BENEFIT BOOKLET

FOR

BRIGHTSPRING HEALTH SERVICES

$3500 DED PLAN AND
$4500 DED W/HSA PLAN

EFFECTIVE: JANUARY 1, 2021

RESTATED: JANUARY 1, 2026

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GENERAL INFORMATION AND PURPOSE

This Benefit Booklet describes the benefits for the Employees of BrightSpring Health Services. It sets forth the terms and provisions of the Plan that provide for the payment or reimbursement of all or a portion of certain covered expenses for medical charges. The Benefit Booklet is maintained by **BrightSpring Health Services** and may be inspected at any time during normal working hours by any Covered Person. *Refer to the BHS Welfare Benefit Plan for information regarding Eligibility for Benefits under the Plan.*

Plan Sponsor
BrightSpring Health Services
805 N. Whittington Parkway
Louisville, Kentucky 40222
502-394-2100

Plan Administrator
BrightSpring Health Services
805 N. Whittington Parkway
Louisville, Kentucky 40222
502-394-2100

Claims Administrator
Imagine360 Administrators, LLC
PO Box 749075
Dallas, Texas 75374-9075
972-238-7900 ◆ 800-827-7223
The Plan Administrator has retained the services of the Claims Administrator to administer Claims under the Plan.

Utilization Review Company
Quantum Health
866-885-1491

Plan Year
The twelve (12) month period beginning January 1 and ending December 31 of each Calendar Year

Group Number
H880335

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

INTRODUCTION

PLAN ADMINISTRATOR AND IMAGINE360

The Plan is administered by the Plan Administrator in accordance with the provisions of the Employee Retirement Income Security Act of 1974 (ERISA), as amended. An individual or entity may be appointed by the Plan Sponsor to be Plan Administrator and serve at the convenience of the Plan Sponsor. If the Plan Administrator resigns, dies, is otherwise unable to perform, is dissolved, or is removed from the position, the Plan Sponsor shall appoint a new Plan Administrator as soon as reasonably possible.

Notwithstanding any provisions of this Benefit Booklet to the contrary, the Plan Sponsor has the authority to, and hereby does, allocate certain Fiduciary responsibility to Imagine360. The Fiduciary responsibility allocated to Imagine360 is limited to discretionary authority and decision-making authority with respect to any appeals of denied Claims, which shall be referred to Imagine360 by the Plan Administrator (the "Referred Appeals"). The Plan Sponsor has allocated additional Fiduciary responsibility to Imagine360, limited to discretionary authority and decision-making authority with respect to the review and audit of certain Claims in accordance with the applicable Plan provisions under the section, "Claim Review and Audit Program." Such Claims selected as eligible for review and audit shall be identified by Imagine360 under guidelines to which the Plan Sponsor has agreed, and shall be referred to Imagine360 by the Plan Administrator. Imagine360 shall have no authority, responsibility or liability other than with respect to the Referred Appeals and its duties under the Claim Review and Audit Program.

The Plan Administrator shall establish the policies, practices and procedures of this Benefit Booklet. The Plan Administrator and Imagine360 shall administer this Benefit Booklet in accordance with its terms. It is the express intent of this Benefit Booklet that the Plan Administrator and Imagine360 shall have maximum legal discretionary authority to construe and interpret the terms and provisions of the Plan, to make determinations regarding issues which relate to eligibility for benefits (including the determination of which services, supplies, care and treatment are Experimental/Investigational), to decide disputes which may arise relative to a Covered Person's rights, and to decide questions of Plan interpretation and those of fact relating to the Plan. The decisions of the Plan Administrator and/or Imagine360 as to the facts related to any Claim for benefits and the meaning and intent of any provision of the Plan, or its application to any Claim, shall receive the maximum deference provided by law and will be final and binding on all interested parties. Benefits under this Benefit Booklet will be paid only if the Plan Administrator or Imagine360 decides, in its discretion, that the Covered Person is entitled to them.

DUTIES OF THE PLAN ADMINISTRATOR

The duties of the Plan Administrator include the following:

1. To administer the Plan in accordance with its terms;
2. To determine all questions of eligibility, status and coverage under the Plan;
3. To interpret the Plan, including the authority to construe possible ambiguities, inconsistencies, omissions and disputed terms;
4. To make factual findings;
5. To decide disputes which may arise relative to a Plan Participant's rights;
6. To prescribe procedures for filing a Claim for benefits, to review Claim denials and appeals relating to them and to uphold or reverse such denials;
7. To keep and maintain the Plan documents and all other records pertaining to the Plan;
8. To appoint and supervise a third party administrator to pay Claims;
9. To perform all necessary reporting as required by ERISA;
10. To ensure that the Plan is administered in accordance with applicable law;
11. To establish and communicate procedures to determine whether a Medical Child Support Order or national medical support notice is a QMCSO;
12. To delegate to any person or entity such powers, duties and responsibilities as it deems appropriate; and
13. To perform each and every function necessary for or related to the Plan's administration.

DUTIES OF IMAGINE360

Imagine360 shall have the following duties with respect to the Referred Appeals and the Claim Review and Audit Program:

1. To administer the Plan in accordance with its terms;
2. To determine all questions of eligibility, status and coverage under the Plan;
3. To interpret the Plan, including the authority to construe possible ambiguities, inconsistencies, omissions and disputed terms;
4. To make factual findings;
5. To decide disputes which may arise relative to benefits payable under the Plan and negotiating settlements, if appropriate;
6. To review Referred Appeals and to uphold or reverse any denials;
7. To keep and maintain records pertaining to the Referred Appeals;
8. To perform the duties in conjunction with the provisions of the Claim Review and Audit Program; and
9. To keep and maintain records pertaining to the Claim Review and Audit Program.

The duties of Imagine360 shall be limited to those set forth above.

PHYSICIAN-PATIENT RELATIONSHIP

The Plan is not intended to disturb the Physician-Patient relationship. Physicians and other healthcare Providers are not agents or delegates of the Plan Sponsor, Company, Plan Administrator, Employer or Claims Administrator. The delivery of medical and other healthcare services on behalf of any Covered Person remains the sole prerogative and responsibility of the attending Physician or other healthcare Provider.

FREE CHOICE OF HOSPITAL AND PHYSICIAN

Nothing contained in this Benefit Booklet 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 this Benefit Booklet, and the Covered Person may have higher out-of-pocket expenses if the Covered Person uses the services of a Non-Preferred Provider Physician.

PREFERRED PROVIDER INFORMATION

The Preferred Provider Network (PPO) includes Physicians and other professional Providers who have contracted with the medical Provider Networks. For Physicians and all other professional Providers of service, this Plan contains provisions under which a Plan Participant may receive more benefits by using certain Providers. There is a section in the Schedule of Benefits which describes the benefits for PPO Providers (Level II). PPO Providers are individuals and entities that have contracted with the Plan to provide services to Plan Participants at pre-negotiated rates. A list of these Preferred Providers can be accessed on the PPO website free of charge. In addition, a Plan Participant may request a Preferred Provider list by contacting the Plan Administrator. The Preferred Provider list changes frequently; therefore, it is recommended that a Plan Participant verify with the Provider that the Provider is still a Preferred Provider before receiving services. Access BrightSping.Quantum-Health.com to locate a PPO Provider.

The Preferred Provider Network (PPO) does **not** include services and supplies provided by Facilities such as Hospital Facilities, Ambulatory Surgery Center Facilities, and dialysis clinics or Facilities. You may contact the Claims Administrator or the Plan Administrator with any questions regarding which Facilities may be included under the Claim Review and Audit Program, and which may be included under the PPO Network agreement.

For all Facility Providers and those Physicians and professional Providers not participating in the PPO, the Plan will identify the Reasonable cost for the services and supplies through its Claim Review and Audit Program. There is a section in this Benefit Booklet that fully describes the Claim Review and Audit Program. The benefits for Facility Providers are described in the Schedule of Benefits under Level I and the benefits for those Physicians and professional Providers not participating in the PPO (Non-PPO) are described in Level II.

This Benefit Booklet may use Allowable Claim Limits to determine Covered Charges in lieu of a PPO discount.

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

EFFECTIVE DATE

January 1, 2026

CLAIMS ADMINISTRATOR

The Claims Administrator of the Plan is shown in the General Information and Purpose section.

CLAIMS PROCEDURE

In accordance with Section 503 of ERISA, the Plan Administrator shall provide adequate notice in writing to any covered Plan Participant whose Claim for benefits under this Benefit Booklet has been denied, setting forth the specific reasons for such denial and written in a manner calculated to be understood by the Plan Participant. Further, the Plan Administrator shall afford a reasonable opportunity to any Plan Participant, whose Claim for benefits has been denied, for a fair review of the decision denying the Claim by the person designated by the Plan Administrator for that purpose. Details of the Claims procedure, which are in compliance with ERISA regulations, are found in this Benefit Booklet under the section entitled "Procedures for Claims and Appeals."

PROTECTION AGAINST CREDITORS

No benefit payment under this Benefit Booklet shall be subject in any way to alienation, sale, transfer, pledge, attachment, garnishment, execution or encumbrance of any kind, and any attempt to accomplish the same shall be void. If the Plan Administrator shall find that such an attempt has been made with respect to any payment due or to become due to any Plan Participant, the Plan Administrator in its sole discretion may terminate the interest of such Plan Participant or former Plan Participant in such payment. And in such case the Plan Administrator shall apply the amount of such payment to or for the benefit of such Plan Participant or former Plan Participant, his/her spouse, parent, adult Child, guardian of a minor Child, brother or sister, or other relative of a Dependent of such Plan Participant or former Plan Participant, as the Plan Administrator may determine, and any such application shall be a complete discharge of all liability with respect to such benefit payment. However, at the discretion of the Plan Administrator, benefit payments may be assigned to health care Providers.

PLAN IS NOT A CONTRACT

The Plan will not be deemed to constitute a contract of employment or give any Covered Employee the right to be retained in the service of the Employer or to interfere with the right of the Employer to discharge or otherwise terminate the employment of any Covered Employee.

SCHEDULE OF BENEFITS – $3500 DEDUCTIBLE PLAN

MAJOR MEDICAL BENEFITS FOR COVERED PERSONS

NOTE: All Claims are subject to review and/or audit to ensure that charges are payable in accordance with the terms and limitations of this Benefit Booklet.

LEVEL I PROVIDERS – Facilities and Providers billing as a Facility to include, but not limited to:

- Hospitals (Inpatient and Outpatient treatment)
- Inpatient Facilities (such as Rehabilitation Facilities, Skilled Nursing Facilities and Hospice)
- Inpatient and Outpatient Facilities for treatment of Mental Disorders, Chemical Dependency, Drug and Substance Abuse
- Ambulatory Surgery Centers
- Dialysis Clinics
- Ambulance (air and ground)

LEVEL II PROVIDERS – Physicians and all other Providers of service

Maximum Benefits	
Lifetime Maximum Dollar Benefit (All Covered Essential Health Benefits)	Unlimited
Annual Maximum Dollar Benefit (All Covered Essential Health Benefits)	Unlimited

Deductible and Annual Out-of-Pocket Maximum	Level I Facilities/ Level II PPO Physicians	Level II Non-PPO Physicians
Calendar Year Deductible • Per Covered Person • Family Limit*	$3,500 $7,000	$3,500 $7,000
Benefit Percentage (unless otherwise noted)	70%	70%
Annual Out-of-Pocket Maximum (Includes Deductible, Medical Copays and Prescription Drug Expenses) • Per Covered Person • Family Limit*	$8,550 $17,100	$8,550 $17,100

NOTE: The Calendar Year Deductible and Annual Out-of-Pocket Maximum are determined by combining both Level I and Level II (PPO and Non-PPO) Covered Charges. See Comprehensive Medical Benefits section. Upon reaching the Annual Out-of-Pocket Maximum, Covered Medical Expenses and Covered Prescription Drug Expenses are payable at 100%. The Covered Person's Coinsurance is determined by the Plan's Benefit Percentage reflected in this Schedule of Benefits. The Covered Person is responsible for the difference between the Plan's Benefit Percentage and 100%.

*Applies collectively to all Covered Persons in the same Family.

LEVEL I BENEFITS – PAYMENT LEVELS AND LIMITS

This section applies to covered services rendered by Hospitals and other Facilities shown in the preceding Level I Providers list and to charges for services rendered by Providers billing "as a Facility." The benefits shown apply to all such covered, licensed, accredited Providers of service **without regard to participation in a Preferred Provider Organization (PPO) network**. Covered Charges are subject to Allowable Claim Limits (unless stated otherwise).

$3500 DEDUCTIBLE PLAN	
Utilization Review (UR) Preauthorization Requirements	
Utilization Review required for the following services: • Inpatient Hospital/ Facility Admissions • MRI/MRA and PET scans • Home Health Care • Other Specified Level I and Level II Services	25% reduction in benefits Non-compliance penalty applies for failure to notify Utilization Review. See Utilization Review (UR) Program section for additional information.

Any applicable Maximums or Limitations for specified services are determined by combining Level I and Level II (PPO and Non-PPO) Covered Charges.

$3500 DEDUCTIBLE PLAN		
Benefit Percentage For:	**Level I Facility Benefit**	**Maximum Benefits, Limits and Provisions**
Hospital/Facility Inpatient Services		
Inpatient Hospital Services (Room and Board/ ancillary charges)	70% Deductible applies	UR Preauthorization required.
Maternity Inpatient Hospital Services (Room and Board/ ancillary charges)	70% Deductible applies	Contact Utilization Review for Coordination of Care.
Routine Newborn Care Inpatient Hospital Services (nursery Room and Board/ancillary charges) (to date of mother's discharge)	70% Deductible waived	Payable under covered mother's Claim. Baby must be added as a Dependent within 31 days after birth to be eligible for this benefit.
Skilled Nursing Facility/ Rehabilitation Facility (Room and Board/ ancillary charges)	70% Deductible applies	Limited to 120 combined days per Calendar Year. UR Preauthorization required.
Mental Disorders/ Chemical Dependency, Drug and Substance Abuse Inpatient Hospital Services/Residential Treatment Center (Room and Board/ ancillary charges)	70% Deductible applies	UR Preauthorization required.
Emergency Room (Hospital Emergency Room Services/ Independent Freestanding Emergency Department Services)		
Emergency Room (ER Copay waived if admitted Inpatient)	70% after $500 ER Copay Deductible waived	UR Preauthorization required if admitted Inpatient.

$3500 DEDUCTIBLE PLAN		
Benefit Percentage For:	**Level I Facility Benefit**	**Maximum Benefits, Limits and Provisions**
Hospital/Facility Outpatient Diagnostic/Preventive Screening Services		
Select Diagnostic Medical Procedures (MRI, CT scan, etc.; see list in Comprehensive Medical Benefits section) **All Other Diagnostic Lab and X-ray**	70% Deductible applies 70% Deductible applies	UR Preauthorization required for MRI/MRA and PET scans.
Routine Bone Density Test, Other Routine Diagnostic Lab and X-ray	100% Deductible waived	Age and/or frequency limitations may apply.
Cholesterol (Lipid) and Blood Sugar (Glucose/ A1C) Testing • Initial Annual Routine or Diagnostic • Additional Diagnostic	100% Deductible waived 70% Deductible applies	Routine benefits will only apply to the initial Cholesterol and Blood Sugar Test regardless of age or diagnosis.
Mammogram • Initial Annual Routine or Diagnostic • Additional Diagnostic	100% Deductible waived 70% Deductible applies	Routine benefits will only apply to the initial Mammogram regardless of age or diagnosis.
Cervical Cancer Screening • Initial Annual Routine or Diagnostic • Additional Diagnostic	100% Deductible waived 70% Deductible applies	Routine benefits will only apply to the initial Cervical Cancer Screening regardless of age or diagnosis.
PSA Screenings • Initial Annual Routine or Diagnostic • Additional Diagnostic	100% Deductible waived 70% Deductible applies	Routine benefits will only apply to the initial PSA (for all men beginning age 40 regardless of diagnosis)
Colonoscopy (including polyp removal) (includes all related charges) • Initial Annual Routine or Diagnostic • Additional Diagnostic	100% Deductible waived 70% Deductible applies	UR Preauthorization required. Routine limited to beginning at age 45 or Family history of colon cancer. Routine benefits will only apply to the initial Colonoscopy regardless of diagnosis.
Women's Sterilization Procedures		
All Covered Expenses	100% Deductible waived	All FDA approved. (Hysterectomies are not covered under this benefit, but are subject to normal Plan provisions instead.)

$3500 DEDUCTIBLE PLAN		
Benefit Percentage For:	**Level I Facility Benefit**	**Maximum Benefits, Limits and Provisions**
Outpatient Surgery/Ambulatory Surgery Centers Covered Services and Supplies		
All Covered Expenses	70% Deductible applies	UR Preauthorization required.
Outpatient Psychiatric Day Treatment Facility and Outpatient Chemical Dependency/Drug Treatment Facility		
Partial Hospitalization/ Day Treatment Facility **Psychological Testing** **Outpatient Therapy** (including group therapy and Family counseling)	70% Deductible applies 70% Deductible applies 70% Deductible applies	UR Preauthorization required.
Physical, Occupational and Speech Therapy Services		
All Covered Expenses	100% after $50 Copay Deductible waived	Limited to 90 combined visits per Calendar Year. Maximum does not apply to treatment for Developmental Delay.
Pulmonary Rehabilitation and Cardiac Rehabilitation		
All Covered Expenses	100% after $50 Copay Deductible waived	
Chemotherapy, Radiation Therapy, Dialysis Facilities Covered Services and Supplies		
All Covered Expenses	70% Deductible applies	UR Preauthorization required.
Infusion Therapy Covered Services and Supplies		
All Covered Expenses	70% Deductible applies	
Diabetic Self-Management Training		
All Covered Expenses	70% Deductible applies	
Hospice		
All Covered Expenses	70% Deductible applies	UR Preauthorization required for Inpatient and Homebound Hospice.
Home Health Care Services		
All Covered Expenses	70% Deductible applies	Limited to 120 visits per Calendar Year. UR Preauthorization required.
Private Duty Nursing (Outpatient)		
All Covered Expenses	70% Deductible applies	Limited to 60 visits per Calendar Year.
Ambulance – Air or Ground Transportation		
All Covered Expenses	80% Deductible applies	

$3500 DEDUCTIBLE PLAN		
Benefit Percentage For:	**Level I Facility Benefit**	**Maximum Benefits, Limits and Provisions**
Urgent Care Facility (Minor Emergency Medical Clinic)		
All Covered Expenses	100% after $50 Copay Deductible waived	
Outpatient Clinic Visit – Facility		
Facility Expenses	70% Deductible applies	
Cellular and Gene Therapy		
All Covered Expenses	70% Deductible applies	
All Other Covered Hospital/Facility Services and Supplies		
All Other Covered Expenses	70% Deductible applies	UR Preauthorization required for Inpatient and other specified Level I services.

LEVEL II BENEFITS – PAYMENT LEVELS AND LIMITS

This section applies to covered services rendered by Physicians and all other Providers not listed in Level I. Benefits shown are payable **based upon the Provider's participation in the Preferred Provider Organization (PPO) network.** PPO Covered Charges are subject to the PPO negotiated rate. Non-PPO Covered Charges are subject to Allowable Claim Limits.

The "Level II PPO Benefit" applies to services rendered by Preferred Providers in the designated PPO Network (In-Network); the "Level II Non-PPO Benefit" applies to services rendered by Providers other than Preferred Providers (Out-of-Network).

NO SURPRISES ACT – Emergency Services and Surprise Bills

For Out-of-Network Claims subject to the No Surprises Act ("NSA") (part of the Consolidated Appropriations Act of 2021), a Participant's cost-sharing will be the same amount as would be applied if the Claim was provided by a PPO Provider and will be calculated as if the Plan's Allowable Expense was the Recognized Amount, regardless of the Plan's actual Maximum Allowable Charge. The NSA prohibits Providers from pursuing Participants for the difference between the Maximum Allowable Charge and the Provider's billed charge for applicable services. Cost-sharing amounts will accrue toward In-Network Deductibles and Out-of-Pocket Maximums.

Benefits for Claims subject to the NSA will be denied or paid within thirty (30) days of receipt of an initial Claim and, if approved, will be paid directly to the Provider.

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

1. Emergency Services; and
2. Covered Out-of-Network air ambulance services.

Maximum Benefits, Limits and Provisions are subject to all other Plan exclusions, limitations and provisions set forth in this Benefit Booklet.

Any applicable Maximums or Limitations for specified services are determined by combining Level I and Level II (PPO and Non-PPO) Covered Charges.

$3500 DEDUCTIBLE PLAN		
Benefit Percentage For:	**Level II PPO and Non-PPO Benefit**	**Maximum Benefits, Limits and Provisions**
Physician Services		
Physician Hospital Visits/ Surgeon/Anesthesia	70% Deductible applies	
Physician Hospital Visit for Mental Disorders/ Chemical Dependency, Drug and Substance Abuse	70% Deductible applies	
Emergency Room Physician (includes Pathologist and Radiologist services in ER)	70% Deductible waived	
Maternity (Including prenatal care, delivery and postnatal care, except initial visit) Lab and X-ray Benefit applies.	70% Deductible applies	Contact Utilization Review for Coordination of Care.
Initial Visit (Office Visit Copay does not apply after initial visit)	100% after $25 Copay PCP $50 Copay Specialist Deductible waived	

$3500 DEDUCTIBLE PLAN		
Benefit Percentage For:	**Level II PPO and Non-PPO Benefit**	**Maximum Benefits, Limits and Provisions**
Physician Services		
Routine Newborn Care (Inpatient routine pediatric care to date of mother's discharge)	70% Deductible waived	Payable under covered mother's Claim. Baby must be added as a Dependent within 31 days after birth to be eligible for this benefit.
***Lab and X-ray Benefits** • Outpatient Hospital Interpretation • Freestanding or Independent Facility (includes interpretation) **Select Diagnostic Medical Procedures** (MRI, CT scan, etc.) **All Other Lab/X-ray**	 70% Deductible applies 70% Deductible applies	See list of Select Diagnostic Medical Procedures in Comprehensive Medical Benefits section. UR Preauthorization required for MRI/MRA and PET scans.
All Covered Physician Office Expenses Including: • Office Visit • Examination • Treatment • Diagnostic tests • Office Surgery • Voluntary Second or Third Surgical Opinion (exam) • Medical Supplies • Telehealth Consultations	100% after $25 Copay PCP $50 Copay Specialist Deductible waived	
NOTE: For purposes of this Plan, Physicians considered a Primary Care Physician (PCP) are: Family Practitioner, General Practitioner, Internist, Pediatrician and OB/Gyn. All other Physicians are considered Specialists. A referral from a Primary Care Physician to a Specialist is not required.		
Physician Office Services-Home Visits	70% Deductible applies	
***Sterilization Procedures** (vasectomies) (performed in Physician's office)	100% after $25 Copay PCP $50 Copay Specialist Deductible waived	
Allergy Testing, Serum and Injections	70% Deductible applies	
Office Lab and X-ray (except Select Diagnostic Medical Procedures)	70% Deductible applies	
Select Diagnostic Medical Procedures (performed in Physician's Office)	70% Deductible applies	UR Preauthorization required for MRI/MRA and PET scans.
Mental Disorders/ Chemical Dependency, Drug and Substance Abuse Office Visit/*Group Therapy/*Family Counseling/ *Psychological Testing	100% after $25 Copay Deductible waived	

$3500 DEDUCTIBLE PLAN		
Benefit Percentage For:	**Level II PPO and Non-PPO Benefit**	**Maximum Benefits, Limits and Provisions**
Physician Services		
Acupuncture / Acupuncturist Services	70% Deductible applies	Limited to 12 treatments per Calendar Year.
Chiropractic Services	100% after $50 Copay Deductible waived	Limited to 30 visits per Calendar Year. (Maximum does not include x-rays.)
***Urgent Care Facility** (Minor Emergency Medical Clinic)	100% after $50 Copay Deductible waived	
Retail Limited Service Clinics	100% after $25 Copay Deductible waived	
All Other Covered Physician Services	70% Deductible applies	UR Preauthorization required for specified Level II services.

* **If these services are rendered by Providers billing as a Facility, please refer to the appropriate category under Level I for the benefit.**

$3500 DEDUCTIBLE PLAN		
Benefit Percentage For:	**Level II PPO and Non-PPO Benefit**	**Maximum Benefits, Limits and Provisions**
Other Covered Services		
***Therapy Services** • Physical • Occupational • Speech	100% after $50 Copay Deductible waived	Limited to 90 combined visits per Calendar Year. Maximum does not apply to treatment for Developmental Delay.
***Cardiac Rehabilitation/Pulmonary Rehabilitation**	100% after $50 Copay Deductible waived	
***Chemotherapy/ Radiation Therapy/ Infusion Therapy/ Dialysis** Wig (provided for hair loss as a result of Chemotherapy/ Radiation Therapy)	70% Deductible applies 70% Deductible applies	UR Preauthorization required for Chemotherapy, Radiation Therapy and Dialysis. Limited to one wig per Calendar Year.
***Durable Medical Equipment**	70% Deductible applies	UR Preauthorization required for all rentals and any purchase that exceeds $1,500.
***Orthotic Devices/ Orthotic Insoles**	70% Deductible applies	Limited to 1 pair of foot orthotics per Calendar Year.
***Prosthetics**	70% Deductible applies	Limited to a single purchase of each type of Prosthetic device every three Calendar Years.
Hearing Aids	70% Deductible applies	Limited to a single purchase (including repair/replacement) per hearing impaired ear every 36 months.
***Home Health Care Services**	70% Deductible applies	Limited to 120 visits per Calendar Year. UR Preauthorization required.
***Home Infusion Therapy**	70% Deductible applies	

$3500 DEDUCTIBLE PLAN		
Benefit Percentage For:	**Level II PPO and Non-PPO Benefit**	**Maximum Benefits, Limits and Provisions**
Other Covered Services		
***Enteral Nutrition**	70% Deductible applies	
***Private Duty Nursing** (Outpatient)	70% Deductible applies	Limited to 60 visits per Calendar Year.
***Hospice** Bereavement Counseling	70% Deductible applies 70% Deductible applies	UR Preauthorization required for Inpatient and Homebound Hospice.
***Diabetic Self-Management Training Office Visit**	100% after $25 Copay PCP $50 Copay Specialist Deductible waived	
***Diabetic Supplies**	70% Deductible applies	
***Temporomandibular Joint (TMJ) Disorders**	Related services will be considered at the applicable benefit level (Surgery, devices, diagnostic services, etc.)	Limited to $2,500 Lifetime Maximum Benefit.
***Sleep Disorders**	Related services will be considered at the applicable benefit level (sleep studies, diagnostic testing, Surgery, devices and equipment, etc.)	Limited to treatment for sleep apnea only.
***Ambulance – Air or Ground Transportation**	80% Deductible applies (PPO Deductible and PPO Out-of-Pocket apply)	
***Cellular and Gene Therapy**	Related services will be considered at the applicable benefit level (therapy, office visits, diagnostic services, etc.)	
Recuro Health Telehealth (telephone or online – 24/7 unlimited access • Virtual Urgent Care • Virtual Primary Care • Virtual Mental Health Services	 100%; no Copay or Consultation fee 100% after $25 Copay Deductible waived 100% after $25 Copay Deductible waived	
***All Other Covered Expenses**	70% Deductible applies	UR Preauthorization required for specified Level II services.

*** If these services are rendered by Providers billing as a Facility, please refer to the appropriate category under Level I for the benefit.**

Preventive and Wellness Care Benefits
This benefit is payable for Covered Procedures incurred as part of a Preventive and Wellness Care Program and is not payable for treatment of a diagnosed Illness or Injury. Services must be identified and billed as routine or part of a routine physical exam or as specified below.

$3500 DEDUCTIBLE PLAN		
Benefit Percentage For:	**Level II PPO and Non-PPO Benefit**	**Limits and Provisions**
All Covered Wellness Benefits	100% Copay and Deductible waived	See age and frequency limits and other special provisions below.

Examples of Covered Wellness Procedures to include but are not limited to:

1. Routine Physical Exam
2. Annual Well Woman Exam
3. *Annual Pap smear and other routine lab
4. *Annual Routine/Diagnostic Mammogram (initial Mammogram regardless of age or diagnosis)
5. *Annual Cervical Cancer Screening (initial Cervical Cancer Screening regardless of age or diagnosis)
6. *Bone Density test (routine)
7. *Annual Routine/Diagnostic PSA test (initial PSA for all men beginning age 40 regardless of diagnosis)
8. Well Baby Care Exam/Well Child Care Exam
9. Routine Immunizations
10. Flu vaccine/pneumonia vaccine
11. *Routine lab, x-ray, diagnostic testing and other medical screenings (initial cholesterol and blood sugar test regardless of age or diagnosis)
12. Routine Vision Screening for Covered Dependent Children
13. Routine Hearing Screening for Covered Dependent Children
14. *Annual Routine/Diagnostic Colonoscopy (including polyp removal – routine beginning at age 45 or Family history of colon cancer) (initial Colonoscopy regardless of diagnosis)
15. Tobacco Use Screening/Cessation Intervention
16. *All FDA approved Women's Contraceptive methods and Women's Sterilization procedures**

NOTE: Refer to the definition of "Preventive Care" for a link to a website that lists additional services that may be covered for preventive treatment.

*** If these services are rendered by Providers billing as a Facility, please refer to the appropriate category under Level I for the benefit.**

**** Hysterectomies will not be covered under Preventive and Wellness Care Benefits but will be payable subject to normal Plan provisions instead.**

SCHEDULE OF BENEFITS – $4500 DEDUCTIBLE PLAN WITH HSA

MAJOR MEDICAL BENEFITS FOR COVERED PERSONS

NOTE: All Claims are subject to review and/or audit to ensure that charges are payable in accordance with the terms and limitations of this Benefit Booklet.

LEVEL I PROVIDERS – Facilities and Providers billing as a Facility to include, but not limited to:

- Hospitals (Inpatient and Outpatient treatment)
- Inpatient Facilities (such as Rehabilitation Facilities, Skilled Nursing Facilities and Hospice)
- Inpatient and Outpatient Facilities for treatment of Mental Disorders, Chemical Dependency, Drug and Substance Abuse
- Ambulatory Surgery Centers
- Dialysis Clinics
- Ambulance (air and ground)

LEVEL II PROVIDERS – Physicians and all other Providers of service

Maximum Benefits	
Lifetime Maximum Dollar Benefit (All Covered Essential Health Benefits)	Unlimited
Annual Maximum Dollar Benefit (All Covered Essential Health Benefits)	Unlimited

Deductible and Annual Out-of-Pocket Maximum	Level I Facilities/ Level II PPO Physicians	Level II Non-PPO Physicians
Calendar Year Deductible (Includes Covered Medical and Prescription Drug Expenses) • Per Covered Person • Family Limit*	 $4,500 $9,000	 $4,500 $9,000
Benefit Percentage (unless otherwise noted)	70%	70%
Annual Out-of-Pocket Maximum (Includes Calendar Year Deductible, Covered Medical and Prescription Drug Expenses) • Per Covered Person • Family Limit*	 $6,550 $13,100	 $6,550 $13,100

NOTE: The Calendar Year Deductible and Annual Out-of-Pocket Maximum are determined by combining both Level I and Level II (PPO and Non-PPO) Covered Charges. See Comprehensive Medical Benefits section. Upon reaching the Annual Out-of-Pocket Maximum, Covered Medical Expenses and Covered Prescription Drug Expenses are payable at 100%. The Covered Person's Coinsurance is determined by the Plan's Benefit Percentage reflected in this Schedule of Benefits. The Covered Person is responsible for the difference between the Plan's Benefit Percentage and 100%.

