diagnostic services including radiology and laboratory services; and

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

4. Open Negotiation Period

a. A ***nonpreferred provider*** may initiate an open negotiation period with the ***Plan*** regarding ***covered expenses*** as described above. This open negotiation period must be initiated during the thirty (30) business day period beginning on the day the ***nonpreferred provider*** receives an initial payment or a notice of denial of payment for ***covered expenses*** as described above. To initiate the open negotiation period, the ***nonpreferred provider*** must send notice, consistent with applicable regulations, to the ***Plan*** on a standard form developed by Federal regulators.

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

5. Independent Dispute Resolution

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

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

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

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

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

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

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

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

6. Notice and Consent Criteria

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

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

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

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

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

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

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

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

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

7. Continuity of Care

In certain situations, if a ***preferred provider*** becomes a ***nonpreferred provider***, and the ***covered person*** is a ***continuing care patient***, the ***Plan*** will provide the ***covered person*** with notice and an opportunity to elect continuing care from such provider. This election will allow the ***covered person*** to continue to receive benefits under the ***Plan*** in accordance with the ***preferred provider cost sharing***, beginning on the date of the notice and continuing for a period ending of the earlier of a. Ninety (90) days from the date of the notice; or b. The date on which the ***covered person*** is no longer a ***continuing care patient*** with respect to such provider.

REFERRALS

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

EXCEPTIONS

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

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

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

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

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

4. Lactation counseling providers.

5. Diagnostic laboratory and surgical pathology tests referred to a ***nonpreferred provider*** by a ***preferred provider***

MEDICAL EXPENSE BENEFIT

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

COPAY

The ***copay*** is the amount payable by the ***covered person*** for certain services, supplies or treatment are shown on the *Schedule of Benefits*. The ***Plan*** pays the remaining ***covered expenses*** at the ***negotiated rate*** for ***preferred providers*** or the ***customary and reasonable amount*** for ***nonpreferred providers***, except as described in the *Nonpreferred Provider* subsection, under the *Preferred Provider or Nonpreferred Provider* section. The ***copay*** must be paid each time a treatment or service is rendered.

DEDUCTIBLES

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

COINSURANCE

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

OUT-OF-POCKET EXPENSE LIMIT

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

Out-of-Pocket Expense Limit Exclusions

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

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

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

MAXIMUM BENEFIT

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

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

HOSPITAL/AMBULATORY SURGICAL FACILITY

Covered expenses shall include:

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

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

    a. Admission fees, and other fees assessed by the ***hospital*** for rendering services, supplies and treatments;
    b. Use of operating, treatment or delivery rooms;
    c. Anesthesia, anesthesia supplies and its administration by an employee of the ***hospital***;
    d. Medical and surgical dressings and supplies, casts and splints;
    e. Blood transfusions, including the cost of whole blood, the administration of blood, blood processing and blood derivatives (to the extent blood or blood derivatives are not donated or otherwise replaced);
    f. Drugs and medicines (except drugs not used or consumed in the ***hospital***);
    g. X-ray and diagnostic laboratory procedures and services;
    h. Oxygen and other gas therapy and the administration thereof;
    i. Therapy services.

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

AMBULANCE SERVICES

Ambulance services must be by a licensed air or ground ambulance.

Covered expenses shall include:

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

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

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

EMERGENCY SERVICES/EMERGENCY ROOM SERVICES

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

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

URGENT CARE CENTER

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

PHYSICIAN SERVICES AND PROFESSIONAL PROVIDER SERVICES

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

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

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

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

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

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

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

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

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

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

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

DIAGNOSTIC SERVICES AND SUPPLIES

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

TRANSPLANT

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

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

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

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

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

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

Cigna Transplant LifeSource Network

In addition to the above transplant benefits the ***covered person*** may be eligible to participate in the Cigna Transplant LifeSource Network. ***Covered persons*** should contact the ***Health Care Management Organization*** to discuss this benefit by calling the number shown on the ***covered person's*** ID card.

A Cigna Transplant LifeSource Network facility is a ***facility*** within the Cigna Transplant LifeSource Network that has been chosen for its proficiency in performing one or more transplant procedures. Usually located throughout the United States, the Cigna Transplant LifeSource Network ***facilities*** have greater transplant volumes and surgical team experience than other similar ***facilities***.

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

PREGNANCY

Covered expenses shall include services, supplies and treatment related to ***pregnancy*** or ***complications of pregnancy*** for a covered pregnant ***employee***, a covered pregnant spouse of a covered ***employee***, and ***dependent*** pregnant children.

The ***Plan*** shall cover services, supplies and treatments for abortions (where legal); and where the life of the mother would be endangered if the fetus were carried to term or where medical complications have arisen from an abortion pursuant to the Pregnancy Discrimination Act if applicable for a covered pregnant ***employee***, a covered pregnant spouse of a covered ***employee***, and ***dependent*** pregnant children.

BIRTHING CENTER

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

STERILIZATION

Covered expenses shall include elective surgical sterilization procedures for the covered male ***employee*** or covered male spouse. Reversal of surgical sterilization is not a ***covered expense***.

Covered expenses shall include surgical implant and removal or replacement of FDA approved implantable contraceptive devices and similar devices. ***Covered expenses*** for elective surgical sterilization procedures for women shall be considered under the subsection, *Women's Preventive Services*.

INFERTILITY SERVICES

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

WELL NEWBORN CARE

The ***Plan*** shall cover well newborn care as part of the mother's claim while the mother is confined for delivery.

Such care shall include, but is not limited to:

1. ***Physician*** services
2. ***Hospital*** services
3. Circumcision

ROUTINE PREVENTIVE CARE/WELLNESS BENEFITS

Routine Preventive Care/Wellness Benefits shall include:

1. Evidence-based supplies or services that have in effect a rating of A or B in the current recommendations of the United States Preventive Services Task Force (USPSTF).
2. Annual routine mammograms for women.
3. Colonoscopies and follow-up colonoscopies conducted after a positive non-invasive stool-based screening test or direct visualization screening test including pre-procedure consultation, bowel preparation kits and pathology exam.
4. Routine immunizations, as recommended by the Advisory Committee on Immunization Practices of the Centers of Disease Control and Prevention for infants and children through age six (6); children and adolescents age seven (7) through eighteen (18) years and adults age nineteen (19) years and older.
5. Evidence-informed Routine Preventive Care and screenings as provided by the Health Resources Services Administration for infants, children, adolescents and adult women, unless included in the USPSTF recommendations.
6. Screening for tobacco use and two (2) tobacco cessation attempts per year and tobacco cessation medications for a ninety (90) day treatment regimen when prescribed by a ***physician.***

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

WOMEN'S PREVENTIVE SERVICES

Covered expenses shall include preventive services recommended in guidelines issued by the U.S. Department of Health and Human Services' Health Resources and Services Administration including but not limited to:

1. Annual well-woman office visits to obtain preventive care and pregnancy, prenatal, postpartum and interpregnancy office visits;

2. Screening for gestational diabetes in a pregnant woman:

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

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

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

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

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

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

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

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

ROUTINE PROSTATE EXAMINATIONS

Covered expenses shall include a prostate examination per benefit period.

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

THERAPY SERVICES

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

Covered expenses shall include:

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

2. Radiation therapy and chemotherapy.

3. Dialysis therapy or treatment. In addition to ***preferred providers***, this ***Plan*** also utilizes the Golden Triangle Specialty Network, LLC (GTSN) for dialysis therapy or treatment. If the ***professional provider*** is in the GTSN network, ***covered expenses*** will be paid in accordance with the ***preferred provider cost sharing***. If the ***professional provider*** is not a ***preferred provider*** and is not in the GTSN network, ***covered expenses*** will be subject to the ***customary and reasonable amount*** and paid in accordance with the ***nonpreferred provider cost sharing***.

4. Infusion therapy.

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

HABILITATIVE SERVICES

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

EXTENDED CARE FACILITY

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

Covered expenses shall include:

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

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

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

HOME HEALTH CARE

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

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

2. Physical, respiratory, occupational or speech therapy;

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

4. Medical social service consultations;

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

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

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

HOSPICE CARE

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

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

1. The ***covered person*** is terminally ill, and
2. The ***covered person*** has a life expectancy of six (6) months or less.

Covered expenses shall include:

1. ***Confinement*** in a ***hospice*** to include ancillary charges and ***room and board***.
2. Services, supplies and treatment provided by a ***hospice*** to a ***covered person*** in a home setting.
3. ***Physician*** services and/or nursing care by a ***nurse***.
4. Physical therapy, occupational therapy, speech therapy or respiratory therapy.
5. Nutrition services to include nutritional advice by a registered dietitian, and nutritional supplements such as diet substitutes administered intravenously or through hyperalimentation as determined to be ***medically necessary***.
6. Counseling services provided through the ***hospice***.
7. Respite care by an aide who is employed by the ***hospice*** for up to four (4) hours per day. (Respite care provides care of the ***covered person*** to allow temporary relief to family members or friends from the duties of caring for the ***covered person***).
8. Bereavement counseling as a supportive service to ***covered persons*** in the terminally ill ***covered person's*** immediate family. Benefits will be payable on the date immediately before death, the terminally ill person was covered under the ***Plan*** and receiving ***hospice*** care benefits.

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

DURABLE MEDICAL EQUIPMENT

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

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

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

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

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

PROSTHESES

The initial purchase of a prosthesis (other than dental) provided for functional reasons when replacing all or part of a missing body part (including contiguous tissue) or to replace all or part of the function of a permanently inoperative or malfunctioning body organ shall be a ***covered expense***. A charge for the purchase of a prosthesis is considered ***incurred*** on the date the prosthesis is received/delivered. A prosthesis that is received/delivered after the termination date of a ***covered person's*** coverage under the ***Plan*** is not covered. Repair or replacement of a prosthesis which is ***medically necessary*** due to normal use or a physiological change in the patient's condition will be considered a ***covered expense***.

ORTHOTICS

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

DENTAL SERVICES

Covered expenses shall include repair of sound natural teeth or surrounding tissue provided it is the result of an ***injury***. Damage to the teeth as a result of chewing or biting shall not be considered an ***injury*** under this benefit.

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

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

TEMPOROMANDIBULAR JOINT DYSFUNCTION

Non-surgical treatment of temporomandibular joint dysfunction (TMJ) or myofascial pain syndrome shall be a ***covered expense.***

SPECIAL EQUIPMENT AND SUPPLIES

Covered expenses shall include ***medically necessary*** special equipment and supplies including, but not limited to: casts; splints; braces; trusses; surgical and orthopedic appliances; colostomy and ileostomy bags and supplies required for their use; catheters; blood sugar measurement devices; insulin pumps and supplies; allergy serums; crutches; electronic pacemakers; oxygen and the administration thereof; the initial pair of eyeglasses or contact lenses due to cataract surgery; soft lenses or sclera shells intended for use in the treatment of ***illness*** or ***injury*** of the eye; support stockings, such as Jobst stockings, surgical dressings and other medical supplies ordered by a ***professional provider*** in connection with medical treatment, but not common first aid supplies.

COSMETIC/RECONSTRUCTIVE SURGERY

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

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

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

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

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

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

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

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

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

An external breast prosthesis shall be covered once every three (3) calendar years, unless recommended more frequently by a ***physician***. The first permanent internal breast prosthesis necessary because of a mastectomy shall also be a ***covered expense***. Prostheses (and ***medically necessary*** replacements) and physical complications from all stages of mastectomy, including lymphedemas will also be considered ***covered expenses*** following all ***medically necessary*** mastectomies.

MENTAL HEALTH DISORDERS

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

Covered expenses shall include:

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

2. Individual psychotherapy;

3. Group psychotherapy;

4. Psychological testing;

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

SUBSTANCE USE DISORDER

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

AUTISM SPECTRUM DISORDERS

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

PRESCRIPTION DRUGS

The ***Plan*** shall cover prescription drugs as specified on the *Schedule of Benefits*. Such drugs must be approved by the Food and Drug Administration and must be dispensed by a licensed pharmacist, ***physician*** or ***dentist***.

1. Certain ***outpatient*** medications are not a ***covered expense*** under the ***Plan*** if they are subject to the criteria of the SmithRx Drug Sourcing Program.

2. Administration and supplies are a ***covered expense***.

ROUTINE PATIENT COSTS FOR APPROVED CLINICAL TRIALS

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

1. An investigational item, device or service;

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

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

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

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

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

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

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

PODIATRY SERVICES

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

HEARING BENEFIT

Services of a licensed audiologist to determine and measure hearing loss are a ***covered expense***. Prescription hearing aids area ***covered expense***, subject to the non-***Essential Health Benefits maximum benefit*** as specified on the *Schedule of Benefits*.

CHIROPRACTIC CARE

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

PATIENT EDUCATION

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

OUTPATIENT CARDIAC/PULMONARY REHABILITATION PROGRAMS

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

WEIGHT MANAGEMENT

Surgical Treatment for Weight Loss

Covered expenses shall include ***medically necessary*** surgical treatment for weight loss including, but not limited to gastric by-pass, gastric stapling or gastric balloon.

SLEEP DISORDERS

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

COCHLEAR IMPLANT

Covered expenses shall include charges for all services, supplies and treatment related to a ***medically necessary*** cochlear implant.

BIOFEEDBACK

Covered expenses shall include charges for ***medically necessary*** biofeedback for a diagnosis of female stress incontinence.

MEDICAL EXCLUSIONS

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

1. Charges for services, supplies or treatment for the reversal of surgical sterilization procedures.

2. Medications obtained in a foreign country obtained under the criteria of the SmithRx Drug Sourcing Program as determined by the authority of the ***Plan*** and ***Plan Fiduciary***"

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

3. Charges for services, supplies or treatment for transsexualism, gender dysphoria or sexual reassignment or change, including medications, implants, hormone therapy, surgery, medical or psychiatric treatment. However, treatment of congenital intersex state is a ***covered expense***.

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

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

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

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

8. Charges for marriage, family, career or legal counseling.

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

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

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

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

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

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

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

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

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

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

19. Charges ***incurred*** as a result of, or in connection with, any procedure or treatment excluded by the ***Plan, which*** has resulted in medical complications, except for complications from a non-covered abortion as specified herein.

20. Charges for non-surgical treatment for weight loss including, but not limited to: exercise programs or use of exercise equipment; special diets or diet foods or diet supplements; appetite suppressants; Nutri/System, Weight Watchers or similar programs; and any overnight stays at any exercise programs or ***hospital confinements*** for weight reduction programs except as required by the United States Preventive Services Task Force (USPSTF) A & B recommendations.

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

22. Charges related to acupuncture treatment.

23. Except as specifically stated in *Medical Expense Benefit, Temporomandibular Joint Dysfunction*, charges for treatment of temporomandibular joint dysfunction and myofascial pain syndrome including, but not limited to charges for treatment to alter vertical dimension or to restore abraded dentition, orthodontia and intra oral.

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

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

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

27. Charges for expenses related to hypnosis.

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

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

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

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

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

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

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

35. Charges for holistic medicines or providers of naturopathy.

36. Charges for or related to the following types of treatment:
    a. primal therapy;
    b. rolfing;
    c. psychodrama;
    d. megavitamin therapy;
    e. visual perceptual training.

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

38. Charges for treatment of sleep disorders.

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

40. Charges for immunizations required for travel.

41. Charges for barrier-free home modifications whether or not recommended by a ***physician***, including but not limited to, ramps, grab bars, railings or standing frames.