* The Calendar Year Deductible per Covered Person (individual Deductible) is embedded in the Deductible Family Limit and the Annual Out-of-Pocket Maximum per Covered Person (individual Annual Out-of-Pocket) is embedded in the Annual Out-of-Pocket Maximum Family Limit. Each covered Family member is only required to satisfy his/her own individual Deductible and individual Annual Out-of-Pocket, not the entire Family Limit, in order to receive Plan benefits. The Deductible Family Limit and Annual Out-of-Pocket Maximum Family Limit are satisfied by two (2) or more Family members collectively; however, each Family member cannot contribute more than his/her own individual Deductible or individual Annual Out-of-Pocket Maximum.

LEVEL I BENEFITS – PAYMENT LEVELS AND LIMITS

This section applies to covered services rendered by Hospitals and other Facilities shown in the preceding Level I Providers list and to charges for services rendered by Providers billing "as a Facility." The benefits shown apply to all such covered, licensed, accredited Providers of service **without regard to participation in a Preferred Provider Organization (PPO) network**. Covered Charges are subject to Allowable Claim Limits (unless stated otherwise).

$4500 DEDUCTIBLE PLAN WITH HSA	
Utilization Review (UR) Preauthorization Requirements	
Utilization Review required for the following services: • Inpatient Hospital/ Facility Admissions • MRI/MRA and PET scans • Home Health Care • Other Specified Level I and Level II Services	25% reduction in benefits Non-compliance penalty applies for failure to notify Utilization Review. See Utilization Review (UR) Program section for additional information.

Any applicable Maximums or Limitations for specified services are determined by combining Level I and Level II (PPO and Non-PPO) Covered Charges.

$4500 DEDUCTIBLE PLAN WITH HSA		
Benefit Percentage For:	**Level I Facility Benefit**	**Maximum Benefits, Limits and Provisions**
Hospital/Facility Inpatient Services		
Inpatient Hospital Services (Room and Board/ ancillary charges)	70% Deductible applies	UR Preauthorization required.
Maternity Inpatient Hospital Services (Room and Board/ ancillary charges)	70% Deductible applies	Contact Utilization Review for Coordination of Care.
Routine Newborn Care Inpatient Hospital Services (nursery Room and Board/ancillary charges) (to date of mother's discharge)	70% Deductible waived	Payable under covered mother's Claim. Baby must be added as a Dependent within 31 days after birth to be eligible for this benefit.
Skilled Nursing Facility/ Rehabilitation Facility (Room and Board/ ancillary charges)	70% Deductible applies	Limited to 120 combined days per Calendar Year. UR Preauthorization required.
Mental Disorders/ Chemical Dependency, Drug and Substance Abuse Inpatient Hospital Services/Residential Treatment Center (Room and Board/ ancillary charges)	70% Deductible applies	UR Preauthorization required.

$4500 DEDUCTIBLE PLAN WITH HSA		
Benefit Percentage For:	**Level I Facility Benefit**	**Maximum Benefits, Limits and Provisions**
Emergency Room (Hospital Emergency Room Services/ Independent Freestanding Emergency Department Services)		
Emergency Room (ER Copay waived if admitted Inpatient)	80% Deductible applies (PPO Deductible and PPO Out-of-Pocket apply)	UR Preauthorization required if admitted Inpatient.
Hospital/Facility Outpatient Diagnostic/Preventive Screening Services		
Select Diagnostic Medical Procedures (MRI, CT scan, etc.; see list in Comprehensive Medical Benefits section) **All Other Diagnostic Lab and X-ray**	70% Deductible applies 70% Deductible applies	UR Preauthorization required for MRI/MRA and PET scans.
Routine Bone Density Test, Other Routine Diagnostic Lab and X-ray	100% Deductible waived	Age and/or frequency limitations may apply.
Cholesterol (Lipid) and Blood Sugar (Glucose/ A1C) Testing • Initial Annual Routine or Diagnostic • Additional Diagnostic	100% Deductible waived 70% Deductible applies	Routine benefits will only apply to the initial Cholesterol and Blood Sugar Test regardless of age or diagnosis.
Mammogram • Initial Annual Routine or Diagnostic • Additional Diagnostic	100% Deductible waived 70% Deductible applies	Routine benefits will only apply to the initial Mammogram regardless of age or diagnosis.
Cervical Cancer Screening • Initial Annual Routine or Diagnostic • Additional Diagnostic	100% Deductible waived 70% Deductible applies	Routine benefits will only apply to the initial Cervical Cancer Screening regardless of age or diagnosis.
PSA Screenings • Initial Annual Routine or Diagnostic • Additional Diagnostic	100% Deductible waived 70% Deductible applies	Routine benefits will only apply to the initial PSA (for all men beginning age 40 regardless of diagnosis)

$4500 DEDUCTIBLE PLAN WITH HSA		
Benefit Percentage For:	**Level I Facility Benefit**	**Maximum Benefits, Limits and Provisions**
Hospital/Facility Outpatient Diagnostic/Preventive Screening Services		
Colonoscopy (including polyp removal) (includes all related charges) • Initial Annual Routine or Diagnostic • Additional Diagnostic	100% Deductible waived 70% Deductible applies	UR Preauthorization required. Routine limited to beginning at age 45 or Family history of colon cancer. Routine benefits will only apply to the initial Colonoscopy regardless of diagnosis.
Women's Sterilization Procedures		
All Covered Expenses	100% Deductible waived	All FDA approved. (Hysterectomies are not covered under this benefit, but are subject to normal Plan provisions instead.)
Outpatient Surgery/Ambulatory Surgery Centers Covered Services and Supplies		
All Covered Expenses	70% Deductible applies	UR Preauthorization required.
Outpatient Psychiatric Day Treatment Facility and Outpatient Chemical Dependency/Drug Treatment Facility		
Partial Hospitalization/ Day Treatment Facility **Psychological Testing** **Outpatient Therapy** (including group therapy and Family counseling)	70% Deductible applies 70% Deductible applies 70% Deductible applies	UR Preauthorization required.
Physical, Occupational and Speech Therapy Services		
All Covered Expenses	70% Deductible applies	Limited to 90 combined visits per Calendar Year. Maximum does not apply to treatment for Developmental Delay.
Pulmonary Rehabilitation and Cardiac Rehabilitation		
All Covered Expenses	70% Deductible applies	
Chemotherapy, Radiation Therapy, Dialysis Facilities Covered Services and Supplies		
All Covered Expenses	70% Deductible applies	UR Preauthorization required.
Infusion Therapy Covered Services and Supplies		
All Covered Expenses	70% Deductible applies	
Diabetic Self-Management Training		
All Covered Expenses	70% Deductible applies	

$4500 DEDUCTIBLE PLAN WITH HSA		
Benefit Percentage For:	**Level I Facility Benefit**	**Maximum Benefits, Limits and Provisions**
Hospice		
All Covered Expenses	70% Deductible applies	UR Preauthorization required for Inpatient and Homebound Hospice.
Home Health Care Services		
All Covered Expenses	70% Deductible applies	Limited to 120 visits per Calendar Year. UR Preauthorization required.
Private Duty Nursing (Outpatient)		
All Covered Expenses	70% Deductible applies	Limited to 60 visits per Calendar Year.
Ambulance – Air or Ground Transportation		
All Covered Expenses	80% Deductible applies (PPO Deductible and PPO Out-of-Pocket apply)	
Urgent Care Facility (Minor Emergency Medical Clinic)		
All Covered Expenses	70% Deductible applies	
Outpatient Clinic Visit – Facility		
Facility Expenses	70% Deductible applies	
Cellular and Gene Therapy		
All Covered Expenses	70% Deductible applies	
All Other Covered Hospital/Facility Services and Supplies		
All Other Covered Expenses	70% Deductible applies	UR Preauthorization required for Inpatient and other specified Level I services.

LEVEL II BENEFITS – PAYMENT LEVELS AND LIMITS

This section applies to covered services rendered by Physicians and all other Providers not listed in Level I. Benefits shown are payable **based upon the Provider's participation in the Preferred Provider Organization (PPO) network.** PPO Covered Charges are subject to the PPO negotiated rate. Non-PPO Covered Charges are subject to Allowable Claim Limits.

The "Level II PPO Benefit" applies to services rendered by Preferred Providers in the designated PPO Network (In-Network); the "Level II Non-PPO Benefit" applies to services rendered by Providers other than Preferred Providers (Out-of-Network).

NO SURPRISES ACT – Emergency Services and Surprise Bills

For Out-of-Network Claims subject to the No Surprises Act ("NSA") (part of the Consolidated Appropriations Act of 2021), a Participant's cost-sharing will be the same amount as would be applied if the Claim was provided by a PPO Provider and will be calculated as if the Plan's Allowable Expense was the Recognized Amount, regardless of the Plan's actual Maximum Allowable Charge. The NSA prohibits Providers from pursuing Participants for the difference between the Maximum Allowable Charge and the Provider's billed charge for applicable services. Cost-sharing amounts will accrue toward In-Network Deductibles and Out-of-Pocket Maximums.

Benefits for Claims subject to the NSA will be denied or paid within thirty (30) days of receipt of an initial Claim and, if approved, will be paid directly to the Provider.

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

1. Emergency Services; and
2. Covered Out-of-Network air ambulance services.

Maximum Benefits, Limits and Provisions are subject to all other Plan exclusions, limitations and provisions set forth in this Benefit Booklet.

Any applicable Maximums or Limitations for specified services are determined by combining Level I and Level II (PPO and Non-PPO) Covered Charges.

$4500 DEDUCTIBLE PLAN WITH HSA		
Benefit Percentage For:	**Level II PPO and Non-PPO Benefit**	**Maximum Benefits, Limits and Provisions**
Physician Services		
Physician Hospital Visits/ Surgeon/Anesthesia	70% Deductible applies	
Physician Hospital Visit for Mental Disorders/ Chemical Dependency, Drug and Substance Abuse	70% Deductible applies	
Emergency Room Physician (includes Pathologist and Radiologist services in ER)	80% Deductible applies (PPO Deductible and PPO Out-of-Pocket apply)	
Maternity (Including prenatal care, delivery and postnatal care) Lab and X-ray Benefit applies.	70% Deductible applies	Contact Utilization Review for Coordination of Care.
Routine Newborn Care (Inpatient routine pediatric care to date of mother's discharge)	70% Deductible waived	Payable under covered mother's Claim. Baby must be added as a Dependent within 31 days after birth to be eligible for this benefit.

$4500 DEDUCTIBLE PLAN WITH HSA		
Benefit Percentage For:	**Level II PPO and Non-PPO Benefit**	**Maximum Benefits, Limits and Provisions**
Physician Services		
***Lab and X-ray Benefits** • Outpatient Hospital Interpretation • Freestanding or Independent Facility (includes interpretation) **Select Diagnostic Medical Procedures** (MRI, CT scan, etc.) **All Other Lab/X-ray**	 70% Deductible applies 70% Deductible applies	See list of Select Diagnostic Medical Procedures in Comprehensive Medical Benefits section. UR Preauthorization required for MRI/MRA and PET scans.
All Covered Physician Office Expenses Including: • Office Visit • Examination • Treatment • Diagnostic tests • Allergy Testing, Serum and Injections • Office Surgery • Voluntary Second or Third Surgical Opinion (exam) • Medical Supplies • Telehealth Consultations	70% Deductible applies	
Physician Office Services-Home Visits	70% Deductible applies	
***Sterilization Procedures** (vasectomies) (performed in Physician's office)	70% Deductible applies	
Office Lab and X-ray (except Select Diagnostic Medical Procedures)	70% Deductible applies	
Select Diagnostic Medical Procedures (performed in Physician's Office)	70% Deductible applies	UR Preauthorization required for MRI/MRA and PET scans.
Mental Disorders/ Chemical Dependency, Drug and Substance Abuse Office Visit/*Group Therapy/*Family Counseling/ *Psychological Testing	70% Deductible applies	
Acupuncture / Acupuncturist Services	70% Deductible applies	Limited to 12 treatments per Calendar Year.
Chiropractic Services	70% Deductible applies	Limited to 30 visits per Calendar Year. (Maximum does not include x-rays.)
***Urgent Care Facility** (Minor Emergency Medical Clinic)	70% Deductible applies	
Retail Limited Service Clinics	70% Deductible applies	
All Other Covered Physician Services	70% Deductible applies	UR Preauthorization required for specified Level II services.

*** If these services are rendered by Providers billing as a Facility, please refer to the appropriate category under Level I for the benefit.**

$4500 DEDUCTIBLE PLAN WITH HSA		
Benefit Percentage For:	**Level II PPO and Non-PPO Benefit**	**Maximum Benefits, Limits and Provisions**
Other Covered Services		
***Therapy Services** • Physical • Occupational • Speech	70% Deductible applies	Limited to 90 combined visits per Calendar Year. Maximum does not apply to treatment for Developmental Delay.
***Cardiac Rehabilitation/ Pulmonary Rehabilitation**	70% Deductible applies	
***Chemotherapy/ Radiation Therapy/ Infusion Therapy/ Dialysis** Wig (provided for hair loss as a result of Chemotherapy/ Radiation Therapy)	70% Deductible applies 70% Deductible applies	UR Preauthorization required for Chemotherapy, Radiation Therapy and Dialysis. Limited to one wig per Calendar Year.
***Durable Medical Equipment**	70% Deductible applies	UR Preauthorization required for all rentals and any purchase that exceeds $1,500.
***Orthotic Devices/ Orthotic Insoles**	70% Deductible applies	Limited to 1 pair of foot orthotics per Calendar Year.
***Prosthetics**	70% Deductible applies	Limited to a single purchase of each type of Prosthetic device every three Calendar Years.
Hearing Aids	70% Deductible applies	Limited to a single purchase (including repair/replacement) per hearing impaired ear every 36 months.
***Home Health Care Services**	70% Deductible applies	Limited to 120 visits per Calendar Year. UR Preauthorization required.
***Home Infusion Therapy**	70% Deductible applies	
***Enteral Nutrition**	70% Deductible applies	
***Private Duty Nursing** (Outpatient)	70% Deductible applies	Limited to 60 visits per Calendar Year.
***Hospice** Bereavement Counseling	70% Deductible applies 70% Deductible applies	UR Preauthorization required for Inpatient and Homebound Hospice.
***Diabetic Self-Management Training Office Visit**	70% Deductible applies	
***Diabetic Supplies**	70% Deductible applies	
***Temporomandibular Joint (TMJ) Disorders**	Related services will be considered at the applicable benefit level (Surgery, devices, diagnostic services, etc.)	Limited to $2,500 Lifetime Maximum Benefit.

$4500 DEDUCTIBLE PLAN WITH HSA		
Benefit Percentage For:	**Level II PPO and Non-PPO Benefit**	**Maximum Benefits, Limits and Provisions**
Other Covered Services		
***Sleep Disorders**	Related services will be considered at the applicable benefit level (sleep studies, diagnostic testing, Surgery, devices and equipment, etc.)	Limited to treatment for sleep apnea only.
***Ambulance – Air or Ground Transportation**	80% Deductible applies (PPO Deductible and PPO Out-of-Pocket apply)	
***Cellular and Gene Therapy**	Related services will be considered at the applicable benefit level (therapy, office visits, diagnostic services, etc.)	
Recuro Health Telehealth (telephone or online – 24/7 unlimited access • Virtual Urgent Care • Virtual Primary Care • Virtual Mental Health Services	 $10 Consultation Fee Fee applies to satisfy PPO Deductible and PPO Annual Out-of-Pocket Maximum. 70% after PPO Deductible 70% after PPO Deductible	
***All Other Covered Expenses**	70% Deductible applies	UR Preauthorization required for specified Level II services.

*** If these services are rendered by Providers billing as a Facility, please refer to the appropriate category under Level I for the benefit.**

Preventive and Wellness Care Benefits
This benefit is payable for Covered Procedures incurred as part of a Preventive and Wellness Care Program and is not payable for treatment of a diagnosed Illness or Injury. Services must be identified and billed as routine or part of a routine physical exam or as specified below.

$4500 DEDUCTIBLE PLAN WITH HSA		
Benefit Percentage For:	**Level II PPO and Non-PPO Benefit**	**Limits and Provisions**
All Covered Wellness Benefits	100% Deductible waived	See age and frequency limits and other special provisions below.

Examples of Covered Wellness Procedures to include but are not limited to:

1. Routine Physical Exam
2. Annual Well Woman Exam
3. *Annual Pap smear and other routine lab
4. *Annual Routine/Diagnostic Mammogram (initial Mammogram regardless of age or diagnosis)
5. *Annual Cervical Cancer Screening (initial Cervical Cancer Screening regardless of age or diagnosis)
6. *Bone Density test (routine)
7. *Annual Routine/Diagnostic PSA test (initial PSA for all men beginning age 40 regardless of diagnosis)
8. Well Baby Care Exam/Well Child Care Exam
9. Routine Immunizations
10. Flu vaccine/pneumonia vaccine
11. *Routine lab, x-ray, diagnostic testing and other medical screenings (initial cholesterol and blood sugar test regardless of age or diagnosis)
12. Routine Vision Screening for Covered Dependent Children
13. Routine Hearing Screening for Covered Dependent Children
14. *Annual Routine/Diagnostic Colonoscopy (including polyp removal – routine beginning at age 45 or Family history of colon cancer) (initial Colonoscopy regardless of diagnosis)
15. Tobacco Use Screening/Cessation Intervention
16. *All FDA approved Women's Contraceptive methods and Women's Sterilization procedures**

NOTE: Refer to the definition of "Preventive Care" for a link to a website that lists additional services that may be covered for preventive treatment.

*** If these services are rendered by Providers billing as a Facility, please refer to the appropriate category under Level I for the benefit.**

**** Hysterectomies will not be covered under Preventive and Wellness Care Benefits but will be payable subject to normal Plan provisions instead.**

ORGAN TRANSPLANT BENEFITS

Benefits are available for a human organ, tissue and bone marrow transplant subject to the following conditions:

1. Benefits will be provided subject to determination made on an individual case by case basis in order to establish Medical Necessity;
2. Benefits will be provided only when the Hospital and Physician customarily bill for the medical care and services involved in the human organ, tissue or bone marrow transplant;
3. Under no circumstances will benefits be available for any "personal service" fee, organ, tissue or bone marrow fee or any other similar charge or fee;
4. Only those necessary Hospital and Physician's medical care and service expenses, with respect to the donation, will be considered for benefits; and
5. Benefits will be provided for the appropriate Hospital standard organ, tissue or bone marrow acquisition costs (live Donor or cadaver), storage and transportation of human organ, tissue or bone marrow donation.

When a Hospital's or a Physician's medical care and services are required for any type of human organ, tissue or bone marrow transplant from a living Donor (to a transplant recipient) which requires surgical removal of the donated organ, tissue or bone marrow, coverage under the Plan is available only under the following circumstances:

1. When only the transplant recipient is a Covered Person, the benefits of the Plan will be provided to the Donor to the extent that benefits are not provided to the Donor under any other available coverage; or
2. When the transplant recipient and the Donor are both Covered Persons, benefits will be provided for both in accordance with the recipient's Covered Expenses.

Transplant Benefits will be payable based on the Covered Person's participation in the Transplant Program as follows:

Benefit Percentage For:	Transplant Program	Non-Transplant Program	Limits and Provisions
Organ, Tissue and Bone Marrow Transplants (Non-experimental transplants only)	70% of Program rate PPO Deductible applies	Not covered	UR Notification required for a transplant procedure, transplant evaluations and for access to the Transplant Program.
Donor Expenses Donor expenses covered if recipient is covered by this Benefit Booklet. Payable under recipient's Claim.	70% of Program rate PPO Deductible applies	Not covered	
Organ Transplant Travel/Lodging Benefit	100% Deductible waived	Not covered	Transplant Program Travel/Lodging limited to $10,000 Maximum Benefit per Transplant.

NOTIFICATION TO UTILIZATION REVIEW REQUIRED*

Expenses incurred in connection with any Organ or Tissue Transplant will be covered subject to notification and referral to the Plan Administrator's authorized review specialist. (Corneal transplants and heart valve replacements are not subject to this notification provision, but will be considered on the same basis as any other medical expense coverage under this Benefit Booklet.) Transplant coverage is offered under this Benefit Booklet through a Preferred Provider Transplant Program of specialized professionals and Facilities.

As soon as reasonably possible, but in no event more than ten (10) days* after a Covered Person's attending Physician has indicated that the Covered Person is a potential candidate for a transplant, the Covered Person or his Physician should notify Utilization Review for referral to the program's Medical Review Specialist for evaluation and Coordination of Care. A comprehensive treatment plan must be developed for this Benefit Booklet's medical review, and must include such information as diagnosis, the nature of the transplant, the setting of the procedure (i.e., name and address of the Hospital), any secondary medical complications, a five (5) year prognosis, two (2) qualified opinions confirming the need for the procedure, as well as a description and the estimated cost of the proposed treatment (one (1) or both confirming second opinions may be waived by the Plan's Medical Review Specialist). Additional attending Physicians' statements may also be required.

All potential transplant cases will be assessed for their appropriateness by Case Management.

* **Failure to notify Utilization Review of a transplant procedure will result in the application of a 25% reduction in benefits penalty to all Covered Expenses incurred by the transplant recipient as a result of the transplant. If a non-compliance penalty is imposed for failure to notify Utilization Review, that amount will never be included as part of the Calendar Year Deductible, Copay or Annual Out-of-Pocket Maximum.**

ORGAN TRANSPLANT PROGRAM

As a result of the medical review, the Covered Person will be asked to consider obtaining transplant services at a participating Center of Excellence Facility with the Transplant Program arranged by the Plan Administrator's authorized review specialist. The purpose of designating Centers of Excellence Facilities is to perform necessary transplants in the most appropriate setting for the procedure, to improve the quality and probability of a successful outcome and reduce the average cost of the procedures.

There is no obligation for the patient to use a participating Center of Excellence Facility in the Transplant Program. However, there will be no benefits for a transplant and its related expenses if it is performed at a Facility not participating in the Transplant Program.

TRANSPLANT BENEFIT PERIOD

Covered Transplant Expenses will accumulate during a Transplant Benefit Period and will be charged toward the Transplant Benefit Period Maximums, if any, shown in the Transplant Schedule of Benefits. The term "Transplant Benefit Period" means the period beginning on the date of the initial evaluation and ending on the date twelve (12) consecutive months following the date of the transplant. (If the transplant is a bone marrow transplant, the date the marrow is re-infused is considered the date of the transplant.)

COVERED TRANSPLANT EXPENSES

The term "Covered Expenses" with respect to transplants includes the Usual and Customary expenses for services and supplies which are covered under this Benefit Booklet (or which are specifically identified as covered only under this provision) and which are Reasonable and Medically Necessary and appropriate for the transplant, including:

1. Charges incurred in the evaluation, screening and candidacy determination process.

2. Charges incurred for organ transplantation.

3. Charges for organ procurement, including Donor expenses not covered under the Donor's plan of benefits.

   Coverage for organ procurement from a non-living Donor will be provided for costs involved in removing, preserving and transporting the organ.

   Coverage for organ procurement from a living Donor will be provided for the costs involved in screening the potential Donor, transporting the Donor to and from the site of the transplant, as well as for medical expenses associated with removal of the donated organ and the medical services provided to the Donor in the interim and for follow up care.

   If the transplant procedure is a bone marrow transplant, coverage will be provided for the cost involved in the removal of the patient's bone marrow (autologous) or the Donor's marrow (allogeneic). Coverage will also be provided for search charges to identify an unrelated match and treatment and storage cost of the marrow, up to the time of re-infusion. (The harvesting of the marrow need not be performed within the Transplant Benefit Period.)

4. Charges incurred for follow up care, including immunosuppressant therapy.

5. Charges for transportation to and from the site of the covered organ transplant procedure for the recipient and one (1) other individual, or in the event that the recipient or the Donor is a minor, two (2) other individuals. In addition, all reasonable and necessary lodging and meal expenses incurred during the Transplant Benefit Period will be covered up to a Maximum of $10,000 per transplant period.

RE-TRANSPLANTATION

Re-transplantation will be covered up to two (2) re-transplants, for a total of three (3) transplants per person, per lifetime. Each transplant will be subject to the Notification and review requirement for organ transplant. Each transplant and re-transplant will have a new Benefit Period.

ACCUMULATION OF EXPENSES

Expenses incurred during any transplant period for the recipient and for the Donor will accumulate towards the recipient's benefit.

DONOR EXPENSES

Medical expenses of the Donor will be covered under this provision to the extent that they are not covered elsewhere under this Benefit Booklet or any other benefit plan covering the Donor.

PRESCRIPTION DRUG PLAN BENEFITS

$3500 Deductible Plan	
Prescription Drug Expenses apply to satisfy the Medical Annual Out-of-Pocket Maximum. After the Annual Out-of-Pocket Maximum has been met, covered Prescription Drugs will be payable at 100% for the remainder of the Calendar Year.	
Prescription Drug Calendar Year Deductible* (applies to *Retail* Preferred and Non-Preferred Drugs only) Per Covered Person Family Limit** **Applies collectively to all Covered Persons in the same Family.	 $250 $500
	Benefit
Prescription Card Service (Retail) Supply Limit Generic Drugs (Tier 1) Preferred Brand Name Drugs (Tier 2) Non-Preferred Brand Name Drugs (Tier 3)	**100% after applicable Coinsurance** 30 days 70% ($25 Maximum) 70% after Prescription Drug Deductible* ($80 Maximum) 55% after Prescription Drug Deductible* ($130 Maximum)
Mail Order Service Supply Limit Generic Drugs (Tier 1) Preferred Brand Name Drugs (Tier 2) Non-Preferred Brand Name Drugs (Tier 3)	**100% after applicable Coinsurance** 90 days 70% ($62.50 Maximum) 70% ($200 Maximum) 55% ($325 Maximum)
Specialty Drugs*** Supply Limit Generic Drugs (Tier 1) Preferred Brand Name Drugs (Tier 2) Non-Preferred Brand Name Drugs (Tier 3)	**100% after applicable Coinsurance** 30 days 70% ($25 Maximum) 70% ($80 Maximum) 55% ($130 Maximum)
***Specialty Drugs must be obtained through the Prescription Drug Plan's Specialty Pharmacy.	

$4500 Deductible Plan with HSA		
Prescription Drug Expenses apply to satisfy the Medical Plan's Calendar Year Deductible. The Plan requires the Covered Person to pay the entire cost of Prescription Drug Expenses until the Deductible has been met. After the Calendar Year Deductible has been met, Prescription Drug Expenses will apply to satisfy the Medical Annual Out-of-Pocket Maximum. After the Annual Out-of-Pocket Maximum has been met, covered Prescription Drugs will be payable at 100% for the remainder of the Calendar Year.		
	Supply Limit	**Benefit**
Prescription Card Service (Retail) Generic and Brand Name (Preferred and Non-Preferred) Drugs	30 days	70% after Deductible
Mail Order Service Generic and Brand Name (Preferred and Non-Preferred) Drugs	90 days	70% after Deductible
Specialty Drugs* Generic and Brand Name (Preferred and Non-Preferred) Drugs	30 days	70% after Deductible
*Specialty Drugs must be obtained through the Prescription Drug Plan's Specialty Pharmacy.		

NOTE: Medications required for Preventive Care services may be covered at 100%, Deductible waived.

To be covered, Prescription Drugs must be:

1. Purchased from a participating licensed pharmacist;
2. Dispensed to the Covered Person for whom they are prescribed; and
3. Legally prescribed by a Qualified Prescriber.

DEFINITIONS

Brand Name Drugs (Tier 2 and Tier 3)
Trademark Drugs or substances marketed by the original manufacturer. Tier 2 Drugs are commonly used Preferred Brand Name Drugs shown on the Formulary Drug List as "Formulary Alternative(s)." Tier 3 Drugs are Non-Preferred Brand Name Drugs listed as "Non-Formulary" or not shown on the Formulary Drug List.

Generic Drugs (Tier 1)
Drugs or substances which:

1. Are not trademark Drugs or substances; and
2. May be legally substituted for trademark Drugs or substances.

Over the Counter (OTC) Drugs
Drugs which do not require a prescription from a Qualified Prescriber, unless otherwise specified.

Prescription Drugs
Legend Drugs or medicines which are prescribed by a Qualified Prescriber for the treatment of Illness, Injury or Pregnancy.

Qualified Prescriber
A licensed Physician, Dentist, or other health care Practitioner who may, in the legal scope of his/her practice, prescribe Drugs or medicines.

Specialty Drugs
Specialty pharmaceuticals include biotech Drugs produced using living organisms which are high cost or injectable Drugs that require heightened patient management and support.

Maximum Allowable Cost
The pharmacist substitutes more economically priced Generic equivalent Drugs whenever possible unless there is a specific request for a Brand Name by the prescribing Physician or when State law requires no substitution for the Brand Name Drug. **Under this program if the prescribing Physician does not specify the Brand Name, but the Covered Person requests the Brand product when there is a Generic substitute available *or* if the Physician prescribes the Brand Name or the Covered Person requests the Brand Name product when there is a Generic substitute available the Covered Person is required to pay the difference in cost between the Brand and Generic product in addition to the Brand Coinsurance (applies to Prescription Card and Mail Order).**

$3500 Deductible Plan (Generic and Mail Order only) and $4500 Deductible Plan: **The Maximum Allowable Cost penalty does not apply to the Calendar Year Deductible or Annual Out-of-Pocket Maximum. Once the Annual Out-of-Pocket Maximum has been met, the Covered Person will still be required to pay the difference in cost between the Brand and Generic products for the remainder of that Calendar Year.**

$3500 Deductible Plan (Retail Preferred and Non-Preferred Brand Drugs): **The Maximum Allowable Cost penalty does not apply to the separate Prescription Drug Deductible or Calendar Year Deductible or Annual Out-of-Pocket Maximum. Once the Annual Out-of-Pocket Maximum has been met, the Covered Person will still be required to pay the difference in cost between the Brand and Generic products for the remainder of that Calendar Year.**

Most pharmacists, as a courtesy to the patient, will ask whether a Generic Drug is acceptable to the Covered Person if the Physician has specified "product selection permitted" on the prescription. If the Physician has specified "dispense as written," no choice is given to the patient.

Miscellaneous Provisions

The following provisions may be included in your Prescription Drug Plan. Please contact the Prescription Card Service Customer Service phone number listed on the Plan Participant identification card for more information.

Step Therapy: The practice of starting Drug therapy for a medical condition with the most cost-effective and safest Drug available, then progressing to other more costly alternatives if necessary.

Therapeutic Substitution: A Physician-oriented service designed to increase the utilization of more cost-effective products. Substitutes are made for Non-Preferred Brand Name Drugs with either Generic or similar Preferred Brand Name Drugs in the same therapeutic class.

Drug Review

The Plan includes a Drug Review program which is automatically administered by the pharmacist through a nationwide computer network that verifies the eligibility of each Covered Person's card and protects the Covered Person from conflicting prescriptions which might prove harmful if taken at the same time. This program also guards against duplication of medications and incorrect dosage levels.

Covered and Excluded Drugs

The following Covered and Excluded Drug listings are not all inclusive. To find out if a particular Drug is covered, please contact the Prescription Card Service Customer Service phone number listed on the Plan Participant identification card.

NOTE: Some Drugs may require authorization and may only be covered, and/or covered for certain ages, if Medically Necessary.

Prescription Drug Plan – Covered Drugs

1. Legend Drugs (Drugs requiring a prescription either by Federal or State law) (there are certain Legend Drugs that may be excluded);
2. Insulin on prescription;
3. Compounded medications of which at least one ingredient is a prescription legend Drug;
4. All FDA approved women's contraceptive Drugs and methods (Generic covered at 100%, Deductible waived; if no Generic available, Brand covered at 100%, Deductible waived);
5. Tobacco deterrent medications or any other tobacco use OTC cessation aids, all dosage forms limited to two (2) 90-day supplies per Calendar Year (Generic covered at 100%, Deductible waived; if no Generic available, Brand covered at 100%, Deductible waived); and
6. Specialty Drugs.

NOTE: Quantity limitations may apply to some Covered Drugs in addition to those shown above.

NOTE: Refer to the definition of "Preventive Care" for a link to a website that lists additional Drugs that may be covered for preventive treatment.

Prescription Drug Plan – Excluded Drugs

1. Abortifacients;
2. Drugs for Cosmetic purposes;
3. Fertility Drugs;
4. Weight loss medications;
5. Immunization agents (except immunizations and vaccines as required for Preventive Care services; Generic covered at 100%, Deductible waived; if no Generic available, Brand covered at 100%, Deductible waived), biological sera, blood or blood plasma;
6. Therapeutic devices or appliances, including needles, syringes, support garments and other non-medical substances, regardless of intended use, except those listed above;
7. Charges for the administration or injection of any Drug;
8. Prescriptions which a Covered Person is entitled to receive without charge from any Workers' Compensation laws;
9. Drugs labeled "Caution-limited by Federal law to Investigational use," or Experimental Drugs, even though a charge is made to the individual;
10. Medication which is to be taken by or administered to an individual, in whole or in part, while he/she is a patient in a licensed Hospital, Extended Care Facility, nursing home or similar institution which operates on its premises, or allows to be operated on its premises, a Facility for dispensing pharmaceuticals; and
11. 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.

NOTE: Drugs excluded from the Prescription Drug Plan are not payable under Major Medical Expense Benefits.

A Prescription Drug dispensed by a retail pharmacy, Mail Order Service or Specialty Pharmacy for which Coinsurance applies is not considered a Claim for benefits under this Benefit Booklet and, therefore, is not subject to the Plan's Claim Filing Procedures.

When Alternative Care and treatment are identified by Case Management as Medically Necessary and approved by the Plan Administrator, and where there is a reasonable expectation of savings to the Plan without sacrificing the quality of care to the Plan Participant (patient), the Plan may approve and pay for all or part of the charges not shown as a Covered Prescription Drug in this Benefit Booklet.

PRESCRIPTION DRUG UTILIZATION REVIEW

As with all medical and Hospital services, Prescription Drug utilization is subject to determinations of Medical Necessity and appropriate use.

Concurrent Drug Utilization Review generally occurs at the time of service and may include electronic Claim audits which may help to protect patients from potential Drug interactions or Drug-therapy conflicts or overuse/under use of medications.

Retrospective Drug Utilization Review generally involves Claim review and may include communication by the Prescription Drug Plan and/or Utilization Review with the prescribing Physician to coordinate care and verify diagnoses and Medical Necessity. It may include a peer review by a Physician of like specialty to the prescribing Physician reviewing the medical and pharmacy records to determine Medical Necessity.

Should Medical Necessity not be determined by the peer review Physician, the treating Physician and Plan Participant will be notified and provided with the peer review results. The Plan Participant and Physician will be forwarded information on the appeal process as outlined in this Benefit Booklet.

Prospective Drug Utilization Review may include, among other things, Physician or pharmacy assignment in which one Physician and/or one pharmacy is selected to serve as the coordinator of prescription Drug services and benefits for the eligible Plan Participant. The Plan Participant will be notified in writing of this and will be required to designate a Physician and pharmacy as his/her Providers.

ARCHIMEDES

In addition, you may be able to receive certain drugs cost-effectively through a medical specialty prescription drug benefit or other programs administered by Archimedes. If you qualify for benefits in a program administered by Archimedes, specific benefit limitations may apply, such as being required to obtain the drug from a specific location or to satisfy prior authorization, step therapy, or other medical management criteria. You can learn more about Archimedes, the list of drugs available through these programs, and any benefit limitations that may apply to your specific situation by referencing the Archimedes SPD, logging into www.archimedesrx.com or calling Archimedes member services at 888-504-5563.

UTILIZATION REVIEW (UR) PROGRAM

Quantum Health Care Coordination Process

INTRODUCTION

The Plan incorporates a "Care Coordination" process by Quantum Health which leverages resources including but not limited to your Employer, the Plan and the Third-Party Administrator, your provider and your community to help you best navigate the healthcare system. This process includes a staff of Care Coordinators who receive notifications regarding most healthcare services sought by Covered Members, and coordinate activities and information flow between the providers.

Care Coordination is intended to help Covered Members obtain quality healthcare and services in the most appropriate setting, help reduce unnecessary medical costs, and ensure early identification of Covered Members with complex medical conditions. The Care Coordinators are available to Covered Members and their providers for information, assistance, and guidance, and can be reached toll-free by calling:

Care Coordinators: 1-866-885-1491

It is important to note that clinical reviews are done to determine Plan coverage and are conducted by the clinical staff of Quantum Health.

CARE COORDINATION REQUIREMENTS

In order to receive the highest benefits available in the Plan, Covered Members must follow the Care Coordination process outlined in this section, as well as other provisions in the Plan. In some cases, failure to follow this process can result in significant benefit reductions, penalties or even loss of benefits for specific services.

The Care Coordination process generally includes:

- Use of in-network providers
- Designating a Coordinating Provider (PCP)
- The Care Coordination Process and Utilization Management
    - Preauthorization and Clinical Review
    - Concurrent Utilization Review
    - Personal Care Guide Management

Use of In-Network Providers
The Plan offers a broad network of providers and provides the highest level of benefits when Covered Members utilize "In-Network" providers. These networks will be indicated on your Plan identification card. **Services provided by Out-of-Network providers will not be eligible for the highest benefits**. Specific benefit levels are shown in the Schedule of Benefits.

Designated Coordinating Provider
All Covered Members are asked to designate a coordinating Primary Care Provider (PCP) for each covered member of their family. While such designation is not mandatory, it is strongly recommended. **To ensure highest level of benefits, and the best coordination of your care, all Covered Members are encouraged to designate an In-Network Primary Care Provider (PCP) to be their coordinating Provider.** The Care Coordination process generally begins with the coordinating Provider who maintains a relationship with the Covered Member, provides general healthcare evaluation, guidance, and management.

Covered Members are encouraged to begin all healthcare events or inquiries with a call or visit to their designated PCP who will guide Covered Members as appropriate. In addition to providing Care Coordination and submitting preauthorization requests, the PCP may also receive notices regarding healthcare services that their designated patients receive under the Plan. This allows the PCP to provide ongoing healthcare guidance.

If you have trouble obtaining access to a PCP, the Care Coordinators will be able to assist you by providing a list of in-network PCPs. Please contact the Care Coordinators by calling:

Care Coordinators: 1-866-885-1491

UTILIZATION MANAGEMENT

Preauthorization and Clinical Review

To be covered at the highest level of benefit and to ensure complete Care Coordination, the Plan requires that certain care, services, and procedures be preauthorized before they are provided. Preauthorization requests are submitted to the Care Coordinators by a designated PCP, other PCP, specialty provider or other healthcare provider. Your Plan identification card includes instructions and the phone number for them to call. Depending on the request, the Care Coordinators may contact the requesting provider to obtain additional clinical information to support the request for the preauthorization and to ensure that the care, service and/or procedure meet Plan and nationally accepted medical criteria. If a pre-authorization request does not meet Plan and nationally accepted medical criteria, the Covered Member and healthcare provider will be notified, and the Care Coordinators will assist in redirecting care if appropriate.

The following care, services and procedures are subject to preauthorization:

- Inpatient and Skilled Nursing Facility Admissions (hospitalizations to include acute care, skilled nursing, skilled rehabilitation, and treatment for Mental Disorders and Substance Use Disorders)
- Outpatient Surgeries
- MRI/MRA and PET scans
- Oncology Care and Services (chemotherapy & radiation therapy)
- Genetic Testing
- Dialysis
- Organ, Tissue, and Bone Marrow Transplants
- Home Health Care
- Hospice Care
- Durable Medical Equipment - all rentals and any purchase over $1500.
- Partial Hospitalization and Intensive Outpatient for Mental Health/Substance Use Disorders

All preauthorization's and clinical review services are conducted by Quantum Health. Care Coordinators will assist Covered Members in understanding what services require preauthorization.

Failure to notify or comply with these requirements will result in a 25% benefit reduction penalty for the services listed above.

For preauthorization, Providers should call the number listed on the Plan identification card.

Concurrent Utilization Review

Quantum Health will regularly monitor an Inpatient Hospital stay, other institutional admission, or ongoing course of care for any Covered Member, and evaluate the appropriateness of the level of care and if the stay is meeting Medical Necessity. If necessary, they will examine the possible use of alternate levels of care or facilities. Quantum Health will communicate regularly with attending providers, the utilization management staff and/or discharge planners of such facilities, and the Covered Member and/or family to monitor the Covered Member's progress and anticipate and initiate planning for discharge needs. Such concurrent review, and authorization for Plan coverage of inpatient days, is conducted in accordance with the utilization criteria adopted by the Plan, Quantum Health, and nationally accepted medical criteria.

Personal Care Guide Management
Quantum Health utilizes a primary nurse model for chronic condition as well as acute condition management. This enhanced approach provides one nurse to address clinical needs for all chronic and acute issues. The Personal Care Guide (PCG) nurse will consult with the Covered Member, their family (if requested), the attending Physician, and other members of the Covered Person's treatment team to assist in facilitating/implementing proactive plans of care which provide the most appropriate health care and services in a timely, efficient and cost-effective manner. They assist with benefits, incidental health care issues, becoming healthier, finding resources or an unexpected healthcare journey.

During outreach, the Personal Care Guide will touch on the Covered Member's treatment and perform a physical assessment, perform a medication reconciliation to ensure there are no duplications or interactions, perform a depression screening with subsequent referrals to EAP or in-network providers, as well as focus on the physical and emotional needs of the Covered Member.

The Personal Care Guide will look at the Covered Member's psychosocial needs and social determinants of health. In addition to the depression screening, they will evaluate the Covered Member's financial issues, knowledge deficits, as well as any cultural barriers that may exist. Conversations with the Covered Member would occur at least monthly, if not more frequently, and continue until the Covered Member's health goals and needs are met.

The primary Personal Care Guide nurse will align with the Covered Member and be the single point of contact for them, their family, caregivers, and providers.

The primary Personal Care Guide nurse will:

- Provide comprehensive benefit education/utilization support
- Drive PCP designation and steerage to in-network providers
- Encourage provider involvement
- Deliver pre-certification assistance
- Perform pre-admission, pre-discharge, and post-discharge engagement
- Coordinate for utilization review and discharge planning
- Identify gaps in care and alleviate clinical, financial, and humanistic barriers
- Coordinate second opinions, drive utilization to other third-party vendor tools, and introduce community resources
- Perform behavioral health screening

Our primary nurse model has three foundational drivers for the changes:

- Humanistic: to help members with acute and chronic needs by assigning a single nurse to the Covered Member and their family as well as a heightened attention to psychosocial issues that can negatively affect health, quality of life and financial outcomes.
- Clinical: identify and prioritize members in need of clinical outreach. Improve adherence to quality measures for preventive health and management of chronic conditions.
- Financial: identify and outreach to members at risk for future high costs while encouraging preventive care and chronic condition management to improve health and reduce costs.

GENERAL PROVISIONS FOR CARE COORDINATION

Authorized Representative
The Covered Member is ultimately responsible for ensuring that all preauthorization's are approved and in place prior to the time of service to receive the highest level of benefits. However, in most cases, the actual preauthorization process will be executed by the Covered Member's Primary Care Provider or other providers. By subscribing to this Benefit Booklet, the Covered Member authorizes the Plan and its designated service providers (including Quantum Health and the Third-Party Administrator, and others) to accept healthcare providers or those providers who otherwise have knowledge of the Covered Member's medical condition, as their authorized representative in matters of Care Coordination, including preauthorization requests. Communications with and notifications to such healthcare providers shall be considered as notification to the Covered Member.

Time of Notice
The preauthorization request should be made to the Care Coordinators within the following timeframe:

- At least **three business days,** before a scheduled (elective) Inpatient admission
- By the next business day after, an emergency Hospital admission
- Upon being identified as a potential organ or tissue transplant recipient
- At least **three business days** before receiving any other services requiring preauthorization

For preauthorization, Providers should call the number listed on the Plan identification card.

Special Note: The Covered Member will not be penalized for failure to obtain preauthorization if a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect that the absence of immediate medical attention would jeopardize the life or long-term health of the individual. However, Covered Members who receive care on this basis must contact the Care Coordinators as soon as possible within 24 hours of the first business day after receiving care or Hospital admittance. Care Coordinators will then coordinate with Quantum Health Utilization Management to review services provided within 48 hours of being contacted.

"Emergency" Admissions and procedures
Any Inpatient admission or Outpatient procedure that has not been previously scheduled and cannot be delayed without harming the Covered Member's health is considered an emergency for purposes of the Utilization Management notification.

Maternity Admissions
A notice regarding admissions for childbirth should be submitted to the Care Coordinators in advance, preferably 30 days prior to expected delivery. The Plan and the Care Coordination process complies with all state and federal regulations regarding Utilization Management for maternity admissions. The Plan will not restrict benefits for any hospital stay in connection with childbirth for the mother or newborn child to less than 48 hours following a normal vaginal delivery, or less than 96 hours following a cesarean section, or require preauthorization or authorization for prescribing a length of stay not in excess of these periods. If the mother's or newborn's attending provider, after consulting with the mother, discharges the mother or her newborn earlier than the applicable 48 or 96 hours, the Plan will only consider benefits for the actual length of the stay. The Plan will not set benefit levels or out-of-pocket costs so that any later portion of the 48 or 96-hour stay is treated in a manner less favorable to the mother or newborn than any earlier portion of the stay.

Care Coordination is Not a Guarantee of Payment of Benefits
The Care Coordination process does not provide a guarantee of payment of benefits. Approvals of preauthorization's for procedures, hospitalizations and other services indicate that the medical condition, services, and care settings meet the utilization criteria established by the Plan. The Care Coordination approvals do not indicate that the service is a covered benefit, that the Covered Member is eligible for such benefits, or that other benefit conditions such as Copay, Deductible, Coinsurance, or maximums have been satisfied. Final determinations regarding coverage and eligibility for benefits are made by the Plan.

Result of Not Following the Coordinated Process of Care
Failure to comply with the Care Coordination Process of Care may result in reduction or loss in benefits. The Penalties for not obtaining preauthorization section specifies applicable penalties. Charges you must pay due to any penalty for failure to follow the Care Coordination Process do not count toward satisfying any deductible, co-insurance, or out-of-pocket limits of the Plan.

Appeal of Care Coordination Determinations
Covered Members have certain appeal rights regarding adverse determinations in the Care Coordination process, including reduction of benefits and penalties. The Appeal Process is detailed in the Claims and Appeal Procedures section within this document.

COMPREHENSIVE MEDICAL BENEFITS

COVERED MEDICAL EXPENSES (COVERED EXPENSES)

Covered Medical Expenses mean the Reasonable and Usual and Customary charges Allowable Claim Limit charges, and/or contracted PPO charges incurred by or on behalf of a Covered Person for Hospital or other medical services listed below which are:

1. Ordered by a Physician or licensed Practitioner;
2. Medically Necessary for the treatment of an Illness or Injury;
3. Not of a luxury or personal nature; and
4. Not excluded under the Major Medical Exclusions and Limitations section of this Benefit Booklet.

COVERED CHARGES

If a Covered Person incurs Covered Medical Expenses as the result of an Illness or Injury, all treatment is subject to benefit payment provisions shown in the Schedule of Benefits and as determined elsewhere in this document.

HOSPITALS, AMBULATORY SURGERY CENTERS AND OTHER FACILITIES

Facilities do not participate in the PPO Network. Charges for services rendered in these Facilities will be evaluated under the Claim Review and Audit Program, and Covered Charges will be determined based upon the Allowable Claim Limits. Please refer to the Claim Review and Audit Program section for additional information about the program and Allowable Claim Limits.

PHYSICIANS AND ALL OTHER COVERED PROVIDERS

Network Services (PPO): Network Services (PPO) are health care services provided by a Physician or other Provider in the designated PPO with which the Plan has contracted to provide services at specified fees. Network Covered Charges will be payable at the PPO benefit level.

This Benefit Booklet may use Allowable Claim Limits to determine Covered Charges in lieu of a PPO discount.

Out-Of-Network Services (Non-PPO): Out-of-Network Services (Non-PPO) are health care services provided by a Physician or other Provider that is not in the Plan's designated PPO Network. Out-of-Network Covered Charges will be payable at the Non-PPO benefit level unless the Plan has a direct contract for discounting fees with an Out-of-Network Provider or Out-of-Network services are listed as a PPO benefit exception in the Schedule of Benefits, in which case, the PPO benefit level will apply.

Charges for services rendered by Non-PPO Providers will be evaluated under the Claim Review and Audit Program, and Covered Charges will be determined based upon the Allowable Claim Limits. Please refer to the Claim Review and Audit Program section for additional information about the program and Allowable Claim Limits.

HOSPITAL OR MEDICAL FACILITY FEES/PHYSICIAN FEES

The total cost for many medical services/procedures may be comprised of several components: Hospital or other medical Facility fees and Physician fees.

Hospital or Medical Facility Fees: The Hospital or medical Facility fees cover the cost of providing Room and Board and/or technicians, equipment, supplies and miscellaneous expenses involved in the care and treatment of a patient. Medical service fees billed by a Provider billing as a Facility may be separate from medical services billed by a Physician.

Physician Fees: The Physician fees cover the cost of medical services/procedures provided by a Physician or the professional fees billed by a Physician for the supervision, interpretation and consultation involved in the care and treatment of a patient. Each fee may be billed separately by the Physician providing the service.

CALENDAR YEAR DEDUCTIBLE (LEVEL I and LEVEL II)
($3500 Deductible Plan only)
The Deductible amount for each Covered Person is the amount of Covered Expenses which must be incurred each Calendar Year before benefits are payable for Covered Medical Expenses incurred during the remainder of that year. It is the amount shown in the Schedule of Benefits as the Calendar Year Deductible. There is no Deductible carryover from one Calendar Year to the next for Covered Charges incurred and applied to the Deductible in the last three (3) months of a Calendar Year. Level I Covered Charges and Level II PPO and Non-PPO Covered Charges are combined to satisfy the Calendar Year Deductible.

DEDUCTIBLE FAMILY LIMIT (LEVEL I and LEVEL II)
($3500 Deductible Plan only)
The Maximum Deductible amounts to be applied each Calendar Year to a Covered Employee and his/her covered Dependents will not be more than the Family Limit shown in the Schedule of Benefits. As soon as that limit is met (collectively) in the same Calendar Year, no further Deductibles will be applied to Covered Medical Expenses for any covered Family member during the remainder of that Calendar Year. To satisfy the Deductible Family Limit, each covered Family member can contribute no more than his/her own individual Deductible.

CALENDAR YEAR DEDUCTIBLE (LEVEL I and LEVEL II)
($4500 Deductible with HSA Plans only)
The Deductible amount for each Covered Person is the amount of Covered Medical and Prescription Drug Expenses which must be incurred each Calendar Year before benefits are payable for Covered Medical and Prescription Drug Expenses incurred during the remainder of that Calendar Year. It is the amount shown in the Schedule of Benefits as the Calendar Year Deductible. There is no Deductible carryover from one Calendar Year to the next for Covered Charges incurred and applied to the Deductible in the last three (3) months of a Calendar Year. Level I Covered Charges, Level II PPO and Non-PPO and Prescription Drug Expenses Covered Charges are combined to satisfy the Calendar Year Deductible.

DEDUCTIBLE FAMILY LIMIT (LEVEL I and LEVEL II)
($4500 Deductible with HSA Plans only)
The Maximum Deductible amounts to be applied each Calendar Year to a Covered Employee and his/her covered Dependents will not be more than the Family Limit shown in the Schedule of Benefits. As soon as that limit is met (collectively) in the same Calendar Year, no further Deductibles will be applied to Covered Medical Expenses and Prescription Drug Expenses for any covered Family member during the remainder of that Calendar Year. To satisfy the Deductible Family Limit, each covered Family member can contribute no more than his/her own individual Deductible.

COINSURANCE
Coinsurance is the portion of Covered Medical Expenses shared by the Plan and the Covered Person in a specific ratio (i.e., 80%/20% and/or 60%/40%) after the Calendar Year Deductible has been satisfied. The amount of Coinsurance paid by the Covered Person is applied to satisfy the Covered Person's Annual Out-of-Pocket Maximum.

ANNUAL OUT-OF-POCKET MAXIMUM (LEVEL I and LEVEL II)
($3500 Deductible Plan only)
The Annual Out-of-Pocket Maximum does not include expenses which are in excess of the Allowable Claim Limits (please refer to the Claim Review and Audit Program section for additional information regarding Allowable Claim Limits). The Annual Out-of-Pocket Maximum is the maximum dollar amount a Covered Person will pay for Covered Medical Expenses and Prescription Drug Expenses each Calendar Year including the Deductible, Medical Copays and Prescription Drug Copays. Level I Covered Charges and Level II PPO and Non-PPO Covered Charges are combined to satisfy the Annual Out-of-Pocket Maximum. Upon reaching the Annual Out-of-Pocket Maximum, Covered Medical Expenses and Prescription Drug Expenses are payable at 100% for the remainder of the Calendar Year, excluding:

- Any Covered Charges already paid at 100% in any one (1) Calendar Year period, unless otherwise specified in the Schedule of Benefits;
- Charges in excess of Usual and Customary, Allowable Claim Limits, or charges for services that do not meet the Plan's definition of Reasonable; and
- Any non-compliance penalty applied when a Covered Person fails to notify Utilization Review as specified in the Utilization Review (UR) Program.

ANNUAL OUT-OF-POCKET MAXIMUM FAMILY LIMIT (LEVEL I and LEVEL II)
($3500 Deductible Plan only)
The Annual Out-of-Pocket Maximum Family Limit is met when all covered Family members (collectively) incur the amount shown in the Schedule of Benefits as the Annual Out-of-Pocket Maximum Family Limit. As soon as that limit is met (collectively) no further Out-of-Pocket amounts will be applied to Covered Medical Expenses and Prescription Drug Expenses during the remainder of that Calendar Year. To satisfy the Family Limit, each Covered Family member can contribute no more than his/her own individual Annual Out-of-Pocket Maximum.

ANNUAL OUT-OF-POCKET MAXIMUM (LEVEL I and LEVEL II)
($4500 Deductible with HSA Plan only)
The Annual Out-of-Pocket Maximum does not include expenses which are in excess of the Allowable Claim Limits (please refer to the Claim Review and Audit Program section for additional information regarding Allowable Claim Limits). The Annual Out-of-Pocket Maximum is the maximum dollar amount a Covered Person will pay for Covered Medical and Prescription Drug Expenses each Calendar Year including the Deductible. Level I Covered Charges, Level II PPO and Non-PPO Covered Charges and Prescription Drug Expenses are combined to satisfy the Annual Out-of-Pocket Maximum. Upon reaching the Annual Out-of-Pocket Maximum, Covered Medical Expenses and Prescription Drug Expenses are payable at 100% for the remainder of the Calendar Year, excluding:

- Any Covered Charges already paid at 100% in any one (1) Calendar Year period, unless otherwise specified in the Schedule of Benefits;
- Charges in excess of Usual and Customary, Allowable Claim Limits, or charges for services that do not meet the Plan's definition of Reasonable; and
- Any non-compliance penalty applied when a Covered Person fails to notify Utilization Review as specified in the Utilization Review (UR) Program.

ANNUAL OUT-OF-POCKET MAXIMUM FAMILY LIMIT (LEVEL I and LEVEL II)
($4500 Deductible with HSA Plans only)
The maximum Annual Out-of-Pocket amounts to be applied each Calendar Year to a Covered Employee and his/her covered Dependents will not be more than the Annual Out-of-Pocket Maximum Family Limit shown in the Schedule of Benefits. As soon as that limit is met (collectively) no further Out-of-Pocket amounts will be applied to Covered Medical and Prescription Drug Expenses during the remainder of that Calendar Year. To satisfy the Family Limit, each Covered Family member can contribute no more than his/her own individual Annual Out-of-Pocket Maximum.

EMERGENCY ROOM COPAY (PER VISIT – LEVEL I)
($3500 Deductible Plan only)
The Emergency Room Copay is the portion of Covered Medical Expenses, a flat dollar amount, payable by the Covered Person for Covered Charges each time the Covered Person is treated in a Hospital Emergency Room or Independent Freestanding Emergency Department. The Calendar Year Deductible is waived and only applies if the Covered Person is admitted Inpatient. The Emergency Room Copay is waived if admitted Inpatient. The Emergency Room Copay cannot be used to satisfy the Calendar Year Deductible but will apply to satisfy the Annual Out-of-Pocket Maximum.

URGENT CARE FACILITY COPAY (PER VISIT) (LEVEL I AND LEVEL II)
($3500 Deductible Plan only)
The Urgent Care Facility Copay is the portion of Covered Medical Expenses, a flat dollar amount, payable by the Covered Person for Covered Charges each time the Covered Person is treated by a Physician in an Urgent Care Facility (Minor Emergency Medical Clinic) when such services are billed by either an Urgent Care Facility or a Physician. The Calendar Year Deductible is waived. The Urgent Care Facility Copay cannot be used to satisfy the Calendar Year Deductible but will apply to satisfy the Annual Out-of-Pocket Maximum.

OFFICE VISIT COPAY (PER VISIT)
($3500 Deductible Plan only)
The Office Visit Copay is the portion of Covered Medical Expenses, a flat dollar amount, payable by the Covered Person for Covered Charges provided by and billed by the Physician at the time of each Physician Office Visit. Whenever an Office Visit Copay applies, the Calendar Year Deductible is waived for that visit except for office procedures listed in the Schedule of Benefits which are not subject to the Office Visit Copay. The Office Visit Copay cannot be used to satisfy the Calendar Year Deductible but will apply to satisfy the Annual Out-of-Pocket Maximum.

Office Visit Copays for a Primary Care Physician and a Specialist are specified in the Schedule of Benefits. A referral from a Primary Care Physician to a Specialist is not required.

SELECT DIAGNOSTIC MEDICAL PROCEDURES
The following is a list of Select Diagnostic Medical Procedures that may be performed in a Physician's office, the Outpatient department of a Hospital, freestanding center or an independent Facility. Benefits are available under the Plan as specified in the Schedule of Benefits:

1. Bone scan – Specialized x-ray of bone tissues using radioactive injection if more sensitive to bone irregularities than usual x-rays:
   a. Limited area;
   b. Multiple areas;
   c. Whole body;
   d. With vascular flow only;
   e. Three phase technique; or
   f. Tomographic (SPECT).
2. Cardiac stress test:
   a. Thallium – Use of radioactive dye to define areas of decreased blood flow in vessels of the heart while the patient exercises.
   b. Treadmill – Reading of the electrical patterns of the heart (EKG) while the patient exercises on a treadmill.
3. MCG – Myocardial imaging by magnetocardiography.
4. CT Scan – Computerized x-ray picture of a part of the body.
5. MRI (Magnetic Resonance Imaging) and MRA (Magnetic Resonance Angiography) – Diagnostic imaging modality that uses magnetic and radio frequency fields to image body tissue non-invasively.
6. PET Scan (Positron Emission Tomography) – A three-dimensional imaging technique that allows visual examination of the internal organs and illustrates organ function.

7. Ultrasound, Echography and Sonography – The use of inaudible sound waves to outline the shape of organs and tissues in the body. A sonogram during Pregnancy is not considered a Select Diagnostic Medical Procedure and is payable under the Plan's Lab/X-ray Benefit.
8. Myelogram – x-ray of the spine after injection of a contrast medium (dye) into a space in the spinal canal.
9. Aortography, Angiography, Lymphangiography, Venography, Transcatheter, Transluminal Atherectomy and Diskography.
10. Nuclear medicine scans.

CALENDAR YEAR MAXIMUM BENEFIT

The Maximum Amount payable for Covered Expenses during a Calendar Year Benefit Period for each Covered Person is limited to a specific dollar amount, number of days or visits as specified in the Schedule of Benefits. The Calendar Year is from January 1 through December 31 of the same year. The initial Calendar Year Benefit Period is from a Covered Person's effective date through December 31 of the same year. Level I and Level II (PPO and Non-PPO) Covered Charges are combined to determine if a Calendar Year Maximum Benefit has been met.

LIFETIME MAXIMUM BENEFIT

The Maximum Amount payable for applicable Covered Expenses incurred during each Covered Person's lifetime is as specified in the Schedule of Benefits. The word "Lifetime," as used herein, means the duration of participation in this Benefit Booklet maintained by the Company, either as an Employee, Dependent or COBRA Qualified Beneficiary (including prior Plan Years). Level I and Level II (PPO and Non-PPO) Covered Charges are combined to determine if a Lifetime Maximum Benefit has been met.

CONTINUITY OF CARE

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

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

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

- Undergoing a course of treatment for a serious and complex condition from a specific Provider;
- Undergoing a course of institutional or Inpatient care from a specific Provider;
- Scheduled to undergo non-elective surgery from a specific Provider, including receipt of postoperative care with respect to the surgery;
- Pregnant and undergoing a course of treatment for the Pregnancy from a specific Provider; or
- Determined (or was determined) to be terminally ill and is receiving treatment for such Illness from a specific Provider.

Note that during continuation, Plan benefits will be processed as if the termination had not occurred, and the Provider must accept reimbursement from the Plan and any applicable cost sharing from the Participant as payment in full.

CHARGES RELATED TO ACCIDENTAL INJURIES

Prior to obtaining Accident details, the Maximum Benefit payable on charges arising from an Accidental Injury is $500. Once charges for the same related Claim equal or exceed $500, charges will be denied until expenses are determined to be an eligible benefit under this Benefit Booklet.

MAJOR MEDICAL EXPENSE BENEFITS

The following are Covered Medical Expenses under this Benefit Booklet, unless specifically excluded under the Major Medical Plan Exclusions and Limitations. Benefits for these Covered Expenses will be payable as shown in the Schedule of Benefits. Charges are subject to the Reasonable and Usual and Customary amount, the Allowable Claim Limits under the Claim Review and Audit Program and/or the negotiated fee schedule of the Preferred Provider Organization (PPO).