42. Charges for augmentative devices, unless medically necessary.

43. Charges for motorized carts, scooters or strollers.

44. Charges for private duty nursing.

45. Charges for surgical excision or reformation of any sagging skin on any part of the body including but not limited to eyelids, face, neck, abdomen, arms, legs or buttocks.

46. Charges for any services performed in connection with enlargement, reduction, implantation or change in appearance in any portion of the body including but not limited to breasts, face, lips, jaw, chin, nose, ears or genitals except as specifically provided herein.

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

48. Charges for drugs, devices, supplies, treatments, procedures or services that are considered ***experimental/investigational*** by the ***Plan***, except if provided by a ***preferred provider***. The ***Plan*** will consider a drug, device, supply, treatment, procedure or service to be "***experimental***" or "***investigational***":
    a. if, in the case of a drug, device or supply, the drug, device or supply cannot be lawfully marketed without approval of the U.S. Food and Drug Administration and approval for marketing has not been given at the time the drug, device or supply is furnished; or
    b. if the drug, device, supply, treatment, procedure or service, or the patient's informed consent document utilized with respect to the drug, device, supply, treatment, procedure or service was

reviewed and approved by the treating ***facility's*** institutional review board or other body serving a similar function, or if federal law requires such review or approval; or

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

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

PRESCRIPTION DRUG PROGRAM

The *Prescription Drug Program* for ***covered persons*** is administered by SmithRx, which is a ***pharmacy benefits manager***. SmithRx provides a nationwide network of ***participating pharmacies*** and a drug formulary. The presence of a drug on this formulary does not guarantee coverage and the drugs listed on the formulary are subject to change. To find out if a prescribed medication is covered under the ***Plan***, visit the member portal at https://portal.mysmithrx.com/login or call 844.454.5201 for the most current formulary information.

PHARMACY OPTION

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

PHARMACY OPTION COPAY

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

If a drug is purchased from a ***nonparticipating pharmacy*** or a ***participating pharmacy*** when the ***covered person's*** ID card is not used, the ***covered person*** must pay the entire cost of the prescription, including ***copay***, and then submit the receipt to the prescription drug card vendor for reimbursement. If a ***nonparticipating pharmacy*** is used, the ***covered person*** will be responsible for the ***copay***, plus the difference in cost between the ***participating pharmacy*** and ***nonparticipating pharmacy***.

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

When the out-of-pocket expense limit is reached, prescription drugs will be paid at 100%.

MAIL ORDER OPTION

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

MAIL ORDER OPTION COPAY

The ***copay*** is applied to each covered mail order prescription charge and is shown on the *Schedule of Benefits*. The ***copay*** amount is a ***covered expense*** under the out-of-pocket expense limit for the *Medical Expense Benefit*. Any one prescription is limited to a ninety (90) day supply.

If the ***covered person*** purchases a brand name drug when the ***physician*** has indicated a ***generic drug*** can be dispensed, the ***covered person*** will be required to pay the difference between the ***generic drug*** and the brand name requested, plus the usual ***copay***. The ***covered person*** may appeal the adverse benefit determination. Refer to the sub-section, *Appealing a Denied Post-Service Prescription Drug Claim,* for detailed information on how to initiate the appeal process.

This difference between the cost of the brand name drug and the ***generic drug*** shall not accumulate toward the out-of-pocket limit.

When the out-of-pocket expense limit is reached, prescription drugs will be paid at 100%.

COVERED PRESCRIPTION DRUGS

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

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

3. Insulin, insulin needles and syringes and diabetic supplies when prescribed by a ***qualified prescriber***.

4. Contraceptives.

5. Tretinoins, up to age forty-seven (47).

6. Growth hormones up to age nineteen (19).

7. Routine preventive drugs as required by the Affordable Care Act.

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

LIMITS TO THIS BENEFIT

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

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

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

EXPENSES NOT COVERED

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

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

3. Immunization agents or biological sera, blood or blood plasma.

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

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

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

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

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

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

10. A charge for hypodermic syringes and/or needles (other than insulin).

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

12. A charge for infertility medication.

13. A charge for legend vitamins, except pre-natal legend vitamins.

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

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

16. A charge for weight loss drugs.

17. A charge for drugs used in the treatment of erectile dysfunction (*i.e.*, Viagra).

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

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

NOTICE OF AUTHORIZED REPRESENTATIVE

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

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

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

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

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

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

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

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

4. The review takes into account all information submitted by the ***covered person***, even if it was not considered in the initial benefit determination.

5. The review by the ***named fiduciary*** will not afford deference to the original ***adverse benefit determination***.

6. The ***named fiduciary*** will not be:

   a. The individual who originally denied the claim, nor

   b. Subordinate to the individual who originally denied the claim.

7. If the original ***adverse benefit determination*** was, in whole or in part, based on medical judgment:

   a. The ***named fiduciary*** will consult with a ***professional provider*** who has appropriate training and experience in the field involving the medical judgment; and

   b. The ***professional provider*** utilized by the ***named fiduciary*** will be neither:

      (i.) An individual who was consulted in connection with the original ***adverse benefit determination***, nor

      (ii.) A subordinate of any other ***professional provider*** who was consulted in connection with the original ***adverse benefit determination***.

8. If requested, the ***named fiduciary*** will identify the medical or vocational expert(s) who gave advice in connection with the original ***adverse benefit determination***, whether or not the advice was relied upon.

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

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

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

1. The specific reasons for the ***adverse benefit determination***.

2. Reference to specific ***Plan*** provisions on which the ***adverse benefit determination*** is based.

3. A statement that the ***covered person*** has the right to access, free of charge, ***relevant information*** to the claim for benefits.

4. A statement of the ***covered person's*** right to request an external review and a description of the process for requesting such a review.

5. A statement that if the ***covered person's*** appeal is denied, the ***covered person*** has the right to bring a civil action under section 502 (a) of the Employee Retirement Income Security Act of 1974.

6. If an internal rule, guideline, protocol or other similar criterion was relied upon, the Notice of Appeal Decision will contain either:

   a. A copy of that criterion, or

   b. A statement that such criterion was relied upon and will be supplied free of charge, upon request.

7. If the ***adverse benefit determination*** was based on ***medical necessity***, ***experimental/investigational*** treatment or similar exclusion or limit, the ***plan administrator*** (or its designee) will supply either:

   a. An explanation of the scientific or clinical judgment, applying the terms of the ***Plan*** to the claimant's medical circumstances, or

   b. A statement that such explanation will be supplied free of charge, upon request.

EXTERNAL APPEAL

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

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

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

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

RIGHT TO EXTERNAL APPEAL

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

1. Medical judgment; or
2. Rescission of coverage under the ***Plan***.

NOTICE OF RIGHT TO EXTERNAL APPEAL

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

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

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

2. If the request is incomplete, the information or materials necessary to make the request complete and the opportunity for the ***covered person*** to perfect the external review request by the later of the following:
   a. The four (4) month filing period; or
   b. Within the forty-eight (48) hour time period following the ***covered person's*** receipt of notification.

INDEPENDENT REVIEW ORGANIZATION

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

NOTICE OF EXTERNAL REVIEW DETERMINATION

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

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

EXPEDITED EXTERNAL REVIEW

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

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

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

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

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

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

The assigned IRO will provide notice of final external review decision as expeditiously as the ***covered person's*** medical condition or circumstances require, but in no event more than seventy-two (72) hours after receipt of the expedited external review request. The notice shall follow the requirements in the subsection, *Notice of External Review Determination*. If the notice of the expedited external review determination was not in writing, the assigned

IRO shall provide the ***plan administrator*** (or its designee) and the ***covered person*** (or authorized representative) written confirmation of its decision within forty-eight (48) hours after the date of providing that notice.

PLAN EXCLUSIONS

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

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

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

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

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

5. Charges in connection with any ***illness*** or ***injury*** arising out of or in the course of any employment intended for wage or profit, including self-employment.

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

7. Charges in connection with any ***illness*** or ***injury*** of the ***covered person*** resulting from or occurring during commission or attempted commission of a criminal battery or felony by the ***covered person***. This exclusion will not apply to an ***illness*** and/or ***injury*** sustained due to a medical condition (physical or mental) or domestic violence.

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

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

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

11. Charges for services, supplies, treatment that are considered ***experimental/investigational,*** as determined by a qualified independent vendor, except as specified herein.

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

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

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

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

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

17. Charges for telephone or e-mail consultations, completion of claim forms, charges associated with missed appointments.

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

19. If the primary plan provides coverage through the services of an HMO and the ***covered person*** chooses not to use the HMO, the ***Plan*** will not pay for any charges disallowed by the primary plan due to failure to utilize the HMO, if shown on the primary carrier's explanation of benefits.

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

ELIGIBILITY, ENROLLMENT AND EFFECTIVE DATE

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

EMPLOYEE ELIGIBILITY

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

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

EMPLOYEE ENROLLMENT

An ***employee*** must file a written application (or electronic, if applicable) with the ***employer*** for coverage hereunder within thirty-one (31) days of becoming eligible for coverage. The ***employee*** shall have the responsibility of timely forwarding to the ***employer*** all applications for enrollment hereunder. If the ***employee*** failed to make timely enrollment, the ***employee*** is considered a late enrollee and not eligible for coverage under the ***Plan*** until the next open enrollment period unless the ***employee*** otherwise qualifies for special enrollment during the ***Plan*** year.

EMPLOYEE(S) EFFECTIVE DATE

An ***employer*** may require new ***employees*** to complete a one (1) month, less one (1) day, "reasonable and bona fide" orientation period before the eligibility waiting period begins for the ***employer's*** group health plan.

Eligible ***employees***, as described in *Employee Eligibility*, are covered under the ***Plan*** following completion of sixty (60) days of continuous ***full-time*** employment provided the ***employee*** has enrolled for coverage as described in *Employee Enrollment*.

DEPENDENT(S) ELIGIBILITY

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

1. The term "spouse" means the spouse of the ***employee*** under a legally valid existing marriage, as defined by the state in which the ***employee*** was legally married, unless court ordered separation exists.

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

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

is a QMCSO, as defined in Section 609 of ERISA, or a NMSN, as defined in 42 U.S.C.A §666 of the Child Support Performance and Incentive Act of 1998.

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

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

   Proof of incapacitation for such ***dependent*** child who reaches age twenty-six (26) after the ***effective date*** shown on the first page of the ***Plan*** document must be provided within thirty-one (31) days of the date the coverage would otherwise terminate

   Proof of incapacitation for any ***dependent*** child after age twenty-six (26) may be requested by the ***employer*** or ***claims processor***, but not more than once every two (2) years. Eligibility may not be continued beyond the earliest of the following:

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

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

Every eligible ***employee*** may enroll eligible ***dependents***. However, if both husband and wife are ***employees***, each individual may be covered as an ***employee***. An ***employee*** cannot be covered as an ***employee*** and a ***dependent***. Eligible children may be enrolled as ***dependents*** of one spouse, but not both.

DEPENDENT ENROLLMENT

An ***employee*** must file a written application (or electronic, if applicable) with the ***employer*** for coverage hereunder for the ***employee's*** eligible ***dependents*** within thirty-one (31) days of becoming eligible for coverage; and within thirty-one (31) days of marriage or the acquiring of children or birth of a child. The ***employee*** shall have the responsibility of timely forwarding to the ***employer*** all applications for enrollment hereunder. If the ***employee*** failed to make timely enrollment for the ***employee's*** eligible ***dependents***, the ***dependents*** are considered late enrollees and not eligible for coverage under the ***Plan*** until the next open enrollment period, unless the ***dependent*** otherwise qualifies for a special enrollment during the ***Plan*** year.

DEPENDENT(S) EFFECTIVE DATE

Eligible ***dependent(s)***, as described in *Dependent(s) Eligibility*, will become covered under the ***Plan*** on the later of the dates listed below, provided the ***employee*** has enrolled them in the ***Plan*** within thirty-one (31) days of meeting the ***Plan's*** eligibility requirements and any required contributions are made.

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

2. The date the ***dependent*** is acquired, provided the ***employee*** has applied for ***dependent*** coverage within thirty-one (31) days of the date acquired.

3. Newborn children will be considered a ***dependent*** under the ***Plan*** for thirty-one (31) days immediately following birth. For coverage under the ***Plan*** for the newborn beyond that date, the ***employee*** must submit an application for enrollment within thirty-one (31) days of birth.

5. Coverage for a newly adopted or to be adopted child shall be effective on the date the child is ***placed for adoption***, provided the ***employee*** has applied for ***dependent*** coverage within thirty-one (31) days of the date the child is ***placed for adoption***.

SPECIAL ENROLLMENT PERIOD (OTHER COVERAGE)

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

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

2. Cessation of employer contributions toward the other coverage.

3. Legal separation or divorce.

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

5. Death of ***dependent*** or spouse.

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

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

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

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

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

The ***employee*** or ***dependent*** must request the special enrollment and enroll no later than thirty-one (31) days from the date of loss of other coverage.

The ***effective date*** of coverage as the result of a special enrollment shall be the date of loss of other coverage.

SPECIAL ENROLLMENT PERIOD (DEPENDENT ACQUISITION)

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

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

- marriage
- birth of a ***dependent*** child
- adoption or ***placement for adoption*** of a ***dependent*** child

  legal guardianship of a ***dependent*** child
- a ***foster child*** being placed with the ***employee***

The ***employee*** must request the special enrollment within thirty-one (31) days of the acquisition of the ***dependent***.

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

1. in the case of marriage, the date of such marriage;

2. in the case of a ***dependent's*** birth, the date of such birth;

1. in the case of adoption or ***placement for adoption***, the date of such adoption or ***placement for adoption***.

4. in the case of legal guardianship, the date on which such child is placed in the covered ***employee's*** home pursuant to a court order appointing the covered ***employee*** as legal guardian for the child;

5. in the case of a ***foster child*** being placed with the ***employee***, on the date on which such child is placed with the ***employee*** by an authorized placement agency or by judgment, decree or other order of a court of competent jurisdiction.

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

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

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

1. the individual's loss of eligibility is due to termination of coverage under a state children's health insurance program or Medicaid; or

2. the individual is eligible for any applicable premium assistance under a state children's health insurance program or Medicaid.

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

OPEN ENROLLMENT

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

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

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

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

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

TERMINATION OF COVERAGE

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

TERMINATION OF EMPLOYEE COVERAGE

1. The date the ***employer*** terminates the ***Plan*** and offers no other group health plan.

2. The date the ***employee*** ceases to meet the eligibility requirements of the ***Plan***.

3. The date employment terminates, as defined by the ***employer's*** personnel policies.

4. The date the ***employee*** becomes a full-time, active duty member of the armed forces of any country.

5. The date the ***employee*** ceases to make any required contributions.

TERMINATION OF DEPENDENT(S) COVERAGE

1. The date the ***employer*** terminates the ***Plan*** and offers no other group health plan.

2. The date the ***employee's*** coverage terminates.

3. The date such person ceases to meet the eligibility requirements of the ***Plan***, except that for a ***dependent*** child , termination shall be the last day of the month in which the ***dependent*** child reaches age twenty-six (26).

4. The date the ***employee*** ceases to make any required contributions on the ***dependent's*** behalf.

5. The date the ***employee's dependent*** spouse becomes a full-time, active duty member of the armed forces of any country.

6. The date the ***Plan*** discontinues ***dependent*** coverage for any and all ***dependents***.

LEAVE OF ABSENCE

Coverage may be continued for a limited time, contingent upon payment of any required contributions for ***employees*** and/or ***dependents***, when the ***employee*** is on an authorized ***leave of absence*** from the ***employer***.

LAYOFF

Coverage may be continued for a limited time, contingent upon payment of any required contributions for ***employees*** and/or ***dependents***, when the ***employee*** is subject to an ***employer layoff***.

FAMILY AND MEDICAL LEAVE ACT (FMLA)

Eligible Leave

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

Contributions

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

Reinstatement

If coverage under the ***Plan*** was terminated during an approved FMLA leave, and the ***employee*** returns to active work immediately upon completion of that leave, ***Plan*** coverage will be reinstated on the date the ***employee*** returns to active work as if coverage had not terminated, provided the ***employee*** makes any necessary contributions and enrolls for coverage within thirty-one (31) days of his return to active work.

Repayment Requirement

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

EMPLOYEE REINSTATEMENT

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

1. Reinstatement of coverage is available to ***employees*** and ***dependents*** who were previously covered under the ***Plan***.
2. Rehire or return to active service must occur within (13) weeks of the last day worked.
3. The ***employee*** must submit the completed application for enrollment to the ***employer*** within thirty-one (31) days of rehire or return to work.
4. Coverage shall be effective from the date of rehire or return to work. Prior benefits and limitations, such as deductible, ***Essential Health Benefits***/non-***Essential Health Benefits maximum benefit*** shall be applied with no break in coverage.

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

CONTINUATION OF COVERAGE

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

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

QUALIFYING EVENTS

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

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

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

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

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

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

NOTIFICATION REQUIREMENTS

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

   a. The date of the event;

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

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

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

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

2. When eligibility for continuation of coverage results from any qualifying event under the ***Plan*** other than the ones described in Paragraph 1 above, the ***employer*** must notify the ***plan administrator*** (or its designee) not later

than thirty (30) days after the date on which the ***employee*** or ***dependent*** loses coverage under the ***Plan*** due to the qualifying event. Within fourteen (14) days of the receipt of the notice of the qualifying event, the ***plan administrator*** (or its designee) will furnish the Election Notice to the ***employee*** or ***dependent***.

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

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

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

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

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

COST OF COVERAGE

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

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

WHEN CONTINUATION COVERAGE BEGINS

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

FAMILY MEMBERS ACQUIRED DURING CONTINUATION

A spouse or ***dependent*** child newly acquired during continuation coverage is eligible to be enrolled as a ***dependent***. The standard enrollment provision of the ***Plan*** applies to enrollees during continuation coverage. A ***dependent*** acquired and enrolled after the original qualifying event, other than a child born to or ***placed for adoption*** with a covered ***employee*** during a period of COBRA continuation coverage, is not eligible for a separate continuation if a subsequent event results in the person's loss of coverage.

EXTENSION OF CONTINUATION COVERAGE

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

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

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

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

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

   a. The date of that event;

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

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

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

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

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

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

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

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

   a. The date of the disability determination by the Social Security Administration;

   b. The date of the 18-Month Qualifying Event;

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

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

   Should the disabled person fail to notify the ***plan administrator*** (or its designee) in writing within the time frame described above, the disabled person (and others entitled to disability extension on account of that

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

a. The date of the final determination by the Social Security Administration; or

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

END OF CONTINUATION

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

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

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

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

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

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

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

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

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

SPECIAL RULES REGARDING NOTICES

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

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

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

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

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

MILITARY MOBILIZATION

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

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

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

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

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

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

PLAN CONTACT INFORMATION

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

ADDRESS CHANGES

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

MEDICAL CLAIM FILING PROCEDURE

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

POST-SERVICE CLAIM PROCEDURE

FILING A CLAIM

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

   Cigna will determine the Cigna ***negotiated rate*** on claims received for benefits and submit all claims to the ***claims processor*** for benefit determination.

   The date of receipt will be the date the claim is received by Cigna PPO.

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

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

   Cash register receipts, credit card copies, labels from containers and cancelled checks are not acceptable.

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

The ***covered person*** may ask the health care provider to submit the claim directly to Cigna as outlined above, or the ***covered person*** may submit the bill with a claim form. However, it is ultimately the ***covered person's*** responsibility to make sure the claim for benefits has been filed.

NOTICE OF AUTHORIZED REPRESENTATIVE

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

NOTICE OF CLAIM

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

Failure to file a claim within the time provided shall not invalidate or reduce a claim for benefits if: (1) it was not reasonably possible to file a claim within that time; and (2) that such claim was furnished as soon as possible, but no later than the timeframe to submit a claim stated in the sub-section titled, *Filing a Claim*, unless the claimant is legally incapacitated.

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

TIME FRAME FOR BENEFIT DETERMINATION

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

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

NOTICE OF ADVERSE BENEFIT DETERMINATION

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

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

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

b. A statement that such criterion was relied upon and will be supplied free of charge, upon request.

8. If the ***adverse benefit determination*** was based on ***medical necessity***, ***experimental/investigational*** treatment or similar exclusion or limit, the ***plan administrator*** (or its designee) will supply either:

   a. An explanation of the scientific or clinical judgment, applying the terms of the ***Plan*** to the ***covered person's*** medical circumstances, or

   b. A statement that such explanation will be supplied free of charge, upon request.

APPEALING AN ADVERSE BENEFIT DETERMINATION ON A POST-SERVICE CLAIM

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

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

1. The ***covered person*** has the right to submit documents, information and comments and to present evidence and testimony.

2. The ***covered person*** has the right to access, free of charge, ***relevant information*** to the claim for benefits.

3. Before a final ***adverse benefit determination*** on appeal is rendered, the ***covered person*** will be provided, free of charge, with any new or additional rationale or evidence considered, relied upon, or generated by the ***Plan*** in connection with the claim. Such information will be provided as soon as possible and sufficiently in advance of the notice of ***final internal adverse benefit determination***. However there could be circumstances where the new or additional evidence or rationale could be received so late that it would be impossible to provide the ***covered person*** in time to have a reasonable opportunity to respond. In these circumstances, the period for providing notice of final determination on appeal will be tolled until the earliest of the following dates:

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

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

4. The review takes into account all information submitted by the ***covered person***, even if it was not considered in the initial benefit determination.

5. The review by the ***named fiduciary*** will not afford deference to the original ***adverse benefit determination***.

6. The ***named fiduciary*** will not be:

   a. The individual who originally denied the claim, nor

   b. Subordinate to the individual who originally denied the claim.

7. If the original ***adverse benefit determination*** was, in whole or in part, based on medical judgment:

   a. The ***named fiduciary*** will consult with a ***professional provider*** who has appropriate training and experience in the field involving the medical judgment; and

   b. The ***professional provider*** utilized by the ***named fiduciary*** will be neither:

      (i.) An individual who was consulted in connection with the original ***adverse benefit determination***, nor

      (ii.) A subordinate of any other ***professional provider*** who was consulted in connection with the original ***adverse benefit determination***.

8. If requested, the ***named fiduciary*** will identify the medical or vocational expert(s) who gave advice in connection with the original ***adverse benefit determination***, whether or not the advice was relied upon.

NOTICE OF ADVERSE BENEFIT DETERMINATION ON APPEAL

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

If the appeal is denied, the Notice of Adverse Benefit Determination on Appeal will contain an explanation of the decision, including:

1. The specific reasons for the ***adverse benefit determination***.
2. Reference to specific ***Plan*** provisions on which the ***adverse benefit determination*** is based.
3. A statement that the ***covered person*** has the right to access, free of charge, ***relevant information*** to the claim for benefits.
4. As applies to a first level appeal, the Notice of Adverse Benefit Determination on Appeal will include a statement of the ***covered person's*** right to request a second level internal review of an ***adverse benefit determination*** on appeal and a description of the process for requesting such a review.
5. If an internal rule, guideline, protocol or other similar criterion was relied upon, the Notice of Appeal Decision will contain either:
    a. A copy of that criterion, or
    b. A statement that such criterion was relied upon and will be supplied free of charge, upon request.
7. If the ***adverse benefit determination*** was based on ***medical necessity***, ***experimental/investigational*** treatment or similar exclusion or limit, the ***plan administrator*** (or its designee) will supply either:
    a. An explanation of the scientific or clinical judgment, applying the terms of the ***Plan*** to the claimant's medical circumstances, or
    b. A statement that such explanation will be supplied free of charge, upon request.

NOTICE OF BENEFIT DETERMINATION ON APPEAL

The ***plan administrator*** (or its designee) shall provide the ***covered person*** (or authorized representative) with a written notice of the appeal decision within sixty (60) calendar days of receipt of a written request for the appeal.
If the appeal is denied, the Notice of Appeal Decision will contain an explanation of the Decision, including:

1. The specific reasons for the ***adverse benefit determination***.
2. Reference to specific ***Plan*** provisions on which the ***adverse benefit determination*** is based.
3. A statement that the ***covered person*** has the right to access, free of charge, ***relevant information*** to the claim for benefits.
4. A statement of the ***covered person's*** right to request an external review and a description of the process for requesting such a review.

5 A statement that if the ***covered person's*** appeal is denied, the ***covered person*** has the right to bring a civil action under section 502 (a) of the Employee Retirement Income Security Act of 1974.

6. If an internal rule, guideline, protocol or other similar criterion was relied upon, the Notice of Appeal Decision will contain either:
    a. A copy of that criterion, or
    b. A statement that such criterion was relied upon and will be supplied free of charge, upon request.

7. If the ***adverse benefit determination*** was based on ***medical necessity***, ***experimental/investigational*** treatment or similar exclusion or limit, the ***plan administrator*** (or its designee) will supply either:

   a. An explanation of the scientific or clinical judgment, applying the terms of the ***Plan*** to the claimant's medical circumstances, or

   b. A statement that such explanation will be supplied free of charge, upon request.

SECOND LEVEL APPEAL OF A DENIED POST-SERVICE CLAIM

The "***named fiduciary***" for purposes of a second level appeal of a denied post-service claim, as described in U. S. Department of Labor Regulations 2560.503-1 (issued November 21, 2000), is the ***plan administrator*** (or its designee).

The ***Plan*** requires two levels of appeal by a ***covered person***, or the ***covered person's*** authorized representative, before the ***Plan's*** internal appeal process is exhausted. For each level of appeal, the ***covered person***, or the ***covered person's*** authorized representative, and the ***Plan*** are subject to the rights, responsibilities, and notice requirements as stated herein.

A ***covered person***, or the ***covered person's*** authorized representative, may request a review of an ***adverse benefit determination*** on appeal by making written request to the ***named fiduciary*** within sixty (60) calendar days from receipt of notification of the ***adverse benefit determination*** and stating the reasons the ***covered person*** feels the claim should not have been denied.

Upon the conclusion of a second level appeal request, if it is determined by the ***PACE*** that benefits and/or coverage is not available from the ***Plan***, as it relates to claims for benefits submitted to the ***Plan***; when such a ***final post-service adverse benefit determination*** is made, by either the ***plan administrator*** (or its designee), or the ***PACE***, the decision will be considered a ***final internal adverse benefit determination***.

FOREIGN CLAIMS

In the event a ***covered person*** incurs a ***covered expense*** in a foreign country, the ***covered person*** shall be responsible for submitting the claim form, provider invoice and any documentation required to process the claim in the English language to the ***claims processor*** before payment of any benefits due are payable.

PRE-SERVICE CLAIM PROCEDURE

HEALTH CARE MANAGEMENT

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

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

FILING A PRE-CERTIFICATION CLAIM

This pre-certification provision will be waived by the ***Health Care Management Organization*** if the ***covered expense*** is rendered/provided outside of the United States of America or any U.S. Commonwealth, Territory or Possession.

All non-***emergency medical condition inpatient*** admissions, including ***inpatient hospice*** care and ***home health care*** excluding supplies, ***durable medical equipment***, physical therapy, occupational therapy and speech therapy visits are to be certified by the ***Health Care Management Organization***. For non-***emergency medical conditions***, the Cigna ***preferred provider***, in accordance with their agreement with Cigna, must call the ***Health Care Management Organization*** at least fifteen (15) calendar days prior to initiation of services.

If the ***Health Care Management Organization*** is not called at least fifteen (15) calendar days prior to initiation of services for non-***emergency medical conditions***, benefits may be reduced.

Cigna ***preferred providers*** or ***covered persons (or their authorized representatives)*** or ***nonpreferred providers*** **shall contact the** ***Health Care Management Organization*** by calling the number on the back of the ID card.

When a Cigna ***preferred provider***, or a ***covered person*** (or authorized representative) or ***nonpreferred provider*** calls the ***Health Care Management Organization***, should be prepared to provide all of the following information:

1. ***Employee's*** name, address, phone number and Luminare Health Member Identification Number.
2. ***Employer's*** name.
3. If not the ***employee***, the patient's name, address, phone number.
4. Admitting ***physician's*** name and phone number.
5. Name of ***facility.***
6. Date of admission or proposed date of admission.
7. Condition for which patient is being admitted.

Group health plans generally may not, under federal law, restrict benefits for any ***hospital*** *length of stay in connection with childbirth for the mother or newborn child to less than forty-eight (48) hours following a normal vaginal delivery, or less than ninety-six (96) hours following a cesarean section. However, federal law generally does not prohibit the mother's or newborn's attending provider, after consulting with the mother, from discharging the mother or newborn earlier than forty-eight (48) hours (or ninety-six (96) hours as applicable). In any case, plans may not, under federal law, require that a provider obtain authorization from the* ***Plan*** *for prescribing a length of stay not in excess of the above periods.*

However, pre-certification is required on ***hospital*** maternity stays in excess of forty-eight (48) or ninety-six (96) hours as specified above.

For ***nonpreferred provider*** services, if the ***covered person*** (or authorized representative) or provider fails to contact the ***Health Care Management Organization*** prior to the hospitalization or procedures identified and within the timelines detailed above, the amount of benefits payable for ***covered expenses incurred*** shall be reduced by 10 percent

(10%) but not more than $1,000 for the purpose of determining benefits payable. If the ***Health Care Management Organization*** declines to grant the full pre-certification requested, benefits for days not certified, as ***medically necessary*** by the ***Health Care Management Organization*** shall be denied. (Refer to *Post-Service Claim Procedure* discussion above.)

If a Cigna ***preferred provider*** fails to contact the ***Health Care Management Organization*** prior to the hospitalization or procedures identified above and within the timelines detailed above, the Cigna ***preferred provider*** shall not bill the ***covered person*** for the reduction in the amount of benefits payable due to such failure.

NOTIFICATION REQUIREMENT

Notification is required within forty-eight (48) hours or the next business day of an ***emergency medical condition*** admission by the calling the number on the ***covered person's*** ID card.

NOTICE OF AUTHORIZED REPRESENTATIVE

The ***covered person*** may provide the ***plan administrator*** (or its designee) with a written authorization for an authorized representative to represent and act on behalf of a ***covered person*** and consent to release of information related to the ***covered person*** to the authorized representative with respect to a claim for benefits or an appeal. Authorization forms may be obtained from the Human Resource Department. Notwithstanding the foregoing, requests for pre-certification and other pre-service claims or requests by a person or entity other than the ***covered person*** may be processed without a written authorization if the request or claim appears to the ***plan administrator*** (or its designee) to come from a reasonably appropriate and reliable source (*e.g.*, ***physician's*** office, individuals identifying themselves as immediate relatives, etc.).

TIME FRAME FOR PRE-SERVICE CLAIM DETERMINATION

1. In the event the ***Plan*** receives from the ***covered person*** (or authorized representative) a communication that fails to follow the pre-certification procedure as described above but communicates at least the name of the ***covered person***, a specific medical condition or symptom, and a specific treatment, service or product for which prior approval is requested, the ***covered person*** (or the authorized representative) will be orally notified (and in writing if requested), within five (5) calendar days of the failure of the proper procedure to be followed.