Covered Medical Expenses are subject to any Maximum Benefit and/or limitation specified in the Schedule of Benefits.

Abortion. The charges related to an elective abortion.

Acquired Brain Injury. The charges for treatment of Acquired Brain Injury. Benefits are provided for services that are determined by a Physician to be Medically Necessary as a result of and related to an Acquired Brain Injury. Acquired Brain Injury is a neurological insult to the brain which is not hereditary, congenital or degenerative. The Injury to the brain has occurred after birth and results in a change in neuronal activity, which results in an impairment of physical functioning, sensory processing, cognition, or psychological behavior. Covered Medical Expenses include services listed below when they are clinically proven, goal-oriented, efficacious, based on individualized treatment plans, required for and related to treatment of an Acquired Brain Injury and provided by or under the direction of a Physician with the goal of returning the Covered Person to, or maintaining the Covered Person in, the most integrated living environment appropriate to the Covered Person.

1. Cognitive communication therapy. Services designed to address modalities of comprehension and expression, including understanding, reading, writing and verbal expression of information;
2. Cognitive rehabilitation therapy. Services designed to address the therapeutic cognitive activities based on an assessment and understanding of the individual's brain-behavioral deficits;
3. Community reintegration services. Services that facilitate the continuum of care as an affected individual transitions into the community;
4. Neurobehavioral testing. An evaluation of the history of neurological and psychiatric difficulty, current symptoms, current mental status, and pre-morbid history including the identification of problematic behavior and the relationship between behavior and the variables that control behavior;
5. Neurobehavioral treatment. Interventions that focus on behavior and the variables that control behavior;
6. Neurocognitive rehabilitation. Services designed to assist cognitively impaired individuals to compensate for deficits in cognitive functioning by rebuilding cognitive skills and/or developing compensatory strategies and techniques;
7. Neurocognitive therapy. Services designed to address neurological deficits in informational processing and to facilitate the development of higher level cognitive abilities;
8. Neurofeedback therapy. Services that utilize operant conditioning learning procedures based on electroencephalography (EEG) parameters, and which are designed to result in improved mental performance and behavior, and stabilized mood;
9. Neurophysiological testing. An evaluation of the functions of the nervous system;
10. Neurophysiological treatment. Interventions that focus on the functions of the nervous system;
11. Neuropsychological testing. The administering of a comprehensive battery of tests to evaluate neurocognitive, behavioral and emotional strengths and weaknesses and their relationship to normal and abnormal central nervous system functioning;
12. Neuropsychological treatment. Interventions designed to improve or minimize deficits in behavioral and cognitive processes;
13. Post-acute transition services. Services that facilitate the continuum of care beyond the initial neurological insult through rehabilitation and community reintegration;
14. Psychophysiological testing. An evaluation of the interrelationships between the nervous system and other bodily organs and behavior;
15. Psychophysiological treatment. Interventions designed to alleviate or decrease abnormal physiological responses of the nervous system due to behavioral or emotional factors;
16. Remediation. The process of restoring or improving a specific function;

17. Outpatient day treatment services and post-acute care treatment. Services Medically Necessary as a result of and related to an Acquired Brain Injury. Post-acute care treatment is limited to Reasonable expenses related to periodic reevaluation of care provided to an individual who has incurred an Acquired Brain Injury, has been unresponsive to treatment and becomes responsive to treatment at a later date. Reasonable fees may be determined by cost; the time that has expired since the previous evaluation; any difference in the expertise of the Physician or Practitioner performing the evaluation; changes in technology and advances in medicine; and
18. Treatment Facilities. Treatment for an Acquired Brain Injury may be provided at a Facility at which the services listed above may be provided including a Hospital, acute or post-acute Rehabilitation Hospital and Assisted Living Facility. Benefits are not available for Custodial Care, Private Duty Nursing, domiciliary care, and personal care assistants.

Acupuncture. The charges for Acupuncture treatment and Acupuncturist services *for all diagnoses* by a licensed Practitioner. *Covered charges also includes treatment of nausea as a result of Chemotherapy, Pregnancy and related to surgery.*

Admit Kits. The charges for Hospital "admit kits."

Allergy Testing, Allergy Injections and Allergy Serums. The charges for allergy testing, allergy injections, allergy serums and treatment.

Ambulance Services. The charges for professional licensed ambulance service as follows:

1. Ground transportation when Medically Necessary and used locally to or from the nearest Facility qualified to render treatment;
2. Air ambulance where air transportation is medically indicated to transport a Covered Person to the nearest Facility qualified to render treatment (excluding commercial flights); or
3. "CARE" and "LIFE" flights in a life-threatening situation.

Ambulatory Surgery Center. The charges made by an Ambulatory Surgery Center.

Anesthesia. The charges for the cost and administration of an Anesthesia and/or anesthetic.

Assistant Surgeon. The charges for services of an assistant surgeon and/or Licensed Surgical Assistant when such a Provider is required to render technical assistance at an operation. The Covered Expense for such services shall be limited to 25% of the allowable surgical fee. See definition of Practitioner for covered Providers.

Attention Deficit Disorder (ADD) and Attention Deficit Hyperactivity Disorder (ADHD). The charges for the diagnosis and treatment of Attention Deficit Disorder (ADD) and Attention Deficit Hyperactivity Disorder (ADHD) with the exclusion of charges for education and training.

Audiologist. The charges of an Audiologist under direct supervision of a Physician for treatment of a hearing loss or an impaired hearing function.

Autism Spectrum Disorder. The charges for treatment of Autism Spectrum Disorder, not subject to the Plan's internal Therapy Maximums. Treatment includes all generally recognized services prescribed in relation to Autism Spectrum Disorder by the patient's Physician. "Generally recognized services" may include services such as evaluation and assessment, Applied Behavior Analysis (ABA) Therapy, behavior training and management, Speech Therapy, Occupational Therapy, Physical Therapy and medications or nutritional supplements used to address symptoms of Autism Spectrum Disorder.

Birthing Center. The charges incurred for services in a Birthing Center.

Blood or Blood Components. The charges for the processing and administration of blood or blood components, but not for the cost of the actual blood or blood components if the Facility receives any replacement of blood used for which the patient is not financially responsible.

Breast Reduction (Reduction Mammoplasty). The charges for a reduction mammoplasty, if Medically Necessary.

Cardiac Rehabilitation. The charges for cardiac rehabilitation as deemed Medically Necessary provided services are rendered:

1. Under the supervision of a Physician;
2. In connection with a myocardial infarction, coronary occlusion or coronary bypass Surgery;
3. Initiated within twelve (12) weeks after other treatment for the medical condition ends; and
4. In a Facility whose primary purpose is to provide medical care for an Illness or Injury.

***Cellular and Gene Therapy*.** The charges for Cellular Therapy and Gene Therapy received on an inpatient or outpatient basis at a Hospital, Outpatient Facility or in a Physician's office. Benefits for CAR-T therapy for malignancies are provided under Organ Transplant Benefits when the treatment meets Utilization Review criteria for Medical Necessity.

Chemotherapy. The charges for chemotherapy.

Chiropractic Services. The charges for Chiropractic Services. Charges for covered x-rays are not included in the Maximum.

Clinical and Pathological Laboratory Tests. The charges for clinical and pathological laboratory tests and examinations including fees for professional interpretation of their results.

Clinical Trials (Routine Patient Costs). Benefits are provided to Qualified Individuals for the Routine Patient Costs of items and services furnished in connection with participation in an Approved Clinical Trial. Routine Patient Costs include all items and services consistent with the coverage provided under this Benefit Booklethat are typically covered for a Qualified Individual who is not enrolled in a clinical trial. Routine Patient Costs do not include:

1. The Investigational item, device, or service, itself;
2. Items and services that are provided solely to satisfy data collection and analysis needs and that are not used in the direct clinical management of the patient; or
3. A service that is clearly inconsistent with widely accepted and established standards of care for a particular diagnosis.

If one or more Participating Providers is participating in a clinical trial, the Plan may require that a Qualified Individual participate in the trial through such a Participating Provider if the Provider will accept the individual as a participant in the trial.

Approved Clinical Trial is 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 that is described in any of the following:

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

    a. The National Institutes of Health.
    b. The Centers for Disease Control and Prevention.
    c. The Agency for Health Care Research and Quality.
    d. The Centers for Medicare & Medicaid Services.
    e. A cooperative group or center of any of the entities described in (a) through (d) above or the Department of Defense or the Department of Veterans Affairs.
    f. A qualified non-governmental research entity identified in the guidelines issued by the National Institutes of Health for center support grants.
    g. The Department of Veterans Affairs, the Department of Defense, or the Department of Energy, if the study or investigation has been reviewed and approved through a system of peer review that the Secretary determines:

i. to be comparable to the system of peer review of studies and investigations used by the National Institutes of Health; and
ii. assures unbiased review of the highest scientific standards by Qualified Individuals who have no interest in the outcome of the review; or

2. The study or investigation is conducted under an Investigational new Drug application reviewed by the Food and Drug Administration; or

3. The study or investigation is a Drug trial that is exempt from having such an Investigational new Drug application.

A Qualified Individual must meet the following conditions:

1. The individual must be eligible to participate in an Approved Clinical Trial according to the trial protocol with respect to treatment of cancer or other life-threatening condition; and

2. Either:

   a. The referring health care professional is a Participating Provider and has concluded that the individual's participation in such trial would be appropriate based upon the individual meeting the conditions described in paragraph (1); or
   b. The individual provides medical and scientific information establishing that the individual's participation in such trial would be appropriate based upon the individual meeting the conditions described in paragraph (1).

A *life-threatening condition* means any Disease or condition from which the likelihood of death is probable unless the course of the Disease or condition is interrupted.

Cochlear Devices and Systems. The charges for external cochlear devices and systems, including surgery to place a cochlear implant. Cochlear implantation can either be an inpatient or outpatient procedure.

Cochlear Implant Aural Therapy. The charges for Post-cochlear implant aural therapy.

Cognitive Rehabilitation Therapy. The charges for Cognitive rehabilitation therapy when Medically Necessary following a post-traumatic brain Injury or cerebral vascular accident.

Congenital Heart Disease (CHD) Surgeries. The Plan pays Benefits for CHD surgeries which are ordered by a Physician. CHD surgical procedures include surgeries to treat conditions such as coarctation of the aorta, aortic stenosis, tetralogy of fallot, transposition of the great vessels and hypoplastic left or right heart syndrome. Surgery may be performed as open or closed surgical procedures or may be performed through interventional cardiac catheterization.

Benefits are available for the following CHD services:

- Outpatient diagnostic testing.
- Evaluation.
- Surgical interventions.
- Interventional cardiac catheterizations (insertion of a tubular device in the heart).
- Fetal echocardiograms (examination, measurement and diagnosis of the heart using ultrasound technology).
- Approved fetal interventions.

Contraceptives. The charges for all FDA approved women's contraceptive methods.

Corneal Transplants. The charges for services and supplies in connection with corneal transplants on the same basis as any other Illness.

Cosmetic Surgery. The charges for Cosmetic Surgery only in the following situations:

1. Reconstructive Surgery as a result of an accidental bodily Injury;
2. The surgical correction required as a result of a congenital Disease or Congenital Anomaly;
3. Reconstructive Surgery following neoplastic (cancer) Surgery;
4. Reconstruction of the breast on which a mastectomy has been performed;
5. Surgery and reconstruction of the other breast to produce symmetrical appearance;
6. Coverage for prostheses and physical complications related to all stages of covered mastectomy including lymphedema, in a manner determined in consultation with the attending Physician and patient; and
7. Removal of breast implants if deemed to be Medically Necessary and reconstructive breast Surgery after implant removal. Breast reconstruction is not covered if the original implants were for cosmetic reasons. However, the removal of the implant is covered, if Medically Necessary, even if the original implant was for cosmetic reasons.

NOTE: The Plan's breast reconstruction Surgery benefits are subject to the requirements of the mastectomy provision of the Women's Health and Cancer Rights Act of 1998.

Counseling. The charges for Family counseling.

Custom Bras for Prostheses. The charges for custom bras for prostheses following a mastectomy, limited to six (6) per Calendar Year.

Dental Expenses and Oral Surgery Procedures. The charges for the following Dental expenses and Oral Surgery procedures:

1. Excision of impacted or partially impacted teeth;
2. Cutting procedures in the oral cavity for excision of tumors and cysts of the jawbone;
3. Cutting procedures on gums or mouth tissues needed to treat a Disease;
4. External incision and drainage of cellulitis;
5. Open or closed reduction of a fracture or dislocation of the jaw; and
6. Treatment necessitated by Accidental Injury to sound natural teeth if services are performed within three (3) months from the date of the Accident, *or if the Covered Person was not covered under the Plan at the time of the accident, within the first three (3) months of coverage under the Plan, unless extenuating circumstances exist (such as prolonged hospitalization or the presence of fixation wires from fracture care), treatment must be completed within twelve (12) months of the accident, or if not a Covered Person at the time of the accident, within the first twelve (12) months of coverage under the Plan*.

If Medically Necessary for Dental work or Oral Surgery to be performed at an Outpatient Facility or Hospital, only the Facility and related anesthesia fees are Covered Charges.

Dental Services (Accident Only). The charges for treatment when necessary due to severe accidental damage if services are performed within seventy-two (72) hours of the accident. An extension of the time period may be requested within 60 days of the accidental damage and if extenuating circumstances exist due to the severity of the Injury. Dental damage that occurs as a result of normal activities of daily living or extraordinary use of the teeth is not considered having occurred as an accident. Benefits are not available for repairs to teeth that are damaged as a result of such activities.

Diabetic Supplies. The charges for insulin syringes, other necessary diabetic supplies and glucometers when ordered by a Physician. The charges for insulin on prescription are covered by the Prescription Drug Card or Mail Order Service.

Diabetic Training. The charges for diabetic self-management medical and nutritional training for diagnosed cases of diabetes rendered by a licensed Practitioner when recommended as a course of treatment by a Physician.

Diagnostic Tests. The charges for electrocardiograms, electroencephalograms, pneumoencephalograms, basal metabolism tests, or similar well established diagnostic tests generally approved by Physicians throughout the United States.

Diagnostic X-Rays. The charges for radiation services including diagnostic x-rays and interpretation.

Dialysis. The charges for dialysis. Dialysis charges may be subject to Medicare rules and reimbursement rates.

Dietitian. The charges for services of a licensed Dietitian when recommended by a licensed MD or DO except for services which are otherwise excluded by the Plan.

Drugs. The charges for Drugs requiring the written prescription of a licensed Physician; such Drugs must be Medically Necessary for the treatment of an Illness or Injury. See Prescription Drug Plan section. Prescription Drugs are covered by the Prescription Drug Card, or Mail Order Service or Specialty Pharmacy and not payable under Major Medical Expense Benefits.

Durable Medical Equipment. The charges for rental or purchase of a wheelchair, Hospital bed and other Durable Medical Equipment prescribed by a Physician and required for therapeutic use, whichever is most cost effective. *If more than one piece of DME can meet your functional needs, benefits are available only for the equipment that meets the minimum specifications for your needs. Benefits are provided for a single unit of DME and for repairs of that unit.*

Benefits also include dedicated speech generating devices and tracheo-esophageal voice devices required for treatment of severe speech impediment or lack of speech directly attributed to an Injury or Illness. Benefits for the purchase of these devices are only available after completing a three-month rental period and are limited to the purchase of one device during the entire period of time a Covered Person is enrolled under the Plan. Benefits for repair/replacement are limited to once every three years.

Benefits under this section do not include any device, appliance, pump, machine, stimulator, or monitor that is fully implanted into the body.

Benefits are provided for the repair/replacement of a type of Durable Medical Equipment once every three calendar years.

Replacements are covered for damage beyond repair with normal wear and tear, when repair costs exceed new purchase price, or when a change in the Covered Person's medical condition occurs sooner than the three year timeframe. Repairs, including the replacement of essential accessories, such as hoses, tubes, mouth pieces, etc., for necessary DME are only covered when required to make the item/device serviceable and the estimated repair expense does not exceed the cost of purchasing or renting another item/device. Requests for repairs may be made at any time and are not subject to the three year timeline for replacement.

Elastic/Surgical Stockings. The charges for elastic/surgical stockings when ordered by a Physician, limited to three (3) pairs per Calendar Year.

Enteral Nutrition. The charges for enteral formulas and low protein modified food products, administered either orally or by tube feeding as the primary source of nutrition, for certain conditions which require specialized nutrients or formulas. Examples of conditions include Metabolic diseases, severe food allergies and impaired absorption of nutrients caused by disorders affecting the gastrointestinal tract.

Benefits for prescription or over-the-counter formula are available when a Physician issues a prescription or written order stating the formula or product is Medically Necessary for the therapeutic treatment of a condition requiring specialized nutrients and specifying the quantity and the duration of the prescription or order.

The formula or product must be administered under the direction of a Physician or registered Dietitian. For the purpose of this Benefit, "enteral formulas" include:

- Amino acid-based elemental formulas;
- extensively hydrolyzed protein formulas; or
- modified nutrient content formulas.

For the purpose of this Benefit, "severe food allergies" mean allergies which if left untreated will result in:

- Malnourishment;
- Chronic physical disability;
- Intellectual disability; or
- Loss of life.

Gender Reassignment. The charges for the following gender reassignment services when ordered by a Provider or Physician :

- Psychotherapy;
- Pre- and post-surgical hormone therapy;
- Gender reassignment Surgery/ies (Surgery must be performed by a qualified Provider).

Genetic Testing. The charges for genetic testing.

Group Therapy. The charges for group therapy for treatment of Mental Disorders, Chemical Dependency, Drug and Substance Abuse.

Hearing Aids/Devices. The charges for hearing aids/devices and the charges for the fitting and testing. *Bone anchored hearing aids are only covered under the Plan for Covered Persons who have craniofacial anomalies whose abnormal or absent ear canals preclude the use of a wearable hearing aid and hearing loss of sufficient severity that it would not be adequately remedied by a wearable hearing aid. Limited to one bone anchored hearing aid per Lifetime. Repair and/or replacement are excluded under the Plan other than for malfunctions.*

Hearing Screening. The charges for hearing screening as required for Preventive Care for Children.

Heart Valve Replacements. The charges for heart valve replacements on the same basis as any other Illness.

Home Health Care. The charges by a Home Health Care Agency for care for a Homebound patient in accordance with a Home Health Care Plan. Home Health Care Visit means a visit by a member of a home health care team. Each visit that lasts for a period of four (4) hours or less is treated as one (1) home health care visit. If the visit exceeds four (4) hours, each period of four (4) hours is treated as one (1) visit and any part of a four (4) hour period that remains is treated as one (1) home health care visit.

Home Health Care Plan Covered Services and Supplies are limited to:

1. Part-time or intermittent nursing care visits by a Registered Nurse (RN), a Licensed Practical Nurse (LPN), a Licensed Vocational Nurse (LVN), or Public Health Nurse who is under the direct supervision of a Registered Nurse (RN);
2. Part-time or intermittent Home Health Aide services which consist primarily of caring for the patient;
3. Physical, Occupational, Speech and respiratory Therapy services by licensed therapists;
4. Services of a Licensed Clinical Social Worker (LCSW); and
5. Medical supplies, Drugs and medications prescribed by a Physician, and laboratory services provided by or on behalf of a Hospital, but only to the extent that they would have been covered under this Benefit Bookletif the patient had remained in the Hospital. **NOTE:** Home Infusion Therapy is a separate benefit and charges are not considered under Home Health Care.

Home Infusion Therapy. The charges for Home Infusion Therapy by a licensed Provider to include intravenous infusion or injection of fluids, nutrition or medication furnished in the home setting.

Hospice Care. The charges relating to Hospice care provided that the Covered Person has a life expectancy of six (6) months or less. Covered Hospice expenses are limited to:

1. Room and Board for confinement in a Hospice;
2. Ancillary charges furnished by the Hospice while the Covered Person is confined therein, including rental of Durable Medical Equipment which is used solely for treating an Injury or Illness;
3. Medical supplies, Drugs and medicines prescribed by the attending Physician, but only to the extent such items are necessary for pain control and management of the terminal condition;
4. Physician services and/or nursing care by a Registered Nurse (RN), a Licensed Practical Nurse (LPN) or a Licensed Vocational Nurse (LVN);
5. Home health aide services;
6. Charges for home care furnished by a Hospital or Home Health Care Agency, under the direction of a Hospice, including Custodial Care if it is provided during a regular visit by a Registered Nurse (RN), a Licensed Practical Nurse (LPN), a Licensed Vocational Nurse (LVN) or a home health aide;
7. Medical social services by licensed or trained social workers, psychologists or counselors;
8. Nutrition services provided by a licensed Dietitian; and
9. Bereavement counseling.

Hospital. The charges for:

1. The actual Room and Board expenses incurred for confinement in a regular Hospital room;
2. The actual expense incurred for confinement in an Intensive Care Unit, a Cardiac Care Unit or Burn Unit;
3. Miscellaneous Hospital services and supplies during Hospital confinement;
4. Inpatient Charges for nursery Room and Board;
5. Outpatient Hospital services and supplies; and
6. Hospital Emergency Room services and supplies.

Immunizations. The charges for Immunizations and vaccinations to include complications incurred as a result of such Immunizations.

Independent Freestanding Emergency Department. The charges for an Independent Freestanding Emergency Department and for services rendered therein.

Infertility. The charges for diagnostic testing for the initial diagnosis of infertility.

Infusion Therapy. The charges for infusion therapy.

Maternity Care. The charges for maternity care, on the same basis as any Illness covered under this Benefit Bookletfor Covered Employees and covered Dependents. Plan coverage for a Hospital stay in connection with childbirth for both the mother and the newborn Child will be no less than: forty-eight (48) hours following a normal vaginal delivery, or ninety-six (96) hours following a cesarean section, unless a shorter stay is agreed to by both the mother and her attending Physician.

Medical Services Outside the United States. The charges for medical services incurred outside the United States and its territories provided that:

1. Treatment is a result of a Medical Emergency, and services are Medically Necessary and recognized as usual treatment for that condition;
2. Medical expenses are considered Reasonable and Usual and Customary based on the nearest U.S. geographic location to point of service;
3. Procedures are approved by the AMA;
4. All usual Plan provisions, Maximum Benefits, exclusions and limitations apply;

5. Expenses must be filed in U.S. dollar amounts;
6. Services must be translated into English; and
7. Benefits may not be assigned to a Provider.

Medical Supplies. The charges for dressings, sutures, casts, splints, trusses, crutches, braces (except dental braces *and braces as specified under Orthotic Devices*), Corrective Shoes and other necessary medical supplies.

Mental Disorders, Chemical Dependency, Drug and Substance Abuse. The charges for treatment of Mental Disorders, Chemical Dependency, Drug and Substance Abuse to include Inpatient, Outpatient/Partial Hospitalization Psychiatric/Day Treatment Facility, Outpatient/Partial Hospitalization Chemical Dependency/Drug Treatment Facility, Outpatient therapy and Office Visit expenses. Benefits for Mental Disorders are subject to the provisions of the Mental Health Parity Act and any related amendments.

Midwife. The charges for the services of a Certified Nurse Midwife (CNM).

Morbid Obesity. The charges for the treatment of Morbid Obesity only when the treatment meets Utilization Review's criteria for Medical Necessity to include surgical treatment, non-surgical treatment and complications from such treatment.

Multiple Surgical Procedures. The charges for multiple Surgical Procedures when two (2) or more procedures are performed during the same operation. The Covered Expenses are as follows:

1. When multiple or bilateral Surgical Procedures that increase the time and amount of patient care are performed, the Covered Expense is the allowable fee for the major procedure plus 50% of the allowable fee for each of the lesser ones or the actual fee charged, whichever is less. This provision will not apply to those procedures which are not subject to the Multiple Procedures Reduction Rules per Medicare; and
2. When an incidental procedure is performed through the same incision, the Covered Expense is the fee for the major Surgical Procedure only. Examples of incidental procedures are: excision of a scar, appendectomy, lysis of adhesions, etc.

Nerve Stimulators. The charges for nerve stimulators and TENS units.

Occupational Therapy. The charges for Occupational Therapy for treatment rendered by a licensed Occupational Therapist under supervision of a Physician at a Facility whose primary purpose is to provide medical care for an Injury or Illness. Also covered are the charges for Occupational Therapy to treat Developmental Delay; however, such Therapy is not subject to the Plan's internal Therapy Maximums.

Organ, Tissue and Bone Marrow Transplants. The charges for services and supplies in connection with non-experimental human Organ, Tissue and Bone Marrow Transplant procedures subject to special conditions and provisions specified in the Organ Transplant Program. See the Organ Transplant Benefits section for information regarding benefits and participation requirements for organ transplants, organ Donors and travel and lodging.

Orthotic Devices. The charges for Orthotic Devices when Medically Necessary and prescribed by a Physician or licensed Practitioner, medically designed for a given patient and used to support, align, prevent or correct deformities or to improve the function of movable parts of the body. *Braces that straighten or change the shape of a body part are Orthotic Devices and are excluded under the Plan.*

Orthotic Insoles. The charges for orthotic insoles for the feet when prescribed by a Physician or licensed Practitioner, medically designed for a given patient

Oxygen. The charges for oxygen and other gases and their administration.

Phenylketonuria. The charges for formulas necessary for the treatment of phenylketonuria or other heritable Diseases. The benefits will be paid on the same basis that benefits would be paid for Drugs ordered by a Physician. Phenylketonuria means an inherited condition that may cause severe intellectual disability if not treated.

Physical Therapy. The charges for Physical Therapy for the treatment or services rendered by a licensed Physical Therapist under direct supervision of a Physician at a Facility or institution whose primary purpose is to provide medical care for an Illness or Injury. Also covered are the charges for Physical Therapy to treat Developmental Delay; however, such Therapy is not subject to the Plan's internal Therapy Maximums.

Physician. The charges for the services of a legally qualified Physician for medical care and/or surgical treatment including Office Visits, home visits, Hospital Inpatient care, Hospital Outpatient visits/exams, clinic care and second/third opinion consultations.

Private Duty Nursing *(Outpatient)*. The charges for a Registered Nurse (RN), Licensed Practical Nurse (LPN) or Licensed Vocational Nurse (LVN) for *Outpatient* Private Duty Nursing. *Inpatient Private Duty Nursing is excluded under the Plan.*

Prosthetics. The charges for Prosthetics including artificial limbs and eyes to replace natural limbs and eyes and other necessary prosthetic devices, but not the replacement thereof, unless the replacement is necessary because of physiological changes.

Psychological Testing. The charges for psychological testing.

Pulmonary Rehabilitation. The charges for Pulmonary Rehabilitation.

Radiation Therapy. The charges for radiation therapy.

Recuro Health Telehealth. The charges for Virtual Urgent Care and Virtual Primary Care/Virtual Mental Health Services consultation (telephone or online) with a Physician and/or other Provider through Recuro Health.

To contact a Recuro Health call (844) 715-1724 or access their webpage at www.member.recurohealth.com for additional information.

Telehealth services not Incurred through Recuro Health Telehealth will be a Covered Medical Service subject to the same deductible, copayment, or coinsurance requirements that apply to comparable health services provided in person.

Rehabilitation Facility. The charges incurred for rehabilitative and habilitative services and devices and/or confinement in a Rehabilitation Facility.

Residential Treatment Center. The charges for treatment of Mental Disorders, Chemical Dependency, Drug and Substance Abuse in a Residential Treatment Center.

Routine Newborn Care. The charges for Routine Newborn Care for a well newborn Child for Nursery Room and Board and routine Inpatient services required for the healthy newborn following birth. Covered Expenses will also include charges for pediatric services, newborn hearing exams and circumcision. Benefits will be payable from the date of birth until the date the mother is discharged, provided the baby is added to the Plan as a Dependent within thirty-one (31) days after the Child's date of birth. Covered Charges are not subject to a separate Calendar Year Deductible and are payable under the covered mother's Claim.

Sales Tax. The applicable sales tax for covered services and supplies.

Second or Third Surgical Opinion. The charges incurred for a second or third surgical opinion when Surgery or other non-surgical treatment has been recommended.

Skilled Nursing Facility/Extended Care Facility. The charges incurred for confinement in a Skilled Nursing Facility/Extended Care Facility; however, the attending Physician must certify that confinement is Medically Necessary and only charges incurred in connection with care related to the Injury or Illness for which the Covered Person was Hospital confined will be eligible.

Sleep Disorders. The charges for the treatment of sleep apnea (other Sleep Disorders are not covered) to include sleep studies/diagnostic testing, Surgery, Facility, devices and equipment. However, Surgical Procedures to correct snoring are not covered, *except when provided as a part of treatment for documented obstructive sleep apnea. Oral appliances for snoring are excluded under the Plan.*

Speech Language Pathologist/Speech Therapy. The charges of a legally qualified Speech Language Pathologist under direct supervision of a Physician for restorative Speech Therapy for speech loss or speech impairment due to an Illness, Injury or Congenital Anomaly or due to Surgery performed because of an Illness or Injury, other than a functional nervous disorder (i.e., stuttering, repetitive speech). Also covered are the charges for developmental Speech Therapy to correct pre-speech deficiencies or improve speech skills not fully developed; however, such Therapy is not subject to the Plan's internal Therapy Maximums.

Sterilization. The charges for all FDA approved women's sterilization procedures. Also covered are the charges for elective vasectomies for Covered Employees and covered Dependents.

Surgical Lens Implants. The charges for surgical lens implants for cataracts and other Diseases of the eye.

Surgical Procedure. The charges incurred for a Medically Necessary Surgical Procedure.

Temporomandibular Joint (TMJ) Disorders. The charges for medical treatment of Temporomandibular Joint (TMJ) Syndrome and related services to include the initial diagnostic visit, x-rays of the joint, injections into the joint, *oral appliances (orthotic splints),* and surgical repair of the temporomandibular joint, to exclude dental and orthodontic services. *Surface electromyography, Doppler analysis, vibration analysis, computerized mandibular scan or jaw tracking, craniosacral therapy, occlusal adjustment are excluded under the Plan.*

Tobacco Use Screening/Cessation Intervention. The charges for tobacco use screening/cessation intervention.

Total Parenteral Nutrition (TPN). The charges for hyperalimentation or total parenteral nutrition (TPN) for persons recovering from or preparing for Surgery.

Urgent Care Facility (Minor Emergency Medical Clinic). The charges for an Urgent Care Facility and for services rendered therein.

Vision Screening. The charges for routine vision screening as required for Preventive Care for Children.

Wellness Procedures. The charges for covered wellness procedures listed as Preventive and Wellness Care Benefits.

Wigs. The charges for one (1) wig per Calendar Year per Covered Person for hair loss as a result of chemotherapy or radiation therapy, or for treatment of alopecia areata.

MAJOR MEDICAL PLAN EXCLUSIONS AND LIMITATIONS

GENERAL EXCLUSIONS AND LIMITATIONS

The following exclusions and limitations apply to expenses incurred by all Covered Persons:

Adoption Fees. Charges for adoption fees.