2. After a completed pre-certification request for non-***urgent care*** has been submitted to the ***Plan***, and if no additional information is required, the ***Plan*** will generally complete its determination of the claim within a reasonable period of time, but no later than fifteen (15) calendar days from receipt of the request.

3. After a pre-certification request for non-***urgent care*** has been submitted to the ***Plan***, and if an extension of time to make a decision is necessary due to circumstances beyond the control of the ***Plan***, the ***Plan*** will, within fifteen (15) calendar days from receipt of the request, provide the ***covered person*** (or authorized representative) with a notice detailing the circumstances and the date by which the ***Plan*** expects to render a decision. If the circumstances include a failure to submit necessary information, the notice will specifically describe the needed information. The ***covered person*** will have forty-five (45) calendar days to provide the information requested, and the ***Plan*** will complete its determination of the claim no later than fifteen (15) calendar days after receipt by the ***Plan*** of the requested information. Failure to respond in a timely and complete manner will result in an ***adverse benefit determination***.

CONCURRENT CARE CLAIMS

If an extension beyond the original certification is required the Cigna ***preferred provider***, or ***covered person*** (or authorized representative) or ***nonpreferred provider*** for ***nonpreferred provider*** services, shall call the ***Health Care Management Organization*** for continuation of certification.

1. If a ***provider*** or ***covered person*** (or authorized representative) requests to extend benefits for a previously approved hospitalization or an ongoing course of treatment, and;

a. The request involves non-***urgent care***, then the extension request must be processed within fifteen (15) calendar days after the request was received.

b. The ***inpatient*** admission or ongoing course of treatment involves ***urgent care***, and

(i.) The request is received at least twenty-four (24) hours before the scheduled end of the hospitalization or course of treatment, then the request must be ruled upon and the ***provider*** or the ***covered person*** (or authorized representative) notified as soon as possible taking into consideration medical exigencies but no later than twenty-four (24) hours after the request was received; or

(ii.) The request is received less than twenty-four (24) hours before the scheduled end of the hospitalization or course of treatment, then the request must be ruled upon and the ***provider*** or ***covered person*** (or authorized representative) notified as soon as possible but no later than seventy-two (72) hours after the request was received; or

(iii.) The request is received less than twenty-four (24) hours before the scheduled end of the hospitalization or course of treatment and additional information is required, the ***provider*** or ***covered person*** (or authorized representative) will be notified within twenty-four (24) hours of the additional information required. The ***provider*** or ***covered person*** (or authorized representative) has forty-eight (48) hours to provide such information (may be oral unless written is requested). Upon timely response, the ***provider*** or ***covered person*** (or authorized representative) will be notified as soon as possible but no later than forty-eight (48) hours after receipt of additional information. Failure to submit requested information timely will result in an ***adverse benefit determination*** of such request.

If the ***Health Care Management Organization*** determines that benefits for the ***hospital*** stay or course of treatment should be decrease or terminated before the end of the fixed number of days and/or treatments, or the fixed time period that was previously approved, then the ***Health Care Management Organization*** shall:

1. Notify the ***provider*** or ***covered person*** of the proposed change, and

2. Allow the ***covered person*** to file an appeal and obtain a decision, before the end of the fixed number of days and/or treatments, or the fixed time period that was previously approved.

If, at the end of previously approved benefits for a hospitalization or course of treatment, the ***Health Care Management Organization*** determines that continued ***confinement*** is no longer ***medically necessary***, additional days will not be certified. (Refer to *Appealing an Adverse Benefit Determination of a Denied Pre-Service Claim* discussion below.)

NOTICE OF ADVERSE BENEFIT DETERMINATION ON A PRE-SERVICE CLAIM

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

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

1. Information sufficient to identify the claim involved.
2. The specific reasons for the denial, to include:
   a. The denial code and its specific meaning, and
   b. A description of the ***Plan's*** standards, if any, used when denying the claim.
3. Reference to the ***Plan*** provisions on which the ***adverse benefit determination*** is based.

4. A description of any additional material or information needed and an explanation of why such material or information is necessary.

5. A description of the ***Plan's*** claim appeal procedure and applicable time limits.

6. A statement that if the ***covered person's*** appeal (Refer to *Appealing an Adverse Benefit Determination on a Pre-Service Claim* below) is denied, the ***covered person*** has the right to bring a civil action under section 502 (a) of the Employee Retirement Income Security Act of 1974.

7. If an internal rule, guideline, protocol or other similar criterion was relied upon, the Notice of Adverse Benefit Determination on a Pre-Service Claim will contain either:

   a. A copy of that criterion, or

   b. A statement that such criterion was relied upon and will be supplied free of charge, upon request.

8. If the ***adverse benefit determination*** was based on ***medical necessity***, ***experimental/investigational*** treatment or similar exclusion or limit, the ***plan administrator*** (or its designee) will supply either:

   a. An explanation of the scientific or clinical judgment, applying the terms of the ***Plan*** to the ***covered person's*** medical circumstances, or

   b. A statement that such explanation will be supplied free of charge, upon request.

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

The "***named fiduciary***" for purposes of an appeal of a pre-service claim, as described in U. S. Department of Labor Regulations 2560.503-1 (issued November 21, 2000), is the Cigna PPO.

A ***covered person*** (or authorized representative) may request a review of an Adverse Benefit Determination of a Pre-Service claim by making a verbal or written request to the ***named fiduciary*** within one hundred eighty (180) calendar days from receipt of notification of the ***adverse benefit determination*** and stating the reasons the ***covered person*** feels the claim should not have been denied. If the ***covered person*** (or authorized representative) wishes to appeal the ***adverse benefit determination*** when the services in question have already been rendered, such an appeal will be considered as a separate post-service claim. (Refer to *Post-Service Claim Procedure* discussion above.)

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

1. The ***covered person*** has the right to submit documents, information and comments and to present testimony.

2. The ***covered person*** has the right to access, free of charge, ***relevant information*** to the claim for benefits.

3. Before a final determination on appeal is rendered, the ***covered person*** will be provided, free of charge, with any new or additional rationale or evidence considered, relied upon, or generated by the ***Plan*** in connection with the claim. Such information will be provided as soon as possible and sufficiently in advance of the notice of final internal determination to give the ***covered person*** an opportunity to respond. The period for providing notice of final determination on appeal will be tolled until the earliest of the following dates:

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

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

4. The review takes into account all information submitted by the ***covered person***, even if it was not considered in the initial benefit determination.

5. The review by the ***named fiduciary*** will not afford deference to the original ***adverse benefit determination***.

6. The ***named fiduciary*** will not be:

   a. The individual who originally denied the claim, nor

   b. Subordinate to the individual who originally denied the claim.

7. If the original ***adverse benefit determination*** was, in whole or in part, based on medical judgment:

   a. The ***named fiduciary*** will consult with a ***professional provider*** who has appropriate training and experience in the field involving the medical judgment.

   b. The ***professional provider*** utilized by the ***named fiduciary*** will be neither:

      (i.) An individual who was consulted in connection with the original ***adverse benefit determination***, nor

      (ii.) A subordinate of any other ***professional provider*** who was consulted in connection with the original ***adverse benefit determination***.

8. If requested, the ***named fiduciary*** will identify the medical or vocational expert(s) who gave advice in connection with the original ***adverse benefit determination***, whether or not the advice was relied upon.

NOTICE OF PRE-SERVICE DETERMINATION ON APPEAL

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

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

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

   a. A copy of that criterion, or

   b. A statement that such criterion was relied upon and will be supplied free of charge, upon request.

7. If the ***adverse benefit determination*** was based on ***medical necessity***, ***experimental/investigational*** treatment or similar exclusion or limit, the ***plan administrator*** (or its designee) will supply either:

   a. An explanation of the scientific or clinical judgment, applying the terms of the ***Plan*** to the claimant's medical circumstances, or

   b. A statement that such explanation will be supplied free of charge, upon request.

CASE MANAGEMENT

In cases where the ***covered person's*** condition is expected to be or is of a serious nature, the ***Health Care Management Organization*** may arrange for review and/or case management services from a professional qualified to perform such services. The ***plan administrator*** shall have the right to alter or waive the normal provisions of the ***Plan*** when it is reasonable to expect a cost-effective result without a sacrifice to the quality of care.

In addition, the ***Health Care Management Organization*** may recommend (or change) alternative:

1. methods of medical care or treatment;
2. equipment; or
3. supplies

that differ from the medical care or treatment, equipment or supplies that are considered ***covered expenses*** under the ***Plan***.

The recommended alternatives will be considered as ***covered expenses*** under the ***Plan*** provided the expenses can be shown to be viable, ***medically necessary***, and are included in a written case management report or treatment plan proposed by the ***Health Care Management Organization***.

Case management will be determined on the merits of each individual case, and any care or treatment provided will not be considered as setting any precedent or creating any future liability with respect to that ***covered person*** or any other ***covered person***.

POST-SERVICE AND PRE-SERVICE CLAIM EXTERNAL APPEALS PROCEDURE

EXTERNAL APPEAL

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

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

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

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

RIGHT TO EXTERNAL APPEAL

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

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

NOTICE OF RIGHT TO EXTERNAL APPEAL

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

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

1. The reason for ineligibility and the availability of the Employee Benefits Security Administration at 1-866-444-3272, if the request is complete but not eligible for external review.
2. If the request is incomplete, the information or materials necessary to make the request complete and the opportunity for the ***covered person*** to perfect the external review request by the later of the following:

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

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

INDEPENDENT REVIEW ORGANIZATION

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

NOTICE OF EXTERNAL REVIEW DETERMINATION

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

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

EXPEDITED EXTERNAL REVIEW

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

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

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

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

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

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

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

COORDINATION OF BENEFITS

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

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

DEFINITIONS APPLICABLE TO THIS PROVISION

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

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

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

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

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

1. Group insurance or any other arrangement for coverage for ***covered persons*** in a group, whether on an insured or uninsured basis, including, but not limited to, ***hospital*** indemnity benefits and ***hospital*** reimbursement-type plans;
2. ***Hospital*** or medical service organization on a group basis, group practice, and other group prepayment plans or on an individual basis having a provision similar in effect to this provision;
3. A licensed Health Maintenance Organization (HMO);
4. Any coverage for students, which is sponsored by, or provided through, a school or other educational institution;
5. Any coverage under a government program and any coverage required or provided by any statute;
6. Group automobile insurance;
7. Individual automobile insurance coverage;
8. Individual automobile insurance coverage based upon the principles of "No-fault" coverage;

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

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

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

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

EFFECT ON BENEFITS

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

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

ORDER OF BENEFIT DETERMINATION

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

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

2. Member/Dependent
   The plan which covers the claimant directly pays before a plan that covers the claimant as a dependent.

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

4. Dependent Children of Separated or Divorced Parents
   When parents are separated or divorced, the birthday rule does not apply, instead:

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

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

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

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

COORDINATION WITH MEDICARE

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

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

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

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

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

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

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

LIMITATIONS ON PAYMENTS

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

RIGHT TO RECEIVE AND RELEASE NECESSARY INFORMATION

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

FACILITY OF BENEFIT PAYMENT

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

AUTOMOBILE ACCIDENT BENEFITS

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

1. No-fault automobile insurance laws
2. Financial responsibility laws
3. Other automobile liability insurance laws

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

1. In the event a ***covered person*** incurs medical expenses as a result of ***injuries*** sustained in an automobile accident while "covered by an automobile insurance policy," as an operator of the vehicle, as a passenger, or as a pedestrian, benefits will be further limited to medical expenses, that would in no event be payable under the automobile insurance.
2. For the purposes of this section the following people are deemed "covered by an automobile insurance policy."
    a. An owner or principal named insured individual under such policy.
    b. A family member of an insured person for whom coverage is provided under the terms and conditions of the automobile insurance policy.
    c. Any other person who, except for the existence of the ***Plan***, would be eligible for medical expense benefits under an automobile insurance policy.

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

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

SUBROGATION/REIMBURSEMENT

A ***covered person***, 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 ***covered person*** or other entity does not comply with the provisions of this section, the plan administrator shall have the authority, in its sole discretion, to deny payment of any claims for benefits by the ***covered person*** and to deny or reduce future benefits payable (including payment of future benefits for 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 the ***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 thirty (30) days of discovery or demand or incur prejudgment interest of 1.5% per month. If the ***Plan*** must bring an action against a ***covered person***, provider or other person or entity to enforce the provisions of this section, then that ***covered person***, provider or other person or entity agrees to pay the ***Plan's*** attorneys' fees and costs, regardless of the action's outcome.

Further, ***covered persons*** and/or their dependents, beneficiaries, estate, heirs, guardian, personal representative, or assigns (***covered persons***) 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 ***covered persons*** 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 the ***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 the ***Plan*** within two (2) years after the date such coverage commences.
4. With respect to an ineligible person.
5. In anticipation of obtaining a recovery if a ***covered person*** 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 shall not be deemed to require the ***Plan*** to pay benefits under the ***Plan*** in any such instance.

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

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

PAYMENT CONDITION

The ***Plan***, in its sole discretion, may elect to conditionally advance payment of benefits in those situations where an ***injury***, ***illness***, disease or disability is caused in whole or in part by, or results from the acts or omissions of participants, and/or their ***dependents***, beneficiaries, estate, heirs, guardian, personal representative, or assigns (collectively referred to hereinafter in this section as "participant(s)") or a third party, where any party besides the ***Plan*** may be responsible for expenses arising from an incident, and/or other funds are available, including but not limited to 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").

Participant(s), his or her attorney, and/or legal guardian of a minor or incapacitated individual agrees that acceptance of the ***Plan's*** conditional payment of medical benefits is constructive notice of these provisions in their entirety and agrees to maintain 100% of the ***Plan's*** conditional payment of benefits or the full extent of payment from any one or combination of first and third party sources in trust, without disruption except for reimbursement to the ***Plan*** or the ***Plan's*** assignee. The ***Plan*** shall have an equitable lien on any funds received by the participant(s) and/or their attorney from any source and said funds shall be held in trust until such time as the obligations under this provision are fully satisfied. The participant(s) agrees to include the ***Plan's*** name as a co-payee on any and all settlement drafts. Further, by accepting benefits the participant(s) understands that any recovery obtained pursuant to this section is an asset of the ***Plan*** to the extent of the amount of benefits paid by the ***Plan*** and that the participant shall be a trustee over those ***Plan*** assets.

In the event a participant(s) settles, recovers, or is reimbursed by any coverage, the participant(s) agrees to reimburse the ***Plan*** for all benefits paid or that will be paid by the ***Plan*** on behalf of the participant(s). If the participant(s) fails to reimburse the ***Plan*** out of any judgment or settlement received, the participant(s) will be responsible for any and all expenses (fees and costs) associated with the ***Plan's*** attempt to recover such money.

If there is more than one party responsible for charges paid by the ***Plan***, or may be responsible for charges paid by the ***Plan***, the ***Plan*** will not be required to select a particular party from whom reimbursement is due. Furthermore, unallocated settlement funds meant to compensate multiple injured parties of which the participant(s) is/are only one or a few, that unallocated settlement fund is considered designated as an "identifiable" fund from which the ***Plan*** may seek reimbursement.

SUBROGATION

As a condition to participating in and receiving benefits under this ***Plan***, the participant(s) agrees to assign to the ***Plan*** the right to subrogate and pursue any and all claims, causes of action or rights that may arise against any person, corporation and/or entity and to any coverage to which the participant(s) is entitled, regardless of how classified or characterized, at the ***Plan's*** discretion, if the participant(s) fails to so pursue said rights and/or action.

If a participant(s) receives or becomes entitled to receive benefits, an automatic equitable lien attaches in favor of the ***Plan*** to any claim, which any participant(s) may have against any coverage and/or party causing the illness or injury to the extent of such conditional payment by the ***Plan*** plus reasonable costs of collection. The participant is obligated to notify the ***Plan*** or its authorized representative of any settlement prior to finalization of the settlement, execution of a release, or receipt of applicable funds. The participant is also obligated to hold any and all funds so received in trust on the ***Plan's*** behalf and function as a trustee as it applies to those funds until the ***Plan's*** rights described herein are honored and the ***Plan*** is reimbursed.

The ***Plan*** may, at its discretion, in its own name or in the name of the participant(s) commence a proceeding or pursue a claim against any party or coverage for the recovery of all damages to the full extent of the value of any such benefits or conditional payments advanced by the ***Plan***.

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

1. The responsible party, its insurer, or any other 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 participant(s) authorizes the ***Plan*** to pursue, sue, compromise and/or settle any such claims in the participant's/participants' and/or the ***Plan's*** name and agrees to fully cooperate with the ***Plan*** in the prosecution of any such claims. The participant(s) assigns all rights to the ***Plan*** or its assignee to pursue a claim and the recovery of all expenses from any and all sources listed above.

RIGHT OF REIMBURSEMENT

The ***Plan*** shall be entitled to recover 100% of the benefits paid, 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 participant(s) is fully compensated by his or her recovery from all sources. The ***Plan*** shall have an equitable lien which supersedes all common law or statutory rules, doctrines, and laws of any State prohibiting assignment of rights which interferes with or compromises in any way the ***Plan's*** equitable lien and right to reimbursement. The obligation to reimburse the ***Plan*** in full exists regardless of how the judgment or settlement is classified and whether or not the judgment or settlement specifically designates the recovery or a portion of it as including medical, disability, or other expenses. If the participant's/participants' recovery is less than the benefits paid, then the ***Plan*** is entitled to be paid all of the recovery achieved. Any funds received by the participant are deemed held in constructive trust and should not be dissipated or disbursed until such time as the participant's obligation to reimburse the ***Plan*** has been satisfied in accordance with these provisions. The participant is also obligated to hold any and all funds so received in trust on the ***Plan's*** behalf and function as a trustee as it applies to those funds until the ***Plan's*** rights described herein are honored and the Plan is reimbursed.

No court costs, experts' fees, attorneys' fees, filing fees, or other costs or expenses of litigation may be deducted from the Plan's recovery without the prior, express written consent of the ***Plan***.

The ***Plan's*** right of subrogation and reimbursement will not be reduced or affected as a result of any fault or claim on the part of the participant(s), whether under the doctrines of causation, comparative fault or contributory negligence, or other similar doctrine in law. Accordingly, any lien reduction statutes, which attempt to apply such laws and reduce a subrogating plan's recovery will not be applicable to the ***Plan*** and will not reduce the ***Plan's*** reimbursement rights.

These rights of subrogation and reimbursement shall apply without regard to whether any separate written acknowledgment of these rights is required by the ***Plan*** and signed by the participant(s).

This provision shall not limit any other remedies of the ***Plan*** provided by law. These rights of subrogation and reimbursement shall apply without regard to the location of the event that led to or caused the applicable ***illness***, ***injury***, disease or disability.

PARTICIPANT IS A TRUSTEE OVER PLAN ASSETS

Any participant who receives benefits and is therefore subject to the terms of this section is hereby deemed a recipient and holder of ***Plan*** assets and is therefore deemed a trustee of the ***Plan*** solely as it relates to possession of any funds which may be owed to the ***Plan*** as a result of any settlement, judgment or recovery through any other means arising from any ***injury*** or accident. By virtue of this status, the participant understands that he or she is required to:

1. Notify the ***Plan*** or its authorized representative of any settlement prior to finalization of the settlement, execution of a release, or receipt of applicable funds.
2. Instruct his or her attorney to ensure that the ***Plan*** and/or its authorized representative is included as a payee on all settlement drafts.
3. In circumstances where the participant is not represented by an attorney, instruct the insurance company or any third party from whom the participant obtains a settlement, judgment or other source of coverage to include the ***Plan*** or its authorized representative as a payee on the settlement draft.
4. Hold any and all funds so received in trust, on the ***Plan's*** behalf, and function as a trustee as it applies to those funds, until the ***Plan's*** rights described herein are honored and the ***Plan*** is reimbursed.

To the extent the participant disputes this obligation to the ***Plan*** under this section, the participant or any of its agents or representatives is also required to hold any/all settlement funds, including the entire settlement if the settlement is less than the ***Plan's*** interests, and without reduction in consideration of attorneys' fees, for which he or she exercises control, in an account segregated from their general accounts or general assets until such time as the dispute is resolved.

No participant, beneficiary, or the agents or representatives thereof, exercising control over plan assets and incurring trustee responsibility in accordance with this section will have any authority to accept any reduction of the ***Plan's*** interest on the ***Plan's*** behalf.

EXCESS INSURANCE

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

GENERAL PROVISIONS

ADMINISTRATION OF THE PLAN

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

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

APPLICABLE LAW

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

ASSIGNMENT

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

Payment of Benefits

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

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

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

Additional Provisions

The ***Plan's***, ***Plan Sponsor's***, ***claim processor's*** failure to implement or insist upon compliance with any provision of the ***Plan*** at any given time or times, shall not constitute a waiver of the right to implement or insist upon compliance with that provision at any other time or times.

BENEFITS NOT TRANSFERABLE

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

CLAIM EDITS

Claim edits derived from nationally recognized standards, including but not limited to: CPT, HCPCS, ICD-10 and modifiers, may be applied to ***covered expenses*** to ensure appropriate valid code relationships and to identify bundling and unbundling scenarios. As a result, ***covered expenses*** may be reduced.

DUTIES AND RIGHTS OF THE PACE

When the ***PACE*** is assigned by the ***plan administrator*** to act on behalf of the ***Plan***, the task of making a determination regarding a ***final post-service adverse benefit determination*** appeal, the ***PACE*** shall possess the rights and exercise the duties otherwise ascribed to the ***plan administrator*** or other ***named fiduciary*** assigned authority and the duty to otherwise handle appeals, only insofar as it relates to the ***final post-service adverse benefit determination*** appeal. Assignment is achieved by and when the ***plan administrator*** or any other fiduciary appointed to act on behalf of the ***Plan*** makes a request for a final post-service ***adverse benefit determination*** appeal, received by the ***Plan*** or its authorized agent(s), to the ***PACE*** with instructions to provide a decision on the final post-service ***adverse benefit determination*** appeal.

CLERICAL ERROR

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

CONFORMITY WITH STATUTE(S)

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

EFFECTIVE DATE OF THE PLAN

The original ***effective date*** of this ***Plan*** was October 1, 2015. The ***effective date*** of the modifications contained herein is October 1, 2024.

FRAUD OR INTENTIONAL MISREPRESENTATION

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

FREE CHOICE OF HOSPITAL AND PHYSICIAN

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

INCAPACITY

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

INCONTESTABILITY

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

LEGAL ACTIONS

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

LIMITS ON LIABILITY

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

LOST DISTRIBUTEES

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

MEDICAID ELIGIBILITY AND ASSIGNMENT OF RIGHTS

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

PHYSICAL EXAMINATIONS REQUIRED BY THE PLAN

The ***Plan***, at its own expense, shall have the right to require an examination of a person covered under the ***Plan*** when and as often as it may reasonably require during the pendency of a claim.

PLAN IS NOT A CONTRACT

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

PLAN MODIFICATION AND AMENDMENT

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

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

PLAN TERMINATION

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

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

PRONOUNS

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

RECOVERY FOR OVERPAYMENT

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, the ***Plan*** may pay benefits that are later found to be greater than the maximum allowable charge. In this case, the ***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 ***covered person*** or ***dependent*** on whose behalf such payment was made.

SEVERABILITY

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

STATUS CHANGE

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

TIME EFFECTIVE

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

WORKERS' COMPENSATION NOT AFFECTED

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

HIPAA PRIVACY

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

DISCLOSURE BY PLAN TO PLAN SPONSOR

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

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

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

USE AND DISCLOSURE BY PLAN SPONSOR

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

OBLIGATIONS OF PLAN SPONSOR

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

1. Ensure that:

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

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

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

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

    a. For employment-related actions and decisions; or

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

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

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

    a. For access to the individual;

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

    c. To provide an accounting of disclosures.

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

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

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

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

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

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

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

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

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

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

EXCEPTIONS

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

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

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

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

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

3. Use or disclose protected health information:

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

b. To carry out treatment, payment, or health care operations in accordance with the ***privacy rule***; or
c. As otherwise permitted or required by the ***privacy rule***.

Privacy Officer
Brown Investment Properties, Inc.
1007 Battleground Avenue
Suite 401
Greensboro, North Carolina 27408
1-336-541-5511

NOTICE OF PRIVACY PRACTICES

Effective Date of this Notice: Same as the effective date on the cover page of the Plan

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. **Please review it carefully.**

Your Rights

You have the right to:

- Get a copy of your health and claims records
- Correct your health and claims records
- Request confidential communication
- Ask us to limit the information we share
- Get a list of those with whom we've shared your information
- Get a copy of this privacy notice
- Choose someone to act for you
- File a complaint if you believe your privacy rights have been violated

Your Choices

You have some choices in the way that we use and share information as we:

- Answer coverage questions from your family and friends
- Provide disaster relief
- Market our services and sell your information

Our Uses and Disclosures

We may use and share your information as we:

- Help manage the health care treatment you receive
- Run our organization
- Pay for your health services
- Administer your health plan
- Help with public health and safety issues
- Do research
- Comply with the law
- Respond to organ and tissue donation requests and work with a medical examiner or funeral director
- Address workers' compensation, law enforcement, and other government requests
- Respond to lawsuits and legal actions

Your Rights

When it comes to your health information, you have certain rights. This section explains your rights and some of our responsibilities to help you.

Get a copy of health and claims records

- You can ask to see or get a copy of your health and claims records and other health information we have about you. Ask us how to do this.
- We will provide a copy or a summary of your health and claims records, usually within 30 days of your request. We may charge a reasonable, cost-based fee.

Ask us to correct health and claims records

- You can ask us to correct your health and claims records if you think they are incorrect or incomplete. Ask us how to do this.
- We may say "no" to your request, but we'll tell you why in writing within 60 days.

Request confidential communications

- You can ask us to contact you in a specific way (for example, home or office phone) or to send mail to a different address.
- We will consider all reasonable requests, and must say "yes" if you tell us you would be in danger if we do not.

Ask us to limit what we use or share

- You can ask us not to use or share certain health information for treatment, payment, or our operations.
- We are not required to agree to your request, and we may say "no" if it would affect your care.

Get a list of those with whom we've shared information

- You can ask for a list (accounting) of the times we've shared your health information for six years prior to the date you ask, who we shared it with, and why.
- We will include all the disclosures except for those about treatment, payment, and health care operations, and certain other disclosures (such as any you asked us to make). We'll provide one accounting a year for free but will charge a reasonable, cost-based fee if you ask for another one within 12 months.

Get a copy of this privacy notice

You can ask for a paper copy of this notice at any time, even if you have agreed to receive the notice electronically. We will provide you with a paper copy promptly.

Choose someone to act for you

- If you have given someone medical power of attorney or if someone is your legal guardian, that person can exercise your rights and make choices about your health information.
- We will make sure the person has this authority and can act for you before we take any action.

File a complaint if you feel your rights are violated

- You can complain if you feel we have violated your rights by contacting us using the information on page 1.
- You can file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights by sending a letter to 200 Independence Avenue, S.W., Washington, D.C. 20201, calling 1-877-696-6775, or visiting **www.hhs.gov/ocr/privacy/hipaa/complaints/.**
- We will not retaliate against you for filing a complaint.

Your Choices

For certain health information, you can tell us your choices about what we share. If you have a clear preference for how we share your information in the situations described below, talk to us. Tell us what you want us to do, and we will follow your instructions.

In these cases, you have both the right and choice to tell us to:

- Share information with your family, close friends, or others involved in payment for your care
- Share information in a disaster relief situation

If you are not able to tell us your preference, for example if you are unconscious, we may go ahead and share your information if we believe it is in your best interest. We may also share your information when needed to lessen a serious and imminent threat to health or safety.

In these cases we *never* share your information unless you give us written permission:

- Marketing purposes
- Sale of your information

Our Uses and Disclosures

How do we typically use or share your health information?

We typically use or share your health information in the following ways.

Help manage the health care treatment you receive

We can use your health information and share it with professionals who are treating you.

Example: A doctor sends us information about your diagnosis and treatment plan so we can arrange additional services.

Run our organization

- We can use and disclose your information to run our organization and contact you when necessary.
- We are not allowed to use genetic information to decide whether we will give you coverage and the price of that coverage. This does not apply to long term care plans.

Example: We use health information about you to develop better services for you.

Pay for your health services

We can use and disclose your health information as we pay for your health services.

Example: We share information about you with your dental plan to coordinate payment for your dental work.

Administer your plan

We may disclose your health information to your health plan sponsor for plan administration.

Example: Your company contracts with us to provide a health plan, and we provide your company with certain statistics to explain the premiums we charge.

How else can we use or share your health information?

We are allowed or required to share your information in other ways – usually in ways that contribute to the public good, such as public health and research. We have to meet many conditions in the law before we can share your information for these purposes. For more information see: www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/index.html**.**

Help with public health and safety issues

We can share health information about you for certain situations such as:

- Preventing disease
- Helping with product recalls
- Reporting adverse reactions to medications
- Reporting suspected abuse, neglect, or domestic violence
- Preventing or reducing a serious threat to anyone's health or safety

Do research

We can use or share your information for health research.

Comply with the law

We will share information about you if state or federal laws require it, including with the Department of Health and Human Services if it wants to see that we're complying with federal privacy law.

Respond to organ and tissue donation requests and work with a medical examiner or funeral director

- We can share health information about you with organ procurement organizations.
- We can share health information with a coroner, medical examiner, or funeral director when an individual dies.

Address workers' compensation, law enforcement, and other government requests

We can use or share health information about you:

- For workers' compensation claims
- For law enforcement purposes or with a law enforcement official
- With health oversight agencies for activities authorized by law
- For special government functions such as military, national security, and presidential protective services

Respond to lawsuits and legal actions

We can share health information about you in response to a court or administrative order, or in response to a subpoena.

Our Responsibilities

- We are required by law to maintain the privacy and security of your protected health information.
- We will let you know promptly if a breach occurs that may have compromised the privacy or security of your information.
- We must follow the duties and privacy practices described in this notice and give you a copy of it.
- We will not use or share your information other than as described here unless you tell us we can in writing. If you tell us we can, you may change your mind at any time. Let us know in writing if you change your mind.

For more information see: www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/noticepp.html**.**

Changes to the Terms of this Notice

We can change the terms of this notice, and the changes will apply to all information we have about you. The new notice will be available upon request, on our web site, and we will mail a copy to you.

DEFINITIONS

Certain words and terms used herein shall be defined as follows and are shown in ***bold and italics*** throughout the document:

Accident

An unforeseen event resulting in ***injury***.

Adverse Benefit Determination

Adverse benefit determination shall mean any of the following:

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

Air Mileage Rate

A ***contracted rate*** expressed in dollars per loaded mile (statute miles not nautical miles) flown.