Alternate Therapies. Charges for *acupressure, Rolfing, aromatherapy*, hypnotherapy, Applied Behavior Analysis (ABA) Therapy and/or behavior training (except ABA Therapy and/or behavior training for treatment of Autism Spectrum Disorder), biofeedback and similar programs. *Other excluded alternative treatments include the following: Art therapy, music therapy, dance therapy, horseback therapy, Adventure-based therapy, wilderness therapy, and outdoor therapy.*

Blood Procurement. Charges incurred for procurement and storage of one's own blood except for procurement and storage of one's own blood if obtained within three (3) months prior to a scheduled Surgery.

Botox. Charges for Botox injections unless Medically Necessary and not Cosmetic.

Chelation Therapy. The charges for chelation therapy, except to treat heavy metal poisoning.

Chiropractic Maintenance Therapy. Charges for Chiropractic Services for maintenance therapy in accordance with Utilization Review's criteria for maintenance care.

Christian Science Practitioner. The services ordered or delivered by a Christian Science Practitioner.

Claim Received After Filing Deadline. Charges for a Claim received after twelve (12) months from the date the service was rendered.

Close Relative. Charges for treatment, services and supplies provided by a Close Relative of the Covered Person, as defined in this Benefit Booklet.

Continuous Passive Motion Equipment. Charges for purchase or rental of Continuous Passive Motion (CPM) equipment, unless used for post-surgical rehabilitation.

Cosmetic. Charges incurred in connection with the care or treatment of, or operations which are performed for, Cosmetic purposes of any kind, including treatment or Surgery for complications or correction of Cosmetic Surgery or treatment, *except* for Cosmetic Surgery procedures listed as covered in Major Medical Expense Benefits.

Counseling. Charges for marriage counseling.

Custodial Care. Charges for Custodial Care and maintenance care. Unless specifically mentioned otherwise, the Plan does not provide benefits for services and supplies intended primarily to maintain a level of physical or mental function.

Deductible/Coinsurance. Any portion of the billed charges for services or supplies which the Provider offers to waive, such as the portion which would not be paid by the Plan due to Deductible or Coinsurance provisions.

Dental. Charges incurred for treatment on or to the teeth, the nerves or roots of the teeth, gingival tissue or alveolar processes; however, benefits will be payable for covered Oral Surgery procedures and treatment required because of Accidental Injury to sound natural teeth. This exception shall not in any event be deemed to include charges for treatment for the repair or replacement of a denture or bridgework. Injury to teeth from chewing or biting is not considered an Accidental Injury.

Domiciliary Care. The charges for Domiciliary Care.

Durable Medical Equipment Repair. Charges for repair, adjustment or replacement of rented Durable Medical Equipment or components.

Early Discharge. Charges for early discharge against medical advice.

Education. Charges for education or training of any type including those for learning disabilities, except diabetic self-management medical training for diagnosed cases of diabetes and Applied Behavior Analysis (ABA) Therapy and/or behavior training for treatment of Autism Spectrum Disorder.

Excess. Charges that are not payable under the Plan due to application of any Plan maximum or limit or because the charges are in excess of the Usual and Customary amount, Allowable Claim Limits or are for services not deemed to be Reasonable or Medically Necessary, based upon the Plan Administrator's determination as set forth by and within the terms of this document.

Exoskeleton Devices. The charges for powered and non-powered exoskeleton devices.

Experimental. Charges for research studies and Experimental medical procedures, treatment, Drugs, devices and related services considered to be Experimental/Investigational in nature as defined in the Plan Definitions except clinical trials listed as covered in Major Medical Expense Benefits. The Claims Administrator retains the right to have such medical expenses reviewed by an independent panel of peer reviewers to determine whether such expenses are considered accepted, standard medical treatment or are Experimental/Investigational.

Experimental Transplants. Charges related to or in connection with Experimental Organ, Tissue and Bone Marrow Transplants including any animal organ transplants.

Fees. Charges for completion of form fees, *room or facility reservations*, missed appointment fees or late fees.

Foot Care. Charges for callus or corn paring or excision, toenail trimming, any manipulative procedure for weak or fallen arches, flat or pronated foot, foot strain, Orthopedic Shoes (unless attached to a brace) or other devices for support of the feet, except for:

1. An open cutting operation for the treatment of weak, strained, flat, unstable or unbalanced feet, metatarsalgia or bunions;
2. Removal of nail roots; or
3. Foot treatment required because of a metabolic or peripheral vascular Disease; or
4. Orthotic insoles for the feet when Medically Necessary when prescribed by a Physician or licensed Practitioner, medically designed for a given patient.

Government. Charges for Hospital confinement, medical or surgical services or other treatment furnished or paid for by or on behalf of the United States, or any State, province or other political subdivision unless there is an unconditional requirement to pay such charges whether or not there is insurance.

Gynecomastia. The charges for benign gynecomastia.

Hair Loss/Wigs. Charges for treatment of hair loss including wigs, hairpieces and hair transplants except for wigs for hair loss as a result of chemotherapy, radiation therapy or alopecia areata.

Health Services Related to Non-Covered Services. Charges for all services related to a service that is not covered by this Benefit Booklet. This Exclusion does not apply to services the Plan would otherwise determine to be a Covered service if they are to treat complications that arise from the non-covered health service. For purposes of this exclusion, a "complication" is an unexpected or unanticipated condition that is superimposed on an existing disease and that affects or modifies the prognosis of the original disease or condition.

Hearing Exams. Charges incurred in connection with routine hearing exams. This exclusion does not apply to routine hearing screenings as required for Preventive Care for Children.

Health Care Plan Exclusions. Charges for:

1. Services and supplies not included in the Home Health Care Plan;
2. Services of a person who is a Close Relative of the Covered Person;
3. Services of any social worker unless designated LCSW;
4. Transportation services;
5. Food or home delivered meals; and
6. Custodial Care and housekeeping.

Hyperhidrosis. Medical and surgical treatment of excessive sweating.

Illegal Acts. Charges for Injury or Illness incurred as a result of illegal acts involving violence or threat of violence to another person, or in which the Covered Person illegally used a firearm, explosive or other weapon likely to cause physical harm or death, whether or not the Covered Person was charged, convicted or received any type of fine, penalty, imprisonment or other sentence or punishment, unless such Injury is the result of a medical condition (either physical or mental) or is the result of the Covered Person being the victim of an act of domestic violence.

Illegal in the United States. Charges for any services or supplies not considered legal in the United States.

Incurred by Other Persons. Charges for expenses actually incurred by other persons.

Infertility. Charges related to or in connection with the treatment of infertility to include fertility studies, sterility studies, procedures to restore or enhance fertility (except Surgical Procedures to treat the underlying cause of infertility), artificial insemination or in-vitro fertilization or other similar procedures.

Intracellular Micronutrient Testing. The charges for intracellular micronutrient testing.

I.Q. Testing. Charges for I.Q. testing.

Massage Therapy. Charges for massage therapy unless services are provided under a Physical Therapy Treatment Plan.

Medicare. Charges for benefits that are provided, or which would have been provided had the Participant enrolled in, applied for, or maintained eligibility for such care and service benefits, under Title XVIII of the Federal Social Security Act of 1965 (Medicare), including any amendments thereto, or under any Federal law or regulation, except as provided in the sections entitled “Coordination of Benefits” and “Medicare.”

Negligence. Charges for Injuries resulting from negligence, misfeasance, malfeasance, nonfeasance or malpractice on the part of any licensed Provider.

Newborns of Dependent Children. Charges related to or in connection with newborns of Dependent Children, unless the newborn Child meets the definition of an Eligible Dependent.

Not Acceptable. Charges that are not accepted as standard practice by the AMA, ADA or the FDA.

Not Certified/Authorized. Charges for treatment, services or supplies that are not certified or authorized by a Practitioner who is attending the Covered Person as being required for the treatment of Injury or Disease, and performed by an appropriate licensed Practitioner.

Not Connected with Active Illness. Charges for hospitalization primarily for x-rays, laboratory tests, diagnostic study, physiotherapy, hydrotherapy, medical observation, convalescent or rest care, or any medical examination or test not connected with an active Illness or Injury, unless otherwise specified for Preventive and Wellness Care Benefits or otherwise specified as covered in this Benefit Booklet.

Not Legally Obligated to Pay. Charges incurred for which the Covered Person, in the absence of this coverage, is not legally obligated to pay, or for which a charge would not ordinarily be made in the absence of this coverage.

Not Medically Necessary. Charges incurred in connection with services and supplies which are not Medically Necessary for treatment of an active Illness or Injury unless listed as Covered Wellness Procedures in the Preventive and Wellness section of the Schedule of Benefits or otherwise specified as covered in this Benefit Booklet.

Not Rendered by/Provided under Supervision of Physician. Charges for Physicians' fees for any treatment which is not rendered by or provided under the supervision of a Physician.

Nutritional Supplements. Charges for nutritional supplements and related supplies, whether or not prescribed by a Physician. The Plan will consider charges for nutritional supplements, feeding tubes and related supplies only if a Covered Person is unable to get nutrition by any other means and nutritional supplements for treatment of Autism Spectrum Disorder.

Obesity. Charges for the treatment of Obesity and charges related to weight control, including Surgery and complications incurred as a result of such Surgery for Obesity, except for Morbid Obesity and only when the treatment meets Utilization Review's criteria for Medical Necessity.

Occupational. Charges arising out of or in the course of any occupation for wage or profit, whether or not the Covered Person is entitled to benefits under any Workers' Compensation or Occupational Disease Law, or any such similar law.

Organ Donor Expenses. Charges related to or in connection with Organ Donor expenses unless the recipient is covered by this Benefit Booklet.

Organ, Tissue and Bone Marrow Transplants. Charges related to or in connection with Organ, Tissue and Bone Marrow Transplants performed at a Facility not in the Organ Transplant Program.

Personal Convenience. Charges incurred for services or supplies which constitute personal comfort or beautification items, television or telephone use, or charges in connection with Custodial Care. *Excluded items include but are not limited to the following: air conditioners, air purifiers and filters, dehumidifiers, batteries and battery chargers, car seats, chairs, bath chairs, feeding chairs, toddler chairs, ergonomically correct chairs, chair lifts and recliners, exercise equipment and treadmills, hot and cold compresses, hot tubs, humidifiers, Jacuzzis, medical alert systems, motorized beds, non-Hospital beds, comfort beds and mattresses, music devices, personal computers, pillows, power-operated vehicles, radios, safety equipment, saunas, stair lifts and stair glides, strollers, treadmills, vehicle modifications such as van lifts, video players an whirlpools.*

Physical Conditioning Programs. Charges for physical conditioning programs such as athletic training, bodybuilding, exercise, fitness, flexibility, health club memberships and programs, spa treatments and diversion or general motivation.

Physical, Psychiatric or Psychological Exams, Testing, Vaccinations and Immunizations. The charges for physical psychiatric or psychological exams, testing, vaccinations and immunization or treatments when required solely for purposes of education, sports or camp, travel, career or employment insurance, marriage or adoption, or as a result of incarceration; conducted for purposes of medical research, except clinical trials listed as covered in Major Medical Expense Benefits; related to judicial or administrative proceedings or orders; or required to obtain or maintain a license of any type.

Portable Uterine Monitors. Charges for portable uterine monitors unless approved by Utilization Review and/or Case Management.

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

Prior to Effective Date. Charges incurred prior to the effective date of coverage under the Plan, or after coverage is terminated.

Provider Error. Charges for services required as a result of unreasonable Provider error.

Respite Care. Charges for respite care. This exclusion does not apply to respite care that is part of an integrated Hospice Care program of services provided to a terminally ill person by a licensed Hospice Care Agency for which Benefits are provided under the Plan.

Riot/Civil Insurrection. Charges resulting from or sustained as a result of participation in a riot or civil insurrection.

Self-inflicted. Charges incurred in connection with any self-inflicted Injury or Illness unless the Injury or Illness is a result of a medical condition (either physical or mental) or is the result of the Covered Person being the victim of an act of domestic violence.

Sterilization Reversal. Charges resulting from or in connection with the reversal of a sterilization procedure.

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

Surrogate Fees. Charges for surrogate fees *and services or supplies for a person not covered under this Benefit Booklet for a Gestational Carrier or surrogate pregnancy (including, but not limited to, all costs related to reproductive techniques and health care services such as inpatient or outpatient prenatal care and/or preventive care, screenings and/or diagnostic testing and delivery and post-natal care)*.

Temporomandibular Joint (TMJ) Disorders. Charges for dental and orthodontic services related to Temporomandibular Joint (TMJ) Syndrome, disorders of mastication, malocclusion of teeth, misalignment of mandible and maxilla and jaw pain to include services, supplies and splints.

Travel and Lodging for Organ Transplants. Charges related to or in connection with travel and lodging expenses associated with an Organ Transplant if the Transplant Program is not used.

Travel Outside the United States. Charges incurred as the result of travel outside the United States or its territories specifically to receive medical treatment.

Vision Correction Surgery. Charges for any Surgical Procedure for the correction of a visual refractive problem including radial keratotomy, LASIK or similar Surgical Procedures.

Vision Exam and Eyewear. Charges incurred in connection with routine vision exams or eye refractions, and the purchase or fitting of eyeglasses and contact lenses. This exclusion/limitation shall not apply to routine vision screenings as required for Preventive Care for Children or the initial purchase of eyeglasses or contact lenses following cataract Surgery.

Vision Therapy. Charges for eye exercises or vision therapy.

War. Charges incurred as a result of war or any act of war, whether declared or undeclared, or caused during service in the armed forces of any country.

Weight Loss Programs. Charges for weight loss programs even when recommended by a Physician.

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

COORDINATION OF BENEFITS

The Coordination of Benefits provision is intended to prevent the payment of benefits which exceed Covered Expenses. It applies when the Plan Participant is also covered by another plan or plans. When more than one coverage exists, one plan (primary plan) normally pays its benefits in full and the other plans (secondary plans) pay a reduced benefit. This Benefit Booklet may pay either its benefits in full or at a reduced amount which, when added to the benefits payable by the other plan or plans, will not exceed 100% of Allowable Expenses. Only the amount paid by this Benefit Booklet will be charged against the Plan Benefit Maximums.

The Coordination of Benefits provision applies whether or not a Claim is filed under the other plan or plans. If needed, authorization must be given to this Benefit Booklet to obtain information as to benefits or services available from the other plan or plans, or to recover overpayments.

All benefits contained in the Benefit Booklet are subject to this provision except Prescription Drug expenses.

EXCESS INSURANCE

If at the time of Injury, Illness or disability there is available, or potentially available, any Coverage (including but not limited to Coverage resulting from a judgment at law or settlements), the benefits under this Benefit Booklet shall apply only as an excess over such other sources of Coverage.

For purposes of this Coordination of Benefits provision, the term "plan" as used herein will mean any plan providing benefits or services for medical or dental treatment, and such benefits or services are provided by:

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:
   a. Hospital indemnity benefits; and
   b. Hospital reimbursement-type plans which permit the Covered Person to elect indemnity at the time of Claims;
2. Hospital or medical service organizations on a group basis, group practice and other group pre-payment plans;
3. Hospital or medical service organizations on an individual basis having a provision similar in effect to this provision;
4. A Licensed Health Maintenance Organization (HMO);
5. Any coverage for students which is sponsored by, or provided through, a school or other educational institution;
6. Any coverage under a governmental program, and any coverage required or provided by any statute;
7. Group automobile insurance;
8. Individual automobile insurance coverage on an automobile leased or owned by the Employer; or
9. Any individual automobile insurance, including No-Fault Automobile Insurance on an individual basis.

“Plan” will be construed separately with respect to each policy, contract, or other arrangement for benefits or services, and separately with respect to that portion of any such policy, contract, or other arrangement which reserves the right to take the benefits or services of other plans into consideration in determining its benefits and that portion which does not.

“Allowable Expense” is the Usual and Customary charge within Allowable Claim Limits for any Medically Necessary, Reasonable, eligible item of expense, at least a portion of which is covered under this Benefit Booklet. When some other plan provides benefits in the form of services rather than cash payments, the Reasonable cash value of each service rendered, in the amount that would be payable in accordance with the terms of the Plan, shall be deemed to be the benefit. Benefits payable under any other plan include the benefits that would have been payable had claim been duly made.

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

“Claim Determination Period” is a Calendar Year, a Plan Year or that portion of a Calendar or Plan Year during which the Covered Person, for whom Claim is made, has been covered under this Benefit Booklet.

COORDINATION PROCEDURES

Notwithstanding the other provisions of this Benefit Booklet, benefits that would be payable under this Benefit Booklet will be reduced so that the sum of benefits payable under this Benefit Booklet and all benefits payable under all other plans will not exceed the total of Allowable Expenses incurred during any Claim Determination Period with respect to Covered Persons eligible for:

1. Benefits, either as an insured person or Employee or as a Dependent, under any other plan which has no provision similar in effect to this provision.

2. Dependents' benefits under this Benefit Booklet who are also eligible for benefits:

    a. As an insured person or Employee under any other plan; or
    b. As a Dependent Child of an insured person or Employee covered under any other plan.

3. A Covered Person under this Benefit Booklet who is also eligible for benefits as an insured person or Employee under any other plan and has been covered continuously for a longer period of time under such other plan.

For the purpose of determining the applicability of and for implementing this provision or any provision of similar purpose in any other plan, the Plan Administrator may, without the consent of or notice to any person, release to or obtain from any other insurance company or other organization or person any information with respect to any person which the Plan Administrator deems to be necessary for such purposes. Any Covered Person claiming benefits under this Benefit Booklet will furnish to the Plan Administrator such information as may be necessary to implement this provision or to determine its applicability.

ORDER OF BENEFIT DETERMINATION

Each plan makes its Claim payment according to where it falls in this order, if Medicare is not involved:

1. If a plan contains no provision for Coordination of Benefits, then it pays primary before all other plans.

2. The plan which covers the Covered Person as an Employee (or named insured) pays primary as though no other plan existed; remaining recognized charges are paid under a secondary plan which covers the Claimant as a Dependent.

3. If the Covered Person is a Dependent Child:

    a. Whichever parent has a birthday anniversary which occurs earlier in the Calendar Year shall be considered to have the primary plan;
    b. If birthday anniversaries are the same, then the plan of the parent who has been covered under his/her plan for the longer period of time will be primary; and
    c. If the plan with which this Benefit Booklet is to be coordinated does not include the requirements shown above, then the plan without such requirements will be primary.

4. If the Covered Person is a Dependent Child and the parents are divorced, then:

    a. The plan of the parent with custody pays first, unless a court order or decree specifies the other parent to have financial responsibility, in which case that parent's plan would pay first; or
    b. The plan of a step-parent with whom the Child lives pays second (if applicable).

5. If the order set out in 1, 2, 3 or 4 above does not apply in a particular case, then the plan which has covered the Covered Person for the longest period of time will pay first.

FACILITY OF PAYMENT

Whenever payments which should have been made under this Benefit Booklet in accordance with this provision have been made under any other plan or plans, the Plan Administrator will have the right, exercisable alone and in its sole discretion, to pay to any insurance company or other organization or person making such other payments any amounts it will determine in order to satisfy the intent of this provision, and amounts so paid will be deemed paid under this Benefit Booklet and to the extent of such payments, the Plan Administrator will be fully discharged from liability under this Benefit Booklet.

The benefits that are payable will be charged against any applicable Maximum payment or benefit of this Benefit Booklet rather than the amount payable in the absence of this provision.

RIGHT OF RECOVERY

In accordance with the Recovery of Payments provision, whenever payments have been made by this Benefit Booklet with respect to Allowable Expenses in a total amount, at any time, in excess of the Maximum Amount of payment necessary at that time to satisfy the intent of this Article, the Plan shall have the right to recover such payments, to the extent of such excess, from any one or more of the following as this Benefit Booklet shall determine: any person to or with respect to whom such payments were made, or such person's legal representative, any insurance companies, or any other individuals or organizations which the Plan determines are responsible for payment of such Allowable Expenses, and any future benefits payable to the Covered Person or his or her Dependents. **Please see the Recovery of Payments provision for more details.**

COORDINATION WITH MEDICARE

Notwithstanding all other provisions of this Benefit Booklet, Covered Persons who are eligible for Medicare benefits may be entitled to benefits under this Benefit Booklet which will be coordinated with Medicare in accordance with the Coordination of Benefits provision of this Benefit Booklet and subject to the rules and regulations as specified by the Tax Equity and Fiscal Responsibility Act of 1982 as they may be amended from time to time. This Benefit Booklet is primary to Medicare coverage for all active Employees and Dependents (regardless of age) unless Medicare states otherwise for certain medical conditions. In the event that this Benefit Booklet is secondary to Medicare, benefits payable under this Benefit Booklet will be reduced by benefits that would be payable for the same services under Medicare Parts A and B whether or not the Covered Person is enrolled in Medicare Parts A and B.

COORDINATION WITH AUTOMOBILE INSURANCE COVERAGE

The Plan's liability for expenses arising out of an automobile Accident is based on the type of automobile insurance law enacted by the Covered Person's State. Nationally, there are three types of State automobile insurance laws:

1. No-Fault Automobile Insurance laws;
2. Financial responsibility laws; or
3. Other automobile liability insurance laws.

COORDINATION WITH AUTOMOBILE NO-FAULT COVERAGE

Except as required by law, the Plan is secondary to any No-Fault Automobile coverage. It is not intended to reduce the level of coverage that would otherwise be available through a No-Fault Automobile Insurance policy nor does it intend to be primary in order to reduce the premiums or cost of No-Fault Automobile coverage.

If the Covered Person or his/her covered Dependent incur Covered Charges as a result of an automobile Accident (either as driver, passenger or pedestrian), the amount of Covered Charges that the Plan will pay is limited to:

1. Any Deductible under the automobile coverage;
2. Any Copayment under the automobile coverage;
3. Any expense properly excluded by the automobile coverage that is a Covered Charge; and
4. Any expense that the Plan is required to pay by law.

An individual is considered to be covered under an automobile insurance policy if he/she is either:

1. An owner or principal named insured of the policy;
2. A Family member of a person insured under the policy; or
3. A person who would be eligible for medical expense benefits under an automobile insurance policy if this Benefit Booklet did not exist.

COORDINATION WITH FINANCIAL RESPONSIBILITY LAW

The Plan is secondary to automobile coverage or to any other party who may be liable for the Covered Person's medical expenses resulting from the automobile Accident.

If the Covered Person's State has a "financial responsibility" law which does not allow the Plan to pay benefits as secondary or which does not allow the Plan to advance payments with the intent of subrogating or recovering the payment, the Plan will not pay any benefits related to an automobile Accident for the Covered Person or their Dependents.

COORDINATION WITH OTHER AUTOMOBILE LIABILITY INSURANCE

If the Covered Person's State does not have a No-Fault Automobile Insurance law or a "financial responsibility" law, this Benefit Booklet is secondary to their automobile insurance coverage or to any other party who may be liable for the Covered Person's medical expenses resulting from the automobile Accident.

COORDINATION WITH UNDERINSURED/UNINSURED MOTORIST COVERAGE

If the Covered Person is involved in an automobile Accident and, as a result of the Accident, the Plan pays benefits, and if the Covered Person receives a settlement from their underinsured or uninsured motorist policy, the Plan is entitled to receive, from the proceeds of the settlement with the underinsured or uninsured motorist coverage, the expenses of the Plan. The Plan is not entitled to receive any recovery that is in excess of its expenses. The Plan agrees to payment of benefits prior to the receipt by the Covered Person of any recovery from their underinsured or uninsured motorist policy. The Covered Person agrees to notify the Plan of the existence of a recovery from an underinsured or uninsured motorist policy and further agrees to remit to the Plan the proceeds of any recovery received from an underinsured or uninsured motorist policy up to the expenditures made by the Plan. Any expenses by the Plan which are in excess of the proceeds received by the underinsured/uninsured motorist policy will be the responsibility of the Plan pursuant to the terms and conditions of the Plan.

SUBROGATION AND REIMBURSEMENT PROVISIONS

PAYMENT CONDITION

1. The Plan, in its sole discretion, may elect to conditionally advance payment of benefits in those situations where an Injury, Illness or disability is caused in whole or in part by, or results from the acts or omissions of Covered Persons, Plan Beneficiaries and/or their Dependents, beneficiaries, estate, heirs, guardian, personal representative, or assigns (collectively referred to hereafter in this section as "Covered Person(s)") or a third party, where another party 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").

2. A Covered Person(s), his/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 Covered Person(s) and/or his/her attorney from any source and said funds shall be held in trust until such time as the obligations under this provision are fully satisfied. The Covered Person(s) agrees to include the Plan's name as a co-payee on any and all settlement drafts. Further, by accepting benefits the Covered Person(s) understands that any recovery obtained pursuant to this section is an asset of the Plan to the extent of the amount of benefits paid by the Plan and that the Covered Person shall be a trustee over those Plan assets.

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

4. If there is more than one party responsible for charges paid by the Plan, or that 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, in regards to an unallocated settlement fund meant to compensate multiple injured parties of which the Covered Person(s) is/are only one or a few, that unallocated settlement fund is considered designated as an "identifiable" fund from which the Plan may seek reimbursement.

SUBROGATION

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

2. If a Covered Person(s) receives or becomes entitled to receive benefits, an automatic equitable lien attaches in favor of the Plan to any Claim which any Covered Person(s) may have against any Coverage and/or party causing the Illness or Injury to the extent of such conditional payment by the Plan plus

reasonable costs of collection. The Covered Person is obligated to notify the Plan or its authorized representative of any settlement prior to finalization of the settlement, execution of a release, or receipt of applicable funds. The Covered Person is also obligated to hold any and all funds so received in trust on the Plan's behalf and function as a trustee as it applies to those funds until the Plan's rights described herein are honored and the Plan is reimbursed.

3. The Plan may, at its discretion, in its own name or in the name of the Covered Person(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.

4. If the Covered Person(s) fails to file a Claim or pursue damages against:

   a. The responsible party, its insurer, or any other source on behalf of that party;
   b. Any first party insurance through medical payment coverage, personal Injury protection, no-fault coverage, uninsured or underinsured motorist coverage;
   c. Any policy of insurance from any insurance company or guarantor of a third party;
   d. Workers' Compensation or other liability insurance company; or
   e. Any other source, including but not limited to crime victim restitution funds, any medical, disability or other benefit payments, and school insurance coverages;

   then the Covered Person(s) authorizes the Plan to pursue, sue, compromise and/or settle any such Claims in the Covered Person(s) and/or the Plan's name and agrees to fully cooperate with the Plan in the prosecution of any such Claims. The Covered Person(s) assigns all rights to the Plan or its assignee to pursue a Claim and the recovery of all expenses from any and all sources listed above.

RIGHT OF REIMBURSEMENT

1. The Plan shall be entitled to recover 100% of the benefits paid or payable benefits Incurred, that have been paid and/or will be paid by the Plan, or were otherwise Incurred by the Covered Person(s) prior to and until the release from liability of the liable entity, as applicable, without deduction for attorneys' fees and costs or application of the common fund doctrine, made whole doctrine, or any other similar legal or equitable theory, and without regard to whether the Covered Person(s) is fully compensated by his or her recovery from all sources. The Plan shall have an equitable lien which supersedes all common law or statutory rules, doctrines, and laws of any State prohibiting assignment of rights which interferes with or compromises in any way the Plan's equitable lien and right to reimbursement. The obligation to reimburse the Plan in full exists regardless of how the judgment or settlement is classified and whether or not the judgment or settlement specifically designates the recovery or a portion of it as including medical, disability, or other expenses and extends until the date upon which the liable party is released from liability. If the Covered Person's/Covered Persons' recovery is less than the benefits paid, then the Plan is entitled to be paid all of the recovery achieved. Any funds received by the Covered Person are deemed held in constructive trust and should not be dissipated or disbursed until such time as the Covered Person's obligation to reimburse the Plan has been satisfied in accordance with these provisions. The Covered Person is also obligated to hold any and all funds so received in trust on the Plan's behalf and function as a trustee as it applies to those funds until the Plan's rights described herein are honored and the Plan is reimbursed.

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

3. The Plan's right of subrogation and reimbursement will not be reduced or affected as a result of any fault or Claim on the part of the Covered Person(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.

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

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

PARTICIPANT IS A TRUSTEE OVER PLAN ASSETS

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

    a. Notify the Plan or its authorized representative of any settlement prior to finalization of the settlement, execution of a release, or receipt of applicable funds;
    b. Instruct his/her attorney to ensure that the Plan and/or its authorized representative is included as a payee on all settlement drafts;
    c. In circumstances where the Covered Person is not represented by an attorney, instruct the insurance company or any third party from whom the Plan 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; and
    d. Hold any and all funds so received in trust, on the Plan's behalf, and function as a trustee as it applies to those funds, until the Plan's rights described herein are honored and the Plan is reimbursed.

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

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

RELEASE OF LIABILITY

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

EXCESS INSURANCE

If at the time of Injury, Illness or disability there is available, or potentially available, any Coverage (including but not limited to Coverage resulting from a judgment at law or settlements), the benefits under this Benefit Booklet 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:

1. The responsible party, its insurer, or any other source on behalf of that party;
2. Any first party insurance through medical payment coverage, personal Injury protection, no-fault coverage, uninsured or underinsured motorist coverage;
3. Any policy of insurance from any insurance company or guarantor of a third party;
4. Workers' Compensation or other liability insurance company; or
5. Any other source, including but not limited to crime victim restitution funds, any medical, disability or other benefit payments, and school insurance coverage.

SEPARATION OF FUNDS

Benefits paid by the Plan, funds recovered by the Covered Person(s), and funds held in trust over which the Plan has an equitable lien exist separately from the property and estate of the Covered Person(s), such that the death of the Covered Person(s), or filing of bankruptcy by the Covered Person(s), will not affect the Plan's equitable lien, the funds over which the Plan has a lien, or the Plan's right to subrogation and reimbursement.

WRONGFUL DEATH CLAIMS

In the event that the Covered Person(s) dies as a result of his/her injuries and a wrongful death or survivor Claim is asserted against a third party or any Coverage, the Plan's subrogation and reimbursement rights shall still apply.

OBLIGATIONS

1. It is the Covered Person(s) obligation at all times, both prior to and after payment of medical benefits by the Plan to:

    a. Cooperate with the Plan, or any representatives of the Plan, in protecting its rights, including discovery, attending depositions, and/or cooperating in trial to preserve the Plan's rights;
    b. Provide the Plan with pertinent information regarding the Illness, disability or Injury, including Accident reports, settlement information and any other requested additional information;
    c. Take such action and execute such documents as the Plan may require to facilitate enforcement of its subrogation and reimbursement rights;
    d. Do nothing to prejudice the Plan's rights of subrogation and reimbursement;
    e. Promptly reimburse the Plan when a recovery through settlement, judgment, award or other payment is received;
    f. Notify the Plan or its authorized representative of any incident related claims or care which may not be identified within the lien (but has been Incurred) and/or reimbursement request submitted by or on behalf of the Plan;
    g. Notify the Plan or its authorized representative of any settlement prior to finalization of the settlement;
    h. Not settle or release, without the prior consent of the Plan, any Claim to the extent that the Plan Beneficiary may have against any responsible party or Coverage;
    i. Instruct his/her attorney to ensure that the Plan and/or its authorized representative is included as a payee on any settlement draft;
    j. In circumstances where the Covered Person is not represented by an attorney, instruct the insurance company or any third party from whom the Covered Person obtains a settlement to include the Plan or its authorized representative as a payee on the settlement draft; and
    k. Make good faith efforts to prevent disbursement of settlement funds until such time as any dispute between the Plan and Covered Person over settlement funds is resolved.