Affordable Care Act

The Patient Protection and Affordable Care Act, as amended by the Health Care and Education Reconciliation Act of 2010 and all applicable regulations and regulatory guidance.

Alternate Recipient

Any child of an ***employee*** or their spouse who is recognized in a Qualified Medical Child Support Order (QMCSO) or National Medical Support Notice (NMSN) which has been issued by any court judgment, decree, or order as being entitled to enrollment for coverage under the ***Plan***.

Ambulatory Surgical Facility

A ***facility*** provider with an organized staff of ***physicians*** which has been approved by the Joint Commission on the Accreditation of Healthcare Organizations, or by the Accreditation Association for Ambulatory Health, Inc., or by ***Medicare***; or that has a contract with the ***Preferred Provider Organization*** as a ***preferred provider***. An ***ambulatory surgical facility*** is a ***facility*** that:

1. Has permanent facilities and equipment for the purpose of performing surgical procedures on an ***outpatient*** basis;
2. Provides treatment by or under the supervision of ***physicians*** and nursing services whenever the ***covered person*** is in the ***ambulatory surgical facility***;

3. Does not provide ***inpatient*** accommodations; and

4. Is not, other than incidentally, a ***facility*** used as an office or clinic for the private practice of a ***physician***.

Anesthesia Conversion Factor

A ***median contracted rate*** expressed in dollars per unit.

Approved Clinical Trial

A Phase I, Phase II, Phase III, or Phase IV clinical trial that is conducted in relation to the prevention, detection, or treatment of cancer or other" life-threatening disease or condition" and is further described in accordance with federal law and applicable federal regulations.

Applied Behavioral Analysis (ABA)

A type of intensive behavioral therapy in which individuals trained in objective observation, evidence based assessment, data collection, and functional analyses utilize these data to produce meaningful changes in human behavior.

Autism Spectrum Disorder

A condition related to brain development that affects how a person perceives and socializes with others, causing problems in social interaction and communication. This disorder also includes limited and repetitive behavior.

Base Unit

For an anesthesia service code, ***base units*** are specified in the most recent edition (as of the date of service) of the American Society of Anesthesiologists Relative Value Guide.

Birthing Center

A ***facility*** that meets professionally recognized standards and complies with all licensing and other legal requirements that apply.

CancerCARE Allowable

For inpatient and outpatient hospital and professional services, ***CancerCARE Allowable*** means billed charges for ***covered expenses*** provided in compliance with the ***CancerCARE Program***, minus non-covered services and supplies, negotiated price concessions, discounts and professional charges beyond ***customary and reasonable amounts*** for such services. Once treatment is authorized by the ***Plan*** for services from a ***COE Network Provider***, payment to the provider will be paid at the applicable benefit reimbursement percentage based on the applicable contract allowable.

CancerCARE Program

A comprehensive cancer management program operated by INTERLINK, which employs care coordinator nurses to monitor care and coordinate care at ***COE Network Providers*** for appropriate ***covered persons***.

Case Management Recommendation

Alternate providers may be identified and recommended by a ***CancerCARE Program*** Nurse as a cost effective alternative if there is no reduction in the quality of care. In these instances, alternate providers will be reimbursed at the applicable CancerCARE benefit level currently in effect with the existing provider. If pharmacy benefits are utilized to obtain medications otherwise provided in a provider's office, normal copays shall be waived if savings to the ***Plan*** are realized and the ***covered person*** has paid any applicable deductible.

Certified IDR Entity

An entity responsible for conducting payment determinations, through the Federal independent dispute resolution process, that has been certified by the Secretaries of Labor, Health and Human Services and the Treasury.

Chiropractic Care

Services as provided by a licensed Chiropractor, M.D., or D.O. for manipulation or manual modalities in the treatment of the spinal column, neck, extremities or other joints, other than for a fracture or surgery.

Clear Value Participation

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

Claims Processor

Refer to the *Summary Plan Description* (SPD) section of this document.

Close Relative

The ***employee's*** spouse, children, brothers, sisters, or parents; or the children, brothers, sisters or parents of the ***employee's*** spouse.

COE Network Provider

A cancer center, hospital or other institution, ***physician*** or ancillary provider that has been designated by the ***CancerCARE Program*** to provide complex cancer care services. ***COE Network Providers*** must have their designation as a National Cancer Institute (NCI) Cancer Center or ***NCCN®*** member institution and be a network provider with the PPO network indicated on the ***covered person's*** identification card.

COE Referral

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

Compliant Benefit Level

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

Course of Care Authorization Waiver

Pre-service authorization for CancerCARE confirmed ***Value Pathway*** courses of treatment is required, but pre-service authorization for services and products included in each Value

Pathway is waived if 1) the ***covered person*** has enrolled in the ***CancerCARE Program***, and 2) the ***covered person*** has obtained a ***Compliant Benefit Level*** status. ***Course of Care Authorization Waiver*** for courses of treatment shall apply to ***COE Network Providers*** if they achieve ***Clear Value Participation***.

Coinsurance

The benefit percentage of ***covered expenses*** payable by the ***Plan*** for benefits that are provided under the ***Plan***. The ***coinsurance*** is applied to ***covered expenses*** after the deductible(s) have been met, if applicable.

Complications of Pregnancy

A disease, disorder or condition, which is diagnosed as distinct from ***pregnancy***, but is adversely affected by or caused by ***pregnancy***. Some examples are:

1. Intra-abdominal surgery (but not elective Cesarean Section).
2. Ectopic ***pregnancy***.
3. Toxemia with convulsions (Eclampsia).
4. Pernicious vomiting (hyperemesis gravidarum).
5. Nephrosis.
6. Cardiac Decompensation.
7. Missed Abortion.
8. Miscarriage.

These conditions are not included: false labor; occasional spotting; rest during ***pregnancy*** even if prescribed by a ***physician***; morning sickness; or like conditions that are not medically termed as ***complications of pregnancy***.

Concurrent Care

A request by a ***covered person*** (or their authorized representative) to the ***Health Care Management Organization*** prior to the expiration of a ***covered person's*** current course of treatment to extend such treatment OR a determination by the ***Health Care Management Organization*** to reduce or terminate an ongoing course of treatment.

Confinement

A continuous stay in a ***hospital***, ***treatment center***, ***extended care facility***, ***hospice***, or ***birthing center*** due to an ***illness*** or ***injury*** diagnosed by a ***physician***. Later stays shall be deemed part of the original ***confinement*** unless there was either complete recovery during the interim from the ***illness*** or ***injury*** causing the initial stay, or unless the latter stay results from a cause or causes unrelated to the ***illness*** or ***injury*** causing the initial stay.

Continuing Care Patient

A ***covered person*** who, with respect to a ***preferred provider*** is:

1. Undergoing a course of treatment for a ***serious and complex condition*** from the ***preferred provider***;

2. Undergoing a course of institutional or ***inpatient*** care from the ***preferred provider***;

3. Scheduled to undergo nonelective surgery from the ***preferred provider***, including postoperative care;

4. Pregnant and undergoing a course of treatment for the pregnancy from the ***preferred provider***; or

Determined to be terminally ill with a life expectancy of 6 months or less, and is receiving treatment for such ***illness*** from the ***preferred provider***.

Contracted Rate

The total amount (including ***cost sharing***) that plan sponsors of self-funded plans administered by ***claims processor*** are contractually agreed to pay a ***preferred provider*** for ***covered expenses***.

Copay

A cost sharing arrangement whereby a ***covered person*** pays a set amount to a provider for a specific service at the time the service is provided.

Cosmetic Surgery

Surgery for the restoration, repair, or reconstruction of body structures directed toward altering appearance.

Cost Sharing

The amount a ***covered person*** is responsible for paying for ***covered expenses***. ***Cost sharing*** includes applicable ***copays***, ***coinsurance*** and deductible. ***Cost sharing*** does not include balance billing by ***nonpreferred providers***, or the cost of items or services that are not ***covered expenses***.

Covered Expenses

Medically necessary services, supplies or treatments that are recommended or provided by a ***physician***, ***professional provider*** or covered ***facility*** for the treatment of an ***illness*** or ***injury*** and that are not specifically excluded from coverage herein. ***Covered expenses*** shall include specified preventive care services.

Covered Person

A person who is eligible for coverage under the ***Plan***, or becomes eligible at a later date, and for whom the coverage provided by the ***Plan*** is in effect.

Custodial Care

Care provided primarily for maintenance of the ***covered person*** or which is designed essentially to assist the ***covered person*** in meeting his activities of daily living and which is not primarily provided for its therapeutic value in the treatment of an ***illness*** or ***injury***. ***Custodial care*** includes, but is not limited to: help in walking, bathing, dressing, feeding, preparation of special diets and supervision over self-administration of medications. Such services shall be considered ***custodial care*** without regard to the provider by whom or by which they are prescribed, recommended or performed.

Room and board and skilled nursing services are not, however, considered ***custodial care*** (1) if provided during ***confinement*** in an institution for which coverage is available under the ***Plan***, and (2) if combined with other ***medically***

necessary therapeutic services, under accepted medical standards, which can reasonably be expected to substantially improve the ***covered person's*** medical condition

Customary and Reasonable Amount

Except as otherwise required under state or federal law, the maximum amount the ***Plan*** is obligated to pay for ***covered expenses*** provided by a:

1. ***preferred provider*** – the ***preferred provider negotiated rate;***
2. ***nonpreferred provider*** – calculated as the lesser of:
   a. The provider's billed charge; or
   b. An amount determined by ***claims processor*** or its vendor using one or more of the following:
      i.) Publicly available data reflecting fees typically reimbursed to providers for the same or similar professional services, supplies or treatment, adjusted for geographical differences where applicable; or
      ii.) Publicly available data reflecting the costs for facilities providing the same or similar services, supplies or treatment, adjusted for geographical differences where applicable, plus a margin factor; or
      iii.) An amount negotiated with the ***nonpreferred provider*** for the specific services, supplies or treatment provided; or
      iv.) A fee, which shall not exceed the general level of charges made by others rendering or furnishing such services, supplies or treatment within the area where the charge is ***incurred*** and is comparable in severity and nature to the ***illness*** or ***injury***. Due consideration shall be given to any medical complications or unusual circumstances which require additional time, skill or experience. This amount is determined from a statistical review and analysis of the charges for a given procedure in a given area. The term "area" as it would apply to any particular service, supply or treatment means a county or such greater area as is necessary to obtain a representative cross-section of the level of charges. The percentage applicable to the ***Plan*** is 90% and is applied to CPT and CDT codes using Fair Health benchmarking tables.

Covered expenses provided by a ***nonpreferred provider*** subject to the requirements specified in the *Nonpreferred Provider* subsection, under the *Preferred Provider or Nonpreferred Provider* section, are not subject to the ***customary and reasonable amount***, but instead are subject to the lesser of the ***qualifying payment amount*** or the ***nonpreferred provider's*** actual charge.

Dentist

A Doctor of Dental Medicine (D.M.D.), a Doctor of Dental Surgery (D.D.S.), a Doctor of Medicine (M.D.), or a Doctor of Osteopathy (D.O.), other than a ***close relative*** of the ***covered person***, who is practicing within the scope of that Doctor's license.

Dependent

Refer to the *Eligibility, Enrollment and Effective Date, Dependent(s) Eligibility* section for what constitute a ***dependent***.

Durable Medical Equipment

Medical equipment which:

1. Can withstand repeated use;
2. Is primarily and customarily used to serve a medical purpose;
3. Is generally not used in the absence of an ***illness*** or ***injury***;
4. Is appropriate for use in the home.

All provisions of this definition must be met before an item can be considered ***durable medical equipment***. ***Durable medical equipment*** includes, but is not limited to: crutches, wheel chairs, ***hospital*** beds, etc.

Effective Date

The date of the ***Plan*** or the date on which the ***covered person's*** coverage commences, whichever occurs later.

Emergency Medical Condition

A medical condition, including a ***mental health disorder*** or ***substance use disorder***, manifesting itself by acute symptoms of sufficient severity (including severe pain) so that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in:

1. Placing the ***covered person's*** life (or with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy, or

2. Causing serious impairment to bodily functions, or

3. Causing serious dysfunction of any bodily organ or part.

Emergency Services

1. With respect to an ***emergency medical condition***, a medical screening examination that is within the capability of the emergency department of a ***hospital*** or of an ***independent freestanding emergency department***, including ancillary services routinely available to the emergency department to evaluate such ***emergency medical condition***, and such further medical examination and treatment, to the extent they are within the capabilities of the staff and facilities available at a ***hospital*** or an ***independent freestanding emergency department***, as are required to ***stabilize*** the patient; and

2. Additional items and services,

    a. For which benefits are provided or covered under the ***Plan***; and

    b. That are furnished by a ***nonpreferred provider*** (regardless of the department of the ***hospital*** or ***independent freestanding emergency department*** in which such items or services are furnished) after the ***covered person*** is ***stabilized*** and as part of ***outpatient*** observation or an ***inpatient*** or ***outpatient*** stay with respect to the visit in which the services provided by the emergency department are furnished; however, such items and services shall not be included as ***emergency services*** if:

        i. The attending ***physician*** or treating provider determines that the ***covered person*** is able to travel using nonmedical transportation or nonemergency medical transportation to an available ***preferred provider*** or ***facility*** located within a reasonable travel distance, taking into account the individual's medical condition;

        ii. Notice and Consent Criteria is satisfied, as specified in section, *Preferred Provider or Nonpreferred Provider*, under number 6. of subsection *Nonpreferred Provider*; and

        iii. The ***covered person*** (or an authorized representative) is in a condition to receive the notice and consent described in the Notice and Consent Criteria as determined by the attending emergency ***physician*** or treating provider using appropriate medical judgment, and to provide informed consent in accordance with applicable law.

Employee

A person directly involved in the regular business of and compensated for services, as reported on the individual's annual W-2 form, by the ***employer***, who is regularly scheduled to work not less than the hours per work week as listed in the section titled *Eligibility, Enrollment and Effective Date, Employee Eligibility* on a ***full-time*** status basis.

Employer

The ***employer*** is Brown Investment Properties, Inc.

Experimental/Investigational

Services, supplies, drugs and treatment which do not constitute accepted medical practice properly within the range of appropriate medical practice under the standards of the case and by the standards of a reasonably substantial, qualified, responsible, relevant segment of the medical community or government oversight agencies at the time services were rendered.

The ***claims processor***, ***named fiduciary for post-service claim appeals***, ***named fiduciary for pre-service claim appeals***, ***employer/plan administrator***, or their designee must make an independent evaluation of the ***experimental***/non-experimental standings of specific technologies. The ***claims processor***, ***named fiduciary for post-service claim appeals***, ***named fiduciary for pre-service claim appeals***, ***employer/plan administrator*** or their designee shall be guided by a reasonable interpretation of ***Plan*** provisions and information provided by qualified independent vendors who have also reviewed the information provided. The decisions shall be made in good faith and rendered following a factual background investigation of the claim and the proposed treatment. The ***claims processor***, ***named fiduciary for post-service claim appeals***, ***named fiduciary for pre-service claim appeals***, ***employer/plan administrator*** or their designee will be guided by the following examples of ***experimental*** services and supplies:

1. If the drug or device cannot be lawfully marketed without approval of the U.S. Food and Drug Administration and approval for marketing has not been given at the time the drug or device is furnished; or

2. If the drug, device, medical treatment or procedure, was not reviewed and approved by the treating facility's institutional review board or other body serving a similar function, or if federal law requires such review or approval; or

3. If "reliable evidence" shows that the drug, device, medical treatment or procedure is the subject of on-going Phase I or Phase II clinical trials, is in the research, ***experimental***, study or ***investigational*** arm of on-going Phase III clinical trials, or is otherwise under study to determine its maximum tolerated dose, its toxicity, its safety, or its efficacy as compared with a standard means of treatment or diagnosis; or

4. If "reliable evidence" shows that prevailing opinion among experts regarding the drug, device, medical treatment or procedure is that further studies or clinical trials are necessary to determine its maximum tolerated dose, its toxicity, its safety, or its efficacy as compared with standard means of treatment or diagnosis.