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

3. The Plan's right to reimbursement and/or subrogation is in no way dependent upon the Covered Person(s)' cooperation or adherence to these terms.

OFFSET

If timely repayment is not made, or the Covered Person(s) and/or his or her attorney fails to comply with any of the requirements of the Plan, the Plan has the right, in addition to any other lawful means of recovery, to deduct the value of the Covered Person's amount owed to the Plan. To do this, the Plan may refuse payment of any future medical benefits and any funds or payments due under this Benefit Booklet on behalf of the Covered Person(s) in an amount equivalent to any outstanding amounts owed by the Covered Person to the Plan. This provision applies even if the Covered Person has disbursed settlement funds.

MINOR STATUS

1. In the event the Covered Person(s) is a minor as that term is defined by applicable law, the minor's parents or court-appointed guardian shall cooperate in any and all actions by the Plan to seek and obtain requisite court approval to bind the minor and his/her estate insofar as these subrogation and reimbursement provisions are concerned.

2. If the minor's parents or court-appointed guardian fail to take such action, the Plan shall have no obligation to advance payment of medical benefits on behalf of the minor. Any court costs or legal fees associated with obtaining such approval shall be paid by the minor's parents or court-appointed guardian.

LANGUAGE INTERPRETATION

The Plan Administrator retains sole, full and final discretionary authority to construe and interpret the language of this provision, to determine all questions of fact and law arising under this provision, and to administer the Plan's subrogation and reimbursement rights. The Plan Administrator may amend the Plan at any time without notice.

SEVERABILITY

In the event that any section of this provision is considered invalid or illegal for any reason, said invalidity or illegality shall not affect the remaining sections of this provision and Plan. The section shall be fully severable. The Plan shall be construed and enforced as if such invalid or illegal sections had never been inserted in the Plan.

CLAIM REVIEW AND AUDIT PROGRAM

The Plan has arranged with Imagine360 for a program of Claim review and auditing in order to identify charges billed in error, charges for excessive or unreasonable fees and charges for services which are not medically appropriate. Benefits for Claims which are selected for review and auditing will be reduced for any charges that are determined to be in excess of Allowable Claim Limits (as defined below). The determination of Allowable Claim Limits under this Program will supersede any other Plan provisions related to application of a Usual and Customary fee determination.

Medical care Providers will be given a fully detailed explanation of any charges that are found to be in excess of Allowable Claim Limits, and allowed the rights and privileges to file an appeal of the determination in accordance with the same rights and privileges accorded to Plan Participants, in exchange for the Provider's agreement not to bill the Plan Participant for charges which were not covered as a result of the Claim review and audit.

Any Plan Participant who continues to receive billings from the medical care Provider for these charges should contact Imagine360 **or the Plan Administrator right away for assistance.**

The Plan Administrator is identified in the General Information and Purpose section of this Benefit Booklet. Imagine360 may be contacted at:

Imagine360
1550 Liberty Ridge, Suite 330
Wayne, PA 19087
Phone: 610-321-1030
Fax: 610-321-1031

The Plan Participant must pay for any normal cost-sharing features of the Plan, such as Deductibles, Coinsurance and Copayments, and any amounts otherwise excluded or limited according to the terms of the Plan.

The success of this program will be achieved through a comprehensive review of detailed records including, for example, itemized charges and descriptions of the services and supplies provided. Without this detailed information, the Plan will be unable to make a determination of the amount of Covered Medical Expenses that may be eligible for reimbursement. Any additional information required for the audit will be requested directly from the Provider of service and the Claimant. In the event that the Plan Administrator does not receive information adequate for the Claim review and audit within the time limits required under ERISA required under the Plan, it will be necessary to deny the Claim. Should such a denial be necessary, the Claimant and/or the Provider of service may appeal the denial in accordance with the provisions which may be found in the section, "Procedures for Claims and Appeals," in this Benefit Booklet.

In the following provisions of the Claim Review and Audit Program, the term "Plan Administrator" shall be deemed to mean Imagine360:

"Allowable Claim Limits" means the charges for services and supplies, listed and included as Covered Medical Expenses under the Plan, which are Medically Necessary for the care and treatment of Illness or Injury, but only to the extent that such fees are within the Allowable Claim Limits. Examples of the determination that a charge is within the Allowable Claim Limit include, but are not limited to, the following guidelines:

1. **Errors, Unbundled and/or Unsubstantiated Charges.** Allowable Claim Limits will not include the following amounts:

    a. Charges identified as improperly coded, duplicated, unbundled and/or for services not performed;
    b. Charges for treating Injuries sustained or Illnesses contracted, including infections and complications, which, in the opinion of the Plan Administrator, can be attributed to medical errors by the Provider;
    c. Charges that cannot be identified or understood; and
    d. Charges that cannot be verified from audits of medical records.

2. **Guidelines.** The following guidelines will be used when determining Allowable Claim Limits:

   a. Facilities. The Allowable Claim Limit for Claims by a Facility, including but not limited to, Hospitals, emergency and urgent care centers, rehabilitation and skilled nursing centers, and any other health care Facility, shall be the greater of (I) 112% of the Facility's most recent departmental cost ratio, reported to the Centers for Medicare and Medicaid Services ("CMS") and published in the American Hospital Directory as the "Medicare Cost Report" (the "CMS Cost Ratio"), or (II) the Medicare allowed amount for the services in the geographic area plus an additional 20%. The Allowable Claim Limit for (I) shall not exceed 250% of the federal non-commercial Medicare allowed amount, except for children's hospitals, which shall not exceed 350% of the federal non-commercial Medicare allowed amount. If insufficient information is available to identify either the Facility's most recent departmental cost ratio or the Medicare allowed amount, the Allowable Claim Limit shall be either (I) or (II) herein that can be identified.

   b. Ambulatory Health Care Centers. The Allowable Claim Limit for ambulatory health care centers, including Ambulatory Surgery Centers, which are independent Facilities shall be the Medicare allowed amount for the services in the geographic area plus an additional 20%. In the event that insufficient information is available to identify the Medicare allowed amount, the Allowable Claim Limit for such services shall be to the extent available either the Outpatient or Inpatient Medicare allowed amount for the service, plus an additional 20%.

   c. Out-of-Network Professional Providers. The Allowable Claim Limits for Out-of-Network professional Providers shall be determined using the following:

      i. For general medical and primary care Claims, the Medicare allowed amount in the geographic area plus an additional 40%;
      ii. For Specialist medical and surgical care Claims, the Medicare allowed amount in the geographic area plus an additional 55%;
      iii. For anesthesiologist Claims, the Medicare allowed amount in the geographic area plus an additional 100%; or
      iv. For ambulance and air ambulance Claims, the Medicare allowed amount in the geographic area plus an additional 20%; or
      v. For other non-Facility Claims and supplies (such as, but not limited to, Durable Medical Equipment, laboratory services and supplies, and mid-level Providers, etc.), the Medicare allowed amount in the geographic area.

      For purposes of determining the proper Allowable Claim Limits for professional Providers in categories (i), (ii), (iii), (iv) or (v) above, the Plan Administrator shall determine the applicable category for each Claim based on the taxonomy code used by the professional Provider for that Claim. The Plan Administrator determines, in its sole discretion, the type of Provider for determining Allowable Claim Limits, as detailed above.

      While this Benefit Booklet typically pays professional Providers based on the Medicare allowed amounts above, certain services may be reimbursed at 110% of the Medicare allowed amount for the service. These services may include, but are not limited to, routine diagnostic tests, evaluation services, telehealth and services for ongoing therapy. A full list of services subject to this rule can be found here: www.planlimit.com/prof1. This list will be updated at least annually to reflect the Plan's current plan design.

   d. Directly Contracted Providers. The Allowable Claim Limits for Directly Contracted Providers shall be the negotiated rate as agreed under the Direct Agreement.

   e. Insufficient Information to Determine Allowable Claim Limit. In the event that insufficient information is available to determine Allowable Claim Limits for specific services or supplies using the guidelines listed in Section 2 above as may be applicable, Imagine360 may apply the following guidelines:

i. General Medical and/or Surgical Services. The Allowable Claim Limit for any covered services may be calculated based upon industry-standard resources including, but not limited to, published and publicly available fee and cost lists and comparisons, or any combination of such resources that, in the opinion of the Plan Administrator, results in the determination of a Reasonable expense under the Plan.
ii. Medical and Surgical Supplies, Implants, Devices. The Allowable Claim Limit for charges for medical and surgical supplies made by a Provider may be based upon the invoice price (cost) to the Provider, plus an additional 12%. The documentation used as the resource for this determination will include, but not be limited to, invoices, receipts, cost lists or other documentation as deemed appropriate by the Plan Administrator.
iii. Physician, Medical and Surgical Care, Laboratory, X-ray, and Therapy. The Allowable Claim Limit for these services may be determined based upon the 60th percentile of Fair Health (FH®) Allowed Benchmarks.

Comparable Services or Supplies. In the event that insufficient information is available to determine Allowable Claim Limits for specific services or supplies using the guidelines listed in Section 2 above, Allowable Claim Limits will be determined considering the most comparable services or supplies based upon comparative severity and/or geographic area to determine the Allowable Claim Limit. The Plan Administrator reserves the right, in its sole discretion, to determine any Allowable Claim Limit amount for certain conditions, services and supplies using accepted industry-standard documentation, applied without discrimination to any Covered Person.

In the event that a determination of Allowable Claim Limit for a Claim exceeds the actual charges billed for the services and/or supplies, the actual charges billed for the Claim shall be the Allowable Claim Limit.

PROCEDURES FOR CLAIMS AND APPEALS

The procedures outlined below must be followed by Claimants to obtain payment of benefits under this Benefit Booklet.

NOTICE AND PROOF OF CLAIM

Written notice and proof of an incurred Claim should always be filed with the Claims Administrator as soon as possible. **Claims must be filed within twelve (12) months from the date of service to be covered by the Plan.** If an individual's coverage under the Plan ceases, all Claims incurred prior to termination of coverage **must** be filed within twelve (12) months from the date of service, or the Claims will not be covered by the Plan.

Claims **must** be filed sooner in certain circumstances:

- If the Plan is terminated, all Claims incurred prior to the Plan termination **must** be received within ninety (90) days after the termination or the Claims will not be covered.

Any Claims incurred after termination of Plan coverage for any reason are not covered under the Plan.

Under ERISA,, there are four types of Claims: Pre-service (Urgent), Pre-service (Non-urgent), Concurrent Care, and Post-service.

- A “Pre-service Claim” is a Claim for a benefit under the Plan where the Plan conditions receipt of the benefit, in whole or in part, on approval of the benefit in advance of obtaining medical care. Because the Plan does not require Claimants to obtain approval of a medical service prior to getting treatment on an urgent or non-urgent basis, there are no “Pre-service Claims.” The Claimant simply follows the Plan's procedures with respect to notice that is required after receipt of treatment, and files the Claim as a Post-service Claim.

- A “Concurrent Claim” arises when the Plan has approved an on-going course of treatment to be provided over a period of time or number of treatments, and either: (a) the Plan determines that the course of treatment should be reduced or terminated, or (b) the Claimant requests an extension of the course of treatment beyond that which the Plan has approved. Because the Plan does not require Claimants to obtain approval of medical services prior to getting treatment, there is no need to contact Utilization Review to request an extension of a course of treatment. The Claimant simply follows the Plan's procedures with respect to notice that is required after receipt of treatment, and files the Claim as a Post-service Claim.

- A “Post-service Claim” is a Claim for a benefit under the Plan after the services have been rendered.

A Post-service Claim is considered to be filed when the following information is received by the Claims Administrator with a Form CMS-1500 or Form UB-04 or any successor forms:

1. The date of service;
2. The name, address, telephone number, and tax identification number of the Provider of the services or supplies;
3. The place where the services were rendered;
4. The diagnosis and procedure codes;
5. The amount of charges (including any PPO re-pricing information);
6. The name of the Plan;
7. The name of the Covered Employee; and
8. The name of the patient.

Each Claimant claiming benefits under the Plan shall be responsible for supplying, at such times and in such manner as the Plan Administrator in its sole discretion may require, written proof that the expenses were incurred, or that the benefit is covered under the Plan. This includes any substantiating documentation, Coordination of Benefits information or other information that may be required by the Plan as proof. If the Plan Administrator in its sole discretion determines that the Claimant has not incurred a Covered Expense, or that the benefit is not covered under the Plan, or if the Claimant fails to furnish such proof as is requested, no benefits shall be payable under the Plan.

CLAIMS DETERMINATION

The Plan Administrator shall notify the Claimant, in accordance with the provisions set forth below, of any Adverse Benefit Determination within the following timeframes:

- If the Claimant has provided all of the information needed to process the Claim in a reasonable period of time, but not later than thirty (30) days after receipt of the Claim. This period may be extended by the Plan for up to fifteen (15) days, provided that the Plan Administrator: (a) determines that such an extension is necessary due to matters beyond the control of the Plan, and (b) notifies the Claimant, prior to the expiration of the initial thirty (30) day processing period, of the circumstances requiring the extension of time, and the date by which the Plan expects to render a decision. If an extension has been requested, then the Plan Administrator shall notify the Claimant of any Adverse Benefit Determination prior to the end of the fifteen (15) day extension period.

- If additional information is requested from the Claimant to process the Claim during the initial processing period, then the Claimant will be notified of a determination of benefits prior to the end of the extension period. If additional information is requested from the Claimant during the extension period, then the Claimant will be notified of the determination by a date agreed to by the Plan Administrator and the Claimant.

- Notice to the Claimant of a rescission of coverage will be provided at least thirty (30) days in advance of the retroactive termination of coverage by the Plan.

A Benefit Determination is required to be made within the period of time beginning when a Claim is deemed to be filed in accordance with the procedures of the Plan.

For purposes of the Plan's provisions for internal Claims and appeals and external review processes, a "Claim" for benefits is defined as a request for a plan benefit made by a Claimant in accordance with a plan's reasonable procedure for filing benefit Claims. A call from a Provider who wants to know if an individual is covered under the Plan, or if a certain procedure or treatment is a covered expense before the treatment is rendered, is not a "Claim" since an actual Claim for benefits is not being filed with the Plan. Likewise, presentation of a prescription to a pharmacy does not constitute a Claim.

An "Adverse Benefit Determination" is defined as a denial, reduction, or termination of, or a failure to provide or make a payment (in whole or in part) for a benefit, including any such denial, reduction, rescission of coverage, termination, or failure to provide or make a payment for a Claim that is based on:

1. A determination of an individual's eligibility to participate in a plan or health insurance coverage;
2. A determination that a benefit is not a covered benefit;
3. The imposition of a source-of-Injury exclusion, PPO Provider network exclusion, or other limitation on otherwise covered benefits; or
4. A determination that a benefit is Experimental, Investigational, or not Medically Necessary or appropriate.

Although it is not a Claim for benefits, the definition of an Adverse Benefit Determination also includes a rescission of coverage under the Plan. A "rescission of coverage" is defined as a cancellation or discontinuance of coverage that has retroactive effect, except to the extent it is attributable to a failure to timely pay required premiums or contributions towards the cost of coverage.

NOTICE OF ADVERSE BENEFIT DETERMINATION

If the initial Benefit Determination is an Adverse Benefit Determination, notification will be sent to the Claimant and will include the following information:

1. Information sufficient to identify the Claim involved, including the date of the service, the health care Provider, the Claim amount (if applicable), and, upon request, the diagnosis code and its corresponding meaning, and the treatment code and its corresponding meaning;

2. The reason or reasons for the Adverse Benefit Determination or final internal Adverse Benefit Determination, including the denial code and its corresponding meaning, as well as a description of the Plan's standard, if any, used in denying the Claim. In the case of a final internal Adverse Benefit Determination, this description must also include a discussion of the decision;

3. References to the Plan specific provisions on which the Adverse Benefit Determination is based;

4. A description of any additional material or information necessary for the Claimant to perfect the Claim, and an explanation of why such material or information is necessary;

5. A description of the Plan's review procedures and the time limits applicable to such procedures, including a statement of the Claimant's right to bring a civil action following an Adverse Benefit Determination on final review;

6. A statement that the Claimant is entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records and other information relevant to the Claimant's Claim;

7. The identity of any medical or vocational experts consulted in connection with a Claim, even if the Plan did not rely upon their advice (or a statement that the identity of the expert will be provided upon request);

8. If an internal rule, guideline, protocol, or other similar criterion was relied on in making the Adverse Benefit Determination, either the specific rule, guideline, protocol or other similar criterion, or a statement that such information was relied on in making the Adverse Benefit Determination, and that a copy of the rule, guideline, protocol or other criterion will be provided free of charge on request; and

9. If the Adverse Benefit Determination is based on a medical judgment (such as Medical Necessity or whether the treatment was Experimental), either an explanation of the scientific or clinical judgment for the determination, applying the terms of the Plan to the Claimant's medical circumstances, or a statement that such explanation will be provided free of charge upon written request.

PHYSICAL EXAMINATION

The Plan Administrator or Claims Administrator has the right to have the Claimant examined as often as reasonably necessary while a Claim is pending. Benefits are payable under this Benefit Booklet only if they are Medically Necessary for the Illness or Accidental Injury of the Covered Person. This Benefit Booklet reserves the right to make a Utilization Review to determine whether services are Medically Necessary for the proper treatment of the Covered Person. All such information will be confidential.

CLAIMS AUDIT

Once a written Claim for benefits is received, the Claims Administrator, acting on the discretionary authority of the Plan Administrator, may elect to have such Claim reviewed or audited for accuracy and reasonableness of charges as part of the adjudication process. This process may include, but may not be limited to, identifying: (a) charges for items/services that may not be covered or may not have been delivered, (b) duplicate charges and (c) charges beyond the Reasonable, necessary and Usual and Customary guidelines as determined by the Plan. In addition, please refer to the section entitled "Claim Review and Audit Program" for information regarding Plan provisions related to the audit and adjudication of certain eligible Claims under that Program.

PAYMENT OF CLAIMS

Plan benefits are payable to the Covered Employee, unless the Claimant gives written direction, at the time of filing proof of such loss, to pay directly the health care Provider rendering such services. Such payment to a health care Provider is subject to the approval of the Plan Administrator. If any such benefit remains unpaid at the death of the Covered Employee, if the Claimant is a minor, or if the Claimant is (in the opinion of the Plan Administrator) legally incapable of giving a valid receipt and discharge for any payment, the Plan Administrator may, at its option, pay such benefits to any one or more of the following relatives of the Claimant: wife, husband, mother, father, Child or Children, brother or brothers, sister or sisters. Such payment will constitute a complete discharge of the Plan's obligation to the extent of such payment, and the Plan Administrator will not be required to follow-up and determine how such paid money was used.

APPEAL PROCESS

The Plan provides for two (2) levels of appeal following an Adverse Benefit Determination. The Claimant has one hundred eighty (180) days following an initial Adverse Benefit Determination to file an appeal of that determination, and sixty (60) days following a second Adverse Benefit Determination to file an appeal of that determination. The appeal process will provide the Claimant with a reasonable opportunity for a full and fair review of the Claim and Adverse Benefit Determination and will include the following:

1. Receipt of written request by the Claims Administrator, *or a delegated entity,* from the Claimant, or an Authorized Representative of the Claimant, with the proper form for review of Adverse Benefit Determination, which initiates the appeal process.

2. The Claimant will have the opportunity to submit written comments, documents, records, and other information relating to the Claim.

3. The Claimant will have the opportunity to review the Claim file and to present evidence and testimony as part of the internal claims and appeals process.

4. The Claimant will be provided, free of charge and sufficiently in advance of the date that the notice of final internal Adverse Benefit Determination is required, with new or additional evidence considered, relied upon, or generated by the Plan in connection with the Claim, as well as any new or additional rationale for a denial at the internal appeals stage, and a reasonable opportunity for the Claimant to respond to such new evidence or rationale.

5. The Claimant will be provided, on request and free of charge: (a) reasonable access to, and copies of all documents, records, and other information relevant to the Claimant's Claim in possession of the Plan Administrator, Imagine360 or the Claims Administrator; (b) information regarding any rule, guideline, protocol, or other similar criterion relied upon in making the Adverse Benefit Determination; (c) information regarding any voluntary appeals procedures offered by the Plan; (d) information regarding the Claimant's right to an external review process; and (e) an explanation of the scientific or clinical judgment for the determination, applying the terms of the Plan to the Claimant's medical circumstances.

6. The review of the Adverse Benefit Determination will take into account all comments, documents, records and other information submitted by the Claimant relating to the Claim, without regard to whether such information was submitted or considered in the initial Benefit Determination.

7. No deference will be afforded to the previous Adverse Benefit Determination.

8. The party reviewing the appeal may be neither the party who made the prior Adverse Benefit Determination, nor a subordinate of the party who made the prior Adverse Benefit Determination.

9. In deciding an appeal on which the Adverse Benefit Determination was based in whole or in part on a medical judgment, including whether a particular treatment, Drug, or other item is Experimental, Investigational, or not Medically Necessary or appropriate, the Claims Administrator, Imagine360 or the

Plan Administrator, as appropriate depending on the level of appeal, will consult with a health care professional who has appropriate training and experience in the field of medicine involving the medical judgment. The health care professional consulted for the appeal will not be the health care professional or a subordinate of the health care professional consulted in connection with the Adverse Benefit Determination that is the subject of the appeal.

10. Medical or vocational experts whose advice was obtained on behalf of the Plan in connection with the Adverse Benefit Determination will be identified, even if the Plan did not rely upon their advice.

11. The first level of appeal will be the responsibility of the Claims Administrator and will be decided within thirty (30) days of the Claims Administrator's receipt of the request. The second level of appeal will be the responsibility of Imagine360 and will be decided within thirty (30) days of the Plan's receipt of the request.

NOTE: When the dispute of a Claim payment or denial only involves payment amounts due from the Plan to the Out-of-Network Provider, and the Provider has no recourse against the Plan Participant under the No Surprises Act (NSA), the payment dispute may only be resolved through open negotiation, or the Independent Dispute Resolution (IDR) process as outlined in the NSA. There may be instances when a Plan Participant may appeal a Claim through this section concurrently with an Out-of-Network Provider's payment dispute through the IDR process.

For questions about appeal rights or for assistance, Claimants can contact the Employee Benefits Security Administration at 1-866-444-EBSA (3272). Consumer assistance may be available in your State. Contact your State Department of Insurance to find out if consumer assistance for claim appeals is available. See Appendix I for additional information.

FIRST APPEAL LEVEL

Requirements for First Appeal

The Claimant must file the first appeal, in writing, within one hundred eighty (180) days following receipt of the notice of an Adverse Benefit Determination. The Claimant's appeal must be addressed as follows:

Appeals Department
Imagine360 Administrators, LLC
PO Box 749075
Dallas, Texas 75374-9075

It shall be the responsibility of the Claimant to submit proof that the Claim is covered and payable under the provisions of the Plan. An appeal must include:

1. The name of the Employee/Claimant;
2. The Employee's/Claimant's Social Security number;
3. The group name or identification number;
4. All facts and theories supporting the Claim for benefits. **Failure to include any theories or facts in the appeal will result in such facts being inadmissible. In other words, the Claimant will lose the right to raise such factual arguments and theories which support this Claim if the Claimant fails to include them in the appeal;**
5. A statement in clear and concise terms of the reason or reasons for the disagreement with the handling of the Claim; and
6. Any material or information that the Claimant has which indicates that the Claimant is entitled to benefits under the Plan.

If the Claimant provides all of the required information, it may be that the expenses will be eligible for payment under the Plan.

Timing of Notification of Benefit Determination on First Appeal

The Plan shall notify the Claimant of the Plan's Benefit Determination on review within a reasonable period of time, but not later than thirty (30) days after receipt of the appeal.

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

Notice of Benefit Determination on First Appeal

The Claimant will be notified of the Benefit Determination on appeal. If there is an Adverse Benefit Determination on appeal, the notification will include the following information:

1. The reason or reasons for the Adverse Benefit Determination;

2. References to the Plan provisions on which the Adverse Benefit Determination is based;

3. A description of any additional material or information necessary for the Claimant to perfect the Claim, and an explanation of why such material or information is necessary;

4. A statement that the Claimant is entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the Claimant's Claim;

5. A description of the Plan's review procedures and the time limits applicable to such procedures, including a statement of the Claimant's right to bring a civil action under Section 502(a) of ERISA following an Adverse Benefit Determination on final review;

6. A description of voluntary appeal procedures offered by the Plan and, upon the Claimant's request, any additional information about the voluntary appeal procedures;

7. If an internal rule, guideline, protocol, or other similar criterion was relied on in making the Adverse Benefit Determination, either the specific rule, guideline, protocol or other similar criterion or a statement that such was relied on in making the Adverse Benefit Determination, and that a copy of the rule, guideline, protocol or other criterion will be provided free of charge on request;

8. If the Adverse Benefit Determination is based on a medical judgment (such as Medical Necessity or whether or not treatment is Experimental), either an explanation of the scientific or clinical judgment for the determination, applying the terms of the Plan to the Claimant's medical circumstances, or a statement that such explanation will be provided free of charge on request;

9. The identity of any medical or vocational experts consulted in connection with the Claim, even if the Plan did not rely upon their advice; and

10. The following statement: "You and your Plan may have other voluntary alternative dispute resolution options, such as mediation. One way to find out what may be available is to contact your local U.S. Department of Labor Office and your State Insurance Regulatory Agency."

Furnishing Documents in the Event of an Adverse Determination

In the case of an Adverse Benefit Determination on review, the Plan Administrator shall provide such access to, and copies of, documents, records, and other information described in the section relating to Notice of Benefit Determination on First Appeal, as appropriate.

SECOND APPEAL LEVEL

Adverse Decision on First Appeal; Requirements for Second Appeal
Upon receipt of notice of the Plan's Adverse Benefit Determination regarding the first appeal, the Claimant has sixty (60) days to file a second appeal of the denial of benefits. The Claimant again is entitled to a "full and fair review" of any denial made at the first appeal, which means the Claimant has the same rights during the second appeal as he or she had during the first appeal. As with the first appeal, the Claimant's second appeal must be in writing and must include all of the items set forth in the section entitled "Requirements for First Appeal."

Timing of Notification of Benefit Determination on Second Appeal
The Plan shall notify the Claimant of the Plan's Benefit Determination on review within a reasonable period of time, but not later than thirty (30) days after receipt of the second appeal.

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

Manner and Content of Notification of Adverse Benefit Determination on Second Appeal
The same information must be included in the Plan's response to a second appeal as a first appeal, except for: (a) a description of any additional information necessary for the Claimant to perfect the Claim and an explanation of why such information is needed; and (b) a description of the Plan's review procedures and the time limits applicable to the procedures. See the section entitled "Notice of Benefit Determination on First Appeal."

Furnishing Documents in the Event of an Adverse Determination
In the case of an Adverse Benefit Determination on the second appeal, the Plan Administrator shall provide such access to, and copies of, documents, records, and other information described in the section relating to the Notice of Benefit Determination on First Appeal, as appropriate.

Decision on Second Appeal to be Final
If, for any reason, the Claimant does not receive a written response to the appeal within the appropriate time period set forth above, the Claimant may assume that the appeal has been denied. The decision will be final, binding and conclusive, and will be afforded the maximum deference permitted by law. **All Claim review procedures provided for in the Plan must be exhausted before any legal action is brought. Any legal action for the recovery of any benefits must be commenced within one (1) year after the Plan's Claim review procedures have been exhausted. Any action with respect to a Fiduciary's Breach of any responsibility, duty or obligation hereunder must be brought within one (1) year after the date of service.**

Appointment of Authorized Representative
A Claimant is permitted to appoint an Authorized Representative to act on his behalf with respect to a benefit Claim or appeal of an Adverse Benefit Determination. An Assignment of Benefits by a Claimant to a Provider will not constitute appointment of that Provider as an Authorized Representative. To appoint such a representative, the Claimant must complete a form which can be obtained from the Plan Administrator or the Claims Administrator. In the event a Claimant designates an Authorized Representative, all future communications from the Plan will be with the Authorized Representative, rather than the Claimant, unless the Claimant directs the Plan Administrator, in writing, to the contrary.

PROVIDER OF SERVICE APPEAL RIGHTS

A Claimant may appoint the Provider of service as the Authorized Representative with full authority to act on his or her behalf in the appeal of a denied Claim. An Assignment of Benefits by a Claimant to a Provider of service will not constitute appointment of that Provider as an Authorized Representative. However, in an effort to ensure a full and fair review of the denied Claim, and as a courtesy to a Provider of service that is not an Authorized Representative, the Plan will consider an appeal received from the Provider in the same manner as a Claimant's appeal, and will respond to the Provider and the Claimant with the results of the

review accordingly. Any such appeal from a Provider of service must be made within the time limits and under the conditions for filing an appeal specified under the section, "Appeal Process," above. **Providers requesting such appeal rights under the Plan must agree to pursue reimbursement for Covered Medical Expenses directly from the Plan, waiving any right to recover such expenses from the Claimant, and comply with the conditions of the section, "Requirements for First Appeal," above.**

For purposes of this section, the Provider's waiver to pursue Covered Medical Expenses does not include the following amounts, which will remain the responsibility of the Claimant:

- Deductibles;
- Copayments;
- Coinsurance;
- Penalties for failure to comply with the terms of the Plan;
- Charges for services and supplies which are not included for coverage under the Plan; and
- Amounts which are in excess of any stated Plan maximums or limits. **Note: This does not apply to amounts found to be in excess of Allowable Claim Limits, as defined in the section, "Claim Review and Audit Program."** The Provider must agree to waive the right to balance bill for these amounts.

Also, for purposes of this section, if a Provider indicates on a Form UB-04 or on a Form CMS-1500 (or similar Claim form) that the Provider has an Assignment of Benefits, then the Plan will require no further evidence that benefits are legally assigned to that Provider.

Contact the Claims Administrator or the Plan Administrator for additional information regarding Provider of service appeals.

EXTERNAL REVIEW OF ADVERSE BENEFIT DETERMINATIONS

When the internal appeals procedures have been exhausted, the Claimant may elect to have an additional and final opportunity for a review of an Adverse Benefit Determination (including a final internal Adverse Benefit Determination) by an independent review organization (IRO). The IRO will be accredited by URAC or a similar nationally recognized accrediting organization for the purpose of conducting an independent and unbiased review.

The request for an external review must be filed by the Claimant within four (4) months following the Claimant's receipt of the notice of Adverse Benefit Determination or final internal Adverse Benefit Determination. However, if the Plan fails to strictly adhere to all the requirements of the internal claims and appeals process with respect to a Claim, the Claimant will be deemed to have exhausted the internal claims and appeals process, and the Claimant may initiate an external review and pursue any available remedies under applicable law, such as judicial review.

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

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

1. Any eligible Adverse Benefit Determination (including a Final Internal Adverse Benefit Determination) by a plan or issuer that involves medical judgment (including, but not limited to, those based on the plan's or issuer's requirements for Medical Necessity, appropriateness, health care setting, level of care, or effectiveness of a covered benefit; its determination that a treatment is Experimental or Investigational; its determination whether a Claimant or beneficiary is entitled to a reasonable alternative standard for a reward under a wellness program; its determination whether a plan or issuer is complying with the nonquantitative treatment limitation provisions of Code section 9812 and § 54.9812-1, which generally require, among other things, parity in the application of medical management techniques), as determined by the external reviewer.

2. An Adverse Benefit Determination that involves consideration of whether the Plan is complying with the surprise billing and cost-sharing protections set forth in the No Surprises Act.

3. A rescission of coverage (whether or not the rescission has any effect on any particular benefit at that time).

There are two (2) types of external reviews; standard and expedited. An external review is a standard external review unless the timing required to perform a standard external review involves circumstances that would seriously jeopardize the life or health of the Claimant or would jeopardize the Claimant's ability to regain maximum function, or if the final internal Adverse Benefit Determination concerns an admission, availability of care, continued stay, or health care item or service for which the Claimant received Emergency services but has not yet been discharged from the Facility. In such cases, the Plan will consider the external review to be an expedited review.

EXPEDITED EXTERNAL REVIEW FOR URGENT OR EMERGENCY CARE

This Benefit Booklet does not require a Claimant to obtain prior approval for pre-service urgent care Claims or Emergency care services before getting treatment; therefore, neither the internal appeals nor the external review procedures will apply to these Claims. In an Emergency or urgent care situation, the Claimant should follow instructions from his/her health care Provider, and file the Claim as a post-service Claim. If the post-service Claim results in an Adverse Benefit Determination, the Claimant may file an appeal in accordance with the Plan's provisions for "Appeal Process," which are explained above.

Appeals of Claims involving concurrent care will be subject to the Plan's provisions for expedited external review, as explained below.

PROCEDURES FOR INITIATION OF AN EXTERNAL REVIEW

Standard External Review

A request for an external review must include the same information that is required for an internal appeal, listed above in the section, "Appeal Process."

Once the request for a standard external review is filed, the Plan will have five (5) business days to do a preliminary review of the request to determine whether it is eligible and whether all of the information and forms required to process the external review have been provided.

Within one (1) business day following completion of the preliminary review, the Plan will notify the Claimant in writing whether the request is eligible for external review.

- If the request is complete but is not eligible for external review, the notice will contain an explanation of the reason that the request is ineligible.

- If the request is incomplete, the notice will describe the information or materials needed to make the request complete. The Claimant must submit the information or materials needed within forty-eight (48) hours following receipt of the notice, or the expiration of the original four (4) month filing period, whichever is later.

An eligible request which is complete and timely filed will be assigned to an independent review organization (IRO) by the Plan. The Plan will have arrangements to access at least three (3) accredited IROs to which external reviews will be assigned on a random or rotated basis to ensure an independent and unbiased review. The assigned IRO will notify the Claimant in writing of the request's eligibility and acceptance for external review. This notice will include a statement that the Claimant may submit to the IRO, in writing and within ten (10) business days following receipt of the notice, any additional information that the IRO must consider when conducting the external review.

Within five (5) business days after the date of assignment of the IRO, the Plan must provide to the assigned IRO the documents and any information considered in making the Adverse Benefit Determination or final internal Adverse Benefit Determination. Failure by the Plan to timely provide the documents and information will not delay the conduct of the external review, and the IRO may decide to reverse the Adverse Benefit Determination or final internal Adverse Benefit Determination. In this case, the IRO will notify the Plan and the Claimant within one (1) business day following the decision to reverse the determination.

The assigned IRO will forward any information which is submitted by the Claimant to the Plan, and the Plan may reconsider its Adverse Benefit Determination or final internal Adverse Benefit Determination; however, reconsideration by the Plan will not delay the external review. If the Plan decides to reverse its Adverse Benefit Determination or final internal Adverse Benefit Determination, it may terminate the external review and notify the IRO and the Claimant within one (1) business day of the decision.

The IRO will provide written notice to the Claimant and the Plan of the final external review decision within forty-five (45) days following receipt of the request for review. The notice will contain:

- A general description of the reason for the request for external review, including information sufficient to identify the Claim (including the date or dates of service, the health care Provider, the Claim amount (if applicable), and, upon request, the diagnosis code and its corresponding meaning, the treatment code and its corresponding meaning, and the reason for the previous denial;

- The date the IRO received the request for external review and the date on which it made the decision;

- References to the evidence or documentation, including the specific coverage provisions and evidence-based standards, considered in reaching its decision;

- A discussion of the principal reason or reasons for its decision, including the rationale for its decision and the evidence-based standards that were relied on in making the decision;

- A statement that the determination is binding except to the extent that other remedies may be available under State or Federal law to either the group health plan or to the Claimant;

- A statement that judicial review may be available to the Claimant; and

- Current contact information, including a phone number, for any applicable office of health insurance consumer assistance or ombudsman established under PHS Act section 2793. See Appendix I for additional information.

Expedited External Review

A final internal Adverse Benefit Determination concerning an admission, availability of care, continued stay, or health care item or service for which the Claimant received Emergency services but has not yet been discharged from the Facility will be considered for an expedited external review. These are considered to be pre-service **non-urgent** care Claims and concurrent Claims.

The procedures that apply to standard external reviews will apply to expedited external reviews, except that:

- The preliminary review of the request to determine whether it is eligible and whether all of the information and forms required to process the external review have been provided must be conducted immediately, and the Plan must immediately notify the Claimant regarding the eligibility determination;

- Upon a determination that a request is eligible for external review following the preliminary review, the Plan will immediately assign an IRO pursuant to the requirements set forth for standard external reviews;

- The Plan must provide or transmit all necessary documents and information considered in making the Adverse Benefit Determination or final internal Adverse Benefit Determination to the assigned IRO electronically, by phone, facsimile or any other available expeditious method; and

- The IRO must provide notice of the final external review decision as expeditiously as the Claimant's medical condition or circumstances require, but in no event more than seventy-two (72) hours after the IRO received the request for an expedited external review. If the notice is not in writing, the assigned IRO must provide written confirmation of the decision to the Claimant and the Plan within forty-eight (48) hours following the notice.

DECISION FOLLOWING AN EXTERNAL REVIEW

Upon receipt of a notice from the IRO reversing the decision of an Adverse Benefit Determination or final internal Adverse Benefit Determination, the Plan will immediately provide coverage or payment for the Claim. An external review decision is binding on the Plan as well as the Claimant, except to the extent other remedies are available under State or Federal law.

RECOVERY OF PAYMENTS

Occasionally, benefits are paid more than once, are paid based upon improper billing or a misstatement in a proof of loss or enrollment information, are not paid according to the Plan's terms, conditions, limitations or exclusions, or should otherwise not have been paid by the Plan. As such, this Benefit Booklet may pay benefits that are later found to be greater than the Maximum Allowable Charge. In this case, this Benefit Booklet 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.

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 thirty (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, agree to be bound by the terms of this Benefit Booklet and agree to submit Claims for reimbursement in strict accordance with their State's health care practice acts, ICD-10 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 Person(s) are entitled, for or in relation to Facility-acquired condition(s), Provider error(s), or damages arising from another party's act or omission for which the Plan has not already been refunded.

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

1. In error;
2. Pursuant to a misstatement contained in a proof of loss or a fraudulent act;
3. Pursuant to a misstatement made to obtain coverage under this Benefit Booklet 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 Subrogation and Reimbursement Provisions; or
6. Pursuant to a Claim for which benefits are recoverable under any policy or act of law providing for coverage for occupational Injury or Disease to the extent that such benefits are recovered. This provision (6) shall not be deemed to require the Plan to pay benefits under this Benefit Booklet in any such instance.

The deduction may be made against any Claim for benefits under this Benefit Booklet by a Covered Person or by any of his 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 is the result of the Provider's misstatement, said Provider shall, as part of its Assignment of Benefits from the Plan, abstain from billing the Covered Person for any outstanding amount(s).

GENERAL PROVISIONS

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

MISSTATEMENT OF AGE
If age is a factor in determining eligibility or amount of coverage and there has been a misstatement of age, the coverages or amounts of benefits, or both, for which the person is covered shall be adjusted in accordance with the Covered Person's true age. Any such misstatement of age shall neither continue coverage otherwise validly terminated, nor terminate coverage otherwise validly in force. Benefits will be adjusted following the date of the discovery of such misstatement.

WAIVER OR ESTOPPEL
No term, condition or provision of the Plan shall be waived, and there shall be no estoppel against the enforcement of any provision of the Plan, except by written direction of the Plan Administrator. No such waiver shall be deemed a continuing waiver unless specifically stated. Each waiver shall operate only as to the specific term or condition waived and shall not constitute a waiver of such term or condition for the future or as to any act other than that specifically waived.

WORKERS' COMPENSATION NOT AFFECTED
This Benefit Booklet is not in lieu of and does not affect any requirement for coverage by Workers' Compensation Insurance or, where permitted and applicable, any other alternative form of Workers' Compensation benefits.

CONFORMITY WITH LAW
This Benefit Booklet shall be deemed to automatically be amended to conform as required by any applicable law, regulation or the order or judgment of a court of competent jurisdiction governing provisions of this Benefit Booklet, including, but not limited to, stated maximums, exclusions or limitations. In the event that any law, regulation or the order or judgment of a court of competent jurisdiction causes the Plan Administrator to pay Claims which are otherwise limited or excluded under this Benefit Booklet, such payments will be considered as being in accordance with the terms of this Benefit Booklet. It is intended that the Plan will conform to the requirements of ERISA, as it applies to Employee welfare plans, as well as any other applicable law.

CONFORMITY WITH STATUTE(S)
Any provision of the Plan which is in conflict with statutes that are applicable to this Benefit Booklet is hereby amended to conform to the minimum requirements of said statute(s).

NOTICES
All payments or notices of any kind to Employees, Participants, beneficiaries, or Plan officials may be mailed to the address for that person last appearing on the records of the Plan Administrator. When such a notice is mailed by first class mail, it is deemed to have been: (a) duly delivered on the date post-marked; and (b) duly received three (3) calendar days after being deposited, postage prepaid, in the United States Mail. When such a notice is delivered in person, it is deemed to have been received the same day as delivery. Each person must keep the Plan Administrator notified of his current address. If there is doubt about the accuracy of an address, the Plan may give notice, by registered mail, to any such person's last address, that payments and other mail are being withheld pending receipt of a proper mailing address from that person.

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

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

FRAUD
The following actions by a Covered Person or a Covered Person's knowledge of such actions being taken by another, constitute fraud and will result in immediate, indefinite and permanent termination of all coverage under this Benefit Booklet for the entire Family unit of which the Covered Person is a member:

1. Attempting to submit a Claim for benefits (which includes attempting to fill a prescription) for a person who is not a Covered Person in the Plan;
2. Attempting to file a Claim for a Covered Person for services that were not rendered or Drugs or other items that were not provided;
3. Providing false or misleading information in connection with enrollment in the Plan; or
4. Providing any false or misleading information to the Plan.

MISCELLANEOUS
Section titles are for convenience of reference only and are not to be considered in interpreting this Benefit Booklet.

No failure to enforce any provision of this Benefit Booklet shall affect the right thereafter to enforce such provision, nor shall such failure affect its right to enforce any other provision of this Benefit Booklet.

ALLOCATION AND APPORTIONMENT OF BENEFITS
The Plan reserves the right to allocate the Deductible amount to any Covered Charges and to apportion the benefits to the Covered Person and any assignees. Such allocation and apportionment shall be conclusive and shall be binding upon the Covered Person and all assignees.

FACILITY OF PAYMENT
If a Claimant is a minor or is physically or mentally incapable of giving a valid release for payment, the Claims Administrator, at its option, may make payment to a party who has assumed responsibility for the care of such person. Such payments will be made until Claim is made by a guardian. If a Claimant dies while benefits remain unpaid, benefits will be paid at the Claim Administrator's option to:

1. The person or institution on whose charges Claim is based; or
2. A surviving relative (wife, husband, mother, father, Child or Children, brother or brothers, sister or sisters).

Such payment will release the Plan Administrator and Claims Administrator of all further liability to the extent of payment.

DEFINITIONS

Terminology listed below, along with the definition or explanation of the manner in which the term is used, will be recognized for the purpose of this Benefit Booklet, only if used in this Benefit Booklet. Terms defined, but not used in this Benefit Booklet, are to be considered general in nature and are in no way to be used to define or limit benefits or provisions of the Plan. Words or phrases used in this Benefit Booklet that are capitalized or set forth in bold type but not defined in the Plan are contained in that form as section headings or for ease of review and are intended to have the general meanings associated with such words or phrases based on the context in which they are used.

Masculine pronouns used in this Benefit Booklet shall include masculine or feminine gender unless the context indicates otherwise.

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

Accident: A sudden and unforeseen event, or a deliberate act resulting in unforeseen consequences.

Accidental Injury: See definition of "Injury."

Actively at Work: As applied to an Employee: the Employee will be considered "Actively at Work" on any day the Employee performs in the customary manner all of the regular duties of employment; an Employee will be deemed "Actively at Work" on each day of a regular paid vacation or on a regular non-working day on which the Covered Employee is not totally disabled, provided the Covered Employee was "Actively at Work" on the last preceding regular work day. An Employee shall be deemed Actively at Work if the Employee is absent from work due to a health factor, subject to the Plan's Leave of Absence provisions.

ADA: The American Dental Association.

Adverse Benefit Determination: Any denial, reduction or termination of, or a failure to provide or make a payment (in whole or in part) for a benefit, including any such denial, reduction, rescission of coverage, termination or failure to provide or make payment that is based on certain benefit coverage and eligibility determinations.

Adverse Benefit Determination on Appeal: The upholding or affirmation of an appealed Adverse Benefit Determination.

Allowable Claim Limits: The charges for services and supplies, listed and included as Covered Medical Expenses under the Plan, which are Medically Necessary for the care and treatment of a covered Illness or Injury, but only to the extent that such fees are within the Allowable Claim Limits. See Claim Review and Audit Program section.

Allowable Expense: The Usual and Customary charge within Allowable Claim Limits for any Medically Necessary, Reasonable eligible item of expense, at least a portion of which is covered under this Benefit Booklet. When some other plan provides benefits in the form of services rather than cash payments, the Reasonable cash value of each service rendered, in the amount that would be payable in accordance with the terms of the Plan, shall be deemed to be the benefit. Benefits payable under any other plan include the benefits that would have been payable had claim been duly made.

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

Alternative Care Plan: In circumstances where there is a reasonable expectation of savings for standard of care medical treatment, medication, or other services and this alternative care can be substituted for more costly care while remaining the treatment of choice, an Alternative Care Plan will be developed to optimize the savings obtained by the services substituted. Example: Substituting Home Health Private Duty Nursing for care in an Inpatient Skilled Nursing Facility.

AMA: The American Medical Association.

Ambulatory Surgery Center: An institution or Facility, either freestanding or as a part of a Hospital with permanent Facilities, equipped and operated for the primary purpose of performing Surgical Procedures and to which a patient is admitted and from which a patient is discharged within a twenty-four (24) hour period. An office maintained by a Physician for the practice of medicine or dentistry, or for the primary purpose of performing terminations of Pregnancy, shall not be considered as an Ambulatory Surgery Center.

Ancillary Services: Incidental services that assist a medical procedure, but are not essential to the accomplishment of the medical procedure (i.e., laboratory testing).

Annual: Yearly; occurring once each Calendar Year.

Annual Out-of-Pocket Maximum ($3500 Deductible Plan): The Maximum dollar amount a Covered Person will pay for Covered Medical Expenses, and Prescription Drug Expenses, including the Calendar Year Deductible, Medical Copays and Prescription Drug Copays, but excluding non-compliance penalties and any Covered Charges already paid at 100% in any one Calendar Year period, unless otherwise specified in the Schedule of Benefits.

Annual Out-of-Pocket Maximum ($4500 Deductible with HSA Plan): The Maximum dollar amount a Covered Person will pay for Covered Medical Expenses and Prescription Drug Expenses including the Calendar Year Deductible, but excluding non-compliance penalties and any Covered Charges already paid at 100% in any one Calendar Year period, unless otherwise specified in the Schedule of Benefits.

Applied Behavior Analysis (ABA) Therapy: Applied Behavior Analysis (ABA) Therapy is a scientific approach that applies the understanding of how behavior works to real situations with the goal of increasing behaviors that are helpful, and decreasing behaviors that are harmful or that affect learning. ABA Therapy involves many techniques for understanding and changing behavior. ABA Therapy programs can help to increase language and communication skills; improve attention, social skills, and academics; and decrease problem behaviors.

Approved Clinical Trial: A phase I, II, III or IV trial that is federally funded by specified Agencies (National Institutes of Health, CDCP, Agency for Health Care Research, CMS, Dept. of Defense or Veterans Affairs, or a non-governmental entity identified by NIH guidelines) or is conducted under an Investigational new Drug application reviewed by the FDA (if such application is required). An Approved Clinical Trial is 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.

Assignment of Benefits: An arrangement whereby the Plan Participant assigns his/her right to seek and receive payment of eligible Plan benefits, in strict accordance with the terms of this Benefit Booklet, to a Provider. If a Provider accepts said arrangement, Provider's rights to receive Plan benefits are equal to those of a Plan Participant, and are limited by the terms of this Benefit Booklet. A Provider that accepts this arrangement indicates acceptance of an "Assignment of Benefits" as consideration in full for services, supplies, and/or treatment rendered.

Authorized Representative: Person authorized to act on behalf of a Claimant for a benefit Claim or appeal of an Adverse Benefit Determination.

Autism Spectrum Disorder: A disorder that includes autism, Asperger's Syndrome or pervasive development disorder.

Benefit Determination: A determination by the Plan Administrator or Claims Administrator on a Claim for benefits, including an Adverse Benefit Determination.

Benefit Percentage: The portion of Covered Expenses to be paid by the Plan in accordance with the coverage including the Calendar Year Deductible, Medical Copays and Prescription Drug Copays which are to be paid by the Covered Person.

Birthing Center: A Facility, staffed by Physicians, which is licensed as a Birthing Center in the jurisdiction where it is located.

Breach: A Breach is, generally, an impermissible use or disclosure under the Privacy Rule that compromises the security or privacy of the Protected Health Information such that the use or disclosure poses a significant risk of financial, reputational, or other harm to the affected individual.

Calendar Year: A period of time commencing on January 1 and ending on December 31 of the same given year.

Cellular Therapy: Administration of living whole cells into a patient for the treatment of disease.

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

Chemical Dependency: The abuse of, or psychological or physical dependency on, or addiction to, alcohol or a controlled substance. A "controlled substance" means a toxic inhalant or a substance designated as a controlled substance as declared by Federal or State law where applicable.

Chemical Dependency Treatment Center: A Facility which provides a program for the treatment of Chemical Dependency pursuant to a written treatment plan approved and monitored by a Physician and is also:

1. Accredited as such a Facility by the Council on Accreditation (COA) or Joint Commission on Accreditation of Health Care Organizations or sponsored by the A.M.A. or A.H.A.;
2. Affiliated with a Hospital under contractual agreement with an established system for patient referral;
3. Licensed as a Chemical Dependency treatment program by the applicable State Commission on Alcohol and Drug Abuse; and
4. Licensed, certified or approved as a Chemical Dependency treatment program or center by any other State agency having legal authority to so license, certify or approve.

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

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

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

Claim: A request for a Plan benefit or benefits made by a Claimant in accordance with the Plan's reasonable procedure for filing benefit Claims.

Claim Determination Period: A Calendar Year, a Plan Year or that portion of a Calendar or Plan Year during which the Covered Person, for whom Claim is made, has been covered under this Benefit Booklet.

Claimant: Individual for whom a Claim is filed.

Claims Administrator: The third party or parties with whom the Plan Administrator has contracted to process the Claims for the benefits under this Benefit Booklet.

Clean Claim: A Clean Claim is one that can be processed in accordance with the terms of this document without obtaining additional information from the service Provider or a third party. It is a Claim which has no defect or impropriety. A defect or impropriety shall include a lack of required substantiating documentation as set forth and in accordance with this document, or a particular circumstance requiring special treatment which prevents timely payment as set forth in this document, and only as permitted by this document, from being made. A Clean Claim does not include Claims under investigation for fraud and abuse or Claims under review for Medical Necessity and Reasonableness, or fees under review for Usual and Customariness, or any other matter that may prevent the charge(s) from being covered expenses in accordance with the terms of this document.

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

Close Relative: Includes the spouse, mother, father, sister, brother, Child, or in-laws of the Covered Person.

Coinsurance: The portion of Covered Expenses that is shared by the Plan and the Covered Person in a specific ratio (i.e., 80%/20%) after the Calendar Year Deductible has been satisfied. The amount of Coinsurance paid by or on behalf of the Covered Person is applied toward the Covered Person's or Family's Annual Out-of-Pocket Maximum.

Company: BrightSpring Health Services (Plan Sponsor).

Complications of Pregnancy: A Disease, disorder or condition which is diagnosed as distinct from normal Pregnancy but adversely affected by or caused by Pregnancy. This includes, but is not limited to:

1. Inter-abdominal Surgery, including cesarean section;
2. Excessive vomiting (hyperemesis gravidarum);
3. Toxemia with convulsions (eclampsia);
4. Extra-uterine Pregnancy (ectopic);
5. Postpartum hemorrhage;
6. Rupture or prolapse of the uterus;
7. Spontaneous termination of Pregnancy during a period of gestation in which a viable birth is not possible; or
8. Similar medical and surgical conditions of comparable severity.

Complications of Pregnancy will not include:

1. Elective abortion;
2. False labor;
3. Occasional spotting;
4. Physician prescribed rest;
5. Morning sickness; or
6. Similar conditions associated with the management of a difficult Pregnancy.

Concurrent Review: The Utilization Review *Company's* review of a Hospital stay, periodically evaluating the need for continued hospitalization.

Congenital Anomaly: A Congenital Anomaly may be viewed as a physical, metabolic or anatomic deviation from the normal pattern of development that is apparent at birth or detected during the first year of life.

Copay: The portion of Covered Expenses which is payable by the Covered Person and which is not applicable to the Calendar Year Deductible unless otherwise stated in this Benefit Booklet.

Corrective Shoes: Shoes with a prescription correction which is a permanent and integral part of the shoe.

Cosmetic Procedure/Cosmetic Surgery: A procedure performed solely for the improvement of a Covered Person's appearance rather than for the improvement or restoration of bodily function.

Covered Employee: An Employee meeting the eligibility requirements for coverage as specified in this Benefit Booklet and who is properly enrolled in the Plan.

Covered Medical Expenses (Covered Expenses): The Reasonable and Usual and Customary charges, Allowable Claim Limit charges and/or contracted PPO charges incurred by or on behalf of a Covered Person for the Hospital or other medical services listed below which are:

1. Ordered by a Physician or licensed Practitioner;
2. Medically Necessary for the treatment of an Illness or Injury;
3. Not of a luxury or personal nature; and
4. Not excluded under the Major Medical Exclusions and Limitations section of this Benefit Booklet.

Covered Person: An Employee, a Dependent, a COBRA Qualified Beneficiary or a COBRA Qualified Beneficiary's Dependent meeting the eligibility requirements for coverage as specified in this Benefit Booklet, and who is properly enrolled in the Plan.

Custodial Care: That type of care or service, wherever furnished and by whatever name called, which is designed primarily to assist a Covered Person, whether or not totally disabled, in the activities of daily living. Such activities include, but are not limited to: bathing, dressing, feeding, preparation of special diets, assistance in walking or in getting in and out of bed, and supervision over medication which can normally be self-administered.

Date of Hire: The Employee's first day of Full-time Employment or Part-time Employment with the Employer.

Deductible: A specified dollar amount of Covered Expenses which must be incurred during a Calendar Year before any other Covered Expenses can be considered for payment according to the applicable Benefit Percentage. The Plan Administrator reserves the right to allocate and apportion the Deductible and benefits to any Covered Persons and assignees.

Detoxification: The process whereby an alcohol-intoxicated person or person experiencing the symptoms of Substance Abuse is assisted, in a Facility licensed by the Department of Health, through the period of time necessary to eliminate, by metabolic or other means, the intoxicating alcohol, alcohol dependency factors or alcohol in combination with Drugs as determined by a licensed Physician, while keeping the physiological risk to the patient at a minimum.

Developmental Delay: A significant variation in normal development as measured by appropriate diagnostic instruments and procedures in one or more of the following: cognitive development, physical development, communication development, social or emotional development or adaptive development.

Diagnostic Service: A test or procedure performed for specified symptoms to detect or to monitor a Disease or condition. It must be ordered by a Physician or other professional Provider.

Direct Agreement: A complete agreement between a Directly Contracted Provider and Imagine360 or the Plan Sponsor which contains the terms and conditions under which the Covered Person may access discounted fees and/or negotiated or scheduled reimbursement rates which the Plan adopts as Allowable Claims Limits for Claims submitted by directly contracted Providers.

Directly Contracted Provider: A medical Provider, supplemental benefit provider, and/or supplemental network partner which has entered into a Direct Agreement with Imagine360, including any affiliates, or the Plan Sponsor to provide certain medical services to Covered Persons at agreed upon Allowable Claim Limits.

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

Domiciliary Care: Living arrangements designed to meet the needs of people who cannot live independently but do not require Skilled Nursing Facility services.

Donor: One who furnishes blood, tissue, or an organ to be used in another person.

Drug: Insulin and prescription legend Drugs. A prescription legend Drug is a Federal legend Drug (any medicinal substance which bears the legend: "Caution: Federal law prohibits dispensing without a Prescription") or a State restricted Drug (any medicinal substance which may be dispensed only by Prescription, according to State law) and which, in either case, is legally obtained from a licensed Drug dispenser only upon a prescription of a currently licensed Physician.

Durable Medical Equipment: Equipment which is:

1. Able to withstand repeated use;
2. Primarily and customarily used to serve a medical purpose; and
3. Not generally useful to a person in the absence of Illness or Injury.

Elective Surgical Procedure/Elective Surgery: A non-Emergency Surgical Procedure which is scheduled at the Covered Person's convenience without endangering the Covered Person's life or without causing serious impairment to the Covered Person's bodily functions.

Electronic Protected Health Information (ePHI): "Electronic Protected Health Information (ePHI)" has the meaning set forth in 45 C.F.R. Section 160.103, as amended from time to time, and generally means Protected Health Information that is transmitted or maintained in any electronic media.

Emergency Services: With respect to an Emergency/Medical Emergency:

1. An appropriate medical screening examination (as required under section 1867 of the Social Security Act, 42 U.S.C. 1395dd) that is within the capability of the Emergency department of a Hospital or of an Independent Freestanding Emergency Department, as applicable, including Ancillary Services routinely available to the Emergency department to evaluate such Emergency medical condition; and

2. Within the capabilities of the staff and Facilities available at the Hospital or the Independent Freestanding Emergency Department, as applicable, such further medical examination and treatment as are required under section 1867 of the Social Security Act (42 U.S.C. 1395dd), or as would be required under such section if such section applied to an Independent Freestanding Emergency Department, to stabilize the patient (regardless of the department of the Hospital in which such further examination or treatment is furnished).

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

Employer: The Company and any affiliates adopting the Plan with the consent of the Company by approval of the affiliate entity's governing body.

ERISA: Employee Retirement Income Security Act of 1974 as amended. "ERISA" also refers to a provision or section thereof to which a specific reference is made herein.

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

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

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

Non-approved Phase I and II clinical trials shall be considered Experimental. Non-approved clinical trials include anything that is not listed in the Approved Clinical Trial definition.

A Drug, device, or medical treatment or procedure is Experimental:

1. If the Drug or device cannot be lawfully marketed without approval of the U.S. Food and Drug Administration and approval for marketing has not been given at the time the Drug or device is furnished;

2. If reliable evidence shows that the Drug, device or medical treatment or procedure is the subject of ongoing Phase I, II, or III clinical trials or (unless identified as a covered service elsewhere) under study to determine its:

    a. maximum tolerated dose;
    b. toxicity;
    c. safety;
    d. efficacy; and
    e. efficacy as compared with the standard means of treatment or diagnosis; or

3. Reliable evidence shows that the opinion among experts regarding the treatment, procedure, device, Drug, or medicine is that the preponderance of current evidence does not support its efficacy, safety, or its efficacy as compared with the standard means of treatment or with regard to medication, has not determined its maximum tolerated dose.

Reliable evidence shall mean:

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

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

Medical care and treatment, including prescriptions/diagnostics/labs that are not related directly to a clinical trial are considered for coverage under the Plan for those patients participating in a clinical trial.

Facility/Freestanding Facility: A Facility means a Hospital or treatment center that provides medical services on an Inpatient and/or Outpatient basis. A Freestanding Facility is an independent Facility which provides medical services on an Outpatient basis, which may or may not be affiliated with a Hospital (i.e., Ambulatory Surgery Center). See separate definition for "Independent Freestanding Emergency Department."

Family: A Covered Employee and his/her Eligible Dependents.

Fiduciary: The Plan Administrator, but only with respect to the specific responsibilities relating to the administration of the Plan.

Gene Therapy: Therapeutic delivery of nucleic acid (DNA or RNA) into a patient's cells as a drug to treat a disease.

Genetic Information: Information about genes, gene products and inherited characteristics that may derive from an individual or a Family member. This includes information derived from laboratory tests that identify mutations in specific genes or chromosomes, physical medical examinations, Family histories and direct analyses of genes or chromosomes.

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

Habilitation Services: Services designed to assist individuals in acquiring, retaining and improving the self-help, socialization and adaptive skills necessary to reside successfully in home and community based settings.

Hazardous Pursuit, Hobby or Activity: Services, supplies, care and/or treatment of an Injury or Illness that results from engaging in a Hazardous Pursuit, Hobby or Activity. A pursuit, hobby or activity is hazardous if it involves or exposes an individual to risk of a degree or nature not customarily undertaken in the course of the Covered Person's customary occupation or if it involves leisure time activities commonly considered as involving unusual or exceptional risks, characterized by a constant threat of danger or risk of bodily harm, including but not limited to: hang gliding; skydiving; bungee jumping; parasailing; use of all-terrain vehicles; rock climbing; use of explosives; automobile, motorcycle, aircraft, or speed boat racing; and travel to countries with advisory warnings.

Health Insurance Portability and Accountability Act of 1996 (HIPAA): With regard to health care plans, it should be noted that this Act implemented the portability of health insurance, amended ERISA disclosure requirements and changed health status eligibility provisions for Employee health plans.

Health Maintenance Organization (HMO): An organized system of health care delivery available to individuals residing in a specific geographic area providing comprehensive medical care to enrollees for a predetermined periodic payment.

HIPAA Privacy Standards: The Privacy Standards of the Health Insurance Portability and Accountability Act of 1996, as they may be amended from time to time.