"Reliable evidence" shall mean only published reports and articles in the authoritative medical and scientific literature; the written protocol or protocols used by the treating facility or the protocol(s) of another facility studying substantially the same drug, device, medical treatment or procedure; or the written informed consent used by the treating facility or by another facility studying substantially the same drug, device, medical treatment or procedure.

Extended Care Facility

An institution, or distinct part thereof, operated pursuant to law and one, which meets all of the following conditions:

1. It is licensed to provide, and is engaged in providing, on an ***inpatient*** basis, for persons convalescing from ***illness*** or ***injury***, professional nursing services, and physical restoration services to assist ***covered persons*** to reach a degree of body functioning to permit self-care in essential daily living activities. Such services must be rendered by a Registered Nurse or by a Licensed Practical Nurse under the direction of a Registered Nurse.

2. Its services are provided for compensation from its ***covered persons*** and under the full-time supervision of a ***physician*** or Registered Nurse.

3. It provides twenty-four (24) hour-a-day nursing services.

4. It maintains a complete medical record on each ***covered person***.

5. It is not, other than incidentally, a place for rest, a place for the aged, or a place for custodial or educational care.

6. It is approved and licensed by ***Medicare***.

This term shall also apply to expenses ***incurred*** in an institution referring to itself as an extended care facility, convalescent nursing facility, or any such other similar designation.

Final Internal Adverse Benefit Determination

An ***adverse benefit determination*** that has been upheld by the ***Plan*** at the conclusion of the internal claim and appeal process, or an ***adverse benefit determination*** with respect to which the internal claim and appeal process has been deemed exhausted.

Foster Child

A child who is placed with the ***employee*** by an authorized placement agency or by judgment, decree, or other order of any court of competent jurisdiction.

Full-time

Employees who are regularly scheduled to work not less than the hours per work week as listed in the section titled *Eligibility, Enrollment and Effective Date, Employee Eligibility*.

Generic Drug

A prescription drug that is generally equivalent to a higher-priced brand name drug with the same use and metabolic disintegration. The drug must meet all Federal Drug Administration (FDA) bioavailability standards and be dispensed according to the professional standards of a licensed pharmacist or ***physician*** and must be clearly designated by the pharmacist or ***physician*** as generic.

Habilitative and Rehabilitative Devices

Medically necessary devices that are designed to assist a ***covered person*** in acquiring, improving, or maintaining, partially or fully, skills and functioning for daily living. Such devices include, but are not limited to, ***durable medical equipment***, orthotics, prosthetics, and low vision aids.

Habilitative Services

Medically necessary health care services that help a ***covered person*** keep, learn or improve skills and functioning for daily living. Examples of ***habilitative services*** include therapy for a ***dependent*** child who is not walking or talking at the expected age. These services may include physical and occupational therapy, speech-language pathology and other ***medically necessary*** services for people with disabilities in a variety of inpatient and/or outpatient settings. ***Habilitative services*** that are not ***medically necessary***, for example when therapy has reached an end point and goals have been reached, will not be a ***covered expense***.

Health Care Management

A process of evaluating if services, supplies or treatment are ***medically necessary*** and appropriate to help ensure cost-effective care.

Health Care Management Organization

The individual or organization designated by the ***plan administrator*** for the process of evaluating whether the service, supply or treatment is ***medically necessary***. The ***Health Care Management Organization*** is Cigna.

Home Health Aide Services

Services which may be provided by a person, other than a Registered Nurse, which are ***medically necessary*** for the proper care and treatment of a person.

Home Health Care Agency

An agency or organization, which meets fully every one of the following requirements:

1. It is primarily engaged in and duly licensed, if licensing is required, by the appropriate licensing authority, to provide skilled nursing and other therapeutic services.

2. It has a policy established by a professional group associated with the agency or organization to govern the services provided. This professional group must include at least one ***physician*** and at least one Registered Nurse. It must provide for full-time supervision of such services by a ***physician*** or Registered Nurse.

3. It maintains a complete medical record on each ***covered person***.

4. It has a full-time administrator.

5. It qualifies as a reimbursable service under ***Medicare***.

Hospice

An agency that provides counseling and medical services and may provide ***room and board*** to a terminally ill ***covered person*** and which meets all of the following tests:

1. It has obtained any required state or governmental Certificate of Need approval.

2. It provides service twenty-four (24) hours-per-day, seven (7) days a week.

3. It is under the direct supervision of a ***physician***.

4. It has a Nurse coordinator who is a Registered Nurse.

5. It has a social service coordinator who is licensed.

6. It is an agency that has as its primary purpose the provision of ***hospice*** services.

7. It has a full-time administrator.

8. It maintains written records of services provided to the ***covered person***.

9. It is licensed, if licensing is required.

Hospital

An institution, which meets the following conditions:

1. It is licensed and operated in accordance with the laws of the jurisdiction in which it is located which pertain to ***hospitals***.

2. It is engaged primarily in providing medical care and treatment to ***ill*** and ***injured*** persons on an ***inpatient*** basis at the ***covered person's*** expense.

3. It maintains on its premises all the facilities necessary to provide for the diagnosis and medical and surgical treatment of an ***illness*** or ***injury***; and such treatment is provided by or under the supervision of a ***physician*** with continuous twenty-four (24) hour nursing services by or under the supervision of Registered Nurses.

4. It qualifies as a ***hospital*** and is accredited by the Joint Commission on the Accreditation of Healthcare Organizations. This condition may be waived in the case of treatment for an ***emergency medical condition*** in a ***hospital*** outside of the United States.

5. It must be approved by ***Medicare***. This condition may be waived in the case of treatment for an ***emergency medical condition*** in a ***hospital*** outside of the United States.

Under no circumstances will a ***hospital*** be, other than incidentally, a place for rest, a place for the aged, or a nursing home.

Hospital shall include a facility designed exclusively for physical rehabilitative services where the ***covered person*** received treatment as a result of an ***illness*** or ***injury***.

The term ***hospital***, when used in conjunction with ***inpatient confinement*** for ***mental health disorders*** or ***substance use disorders***, will be deemed to include an institution which is licensed as a mental ***hospital*** or ***substance use disorder*** rehabilitation and/or detoxification ***facility*** by the regulatory authority having responsibility for such licensing under the laws of the jurisdiction in which it is located.

Illness

A bodily disorder, disease, physical sickness, or ***pregnancy*** of a ***covered person***.

Incurred or Incurred Date

With respect to a ***covered expense***, the date the services, supplies or treatment are provided.

Independent Freestanding Emergency Department

A health care ***facility*** that is geographically separate and distinct and licensed separately from a ***hospital*** under applicable State law and provides ***emergency services***.

Injury

A physical harm or disability, which is the result of a specific incident caused by external means. The physical harm or disability must have occurred at an identifiable time and place. ***Injury*** does not include ***illness*** or infection of a cut or wound.

Inpatient

A ***confinement*** of a ***covered person*** in a ***hospital***, ***hospice***, or ***extended care facility*** as a registered bed patient, for twenty-three (23) or more consecutive hours and for whom charges are made for ***room and board***.

Intensive Care

A service, which is reserved for critically and seriously ill ***covered persons*** requiring constant audio-visual surveillance, which is prescribed by the attending ***physician***.

Intensive Care Unit

A separate, clearly designated service area, which is maintained within a ***hospital*** solely for the provision of ***intensive care***. It must meet the following conditions:

1. Facilities for special nursing care not available in regular rooms and wards of the ***hospital***;

2. Special lifesaving equipment which is immediately available at all times;

3. At least two beds for the accommodation of the critically ill; and

4. At least one Registered Nurse in continuous and constant attendance twenty-four (24) hours-per-day.

This term does not include care in a surgical recovery room, but does include cardiac care unit or any such other similar designation.

Intensive Outpatient Treatment

An ***outpatient substance use disorder*** program that operates a minimum of (3) three hours per day at least (3) three days per week, which includes an individualized treatment plan consisting of assessment, counseling; crisis intervention, and activity therapies or education.

Layoff

A period of time during which the ***employee***, at the ***employer's*** request, does not work for the ***employer***, but which is of a stated or limited duration and after which time the ***employee*** is expected to return to ***full-time***, active work. ***Layoffs*** will otherwise be in accordance with the ***employer's*** standard personnel practices and policies.

Leave of Absence

A period of time during which the ***employee*** does not work, but which is of a stated duration after which time the ***employee*** is expected to return to active work.

Maximum Benefit [for Essential Health Benefits/non-***Essential Health Benefits]***

Any one of the following, or any combination of the following ***Essential Health Benefits/***non-***Essential Health Benefits***:

1. The maximum amount paid by the ***Plan*** for any one ***covered person*** during the entire time the covered person is covered by the ***Plan***.

2. The maximum amount paid by the ***Plan*** for any one ***covered person*** for a particular ***covered expense***. The maximum amount can be for:

    a. The entire time the ***covered person*** is covered under the ***Plan***, or

    b. A specified period of time, such as a plan year.

2. The maximum number as outlined in the ***Plan*** as a ***covered expense***. The maximum number relates to the number of:

    a. Treatments during a specified period of time, or

    b. Days of ***confinement***, or

The ***maximum benefit*** for ***Essential Health Benefits*** and non-***Essential Health Benefits*** is tracked separately.

Measurement Period

The period of time, as determined by the ***employer*** and consistent with Federal law, regulation and guidance, utilized by the ***employer*** to determine whether a ***variable hour employee*** worked on average thirty (30) hours per week for the ***employer***.

Median Contracted Rate

The rate calculated by arranging in order from least to greatest all of the ***contracted rates*** in a geographic area for the same or similar item or service that is provided by a provider or ***facility*** in the same or similar specialty or ***facility*** type, and selecting the middle number. If there are an even number of ***contracted rates***, the ***median contracted rate*** is the average of the middle two ***contracted rates***. ***Median contracted rates*** are:

a. calculated separately for CPT code modifiers 26 (professional component) and TC (technical component);

b. based on an ***anesthesia conversion factor*** for each anesthesia service code;

c. based on air mileage service codes (A0435 and A0436) for air ambulance services; and

calculated separately for each service code-modifier, when ***contracted rates*** vary based on application of a modifier.

Medically Necessary (or Medical Necessity)

Service, supply or treatment which is determined by the ***claims processor***, ***named fiduciary for post-service claim appeals***, ***named fiduciary for pre-service claim appeals***, ***employer/plan administrator*** (or its designee) to be:

1. Appropriate and consistent with the symptoms and provided for the diagnosis or treatment of the ***covered person's illness*** or ***injury*** and which could not have been omitted without adversely affecting the ***covered person's*** condition or the quality of the care rendered; and

2. Supplied or performed in accordance with current standards of medical practice within the United States; and

3. Not primarily for the convenience of the ***covered person*** or the ***covered person's*** family or ***professional provider***; and

4. Is an appropriate supply or level of service that safely can be provided; and

5. Is recommended or approved by the attending ***professional provider***.

The fact that a ***professional provider*** may prescribe, order, recommend, perform or approve a service, supply or treatment does not, in and of itself, make the service, supply or treatment ***medically necessary*** and the ***claims processor***, ***named fiduciary for post-service claim appeals***, ***named fiduciary for pre-service claim appeals***, ***employer/plan administrator*** (or its designee), may request and rely upon the opinion of a ***physician*** or ***physicians***. The determination of the ***claims processor***, ***named fiduciary for post-service claim appeals***, ***named fiduciary for pre-service claim appeals***, ***employer/plan administrator*** (or its designee) shall be final and binding.

Medicare

The programs established by Title XVIII known as the Health Insurance for the Aged Act, which includes: Part A, Hospital Benefits For The Aged; Part B, Supplementary Medical Insurance Benefits For The Aged; Part C, Miscellaneous provisions regarding both programs; and Part D, Medicare Prescription Drug Benefit, including any subsequent changes or additions to those programs.

Mental Health Disorder

An emotional or mental condition characterized by abnormal functioning of the mind or emotions. Diagnosis and classifications of these conditions will be determined based on standard DSM (diagnostic and statistical manual of mental disorders) or the current edition of International Classification of Diseases, published by the U.S. Department of Health and Human Services.

Named Fiduciary for Post-Service Claim Appeals

Luminare Health Benefits (or outside vendor).

Named Fiduciary for Pre-Service Claim Appeals

Cigna.

National Comprehensive Cancer Network (NCCN®)

An alliance of the nation's most prominent hospitals that review outcome information for cancer treatments, publish evidence-based ***NCCN Guidelines®*** and update them as needed.

NCCN Guidelines®

NCCN® disease-specific, committee recommended, evidence-based treatment processes for specific cancers with integrated drugs, dosing and biologics recommendations.

Negotiated Rate

The rate the ***preferred providers*** have contracted to accept as payment in full for ***covered expenses*** of the ***Plan***.

Non-Compliant Benefit

If the ***covered persons*** does not 1) register and participate with the ***CancerCARE Program***, 2) achieve a ***Compliant Benefit Level***, or 3) attend Network Provider, the ***Plan's*** standard benefits apply as outlined within the Schedule of Benefits section

Nonparticipating Pharmacy

Any pharmacy, including a ***hospital*** pharmacy, ***physician*** or other organization, licensed to dispense prescription drugs, which does not fall within the definition of a ***participating pharmacy***.

Nonpreferred Provider

A ***physician***, ***hospital***, or other health care provider who does not have an agreement in effect with the ***Preferred Provider Organization*** at the time services are rendered.

Nurse

A licensed person holding the degree Registered Nurse (R.N.), Licensed Practical Nurse (L.P.N.), Licensed Vocational Nurse (L.V.N.) or Doctorate of Nursing Practice (D.N.P.) who is practicing within the scope of their license.

Out-of-Network Rate

The final payment amount under the ***Plan*** for ***covered expenses*** from a ***nonpreferred provider*** is:

1. Subject to number 3. below, in a State that has in effect an applicable specified State law, the amount determined in accordance with such law.

2. Subject to number 3. below, if no applicable specified State law:

    a. Subject to number 2.b. below, the agreed amount if the ***nonpreferred provider*** and the ***Plan*** agree on an amount of payment (including if the amount agreed upon is the initial amount paid by the ***Plan*** or is agreed through negotiations); or

    b. The amount determined by the ***certified IDR entity***.

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

Outpatient

A ***covered person*** shall be considered to be an ***outpatient*** if the ***covered person*** is treated at:

1. A ***hospital*** as other than an ***inpatient***;

2. A ***physician's*** office, laboratory or x-ray ***facility***; or

3. An ***ambulatory surgical facility***; and

The stay is less than twenty-three (23) consecutive hours.

PACE (Plan Appointed Claim Evaluator)

An entity appointed by the ***plan administrator*** (or its designee) that is assigned the authority and the duty to otherwise decide appeals, with authority to make final, claims processing decisions in response to ***final post-service claim appeals***. The ***PACE's*** fiduciary duties extend only to those determinations actually made by the ***PACE***. The ***PACE*** shall at all times strictly abide by and make determination in accordance with the terms of this ***Plan*** and applicable law, in light of the facts, law, medical records, and all other information submitted to the ***PACE***.

Partial Confinement

A period of at least six (6) hours but less than twenty-four (24) hours per day of active treatment up to five (5) days per week in a ***facility*** licensed or certified by the state in which treatment is received to provide one or more of the following:

1. Psychiatric services.

2. Treatment of ***mental health disorders***.

3. ***Substance use disorder*** treatment.

It may include day, early evening, evening, night care, or a combination of these four.

Participating Pharmacy

Any pharmacy licensed to dispense prescription drugs, which is contracted with the ***pharmacy benefit manager***.

Pharmacy Benefit Manager

The ***pharmacy benefit manager*** is SmithRx.

Pharmacy Organization

The ***pharmacy organization*** is Cigna.

Physical Status Modifier

The standard modifier describing the physical status of the patient used to distinguish between various levels of complexity of an anesthesia service provided expressed as a unit with a value between zero (0) and three (3).

Physician

A Doctor of Medicine (M.D.) or a Doctor of Osteopathy (D.O.), other than a ***close relative*** of the ***covered person*** who is practicing within the scope of his license.

Placed For Adoption

The date the ***employee*** assumes legal obligation for the total or partial financial support of a child during the adoption process.

Plan

"***Plan***" refers to the benefits and provisions for payment of same as described herein. The ***Plan*** is the Brown Investment Properties, Inc. Employee Benefit Plan.

Plan Administrator

The ***plan administrator*** is responsible for the day-to-day functions and management of the ***Plan***. The ***plan administrator*** is the ***employer***.

Plan Sponsor

The ***plan sponsor*** is Brown Investment Properties, Inc.

Preferred Provider

A ***physician***, ***facility*** or other health care provider who has an agreement in effect with the ***Preferred Provider Organization*** at the time services are rendered. ***Preferred providers*** agree to accept the ***negotiated rate*** as payment in full.

Preferred Provider Organization

The organization, designated by the ***plan administrator***, who selects and contracts with certain ***hospitals***, ***physicians***, and other health care providers to provide services, supplies and treatment to ***covered persons*** at a ***negotiated rate***. The ***Preferred Provider Organization's*** name and/or logo is shown on the front of the ***covered person's*** ID card.

Pregnancy

The physical state, which results in childbirth or miscarriage.

Primary Care Physician (PCP)

A licensed Doctor of Medicine (M.D.) or Doctor of Osteopathy (D.O.) who is a general or family practitioner, pediatrician or general internist.

Privacy Rule

Health Insurance Portability and Accountability Act of 1996 (HIPAA) and its implementing regulation concerning privacy of individually identifiable health information, as published in 65 Fed. Reg. 82461 (Dec. 28, 2000) and as modified and published in 67 Fed. Reg. 53181 (Aug. 14, 2002).

Professional Provider

A licensed ***physician***; surgeon, or any other licensed practitioner required to be recognized by state law, if applicable, and performing services within the scope of such license, who is not a family member.

Qualified Prescriber

A ***physician***, ***dentist*** or other health care practitioner other than a ***close relative*** of the ***covered person*** who may, in the legal scope of their license, prescribe drugs or medicines.

Qualifying Payment Amount

a. For items or services furnished during 2022, the ***median contracted rate*** on January 31, 2019;

b. For items or services furnished after 2022, the ***median contracted rate*** in the immediately preceding year;

c. For items or services for which there is insufficient information to calculate the ***median contracted rate***, the ***qualifying payment amount*** will be calculated by identifying the rate that is equal to the median of the ***negotiated rates*** for the same or similar item or service provided in the geographic region in the year immediately preceding the year in which the item or service is furnished determined through the use of any eligible database;

The amount in a., b., or c. above is increased for inflation in accordance with the CPI-U published by the Bureau of Labor Statistics of the Department of Labor.

d. For items or services furnished during 2022 and billed under a new service code where there is insufficient information to calculate the ***median contracted rates***, a reasonably related service code that existed in the immediately preceding year will be identified.

   i. If the Centers for Medicare & Medicaid Services has established a ***Medicare*** payment rate for the item or service billed under the new service code, the ***qualifying payment amount*** will be calculated by first calculating the ratio of the rate that ***Medicare*** pays for the new service code compared to the rate that ***Medicare*** pays for the related service code. This ratio is then multiplied by the ***qualifying payment amount*** for the related service code for the year in which the item or service is furnished.

   ii. If the Centers for Medicare & Medicaid Services has not established a ***Medicare*** payment rate for the item or service billed under the new service code, the ***qualifying payment amount*** will be calculated by first calculating the ratio of the rate that the ***Plan*** reimburses for the new service code compared to the rate the ***Plan*** reimburses for the related service code. This ratio is then multiplied by the ***qualifying payment amount*** for the related service code.

e. For items or services furnished after 2022 and billed under a new service code, the ***qualifying payment amount*** described in letter d. above will be increased for inflation in accordance with the percentage increase in the CPI-U published by federal regulators.

f. For anesthesia services furnished during 2022, the ***median contracted rate*** for the ***anesthesia conversion factor*** on January 31, 2019, increased for inflation in accordance with the increase in the CPI-U published by federal regulators (referred to as the indexed ***median contracted rate*** for the ***anesthesia conversion factor***), multiplied by the sum of the ***base unit***, time unit (measured in 15-minute increments or a fraction thereof), and ***physical status modifier*** unit. For anesthesia services furnished during 2024 or later, the indexed ***median contracted rate*** for the ***anesthesia conversion factor*** will be based on the same or similar item or service in the immediately preceding year.

g. For air ambulance services billed using air mileage service codes (A0435 and A0436), the ***median contracted rate*** increased for inflation in accordance with the increase in the CPI-U published by federal regulators (referred to as the indexed median ***air mileage rate***), multiplied by the number of loaded miles (the number of miles a patient is transported in the air ambulance vehicle).The ***qualifying payment amount*** for other service codes associated with air ambulance services is calculated consistent with a. through e above.

For any other items or services where payment is determined by multiplying a ***contracted rate*** by another unit value, the ***qualifying payment amount*** for such items or services will be based on a calculation methodology similar to f. and g. above.

Recognized Amount

With respect to ***covered expenses*** furnished by a ***nonpreferred provider***:

a. Subject to letter c. of this definition, in a State that has in effect an applicable specified State law, the amount determined in accordance with such law;

b. Subject to letter c. of this definition, in a State that does not have in effect an applicable specified State law, the lesser of:

   i. The provider's actual charge; or

   ii. The ***qualifying payment amount***;

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

Reconstructive Surgery

Surgical repair of abnormal structures of the body, caused by congenital defects, developmental abnormalities, trauma, infection, tumors or disease.

Rehabilitative Services

Medically necessary health care services that help a ***covered person*** get back, keep, or improve skills for daily living that have been lost or impaired after sickness, ***injury***, or disability. These services assist individuals in improving or maintaining, partially or fully, skills and functioning for daily living. ***Rehabilitative services*** include, but are not limited to, physical therapy, occupational therapy, speech-language pathology and audiology, and psychiatric rehabilitation.

Relevant Information

Relevant information, when used in connection with a claim for benefits or a claim appeal, means any document, record or other information:

1. Relied on in making the benefit determination; or
2. That was submitted, considered or generated in the course of making a benefit determination, whether or not relied upon; or
3. That demonstrates compliance with the duties to make benefit decisions in accordance with ***Plan*** documents and to make consistent decisions; or
4. That constitutes a statement of policy or guidance for the ***Plan*** concerning the denied treatment or benefit for the ***covered person's*** diagnosis, even if not relied upon.

Required By Law

The same meaning as the term "required by law" as defined in 45 CFR 164.501, to the extent not preempted by ERISA or other Federal law.

Retail Clinic

A clinic whose primary function is to provide limited routine medical services in a retail-based store location staffed with licensed ***professional providers***.

Room and Board

Room and linen service, dietary service, including meals, special diets and nourishments, and general nursing service. ***Room and board*** does not include personal items.

Semiprivate

The daily ***room and board*** charge which a ***facility*** applies to the greatest number of beds in its ***semiprivate*** rooms containing two (2) or more beds.

Serious and Complex Condition

In the case of an acute ***illness***, a condition that is serious enough to require specialized medical treatment to avoid the reasonable possibility of death or permanent harm. In the case of a chronic ***illness*** or condition, a condition that:

1. Is life-threatening, degenerative, potentially disabling, or congenital; and

2. Requires specialized medical care over a prolonged period of time.

Stability Period

The period of time as determined by the ***employer*** and consistent with Federal law, regulation and guidance, after the ***measurement period*** has been completed.

Stabilize

To provide medical treatment of an ***emergency medical condition*** as necessary, to assure within reasonable medical probability, that no material deterioration of the condition is likely to result from or occur during the transfer of the ***covered person*** from a ***facility***, including delivery with respect to a pregnant woman who is having contractions.

Substance Use Disorder

Any disease or condition that is classified as a ***substance use disorder*** in the current edition of the International Classification of Diseases, in effect at the time services are rendered. The fact that a disorder is listed in the International Classification of Diseases or any other publication does not mean that treatment of the disorder is covered by the Plan.

Treatment Center

1. An institution which does not qualify as a ***hospital***, but which does provide a program of effective medical and therapeutic treatment for ***mental health disorders*** or ***substance use disorders***, and

2. Where coverage of such treatment is mandated by law, has been licensed and approved by the regulatory authority having responsibility for such licensing and approval under the law, or

3. Where coverage of such treatment is not mandated by law, meets all of the following requirements:
   a. It is established and operated in accordance with the applicable laws of the jurisdiction in which it is located.
   b. It provides a program of treatment approved by the ***physician***.
   c. It has or maintains a written, specific, and detailed regimen requiring full-time residence and full-time participation by the ***covered person***.
   d. It provides at least the following basic services:
      (i.) ***Room and board***
      (ii.) Evaluation and diagnosis
      (iii.) Counseling
      (iv.) Referral and orientation to specialized community resources.

Urgent Care

An ***emergency medical condition*** or an onset of severe pain that cannot be managed without immediate treatment.

Urgent Care Center

A ***facility*** which is engaged primarily in providing minor emergency and episodic medical care and which has:

1. a board-certified ***physician***, a Registered Nurse (RN) and a registered x-ray technician in attendance at all times;

2. has x-ray and laboratory equipment and life support systems.

An ***urgent care center*** may include a clinic located at, operated in conjunction with, or which is part of a regular ***hospital***.

Variable Hour Employee

An ***employee*** as defined by Federal law, regulation and guidance.

Value Pathway

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

APPENDIX A PROGRAMS AND SERVICES

PAYMENT SERVICES - SIMPLICITY

Simplicity is a medical payment service, provided by Simplicity Payment Association, enabling ***covered persons*** with the Simplicity logo on their ID card, to streamline their medical bill paying process.

Simplicity applies only to Simplicity members who activate the benefit by accepting the terms and conditions found on the Simplicity portal. When activated by the member, Simplicity prefunds eligible ***covered person's*** deductible and ***coinsurance*** payment obligations under the ***Plan*** to ***preferred providers*** at the time of ***Plan*** benefit payments. Funding for this service is provided by Simplicity Payment Association. Simplicity Payment Association shall offer payment plans to eligible Simplicity ***covered persons*** who need additional time to pay Simplicity Payment Association such obligations in full.

Note: The Simplicity Services Program applies to *covered expenses* under the *Medical Expense Benefit* section only.

ONLINE PAYMENT MANAGER

Claim processor offers the Luminare Health Benefits Online Payment Manager service that enables eligible ***covered persons*** to pay their out-of-pocket obligations directly to providers.

MATERNITY PROGRAM

"Special Delivery" is a voluntary program designed to provide prenatal and postnatal education and support to expectant mothers, and to identify and manage those with risks as early as possible, through continuous monitoring and engagement. This program utilizes proactive outreach from a dedicated maternity nurse specialist. Expectant mothers who choose to participate in the program will receive telephonic education on strategies for a healthy lifestyle and reducing the risk of a complicated pregnancy.

MESSAGING SERVICES

Salesforce.com, Inc. or any other third party to provide telephonic messaging, including text messaging, to ***covered persons*** who opt into the service. Such messaging includes, but is not limited to, information about services and benefits available under the ***Plan***, reminders on preventive care, surveys, and educational information.

CANCERCARE PROGRAM COVERAGE

The ***Plan*** provides benefit coverage for evidence-based cancer care services provided at local, regional and national cancer programs. In order to obtain the best outcomes for ***covered persons***, the ***Plan*** employs INTERLINK's ***CancerCARE Program*** with specialized care coordination nurses, McKesson Clear Value Plus with ***Value Pathways*** powered by ***NCCN®*** and ***NCCN*** Clinical Practice Guidelines in Oncology®. To be eligible for enhanced ***Plan*** benefits, all ***covered persons*** with a cancer diagnosis must as soon as reasonably possible call the ***CancerCARE Program*** at 877-640-9610 and complete registration.

CancerCARE Benefits:

Preferred Provider	***Non-Preferred Provider***
Compliant Benefit	**Non-Compliant Benefit**
• 100% of ***CancerCARE program*** allowable covered by ***Plan*** • ***Covered person's*** deductibles and copays waived • Certain ***Course of Care Authorization*** requirements waived for services included in a confirmed ***Value Pathway*** • ***Covered persons*** choosing not to travel to a ***COE Network Provider*** for complex care, but receiving care in concordance to a ***Value Pathway*** or ***NCCN Guideline®*** • Clinical trials as defined below • Navigator or Compass ***covered persons*** receiving cancer care when a ***Value Pathway*** does not exist if ***Clear Value Participation*** has been achieved with ***NCCN Guideline®*** concordance or ***Plan***-approved deviation • CancerCARE second opinion benefits at 100% of ***CancerCARE Allowable*** • Travel benefits as defined below	• Standard ***Plan*** Benefits apply as outlined on the *Schedule of Benefits*.

ADDITIONAL PROVISIONS

REGISTRATION REQUIREMENT

Upon diagnosis of cancer of any type, ***covered persons*** shall call the ***CancerCARE program*** at 877-640-9610 for registration into the program. Failure to register with the ***CancerCARE Program*** will prevent the ***covered persons*** from receiving enhanced CancerCARE benefits.

COE TRAVEL BENEFITS

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

CANCERCARE SECOND OPINION

The ***Plan*** provides coverage for a CancerCARE Second Opinion through utilization of the ***COE Network Providers***, which may include a review of the diagnosis, review of the treatment plan or both. Second Opinions may require travel to a ***COE Network Provider*** to qualify for benefits. A Second Opinion may consist solely of having pathology slides reviewed by a specialized lab or may include other services. Genetic Testing is a covered service when coordinated by a ***CancerCARE Program*** Nurse.

CLINICAL TRIAL BENEFITS

The ***Plan*** provides Clinical Trial coverage for Routine Patient Costs consistent with the Routine Patient Costs For Approved Clinical Trials provision within the Medical Expense Benefit section.
Routine Patient Costs shall be reimbursed at the ***Compliant Benefit Level***, provided that the Clinical Trial: (1) is provided at a Cancer COE Provider; and (2) is a Phase 1-4 Clinical Trial, that has been approved and coordinated by a ***CancerCARE Program*** Nurse. Otherwise, Clinical Trial Routine Patient Costs shall be reimbursed per standard ***Plan*** benefits as specified on the *Schedule of Benefits*.

Covered Persons are encouraged to contact CancerCARE at 877-640-9610 for further information on clinical trial coverage.

QUESTIONS

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