Home Health Care Agency: A public or private agency or organization that specializes in providing medical care and treatment in the patient's home. Such a Provider must meet all of the following conditions:

1. It is primarily engaged in and duly licensed, if such licensing is required, by the appropriate licensing authority to provide skilled nursing services and other therapeutic services;

2. It has policies established by a professional group associated with the agency or organization. This professional group must include at least one (1) Physician and at least one (1) Registered Nurse (RN) to govern the services provided and it must provide for full-time supervision of such services by a Physician or Registered Nurse (RN);

3. It maintains a complete medical record on each individual; and

4. It has a full-time administrator.

Home Health Care Plan: A program for care and treatment of a Homebound Covered Person, established and approved by the Covered Person's attending Physician, which is in lieu of confinement as an Inpatient in a Hospital or other Inpatient Facility in the absence of the services and supplies provided for under the Home Health Care Plan.

Home Infusion Therapy: The administration of fluids, nutrition or medication (including all additives and chemotherapy) by intravenous or gastrointestinal (enteral) infusion or by intravenous injection in the home setting. Home Infusion Therapy shall include:

1. Drugs and IV solutions;
2. Pharmacy compounding and dispensing services;
3. All equipment and ancillary supplies necessitated by the defined therapy;
4. Delivery services;
5. Patient and Family education; and
6. Nursing services.

Over-the-counter products which do not require a Physician's or other Provider's prescription, including but not limited to standard nutritional formulations used for enteral nutrition therapy, are not included within this definition.

Home Infusion Therapy Provider: An entity that is duly licensed by the appropriate State agency to provide Home Infusion Therapy.

Homebound: A patient's medical condition is such that it significantly restricts the ability to leave the home, and the patient is unable to drive a motor vehicle by himself/herself.

Hospice: A health care program providing a coordinated set of services rendered at home, in Outpatient settings, or in institutional settings for Covered Persons suffering from a condition that has a terminal diagnosis. A Hospice must have an interdisciplinary group of personnel which includes at least one (1) Physician and one (1) Registered Nurse (RN), and it must maintain central clinical records on all patients. A Hospice must meet the standards of the National Hospice Organization (NHO) and applicable State licensing requirements.

Hospice Benefit Period: A specified amount of time during which the Covered Person undergoes Hospice care. Such time period begins on the date the attending Physician of a Covered Person certifies a diagnosis of terminally ill, and the Covered Person is accepted into a Hospice program. The period shall end the earlier of six (6) months from this date or at the death of the Covered Person. A new benefit period may begin if the attending Physician certifies that the Covered Person is still terminally ill; however, additional proof may be required by the Claims Administrator before such a new benefit period can begin.

Hospital: An accredited institution which is approved as a Hospital by the Joint Commission on the Accreditation of Health Care Organizations, or the American Osteopathic, and which meets all of the following criteria:

1. It is primarily engaged in providing, for compensation from its patients and on an Inpatient basis, diagnostic and therapeutic Facilities for the surgical and medical diagnosis, treatment, and care of injured and sick persons by or under the supervision of a staff of Physicians;

2. It continuously provides twenty-four (24) hours per day nursing services by registered professional Nurses under the supervision of Physicians; and

3. It is not, other than incidentally, a place for rest, the aged, or a nursing home, a hotel or the like.

Hospital Expenses: Charges by a Hospital for Room and Board and/or for care in an Intensive Care Unit provided that such care is furnished at the direction of a Physician.

Hospital Miscellaneous Expenses: The actual charges made by a Hospital in its own behalf for services and supplies rendered to the Covered Person which are Medically Necessary for the treatment of such Covered Person. Hospital Miscellaneous Expenses do not include charges for Room and Board or for professional services (including intensive nursing care by whatever name called), regardless of whether the services are rendered under the direction of the Hospital or otherwise.

Illness: A bodily disorder, Disease, physical sickness, mental infirmity, or functional nervous disorder of a Covered Person.

Immunization: The protection of individuals or groups from specific Diseases by vaccination or the injection of immune globulins.

Incurred Date: The date the service is rendered or the supply is obtained. With respect to a course of treatment or procedure which includes several steps or phases of treatment, expenses are incurred for the various steps or phases as the services related to each step are rendered and not when services relating to the initial step or phase are rendered.

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 which provides any Emergency Services. Independent Freestanding Emergency Departments do not include Urgent Care Facilities (Minor Emergency Medical Clinics).

Individual Treatment Plan: A treatment plan with specific attainable goals and objectives appropriate to both the patient and the treatment modality of the program.

Injury: A condition caused by accidental means which results in damage to the Covered Person's body from an external force.

Inpatient: Refers to a patient admitted as a bed patient to a Hospital, Hospice, Rehabilitation Facility or Skilled Nursing Facility for treatment or observation; charges must be incurred for Room and Board or observation for a period of at least twenty-four (24) hours.

Intensive Care Unit (ICU): A separate, clearly designated service which is maintained within a Hospital solely for the care and treatment of patients who are critically ill. This also includes what is referred to as a "coronary care unit" or an "acute care unit." It has Facilities for special nursing care not available in regular rooms and wards of the Hospital, special life-saving equipment which is immediately available at all times, at least two (2) beds for the accommodation of the critically ill and at least one (1) Registered Nurse (RN) in continuous and constant attendance twenty-four (24) hours a day.

Licensed Practical Nurse/Licensed Vocational Nurse: An individual who has received specialized nursing training and practical nursing experience, and is duly licensed to perform such nursing services by the State or regulatory agency responsible for such licensing in the State in which that individual performs such services.

Maximum Allowable Charge: The amount payable for a specific covered item under this Benefit Booklet. For Claim determinations made in accordance with the Claim Review and Audit Program, the Maximum Allowable Charge will be limited to the Allowable Claim Limits. Please refer to the section, "Claim Review and Audit Program" for the definition of Allowable Claim Limits. For all other Claims, the Maximum Allowable Charge will be a negotiated rate, if one exists. For Claims subject to the No Surprises Act (see "No Surprises Act – Emergency Services and Surprise Bills" within the "Schedule of Benefits" section), if no negotiated rate exists, the Maximum Allowable Charge will be an amount deemed payable by a Certified IDR Entity or a court of competent jurisdiction, if applicable.

If none of the above factors is applicable, the Maximum Allowable Charge will be determined and established by the Plan, at the Plan Administrator's discretion, using normative data and submitted information such as, but not limited to, any one (1) or more of the following, in the Plan Administrator's discretion:

- Medicare reimbursement rates (presently utilized by the Centers for Medicare and Medicaid Services ["CMS"]).
- Prices established by CMS utilizing standard Medicare Payment methods and/or based upon supplemental Medicare pricing data for items Medicare does not cover based on data from CMS.
- Prices established by CMS utilizing standard Medicare payment methods and/or based upon prevailing Medicare rates in the community for non-Medicare Facilities for similar services and/or supplies provided by similarly skilled and trained Providers of care.
- Prices established by CMS utilizing standard Medicare payment methods for items in alternate settings based on Medicare rates provided for similar services and/or supplies paid to similarly skilled and trained Providers of care in traditional settings.
- Medicare cost data as reflected in the applicable individual Provider's cost report(s).
- The fee(s) which the Provider most frequently charges the majority of patients for the service or supply.
- Amounts the Provider specifically agrees to accept as payment in full either through direct negotiation or through a Preferred Provider Organization (PPO) network.
- Average wholesale price (AWP) and/or manufacturer's retail pricing (MRP).
- Medicare cost-to-charge ratios or other information regarding the actual cost to provide the service or supply.
- The allowable charge otherwise specified within the terms of this Benefit Booklet.
- The prevailing range of fees charged in the same "area" (defined as a metropolitan area, county, or such greater area as is necessary to obtain a representative cross-section of Providers, persons or organizations rendering such treatment, services, or supplies for which a specific charge is made) by Providers of similar training and experience for the service or supply.

The Plan Administrator may in its discretion, taking into consideration specific circumstances, deem a greater amount to be payable than the lesser of the aforementioned amounts. The Plan Administrator may take any or all of such factors into account but has no obligation to consider any particular factor. The Plan Administrator may also account for unusual circumstances or complications requiring additional, or a lesser, amount of time, skill and experience in connection with a particular service or supply, industry standards and practices as they relate to similar scenarios, and the cause of Injury or Illness necessitating the service(s) and/or charge(s).

In all instances, the Maximum Allowable Charge will be limited to an amount which, in the Plan Administrator's discretion, is charged for services or supplies that are not unreasonably caused by the treating Provider, including errors in medical care that are clearly identifiable, preventable, and serious in their consequence for patients. A finding of Provider negligence and/or malpractice is not required for services or fees to be considered ineligible pursuant to this provision.

The determination that fees for services are includable in the Maximum Allowable Charge will be made by the Plan Administrator, taking into consideration, but not limited to, the findings and assessments of the following entities: (a) The national medical associations, societies, and organizations; and (b) The Food and Drug Administration (FDA). To be includable in the Maximum Allowable Charge, services and fees must be in compliance with generally accepted billing practices for unbundling or multiple procedures.
The Plan Administrator has the discretionary authority to decide if a charge is covered under this Benefit Booklet. The Maximum Allowable Charge will not include any identifiable billing mistakes including, but not limited to, up-coding, duplicate charges, and charges for services not performed.

Maximum Amount: Any limit on benefits that are payable under the Plan.

Maximum Benefit: The Maximum Amount that may be payable for each Covered Person for expenses incurred. The applicable Maximum Benefit is shown in the Schedule of Benefits. No further benefits are payable once the Maximum Benefit is reached.

Medical Care Benefits: Amounts paid for the diagnosis, cure, mitigation, treatment or prevention of Disease or amounts paid for the purpose of affecting any structure or function of the body.

Medical Emergency means a medical condition manifesting itself by acute symptoms of sufficient severity including severe pain such that a prudent layperson with average knowledge of health and medicine could reasonably expect the absence of immediate medical attention to result in (1) serious jeopardy to the health of an individual (or, in the case of a pregnant woman, the health of the woman or her unborn child), (2) serious impairment to body functions, or (3) serious dysfunction of any body organ or part. A Medical Emergency includes such conditions as heart attacks, cardiovascular accidents, poisonings, loss of consciousness or respiration, convulsions or other such acute medical conditions.

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

Medical Review Specialist: An organization under contract to the Plan Administrator to provide the services required under the cost containment features of Utilization Review Notification/Concurrent Review/Coordination of Care/Case Management. The Plan Administrator will furnish the name, address and phone number of the Medical Review Specialist.

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

1. It must not be maintenance therapy or maintenance treatment;
2. Its purpose must be to restore health;
3. It must not be primarily custodial in nature;
4. It must not be a listed item or treatment not allowed for reimbursement by CMS (Medicare); and
5. The Plan reserves the right to incorporate CMS (Medicare) guidelines in effect on the date of treatment as additional criteria for determination of Medical or Dental Necessity and/or an Allowable Expense.

For Hospital stays, this means that acute care as an Inpatient is necessary due to the kind of services the Participant is receiving or the severity of the Participant's condition and that safe and adequate care cannot be received as an Outpatient or in a less intensive medical setting. The mere fact that the service is furnished, prescribed or approved by a Physician or Dentist does not mean that it is "Medically or Dentally Necessary." In addition, the fact that certain services are excluded from coverage under this Benefit Booklet because they are not "Medically or Dentally Necessary" does not mean that any other services are deemed to be "Medically or Dentally Necessary."

To be Medically or Dentally Necessary, all of these criteria must be met. Merely because a Physician or Dentist recommends, approves, or orders certain care does not mean that it is Medically or Dentally Necessary. The determination of whether a service, supply, or treatment is or is not Medically or Dentally Necessary may include findings of the American Medical Association and the Plan Administrator's own medical advisors.

Medicare Benefits: All benefits under Parts A, B and/or D of Title XVIII of the Social Security Act of 1965, as amended from time to time.

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

Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA): In the case of a group health plan (or health insurance coverage offered in connection with such a plan) that provides both medical and surgical benefits and mental health or substance use disorder benefits, such plan or coverage shall ensure that:

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

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

Midwife: A Practitioner who is certified as a Nurse Midwife (CNM) by the American College of Nurse-Midwives and who is authorized to practice as a Nurse Midwife under State regulations.

Morbid Obesity: A diagnosed condition in which the body weight of an individual is the greater of 100 pounds or 100% over the medically recommended weight for a person of the same height, age and mobility and by a BMI (body mass index) greater than 40 (in accordance with Utilization Review's criteria for morbid or severe Obesity).

Newborns' and Mothers' Health Protection Act of 1996 (NMHPA): A regulation that amended ERISA by adding a new section restricting the extent to which group health plans may limit Hospital lengths of stays for mothers and newborn Children following delivery. NMHPA regulations apply as of the first day of the first Plan Year beginning on or after January 1, 1998.

No-Fault Automobile Insurance: Automobile insurance that pays for medical expenses for Injuries sustained during the operation of an automobile, regardless of who may have been responsible for causing the Accident.

Nurse: An individual who has received specialized nursing training and is authorized to use the designation Registered Nurse (RN), Licensed Vocational Nurse (LVN) or Licensed Practical Nurse (LPN), and who is duly licensed by the State or regulatory agency responsible for such license in the State in which the individual performs the nursing services.

Obesity: A diagnosed condition in which the BMI (body mass index) is at least 30 (ranging from 30-39).

Occupational Therapy: Treatment which is rendered for reasons other than restoration of bodily functions and the prevention of disability. Such treatment is usually rendered by the use of work-related skills and leisure tasks for the evaluation of an individual's behavior and/or abilities of self-care, work or play.

Oral Surgery: Maxillofacial Surgical Procedures include, but are not limited to:

1. Excision of non-dental related neoplasms, including benign tumors and cysts and all malignant and pre-malignant lesions and growths;
2. Incision and drainage of facial abscess;
3. Surgical Procedures involving salivary glands and ducts and non-dental related procedures of the accessory sinuses; and
4. Surgical and diagnostic treatment of conditions affecting the temporomandibular joint (including the jaw and the craniomandibular joint) as a result of an Accident, a trauma, a congenital defect, a developmental defect or a pathology.

Orthopedic Shoes: Special shoes designed for support of the feet or the prevention or correction of deformities of the feet.

Orthotic Devices: External devices used to support, align, prevent or correct deformities or to improve the function of movable parts of the body. An orthotic insole is a foot supporting device prescribed by a Physician or licensed Practitioner.

Out-of-Area: "Out-of-Area" applies to a Covered Person living or traveling outside of the geographic zip code area serviced by the Preferred Provider Organization (PPO).

Outpatient: A patient who receives medical services at a Hospital but is not admitted as a registered overnight bed patient; this must be for a period of less than twenty-four (24) hours. This term can also be applicable to services rendered in a freestanding independent Facility, such as an Ambulatory Surgery Center.

Outpatient Chemical Dependency/Drug Treatment Facility: An institution which provides a program for a diagnosis, evaluation and effective treatment of Chemical Dependency, and/or Drug use or abuse; provides Detoxification services needed with its effective treatment program; provides infirmary level medical services or arranges at a Hospital in the area for any other medical services that may be required; is at all times supervised by a staff of Physicians; provides at all times skilled nursing care by licensed Nurses who are directed by a full-time Registered Nurse (RN); prepares and maintains a written plan of treatment for each patient based on medical, psychological and social needs, which is supervised by a Physician; and meets applicable State and Federal, if any, licensing standards.

Outpatient Psychiatric Day Treatment Facility: An administratively distinct governmental, public, private or independent unit or part of such unit that provides for a psychiatrist who has regularly scheduled hours in the Facility, and who assumes the overall responsibility for coordinating the care of all patients.

Physical Therapy: Management of the patient's movement system. This includes conducting an examination; alleviating impairments and functional limitation; preventing Injury, impairment, functional limitation and disability; and engaging in consultation, education and research. Direct interventions include the appropriate use of patient education, therapeutic exercise and physical agents such as massage, thermal modalities, hydrotherapy and electricity.

Physically Handicapped or Intellectually Disabled: The inability of a person to be self-sufficient as the result of a condition such as intellectual disability, cerebral palsy, epilepsy or another neurological disorder and diagnosed by a Physician as a permanent and continuing condition.

Physician: A person acting within the scope of his/her license and holding the degree of Doctor of Medicine (MD) or Doctor of Osteopathy (DO) and who is legally entitled to practice medicine in all its branches under the laws of the State or jurisdiction where the services are rendered.

Plan: Without qualification, this Benefit Booklet, including any Plan Amendments thereto.

Plan Administrator: BrightSpring Health Services, who is responsible for the day-to-day functions and arrangements of the Plan. The Plan Administrator may employ persons or firms to process Claims and perform other Plan connected services.

Plan Participant: Eligible Employee, Eligible Dependent, eligible COBRA Qualified Beneficiary or a COBRA Qualified Beneficiary's Dependent properly enrolled in the Plan.

Plan Sponsor: BrightSpring Health Services.

Plan Year: The twelve (12) month period beginning on January 1 and ending December 31 of each Calendar Year. The Plan Year is the year on which Plan records are kept.

Practitioner: A Physician or person acting within the scope of applicable State licensure/certification requirements including but not limited to the following:

1. Advanced Practice Nurse (APN)
2. Audiologist
3. Board Certified Behavior Analyst (BCBA)
4. Certified Diabetic Educator and Dietitian
5. Certified Nurse Midwife (CNM)
6. Certified Operating Room Technician (CORT)
7. Certified Registered Nurse Anesthetist (CRNA)
8. Certified Surgical Technician (CST)
9. Doctor of Chiropractic (DC)
10. Doctor of Dental Medicine (DMD)
11. Doctor of Dental Surgery (DDS)
12. Doctor of Medicine (MD)
13. Doctor of Optometry (OD)
14. Doctor of Osteopathy (DO)
15. Doctor of Podiatric Medicine (DPM)
16. Licensed Acupuncturist (LAC)
17. Licensed Clinical Social Worker (LCSW)
18. Licensed Marriage and Family Therapist (LMFT)
19. Licensed Occupational Therapist
20. Licensed or Registered Physical Therapist
21. Licensed Practical Nurse (LPN)
22. Licensed Professional Counselor (LPC)
23. Licensed Surgical Assistant (LSA)
24. Licensed Vocational Nurse (LVN)
25. Master of Social Work (MSW)
26. Physician Assistant (PA)
27. Psychologist (PhD, EdD, PsyD)
28. Registered Nurse (RN)
29. Registered Nurse First Assistant (RNFA)
30. Registered Nurse Practitioner (RN-NP)
31. Speech Language Pathologist

Preferred Provider Organization (PPO): An alternate health care delivery system with which Plan Administrators may contract to provide comprehensive medical care for Employees. A PPO is a network of individual Physicians and other Providers who accept pre-negotiated, discounted fees for services rendered. Employee participation is encouraged by plan design for improved benefits when network Providers are used. Employees have flexibility under PPO arrangements in which there is a choice of network or non-network Providers.

Pregnancy: The physical state which results in childbirth, life-threatening abortion, or miscarriage, and any medical complications arising out of, or resulting from, such state.

Prescription Drugs: Licensed medicine that is government regulated which must be prescribed by a Qualified Prescriber before it can be obtained.

Preventive Care: This Benefit Booklet intends to comply with the Patient Protection and Affordable Care Act's (PPACA) requirement to offer in-network coverage for certain preventive services without cost-sharing. To comply with PPACA, and in accordance with the recommendations and guidelines, the Plan will provide in-network coverage for:

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

Copies of the recommendations and guidelines with services listed by group (all adults, women, children) may be found here: https://www.healthcare.gov/coverage/preventive-care-benefits/. For more information, you may contact the Plan Administrator / Employer at 502-394-2100.

Privacy Regulation: The regulations issued under the Health Insurance Portability and Accountability Act of 1996 (HIPAA), as amended.

Private Duty Nursing: Continuous skilled care or intermittent care by a Registered Nurse (RN), Licensed Practical Nurse (LPN) or Licensed Vocational Nurse (LVN) while a patient is not confined in a Hospital.

Protected Health Information (PHI): Individually identifiable health information that is created or received by a Covered Entity (the Plan) and relates to: (a) a person's past, present or future physical or mental health or condition; (b) provision of health care to that person; or (c) past, present or future payment for that person's health care. This term shall be construed in accordance with the Privacy Regulation.

Provider: A Physician, Practitioner, health care professional or health care Facility licensed, certified or accredited as required by State law.

Psychiatric Treatment Facility: A mental health Facility which:

1. Provides treatment for individuals who suffer from acute Mental Disorders;
2. Uses a structured psychiatric program with Individual Treatment Plans that have specified goals and appropriate objectives for the patient and treatment modality of the program; and
3. Is clinically supervised by a Physician of medicine who is certified in psychiatry by the American Board of Psychiatry and Neurology.

Qualified Individual: Someone who is eligible to participate in an "Approved Clinical Trial" and either the individual's doctor has concluded that participation is appropriate or the participant provides medical and scientific information establishing that their participation is appropriate.

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

Reasonable: In the Plan Administrator's discretion, services or supplies, or fees for services or supplies which are necessary for the care and treatment of Illness or Injury not caused by the treating Provider. Determination that fee(s) or services are Reasonable will be made by the Plan Administrator, taking into consideration unusual circumstances or complications requiring additional time, skill and experience in connection with a particular service or supply; industry standards and practices as they relate to similar scenarios; and the cause of Injury or Illness necessitating the service(s) and/or charge(s).

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

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

The Plan reserves for itself and parties acting on its behalf the right to review charges processed and/or paid by the Plan, to identify charge(s) and/or service(s) that are not Reasonable and, therefore, not eligible for payment by the Plan.

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

Reconstructive Surgery: A procedure performed to restore the anatomy and/or functions of the body which were lost or impaired due to an Injury or Illness.

Registered Nurse (RN): An individual who has received specialized nursing training and is authorized to use the designation of "RN," and who is duly licensed by the State or regulatory agency responsible for such licensing in the State in which the individual performs such nursing services.

Rehabilitation Facility: A legally operating institution or distinct part of an institution which has a transfer agreement with one or more Hospitals, and which is primarily engaged in providing comprehensive multi-disciplinary physical restorative services, post-acute Hospital and rehabilitative Inpatient care, and is duly licensed by the appropriate government agency to provide such services. It does not include institutions which provide only minimal care, Custodial Care, ambulatory, or part-time care services, or an institution which primarily provides treatment of Mental Disorders or Chemical Dependency, except if such Facility is licensed, certified or approved as a Rehabilitation Facility for the treatment of mental conditions or Drug addiction or Chemical Dependency in the jurisdiction where it is located, or it is accredited as such a Facility by the Joint Commission on the Accreditation of Health Care Organizations, or the Commission on the Accreditation of Rehabilitation Facilities.

Residential Treatment Center: Facility that provides twenty-four (24) hour treatment for Chemical Dependency, Drug and Substance Abuse or mental health problems on an Inpatient basis. It must provide at least the following: Room and Board; medical services; nursing and dietary services; patient diagnosis, assessment and treatment; individual, Family and group counseling; and educational and support services. A Residential Treatment Center is recognized if it is accredited for its stated purpose by the Joint Commission on Accreditation of Hospitals and carries out its stated purpose in compliance with all relevant State and local laws.

Retrospective Review: A determination by Utilization Review that medical services performed either Inpatient or Outpatient met criteria for Medical Necessity.

Room and Board: All charges, by whatever name called, which are made by a Hospital, Hospice, Skilled Nursing Facility, Rehabilitation Facility or other covered Facilities as a condition of Inpatient confinement as a bed patient. Such charges do not include the professional services of Physicians nor intensive nursing care, by whatever name called.

Routine Newborn Care: Inpatient charges for a well newborn Child for nursery Room and Board, related expenses following birth, including newborn hearing exams and Physician's pediatric services including circumcision. This term does not apply to a newborn Child's diagnosed Illness.

Routine Patient Cost(s): All items and services consistent with the coverage provided in the Plan that is typically covered for a Qualified Individual who is not enrolled in a clinical trial. Routine Patient Costs do not include: 1) the Investigational item, device or service itself; 2) items and services that are provided solely to satisfy data collection and analysis needs and that are not used in the direct clinical management of the patient; and 3) a service that is clearly inconsistent with the widely accepted and established standards of care for a particular diagnosis. Plans are not required to provide benefits for routine patient care services provided outside of the Plan's network area unless out-of-network benefits are otherwise provided under the Plan.

Security Incidents: "Security Incidents" has the meaning set forth in 45 C.F.R. Section 164.304, as amended from time to time, and generally means the attempted or successful unauthorized access, use, disclosure, modification, or destruction of information or interference with systems operations in an information system.

Series of Treatments: A Series of Treatments is a planned, structured program which may include Inpatient or Outpatient treatment and is complete when the Covered Person is discharged on medical advice from Inpatient care, Day Treatment or Outpatient Treatment without a lapse in treatment or when a person fails to materially comply with the treatment program for a period of thirty (30) days.

Serious Mental Illness: Defined as any one of the following eight (8) categories:

1. Schizophrenia;
2. Paranoid and other psychotic disorders;
3. Bipolar disorders (mixed, manic and depressive);
4. Major depressive disorders (single episode or recurrent);
5. Schizo-affective disorders (bipolar or depressive);
6. Pervasive developmental disorders;
7. Obsessive compulsive disorder; and
8. Depression in childhood and adolescence.

Skilled Nursing Facility/Extended Care Facility: An institution that:

1. Primarily provides skilled, as opposed to custodial, nursing services to patients; and
2. Is approved by the Joint Commission on the Accreditation of Health Care Organizations and/or Medicare.

Sleep Disorder: Medical/psychological condition that disrupts the patient's sleep on a chronic basis.

Speech Therapy: A program which evaluates the patient's motor-speech skills, expressive and receptive language skills, writing and reading skills, and determines if the patient requires an extensive hearing evaluation by an audiologist. The therapist also evaluates the patient's cognitive functioning, as well as his/her social interaction skills, such as the ability to maintain eye contact and initiate conversation. Therapy may also involve developing the patient's speech, listening and conversational skills and higher-level cognitive skills, such as understanding abstract thought, making decisions, sequencing, etc. Therapy must be considered medically appropriate even for patients who do not have apparent speech problems, but who do have deficits in higher-level language functioning as a result of trauma or identifiable organic Disease process.

Substance Abuse: The excessive use of a substance, especially alcohol or a Drug. The current edition of *Diagnostic and Statistical Manual of Mental Disorders* definition is applied as follows:

1. A maladaptive pattern of substance use leading to clinically significant impairment or distress, as manifested by one (or more) of the following, occurring within a twelve (12) month period:

    a. Recurrent substance use resulting in a failure to fulfill major role obligations at work, school or home (i.e., repeated absences or poor work performance related to substance use; substance-related absences, suspensions or expulsions from school; neglect of Children or household);

b. Recurrent substance use in situations in which it is physically hazardous (i.e., driving an automobile or operating a machine when impaired by substance use);
c. Recurrent substance-related legal problems (i.e., arrests for substance-related disorderly conduct); and
d. Continued substance use despite having persistent or recurrent social or interpersonal problems caused or exacerbated by the effects of the substance (i.e., arguments with spouse about consequences of intoxication, physical fights).

2. The symptoms have never met the criteria for Substance Dependence for this class of substance.

Substance Abuse Treatment Center: An Institution which provides a program for the treatment of Substance Abuse by means of a written treatment plan approved and monitored by a Physician. This Institution must be:

1. Affiliated with a Hospital under a contractual agreement with an established system for patient referral;
2. Accredited as such a Facility by the Joint Commission on Accreditation of Hospitals; or
3. Licensed, certified or approved as an alcohol or Substance Abuse treatment program or center by a State agency having legal authority to do so.

Substance Dependence: Substance use history which includes the following:

1. Substance Abuse (see above);
2. Continuation of use despite related problems;
3. Development of tolerance (more of the Drug is needed to achieve the same effect); and
4. Withdrawal symptoms.

Surgery: Any of the following:

1. The incision, excision, debridement or cauterization of any organ or part of the body, and the suturing of a wound;
2. The manipulative reduction of a fracture or dislocation or the manipulation of a joint including application of cast or traction;
3. The removal by endoscopic means of a stone or other foreign object from any part of the body or the diagnostic examination by endoscopic means of any part of the body;
4. The induction of artificial pneumothorax and the injection of sclerosing solutions;
5. Arthrodesis, paracentesis, arthrocentesis and all injections into the joints or bursa;
6. Obstetrical delivery and dilatation and curettage; or
7. Biopsy.

Surgical Procedure: Surgical Procedures will include all CPT (Current Procedural Terminology) codes from 10000 to 69999.

TEFRA: Tax Equity and Fiscal Responsibility Act of 1982, as amended from time to time.

Temporomandibular Joint (TMJ) Disorders: Disorders that affect the temporomandibular joints at either side of the jaw also known as myofascial pain-dysfunction syndrome.

Total Disability (Totally Disabled): A physical state of a Covered Person resulting from an Illness or Injury which wholly prevents:

1. An Employee from engaging in any and every business or occupation and from performing any and all work for compensation or profit; or
2. A Dependent or a COBRA Qualified Beneficiary from performing the normal activities of a person of that age and sex in good health.

UR Preauthorization: A Plan requirement for a Covered Person to advise Utilization Review of a Hospital admission, health care service, treatment plan, Prescription Drug or Durable Medical Equipment that results in a decision by the Plan that such service is Medically Necessary. The Plan may require notification for certain services as they are received, except in an Emergency. UR Preauthorization is not a guarantee the Plan will cover the cost of such services.

Urgent Care Facility (Minor Emergency Medical Clinic): A Freestanding Facility which is engaged primarily in providing minor Emergency and episodic medical care to a Covered Person. A board-certified Physician, a Registered Nurse (RN), and a registered x-ray technician must be in attendance at all times that the clinic is open. The clinic's Facilities must include x-ray and laboratory equipment and a life support system. For the purposes of this Benefit Booklet, a clinic meeting these requirements will be considered to be an Urgent Care Facility (Minor Emergency Medical Clinic), by whatever actual name it may be called; however, a clinic located on the premises of, or in conjunction with, or in any way made a part of, a regular Hospital shall be excluded from the terms of this definition.

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

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

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

The term "Usual and Customary" does not necessarily mean the actual charge made nor the specific service or supply furnished to a Plan Participant by a Provider of services or supplies, such as a Physician, therapist, Nurse, Hospital, or pharmacist. The Plan Administrator will determine the usual charge for any procedure, service, or supply, and whether a specific procedure, service or supply is customary.

Usual and Customary charges may, at the Plan Administrator's discretion, alternatively be determined and established by the Plan using normative data such as, but not limited to, Medicare cost to charge ratios, average wholesale price (AWP) for prescriptions and/or manufacturer's retail pricing (MRP) for supplies and devices.

For Claim determinations made in accordance with the Claim Review and Audit Program, the Usual and Customary fee will be the Allowable Claim Limits. Please refer to the section, "Claim Review and Audit Program," for the definition of Allowable Claim Limits.

Utilization Review (UR): Process by which consistent and measurable standards are applied in which to evaluate and control health care utilization by determining appropriateness of care, setting and Medical Necessity.

Utilization Review (UR) Company: Company providing consistent and measurable standards in which to evaluate and control health care utilization by determining appropriateness of care, setting and Medical Necessity. The Utilization Review Company's role is to ensure the best use of health care services, eliminating unnecessary costs while maintaining consideration for the patient's best interests.

Well Baby Care or Well Child Care: Medical treatment, services or supplies rendered to a Child, solely for the purpose of health maintenance and not for the treatment of an Illness or Injury, to include medical screenings for vision and hearing.